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Aggression and accountability: how caregivers and law enforcers cope

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Thèse présentée à la Faculté des Études Supérieures en vue de
l'obtention du grade de doctorat (Ph.D.) en criminologie

Févirer, 2015

Résumé

Objectif. L'objectif est de comprendre comment les intervenants en relation d'aide et les agents des forces de l'ordre composent avec la violence au travail et le stress lié à l'imputabilité. Un cadre théorique basé sur l'identité professionnelle est proposé afin de comprendre la modulation de la santé psychologique au travail et testé via le *Professional Quality of Life* des intervenants en protection de la jeunesse. Les facteurs de prédiction de la banalisation de la violence au travail et des impacts psychologiques de cette banalisation sont également étudiés.

Méthodologie. Un sondage mené auprès d'un échantillon représentatif constitué de 301 intervenants en protection de la jeunesse a permis d'examiner le *Professional Quality of Life*. Les effets de l'exposition à la violence en milieu de travail, à l'exposition au matériel traumatique et du stress lié à l'imputabilité sur la fatigue de compassion ont été analysés à l'aide d'équation structurelle. Les effets indirects attribuables au genre, au soutien organisationnel perçu, à l'adhésion à l'identité professionnelle, aux stratégies d'adaptation et à la confiance en ses moyens pour gérer un client agressif ont été mesurés. Pour l'examen des facteurs de prédiction de la banalisation de la violence au travail, les résultats d'un sondage mené auprès de 1141 intervenants en relation d'aide et des forces de l'ordre ont été analysés à l'aide de régression linéaire. L'analyse des réponses des 376 intervenants de cet échantillon ayant rapporté avoir été perturbé par un acte de violence au travail a permis de mesurer l'impact de la banalisation sur les conséquences psychologiques suite à une victimisation au

travail. Les effets indirects attribuables à la banalisation de la violence ont été mesurés. Des analyses différenciées en fonction du sexe ont également été menées.

Résultats. L'exposition à la violence, le sentiment d'imputabilité et l'évitement amplifiaient la fatigue de compassion chez les intervenants en protection de la jeunesse sondés. Les attitudes masculines, l'adhésion à l'identité professionnelle, la confiance en ses moyens pour gérer les clients agressifs l'atténuaient. Quant aux facteurs de prédiction de la banalisation de la violence au travail, les participants masculins étaient plus enclins que les femmes à la normaliser. Les agents des forces de l'ordre percevaient davantage la violence comme tabou que les intervenants en relation d'aide. Les facteurs organisationnels avaient tous un effet négatif sur le tabou entourant la violence au travail. Finalement, l'âge, les victimisations antérieures, les blessures graves et percevoir la violence au travail comme un tabou augmentaient le nombre de conséquences psychologiques suite à une victimisation. Les analyses différenciées en fonction du sexe ont identifié des facteurs de prédiction spécifiques aux hommes et aux femmes.

Implications. Lors de déploiement de stratégies organisationnelles afin d'aider les employés à gérer avec les stress liés au travail, les organisations doivent considérer l'identité professionnelle de leur travailleur ainsi que des différences en fonction du sexe et du genre.

Mots-clés : violence au travail, sentiment d'imputabilité, identité professionnelle, fatigue de compassion, satisfaction de compassion, intervenants en relation d'aide, agents des forces de

l’ordre, intervenants en protection de la jeunesse, banalisation de la violence au travail, santé psychologique au travail, intervention organisationnelle.

Abstract

Objective. The goal of this thesis is to understand how caregivers and law enforcers cope with workplace aggression and accountability. Relying on identity theory, a theoretical framework is put forth to understand mental health at work and examined through an adapted version of the *Professional Quality of Life* for child protection workers. Individual and organizational predictors of trivialization of workplace aggression are also investigated. The impact of trivializing workplace aggression on psychological wellbeing is assessed.

Method. To examine the *Professional Quality of Life*, a survey conducted among a representative sample of 301 Canadian child protection workers was utilized. The effects of exposure to workplace aggression, exposure to traumatic material and stress emanating from accountability on compassion satisfaction and fatigue were evaluated in a path analysis model. The indirect effects through gender roles, perceived organizational support, adherence to professional identity, coping ability and confidence in coping with patient aggression were also tested. To identify predictors of workplace aggression, responses to a survey research conducted among a convenience sample 1141 Canadian caregivers and law enforcers were computed in linear regression modeling. Using the same dataset but only selecting victims of workplace aggression resulting in a sub-sample of 376 Canadian caregivers and law enforcers, individual and organizational factors were used in path analysis modeling in order to predict psychological consequences. Normalizing and tabooing were introduced as intervening

variables. For the objectives regarding trivialization of workplace aggression, between group differences analyses were also conducted for women and men.

Findings. Exposure to workplace aggression, felt accountability and avoidant coping strategies increased compassion fatigue among child protection workers while masculine attitudes, adherence to professional identity and confidence in coping with client aggression decreased it. As for predictors of trivialization of workplace aggression, male respondents were more likely than women to think that workplace aggression was normal. Law enforcers were more likely than caregivers to taboo workplace aggression. Organizational factors were all significant negative predictors of tabooing violence. Finally, being older, prior direct victimization, injury requiring hospitalization and tabooing workplace aggression were positively associated with negative psychological consequences following workplace aggression victimization. Gender-based analyses revealed specific predictors for males (e.g. normalizing).

Implications. When developing and disseminating policies to help workers to cope with specific work-related stress, organizations must consider the "professional identity" promoted by the job as well as the gender of the workers. Adapted to these identities, they should sensitize workers on the impact of aggression and accountability in order to break the taboo while fostering strategies that dampen the impact of these stressors.

Keywords: workplace aggression, felt accountability, professional identity, compassion fatigue, compassion satisfaction, caregivers, law enforcers, child protection workers, trivialization of workplace aggression, mental health at work, organizational interventions.

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List of acronyms

BSRI:	Bem Sex-Role Inventory
CF:	Compassion fatigue
CONF:	Clinician confidence in coping with patient aggression instrument
CS:	Compassion satisfaction
FA:	Felt Accountability
PI:	Professional identity
PIS:	Professional Identity Scale
POPAS:	Perception of Prevalence of Aggression Scale
POS:	Perception of Organizational Support
ProQol:	Professional Quality of Life
PTSD:	Post-traumatic stress disorder
WCQ:	Ways Of Coping Questionnaire

À ma mère, ma brioche, mes enfants

Et

À tous les aidants

Acknowledgments

The realization and success of this research project were possible mainly because mentors, partners, collaborators, teachers and family members supported me throughout this entire enterprise. I want to acknowledge their special contribution to this thesis and to my career shift.

Batman - Turning point 1

My first thank you goes to someone who has become more than just a friend in the past few years: Frederic Ouellet aka Batman. On a cold night at the Benelux (a microbrewery in Montreal), I was about to give him and Rémi Boivin unique data I had collected in a Montreal barroom for their new positions as professors at the School of Criminology of Université de Montréal. For me, this gift was also a way of saying goodbye to my dream of being a scholar. At this time, I was quite comfortable in my job as a child protection worker and was projecting to become a leading clinician in this field. However, instead of just taking the data, Frederic convinced me to write a paper with them and present it at the next *American Society of Criminology* annual meeting. This is where it all began! Not only did it become the first turning point in my career, but it also allowed me to renew with research. Since then, Frederic has supported me throughout my goal of pursuing an academic career. His reading of my work, his advice, his listening and his wise words have given me confidence in my scholarly skills while making me realize that I was indeed passionate about research. Moreover, his friendship and loyalty have even surpassed all of his academic support! Frederic, we both

know that this is just the beginning of a career partnership. Thank you for everything Dark Knight!

An innocent poster at the ASC – Turning point 2

After this night at the Benelux, Frederic and Remi helped me put together the poster. They even offered to share their hotel room at the ASC meeting. So, I arrived in Washington one hour before the poster session, pinned the poster and was already asked questions about it. Suddenly, a man came to me saying that he really wanted to see this poster. I looked at his nametag and I was shocked: Marcus Felson! He was interested at my work? Honored, I did my best to explain, in poor English, that I applied his theory to a microlevel setting: the barroom. Busy, as he had to see other posters, but clearly excited, he left me an office card telling me he really wanted to discuss with me. A month later, I decided to answer the call without knowing how much this would help my new career. Another month later, a paper with Felson was almost drafted. Thus, Marcus became a second mentor in this enterprise.

Since then, he never stopped advising me as if I were his protégé; generously sharing tricks of the trade, explaining the harsh world of publication and rejection (of one paper in particular), providing letters of reference and advertising my work to his colleagues. All that, without ever asking for anything in return and always giving me full credit for our work. Having such a mentor is something that few can benefit from. I will always be grateful to this man! And Marcus, trust me, I will return that precious support in time.

A lunch with Carlo

Carlo Morselli is another important mentor that helped me ever since I decided to come back to graduate studies and leave my clinical practice aside. A month before beginning my Ph.D. studies, I had lunch with Carlo and other professors of the School of Criminology. Carlo was skeptic about my return to graduate studies. Recognizing my skills as a lecturer at the school, he challenged me to finish the Ph.D. However, this was not just *Italian bravado*; it came with a precious advice: "Steve, what do you need in a director? A friend or someone who would put a gun to your head requesting rigor, commitment and productivity?" He was right; I needed a director that would pressure me to be productive. The next day I requested direction from Stéphane Guay.

However, Carlo's support did not end there. In his Ph.D. class he successfully challenged me to develop the theoretical aspects of my thesis. As the lector will realize, he is second author to my theoretical article. He also guided me through the politics of academia while reinforcing my confidence in my scholarly skills. *Grazie Mile*!

The director – Turning point 3

Following Carlo's advice, I sought direction from Stéphane Guay. I did not know the man apart from two facts. First, he is demanding. Second, he is an expert on the study of trauma, being the director of the Trauma Studies Center at the Institut Universitaire en Santé Mentale de Montréal. His first answer destabilized me. He did not automatically accept me as his Ph.D. student but, as I was expecting, needed convincing. Instead, I had to send him my CV, report cards and an example of a paper. That was exactly what my ego needed at this particular time!

Thus, the first year allowed me to considerably develop my adaptation skills. Involving me rapidly in his research team, I had to find my place in a world of psychologists, which I was not accustomed to. This work environment, Stéphane's directorship, his implication in my data collection, the way he challenged my ideas, his comments on my writing, and his recommendations, speeded up my learning curve as a scholar significantly. All this support and mentoring allowed me to obtain my first scholarship. With this funding, I took an unpaid leave to speed up the process of my thesis. With his supervision, I wrote 3 papers in 6 months, got 2 other scholarships, participated in collaborations with other researchers and became Assistant to the Scientific Direction of the Trauma Studies Center. Without all the resources he gave me, I never could have achieved this much by myself.

There is no doubt that, in my career, I met remarkable people and that, without their support, my path would not have been as successful. Stéphane, not only was your teaching a huge turning point in my career, but with you, the student I was became the researcher I am now. Your advice, your rigor, and most of all, your trust, will be a solid foundation to build a practice that will be imprinted by your contributions. I wish therefore to remain active with you at the Trauma Studies Center and hope that our collaboration will only extend in the coming years. There is a saying that the « greatest good you can do for another is not just share your riches, but to reveal to him his own ». This couldn't translate more to what you have given me. Merci infiniment!

The VISAGE research team and the Trauma Studies Center

Being a part of a research team such as the Trauma Studies Center is a privilege and a career booster. I will forever be grateful to all the members of this team for their support and

contributions. Thank you Isabelle Bernier, Rachel Carrier, Jane Goncalves and Josette Sader, my MVP. Also, a special tribute to Christophe Fortin and our philosophical discussions on the academic path that helped me realize what I truly wanted for the coming years! Merci à vous!

Centre Jeunesse de la Montérégie

Another part of the merit of this thesis goes to the Centre Jeunesse de la Montérégie. First, Mario Morissette, I must thank you for your support as a respondent in the research but especially, for your teaching on political skills. Your interest and support made the knowledge transfer of this research possible. Also, I must thank the Board of Directors who fostered this research and showed great openness towards this delicate subject. Here, special thanks go to Catherine Lemay, Chantal Beauregard and Marie-Josée Audette, who were, from my point of view, the three main supporters of this project. I also want to thank Geneviève Mercier for introducing me to the right people. Finally, I am grateful to Myriam Morin who revealed herself as my professional alter ego and has significantly contributed to the realization of the knowledge transfer. Merci à vous!

Université de Montréal

There have also been many colleagues from UdeM who directly and indirectly contributed to this project. I am therefore grateful to Samuel Tanner and to his instructive and helpful class on epistemology. Thanks to Jean-Pierre Guay who gave me my first chance to come back on the Ph.D. track. Thanks to Rémi Boivin aka Bovin for his collaborations and for having introduced me to SEM. Thanks to Chloé Leclerc aka Cholé who provided moral support and has become a friend. Thank you to Isabelle Daignault who was the president of

my synthesis exam. Thanks to Isabelle Ouellet-Morin who crosschecked my path analysis. Thanks to Amélie Couvrette for her support and with whom I will pursue my research questions but with a qualitative methodology. Thanks to Marie-Pierre Robitaille for our conversations on the Ph.D. process. Thank you also for her revisions and comments that were really helpful. And finally, thanks to my Ph.D. colleagues, Maxime, Catherine and Massil for the two seminars together. Your questions and interest in my project clearly enhanced my work!

Funding

This thesis was also supported by scholarship awards that allowed me to take an unpaid leave from my position as a head of readaptation unit at the Centre Jeunesse de la Montérégie. Therefore, I am grateful to the Fonds de la Recherche du Québec - Société et culture (FRQSC) for their doctoral scholarship. I am also grateful to the Institut de recherche Robert-Sauvé en santé et sécurité au travail (IRSST) for its doctoral scholarship supplement. I am grateful to the Trauma Studies Center of the Institut Universitaire en Santé Mentale de Montréal that gave me my first scholarship, which helped me get all of the others, and for the subsequent supplement they offered me. I am grateful to International Center for Comparative Criminology for the Research and Society Scholarship, Doctoral dissertation scholarship and Conference scholarship. I am grateful to the Institut Universitaire en santé mentale de Montréal Foundation for their Scholarship for academic excellence. Finally, I am grateful to the School of Criminology of the Université de Montréal for their conference scholarships.

Dissertation committee

Thanks are owed to the two members of my dissertation committee who have not been acknowledged yet. First, I must thank Denis Lafortune who accepted to be the president of this committee. His encouragement throughout the process has been helpful and I will always be grateful for his wise comments on my project. I must also acknowledge that his amazing pedagogic skills will always inspire my own lectures and that he will always represent a teaching model for me to rely on. Second, I must thank Peter Smith that accepted to be the external judge and with whom collaborations are awaiting. I must also thank Mr. Smith for offering this very appreciated post-doc opportunity.

Friends

Of course, friends accompany you along the way of such projects. My first thank you here goes to Alexis Despins. Teaching me Fly Fishing was the best gift he could have ever given me. I found a second passion in this sport that is complementary to research. Alexis, you have no idea how taking me outside by the river helped me cope with daily stress and reminded me how life is good! Another thank is owed to Sébastien Sauvé who may be the best critic I will ever have. Sébastien, thank you for all your advice and criticism over the past 15 years. In your own way, you have contributed significantly to this enterprise! Thank you also to David Poncelet who has been like a brother to me for the past 20 years.

Maman

Mother, if you ever thought that the rigorous and draconian methods of creating lessons for me when I was in elementary school might have traumatized me, we do not doubt

it anymore. If I am here today, it is only because of you. You taught me discipline, commitment and professionalism throughout all these years and made me successful today. The unconditional love you gave me protected me from the adversity of our lives and propelled me forward. My recent accomplishments could not have been done without your support and belief in me! Merci Maman, je n'aurai jamais assez de mots pour t'exprimer ma reconnaissance et m'excuser de certains moments plus sombres. Maman, pomme, p-o-m-m-e!

Ma brioche

Of course, all of this would not have been possible if my beloved "brioche" were not there to accompany me on this new path and throughout my career shift. All along, you believed in me and helped me believe in myself when I had doubts. As you know "ma brioche", you have enriched my life since the first day I met you. Not only did you give me back my joy of living that I had lost, but you also allowed me to experience true love that helped me cope with life's adversities. Thank you for being by my side!

Liam & Tessa

If you ever read this manuscript Liam & Tessa, you will finally understand what I was doing when you were 8 and 3 years old, acknowledging that I was always on my computer. Liam & Tessa, you are my greatest teachers! You helped me focus on priorities and remember that life should include "pleasure time". Both of you are unique and intelligent and you are the most important things in my life. I love you and thank you for being extraordinary children!

Foreword

I now cumulated more than 8 years of clinical experience as a child protection worker for the Youth Center of Monteregie. Whether as an educator, a human relation agent specialized in the assessment of reports to the DYP or as the head of a readaptation unit for young delinquents, I have been exposed to several potentially traumatic events. An eleven-year-old fractured the pelvis of a colleague who wanted to tuck him. A young boy tried to drown another one in front of me. My car was vandalized, etc. With this experience, I realized quickly that helping relationship in authoritarian setting requires great emotional and psychological availability.

Early in my clinical career, I thought I was managing well the inherent adversity of this work at the DYP. However, over time I became irritable, cynical, aggressive and I did not have any patience with my own children. In talking with my colleagues, I learned that many also experienced negative outcomes link to this profession: recurrent miscarriages, insomnia, intrusive thoughts, hypervigilance, drinking regularly, etc.

Overwhelmed by these work-related stresses, I sought counselling to redefine my role as a child protection worker. At that time I did not understand why I was so affected by the work. In the past, I had worked as a bouncer and never reacted negatively to aggression exposure. Moreover, none of my colleagues had reported psychological distress because of their victimization. What was happening?

But then, I realized something that made me understood my condition. In the world of bars, the atmosphere is festive. Aggression is circumstantial and does not really impact the life of the belligerents In child protection work, kids and parents are "polytraumatized". Children

act and express daily the consequences of the atrocities they have experienced. Parents and families, ask the impossible to the child workers: to “repair” the youth. When they do not express explicitly this wish, they develop conflictual relations with the child workers often leading to aggression. The atmosphere is then stained by the suffering of clients.

This daily exposure to the sufferings of others is difficult to manage. Whether by the evidence, the report read or by interviews with the clientele, child protection workers know every abuse gestures that were perpetrated over their young clients. Although at times their actions result in little miracles and make a difference in the daily life of young victims, their work is more marked by the sufferings of youths and their families. Moreover, by the clientele’s difficulty to initiate or participate in change resistance to change of the clientele.

The inherent adversity of child protection work does not end there. Indeed, workers are accountable for the decisions they make. For example, it happens regularly that a sexual assault victim is maintained in the same household as the aggressor. Sometimes, leave permission may be granted to a teenager who displays a high suicide risk. If something wrong happens during this permission of between the victim and its aggressor maintained in the same household, the child protection worker is partly responsible for this misfortune and must justify his or her clinical decisions; to parents, to his or her superiors, to his or her colleagues, to the judge of the Youth Court, and even in the public square. And if such a tragedy occurs, how will he or she live with the consequences of his or her decisions?

The objective of this preface was not to draw a dark picture of the DYP. It was more to illustrate how caregivers such as child protection workers can be affected by their work. It was also a way to tell how the research question this thesis addressed came to me; by lived experience. Still, we do not have to be discouraged. The vast majority of caregivers are able to

keep a healthy psychological state that allow them to offer adequate caring services. For my part, I had to adjust my expectations in order to live more therapeutic success. In fact, I now respect their pace rather than impose my own. My need to “save” the children turned into an ability to support them in adversity.

So I believe that it is imperative to further investigation on the processes that allows caregivers as well as law enforcers, to cope with adversity inherent to their profession. If we understand how they manage and maintain psychological balance, then we can help those in distress. By doing so, we will ensure optimal quality of services offered to their clientele.

Chapter 1 – Introduction

"Professional identity" plays a significant role in mental health in the workplace. Derived from social interactions, it acts as a subjective framework that can either protect workers or precipitate psychological distress (Kelchtermans, 1999; Thoits, 1999). The identity and mental health of caregivers (e.g. those working in health care services, social work, child protection work, etc.) and law enforcers (e.g. police officers, security agents, rangers, law officials, etc.) are often negatively affected by the inherent adversity of their work. On a daily basis, they must deal with the aggressive behaviors of their clientele, all while being exposed to stories of trauma, abuse, neglect, violence and other cruelties (Guay, Goncalves, & Jarvis, 2014; Kassam-Adams, 1995; Koritsas, Coles, & Boyle, 2010; Lanctôt & Guay, 2014; Littlechild, 2005; Macdonald & Sirotich, 2005; Schauben & Frazier, 1995). As such, caregivers and law enforcers are the two professions in which workers are most often exposed to workplace aggression (Jackson, Clare, & Mannix, 2002; McCarty, Zhao, & Garland, 2007). In addition, these workers are held accountable for the professional decisions they make in the course of their duties (Osofsky, Putnam, & Lederman, 2008). Providing public service can then become a burden for caregivers and law enforcers since the problems they encounter are complex, and their clients often have difficulty in their interpersonal relationships and face situations that are highly emotional (Strozier & Evans, 1998). Thus, this thesis focuses on how caregivers and law enforcers cope with workplace aggression, exposure to traumatic material, and how they experience accountability.

The literature is comprised of many studies that demonstrate the negative outcomes of exposure to such work-related stressors. Among the most reported consequences experienced

by caregivers and law enforcers are burnout, compassion fatigue, turnover, post-traumatic stress disorder (PTSD), loss of empathy, poor service delivery, depression, anxiety, psychosomatic disorder and absenteeism (Aquino & Thau, 2009; Arnetz & Arnetz, 2001; Barling, 1996; Brown, Fielding, & Grover, 1999; Chapman, Perry, Styles, & Combs, 2009; C. R. Figley, 1995; He, Zhao, & Archbold, 2002; Jackson et al., 2002; Lanctôt & Guay, 2014; Lonne, 2003; Maslach & Jackson, 1982; Pich, Hazelton, Sundin, & Kable, 2011; Piquero, Piquero, Craig, & Clipper, 2013; Wilson, Douglas, & Lyon, 2011). According to the most influential researchers in this field, these consequences are inevitable; they are the "costs of caring" (Figley, 1982; Herman, 1992, Masclach & Jackson, 1982; McCann & Pearlman, 1990).

These work-related stressors impact organizations as well as workers. Physically injured workers, psychologically disturbed workers, interrupted therapeutic treatment, increases in the cost of operations and decreased credibility of the organization are all examples of the consequences that institutions may face (Barak, Nissly, & Levin, 2001; Cooke, 1992; Porporino, 1986; Taylor, Beckett, & McKeigue, 2008). Absenteeism and increased sick leave have also been identified as problematic, given that they generate staff instability and serve to diminish the quality of service delivery (Arnetz & Arnetz, 2001). For instance, from 2009 to 2012 in Quebec, compensation for employees on sick leave due to work-related psychological distress cost between 11 to 13 million dollars annually (Québec, 2014). Moreover, according to data from the *Commission Santé et Sécurité au travail du Québec* (2014), the work-related stressors most often responsible for the psychological distress leading to sick leave were exposure to a potentially traumatic event, armed threat, verbal threat, and assault. Thus, the consequences of workplace aggression and felt accountability

experienced by caregivers and law enforcers negatively affect individuals as well as organizations.

In contrast with the deterministic approach regarding the effects of workplace stressors, Kadambi and Truscott (2004) found that less than 5% of caregivers in their study reported burnout or post-traumatic stress disorder, demonstrating that the majority of these workers seemed to manage the adversity inherent in their work. Furthermore, some researchers have argued that helping others in professional contexts, regardless of the violence and stress, may provide positive outcomes such as pleasure in one's work and a sense of contributing to society, a sentiment referred to as compassion satisfaction (Lonne, 2003; Stamm, 2009). For instance, Stamm (2005) proposed the *Professional Quality of Life* model, which describes compassion satisfaction and compassion fatigue as possible outcomes of stress related to caregiving. Thus, it is possible for caregivers and law enforcers to learn to effectively cope with violence and accountability. Identifying factors that dampen or mitigate the impacts of work-related stressors could then benefit those who are unable to manage such adversity. This thesis is preoccupied with a topic that affects employees as much as employers.

The study of the mental health of caregivers and law enforcers is still in its infancy. Consequently, support provided to these workers is not optimal, even insufficient in some cases. It is thus imperative for researchers to gain a better understanding of the psychological consequences of workplace aggression, exposure to traumatic material and the stress caused by felt accountability. If we understand how some caregivers and law enforcers manage to maintain adequate mental health, thereby allowing them to continue providing decent services, we could prevent the development of psychological distress and help those coping with distress. Moreover, an examination of organizational strategies designed to counter violence

may provide useful information to help workers cope with the inherent adversity of their work. With this knowledge, organizations could better support their employees while they, at the individual level, could adopt behaviors that help them manage the stressors specific to their work. Overall, this would improve prevention as well as post-intervention strategies while promoting evidence-based practices.

1.1 The current thesis

The main aim of the present thesis is to identify individual and organizational factors that allow caregivers and law enforcers to cope with the inherent adversity of their work. The first objective is presented in the fourth chapter. Expanding on the work of Figley and Stamm, a theoretical framework that encompasses workplace aggression, exposure to traumatic material, felt accountability, as well as compassion satisfaction and compassion fatigue is proposed. It is argued that the integration of identity theory into the compassion fatigue model (Figley, 1995) adds a subjective perspective. This allows for the consideration of individual and organizational influence, while assessing the psychological impact of workplace aggression, exposure to traumatic material, and felt accountability. In other words, it proposes to introduce a new stressor (i.e. felt accountability) and considers intervening variables in the existing model.

Derived from this proposed theoretical framework, the second objective is presented and addressed in the fifth chapter, and consists of a quantitative examination of an adapted version of the *Professional Quality of Life* model (Stamm, 2009). Empirically tested among a representative sample of child protection workers, the model is adapted by introducing stressors and intervening variables specific to child protection work. Thus, felt accountability

is empirically tested as a predictor of compassion satisfaction and fatigue. Furthermore, gender roles, perceived organizational support, adhesion to a professional identity, coping strategies, and confidence in coping with aggression are included as intervening variables in the adapted model.

Still relying on identity theory, the third objective, corresponding to the sixth chapter, is to investigate how individual (i.e. gender, age, exposure to violence) and organizational factors (i.e. violence prevention training, support from colleagues and supervisors, 'zero tolerance' management policy and safe physical environment) influence perceptions of workplace aggression. More specifically, the goal is to identify among these factors those that predict the trivialization of workplace aggression, which is referred to as the normalization or tabooing of workplace aggression. Using a convenience sample of caregivers and law enforcers, analyses first included gender and were then conducted separately for men and women in order to assess gender differences in predictors of trivialization.

The fourth objective, which is presented in chapter nine, is to assess the gender differentiated impact of the trivialization of workplace aggression on the psychological consequences experienced by workers who have been exposed to a severe violent act. Relying on a sub-sample of only victims extracted from the previous study, individual and organizational factors are used as predictors of psychological consequences, while normalizing and tabooing are treated as intervening variables. Once again, analyses are performed separately for men and women to assess gender differences.

Overall, this thesis provides an analysis of the mental health of individuals working in sectors characterized by a high risk of workplace aggression and who are accountable for their decisions. Depending on their individual characteristics and the organizational strategies

present in their work environment to help workers cope with work-related stress, predictors of psychological distress and well-being are investigated. Therefore, perceptions and factors that allow workers to maintain adequate mental health are identified, and it is recommended that an understanding of how these factors influence mental health outcomes be promoted within organizations.

Given that studies on stress and gender have shown that men and women perceive and experience their occupational stressors differently (Barnett, Biener, & Baruch, 1987; Johnson, Greaves, & Repta, 2007; Wells, Colbert, & Slate, 2006), this thesis serves to compliment such findings. The underlying hypothesis of the four objectives is that professional identity modulates the mental health of caregivers and law enforcers by influencing their appraisal of work-related stressors. Consistent with the mandate of responding to occupational expectations, it permits the individual to properly deal with the inherent adversity of the work. Thus, the acknowledgements of professional identify in the relationship between workplace stressors and mental health permits the individual to properly deal with the inherent adversity of their work. In contrast to the mission of the profession, however, a misinterpretation of the expected roles and attitudes of the worker, or trespassing the boundary of the work, may amplify the negative consequences of such high-risk work.

1.2 The theoretical framework

This thesis relies on the construct of professional identity in considering the impact of meaning and identity on the mental health consequences that arise as a result of workplace stress/stress at work of caregivers and law enforcers. Compassion fatigue, *Professional Quality of Life* and post-traumatic stress are key mental health outcomes to evaluate in

participants. Exposure to workplace aggression and felt accountability will be the main stressors appraised in the understanding of mental health at work. These concepts are presented briefly in the subsequent section.

1.2.1 Professional identity

Public service professions, such as caregiving and law enforcement, involve constant interaction with individuals who have a wide array of needs and demands (Hawkins, 2001). As such, the inherent adversity of this type of work occurs in micro situations, more precisely within the meaning that participants assign to situations. An individual will appraise what is happening and subjectively define the situation according to the professional nature of the interaction. In other words, caregivers and law enforcers interpret work-related stressful situations, and then act according to these interpretations. The meaning given to these stressors are thus pivotal in the experience of distress in a given work environment (Dewe, 1991, 1992; Eden, 1990; Large & Marcusson, 2000; Marsella, 1994; Dick, 2000). Influenced by identity, the meaning attributed to the stressor can serve to either dampen or amplify its impact on the individual (Thoits, 1999). Therefore, the individual has the capacity to frame his or her interpretation of the situation in order to maintain mental well-being.

Having taken root in Mead's (1934) symbolic interactionism, professional identity refers to a system of meaning associated with the worker's role (Skorikov & Vondracek, 2011). Shaped through professional socialization, it encompasses the worker's past experiences, the occupational culture, as well as the influence of organization (Dick, 2000; Åkerström, 2002). It guides the way in which workers think, act and interact in their professional setting (Fagermoen, 1997). In other words, professional identity provides a

certain meaning specific to a profession and a work environment that a worker can adapt to him or herself in order to define a work-related situation.

Since the majority of studies on mental health at work have focused on the correlations between work-related stress and workers' psychological distress (Alderson, 2004), this thesis proposes a new approach to this problem. Instead of relying exclusively on environmental factors and objectively treating the problem, an understanding of professional identity allows for the individual experience of work-related stress to be considered as a subjective process. Thus, this perspective provides a more in-depth understanding of workers' psychological distress, while improving upon existing practices that help caregivers and law enforcers cope with the inherent adversity of their work.

1.2.2 Compassion fatigue

Compassion fatigue refers to the cumulative psychological effect of working with survivors of trauma, or perpetrators of violence and crime, as part of everyday work (Osofsky et al. 2008, p.91). Caused by an excessive accumulation of primary, secondary and vicarious traumatic stress (Figley, 1995), compassion fatigue may jeopardize a worker's professional sense of self while negatively impacting his or her psychological well-being (Craig & Sprang, 2010). Research has demonstrated that compassion fatigue has a wide array of cognitive, emotional and behavioral impacts on the worker, in a way that mirrors the symptomatology observed in PTSD and burnout (Berzoff & Kita, 2010; Figley & Stamm, 1996; Stamm, 2010). Indeed, many studies have shown that providing social support and care can profoundly change a worker's personal and professional identity (Figley, 2002; Jenkins & Baird, 2002; Kadambi & Truscott, 2004; McCann & Pearlman, 1990).

In this model, exposure to workplace aggression may be associated with primary and secondary traumatic stress whether the worker is a direct victim or a witness to the event. Conversely, caregivers' and law enforcers' repetitive exposure to traumatic material, such as clients' histories of abuse and violence, may lead to vicarious traumatic stress. Compassion fatigue is a reaction to this exposure that builds up over time and arises from the worker's overexposure to human suffering. As described by the first objective, it is argued in this thesis that the stress emanating from felt accountability (e.g., "I often have to explain why I do certain things at work") should be added as a fourth causal stressor to Figley (1995) compassion fatigue model when studying caregivers' and law enforcers' mental health.

1.2.3 Professional Quality of Life

Given that compassion fatigue is not the only outcome related to providing public services, Stamm (2009) proposed a model that reframes Figley (1995) compassion fatigue model by adding compassion satisfaction as an alternative outcome. Thus, the *Professional Quality of Life* model refers to the quality of work one feels they accomplish, and encompasses characteristics of the work environment (organizationally and according to particular tasks) as well as the characteristics of the worker and their exposure to potentially traumatic situations. As described by the second objective, this thesis will provide a quantitative examination of this new model, which accounts for felt accountability as well as intervening variables such as gender, support and coping strategies, which are known to be correlated with compassion satisfaction and fatigue.

1.2.4 Post-traumatic stress

Based on the DSM-IV symptoms of PTSD, post-traumatic stress reactions were assessed in order to evaluate the effects of the trivialization of workplace aggression, as outlined in the fourth objective. The main symptoms used to measure the impact of trivialization on the mental health of caregivers and law enforcers are: flashbacks, nightmares related to the event, avoiding elements that arouse recollection of the event, guilt, irritability, loss of interest in pleasurable or important activities, sleep problems, hypervigilance and problems concentrating.

1.2.5 Exposure to workplace aggression

In this thesis, workplace aggression will refer to type I and type II violence. Type I violence is most likely to occur when a worker has direct public contact and is being assaulted by a criminal outsider (Merchant & Lundell, 2001). In this thesis, this Type I violence applies to law enforcers. Type II violence occurs when a customer, client or patient manifests aggressive behavior while being served by the service provider (Merchant & Lundell, 2001). The term "workplace aggression" will also be used instead of workplace violence, as it encompasses physical assault (violence), threats of assault, and psychological aggression (Barling, Dupré, & Kelloway, 2009). Thus, workplace aggression is defined as "any behavior intended to harm an individual in an organization" (Dupré & Barling, 2006, p.19).

1.2.6 Felt accountability

Felt accountability refers to caregivers' and law enforcers' personal liability concerning their professional decisions and actions (Osofsky et al., 2008). Given that

accountability for decision-making and risk management adds to the complexity of providing public services (Bennett, Evans & Tattersall, 1993; Dollard, Winefield & Winefield, 2001; McLean & Andrew, 1999), it may represent another cause of stress for workers. Both caregivers and law enforcers must abide by codes of conduct and laws that guide their decisions and make them accountable for their professional actions. If their decisions result in serious consequences for the client they may feel personally affected by the event, in addition to having to justify their decisions to some authority. It is argued in this thesis that the additional stressor of felt accountability should be incorporated into our understanding of the mental health of caregivers and law enforcers, as this factor is currently absent from the compassion fatigue and *Professional Quality of Life* models.

1.3 Chapter contents

The four objectives of this thesis are addressed in four different articles. Prior to the presentation of these articles, a review of the literature on compassion fatigue, *Professional Quality of Life*, workplace aggression and felt accountability will be presented in the second chapter. Even if the specific methods for each article will be detailed in their respective chapters, the whole method of this thesis will be presented in the third chapter. Chapters four to seven are the four articles. In conclusion, chapter eight summarizes and expands upon the findings of each article.

Corresponding to the main chapters of the thesis, four articles have been submitted to different peer-reviewed journals. Regarding the first objective, an article entitled *Rethinking Compassion Fatigue Through the Lens of Professional Identity* (Geoffrion, Morselli & Guay) was published in the Journal of Trauma, Violence and Abuse in May 2015. The article

addressing the second objective, *Towards an integrated and adapted model of compassion fatigue: a quantitative examination of the Professional Quality of Life model of child protection workers* (Geoffrion & Guay), was submitted to the Journal Applied Psychology in January 2015. As for the third objective, the article *Predictors of trivialization of violence among caregivers and law enforcers* (Geoffrion, Lanctôt, Marchand, Boyer & Guay) was submitted in September 2014 to the Journal of Threat Assessment and Management. Finally, corresponding to the fourth objective, the article entitled *Psychological Consequences of Trivialization of Workplace Aggression: Is Gender an Issue?* (Geoffrion, Lanctôt, Boyer, Marchand & Guay) was submitted in January 2015 to the journal Work and Stress.

For all the articles, the author of the present thesis has designed the research, collected data, analyzed it, interpreted it, drafted the manuscript and then edited it based on coauthors and blind reviewers' comments. For all articles, coauthors have helped with the structuring of the manuscript, read and approved the final manuscript.

Chapter 2 - Review of the literature

In this chapter, a review of the literature regarding the key concepts of this thesis is presented. Workplace aggression, exposure to traumatic material and felt accountability will first be addressed. For each of these stressors, their magnitude in caregiving and law enforcement settings will be reported. Next, the psychological consequences associated to these work-related stressors are articulated mainly around the concepts of compassion fatigue, compassion satisfaction and post-traumatic stress disorder (PTSD). Present in the four articles, the notion of gender will finally be discussed, setting the premise for gender-differentiated analysis. Since these concepts and the studies that have contributed to their evolution are also covered in the different articles, this chapter will only provide information that guided the conceptualization of these studies.

2.1 Work-related stressors assessed in this thesis

2.1.1 Workplace aggression

Workplace aggression is a major concern in Western countries due to its high prevalence and its various consequences on both individuals and societies. Defined as "any behavior intended to harm an individual in an organization" (Dupré & Barling, 2006, p.19), it encompasses physical assault (violence), threats of assault and psychological aggression (Barling, Dupré, & Kelloway, 2009). Thus, it can manifest itself in different forms: physical assault, homicide, verbal abuse, bullying/mobbing, as well as sexual, racial, and psychological harassment (D. Chappell & V. Di Martino, 2006).

This thesis focuses on Type I and Type II violence. Type I violence is most likely to occur when a worker has direct public contact and is being assaulted by a criminal outsider (Merchant & Lundell, 2001). In this thesis, this Type I violence applies to law enforcers. Type II violence occurs when a customer, client or patient manifests aggressive behavior while being served by the service provider (Merchant & Lundell, 2001). In this thesis, it therefore refers to workplace aggression experienced by caregivers. According to several studies, caregivers (including healthcare workers and social services workers) and law enforcers are among the most frequent victims of these two types of aggression (Brown, Fielding, & Grover, 1999; Chen et al., 2010; De Léséleuc, 2007; Foley & Rauser, 2012; Jayaratne, Croxton, & Mattison, 2004; Konda, Reichard, & Tiesman, 2012; Littlechild, 2005; Macdonald & Sirotich, 2005; Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001; Shin, 2011; Wells, Colbert, & Slate, 2006). In their systematic review of the literature on workplace aggression, Piquero, Piquero, Craig, and Clipper (2013) stated that workers within the healthcare, education, public safety, retail and justice industries are more prone to experience workplace violence. Similarly, Duncan Chappell and Vittorio Di Martino (2006) stated that several sectors are particularly at risk, namely those of healthcare workers (caregivers) and law officials (law enforcers). The commonality of these at-risk sectors is contact with the public. According to these authors (2006), workers who often interact with the general public are more likely to come across intoxicated individuals or people with a history of violence or psychological issues.

2.1.1.1 Prevalence

In a systematic review of the literature on the consequences of workplace aggression, Lanctôt and Guay (2014) found that prevalence estimates of workplace aggression incidents vary from one study to another. The type of violence measured, the employment sector, the country in which the study was conducted, as well as the definition and measurement of aggression all influenced the assessment of the prevalence of workplace aggression. In the U.S., the most recent study on prevalence of workplace aggression indicates that 4 violent crimes per 1 000 employed persons was perpetrated each year while the victims were working (Harrell, 2011). In European countries, one-year prevalence of physical violence in the workplace was about 5% (Parent-Thirion, Macias, Hurley, & Vermeylen, 2007). Workplace violence is also a significant problem in Canada since it represents 17% of all self-reported incidents of violent victimization, accounting for more than 350 000 acts of violence per year across the country within a single year (De Léséleuc, 2007). Therefore, numerous studies tried to ken the extent of workplace aggression in caregiving and law enforcement settings, but percentages vary greatly from one study to another (Jayaratne et al., 2004; Koritsas, Coles, & Boyle, 2010; Ringstad, 2005).

Piquero et al. (2013) indicated that between 7% and 83% of healthcare workers had been victimized by violent acts. According to Elliott (1997), healthcare workers are 16 times more at risk of experiencing violence from patients or clients than other service workers. According to De Léséleuc (2007), 33% of all the workplace aggression reported in Canada in 2004 occurred in healthcare settings (in Canada, healthcare includes social services). Similarly, the *Commission de la Santé et de la Sécurité du Travail du Québec* (CSST, 2014)

reported that healthcare workers were the most affected by injuries due to workplace aggression with 33 % of accepted compensation claim for this type of lesion in 2012.

Studies on the prevalence of workplace aggression in law enforcement settings also revealed high prevalence of this issue (Brown et al., 1999; Dick, 2000; McCarty, Zhao, & Garland, 2007; Wells et al., 2006). After all, managing aggressive behaviors is part of the routine and mandate of law enforcers; on a daily basis, they have to deal with violent situations and pacify belligerents. Thus, Leino, Selin, Summala, and Virtanen (2011) reported that 73% of police officers experienced workplace violence, and 18% were exposed to threats or assaults with a deadly weapon.

In child protection settings, Geoffrion and Ouellet (2013) found that 53.9% of the educators working in Quebec juvenile facilities were victims of physical assaults by a client in the year prior to their study. In this vein, Shin (2011) have demonstrated that the prevalence of this phenomenon may range from 25% to 97% in the field of social work.

In sum, comparing estimates of workplace aggression is a complex task due to methodological differences across studies, especially regarding the type of violence measured and time period considered. Despite the inexactitude of these assessments, it is clear that workplace aggression is a problem for caregivers and law enforcers, not only because of its high prevalence, but especially because of its impact on workers.

2.1.1.2 Consequences

Workplace aggression has multiple consequences. On the individual level, it negatively affects the physical and psychological health of the victim (Hogh & Viitasara, 2005; Lanctôt &

Guay, 2014). More broadly, Steffgen (2008) pointed out that the consequences of workplace aggression also affect the organization employing the worker and society as a whole. However, this study is focused on individual psychological consequences.

In this vein, several studies have found statistically significant associations between exposure to workplace aggression and psychological problems (AbuAlRub & Al-Asmar, 2011; Arnetz & Arnetz, 2001; Demir & Rodwell, 2012; Gates, Gillespie, & Succop, 2011; Whittington, 2002). Exposure to workplace aggression in caregiving as well as in law enforcement settings has then been associated with negative outcomes for the worker such as anger, burnout, turnover, post-traumatic stress disorder (PTSD), loss of empathy, poor service delivery, depression, anxiety, psychosomatic disorder and absenteeism (Aquino & Thau, 2009; Arnetz & Arnetz, 2001; Barling, 1996; Brown et al., 1999; Chapman, Perry, Styles, & Combs, 2009; He, Zhao, & Archbold, 2002; Jackson, Clare, & Mannix, 2002; Pich, Hazelton, Sundin, & Kable, 2011; Wilson, Douglas, & Lyon, 2011).

According to the statistics of the Commission de la Santé et de la Sécurité au travail du Québec (2014) for 2012, 47.3% of physical and mental injuries due to workplace violence led to a work leave of 90 days or less while 24.2% led to a work leave lasting 1 to 2 years . The most common type of reported psychological injury accepted by this compensation agency appeared to be the nervous shock (PTSD), comprising 63.8% of cases.

Schat and Kelloway (2005) found that exposure to workplace aggression was associated with negative emotional reactions such as fear and anger, and various psychological symptoms such as depression, anxiety and somatization. Added to this is an increase in aggression among victims of workplace violence (Björkqvist, Österman, & Hjelt-Bäck, 1994).

In their survey with 596 American workers in different sectors of employment, Budd, Arvey, and Lawless (1996) noted high rates of psychological distress among workers who were victims of workplace aggression. They also observed serious concerns among these victims regarding a possible re-victimization, decreased job satisfaction, increased probability of carrying a weapon at work, considering changing job, absenteeism and a decrease in self-reported productivity.

Being a victim of a violent act may also result in changes in the way an individual perceives himself, others and the world in general (Janoff-Bulman, 1995). For example, a caregiver or law enforcer who was a victim of workplace aggression could begin to see himself as being especially vulnerable. This can then lead to a state of psychological imbalance and crisis thereby increasing anxiety or depressive symptoms while decreasing resistance to stress. Perceiving the world or work environment as hostile, job satisfaction and commitment will be weakened. Consequently, perceptions that any effort to change this situation is futile and useless could lead the worker to develop a sense of helplessness and push him to adopt more passive behaviors (Burns & Seligman, 1991; Peterson & Seligman, 1983).

Fear also turns out to be a major consequence of workplace aggression. Indeed, fear would be the first reaction when an individual perceives his or her physical integrity as threatened (Cox & Leather, 1994). According to Rogers and Kelloway (1997), apprehension of victimization of workplace aggression may increase anxiety. To this point, Taylor, Beckett, and McKeigue (2008) pointed out that Type II violence can increase anxiety levels experienced by workers thus increasing turnover intentions, absenteeism and staff instability.

Subsequently, this instability creates a rise in assaults committed against workers (Arnetz & Arnetz, 2001).

2.1.1.3 Trivialization of workplace aggression

Despite the facts that caregivers and law enforcers are often victims of workplace aggression and that this exposure has been associated with negative outcomes, these workers tend to trivialize violence in the workplace (Åkerström, 2002; Dyrkacz, Mak, & Heck, 2012; Erickson & Williams-Evans, 2000; Macdonald & Sirotich, 2001). Currently, the term "trivialization of workplace aggression" is not clearly defined in the literature. Still, two aspects are repeatedly evoked when this concept is directly or indirectly discussed. The first is normalization of violence. The second is avoiding an open discussion of workers' discomfort with workplace violence, because such a discussion would lead to negative peer judgments. In the present thesis, trivializing violence will therefore refer to normalizing violence or to muting emotional discomfort about it. To our knowledge, no studies have assessed predictors of trivialization of workplace aggression. The present thesis therefore aims to fill a part of the gap in the literature about the trivialization of workplace aggression by identifying what contributes to *normalizing* and *tabooing* workplace aggression. Therefore, chapter 6 answers the third objective of this thesis, which is to identify predictors of the trivialization of workplace aggression among caregivers and law enforcers.

2.1.1.4 Trivialization and psychological consequences

Since few studies have directly investigated the notion of trivialization of workplace aggression, knowledge about the psychological consequences of this trivialization on victims

of such events is very scarce. In this light, studies are needed to better understand the impact of trivialization of workplace aggression on psychological wellbeing in order to help workers better cope with this phenomenon. Therefore, the fourth objective of the present thesis (chapter 7) is to assess the psychological consequences related to the trivialization of workplace aggression on victims of workplace aggression among caregivers and law enforcers.

2.1.2 Exposure to traumatic material

Exposure to traumatic material is the second main stressor studied in this thesis and can refer to the concept of vicarious traumatization. Vicarious traumatization is the psychological consequence associated to repetitive exposure to another's traumas through listening to his or her stories (Schauben & Frazier, 1995). The notions of repetition and accumulation are essentials to this concept (Sexton, 1999). Exposure to traumatic material is considered only in chapter 4 and 5, which are focused on the child protection profession. Even though several studies have assessed vicarious traumatization on child protection workers, this thesis draws on general literature regarding this concept in order to develop its investigation in child protection settings.

2.1.2.1 Prevalence

Stoesen (2007) argued that vicarious traumatization is especially prevalent among child protection workers. Depending on their field of study, researchers have synonymously used the term compassion fatigue, burnout, secondary trauma, secondary traumatic stress and vicarious trauma in order to depict the negative consequences of providing social support or

care (Bride, 2007; Figley, 1999; Jenkins & Baird, 2002). Consequently, no uniform conceptualization currently defines the extent of this traumatic stress leading to considerable variability in the prevalence of vicarious trauma or compassion fatigue from one study to another (Sabin-Farrell & Turpin, 2003). In healthcare professions, for example, the conceptual confusion results in prevalence ranging from 16 % to 85 % (Beck, 2011). In a study with child protection workers, Cornille and Meyers (1999) found that 37 % of them manifested clinical levels of emotional distress associated with compassion fatigue. Thus, studying this notion in child protection settings may contribute to the literature since its manifestations are difficult to measure and may be misinterpreted as other psychological problems such as PTSD (Bober & Reger, 2006).

2.1.2.2 Consequences

Symptoms of this type of traumatic stress can manifest themselves as decreased emotional and psychological energy, feelings of helplessness and guilt, depression, hypervigilance, detachment from loved ones, isolation, increased vulnerability to violence, profound change in values and beliefs, cynicism and despair (Cunningham, 1999; Dane, 2000; Sexton, 1999).

Even though the symptoms of vicarious traumatization are similar to those of burnout and occupational stress, some researchers argued that there is empirical evidence that this type of traumatic stress is different from other forms of psychological distress (McCann & Pearlman, 1990; Schauben & Frazier, 1995). Indeed, this concept differs from others by the profound shift that operates on the long term and that alters the way workers perceive, feel, think and act in their professional and personal lives (Pearlman & Saakvitne, 1995). Mostly

negative, this transformation process would be the result of the empathic bond between the caregiver and his or her client and of exposure to the traumatic stories of the client (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This psychological impairment disrupts the affected individual's self-image and his or her perception of the world (Jenkins & Baird, 2002).

2.1.3 Felt accountability

Accountability stems from personal liability associated with decision-making and risk-management that goes with caregiving and law enforcement duties (e.g. granting provisional release to a juvenile delinquent, using constraints to control aggressive patients, using lethal force to solve a violent situation, etc.). This liability adds to the complexity of public service professions (Bennett, Evans, & Tattersall, 1993; Dollard, Dormann, Boyd, Winefield, & Winefield, 2003; McLean & Andrew, 1999), Moreover, it is sometimes amplified by the organizational climate and institutional procedures of the milieu (Sundet & Cowger, 1990).

Concretely, accountability for caregivers and law enforcers refers to codes of conduct, laws that guide their decision-making and performance evaluation systems (Ferris, Mitchell, Canavan, Frink, & Hopper, 1995). These different regulations make them accountable for their professional actions. If their decisions result in serious consequences for the client, such as suicide or severe physical injuries, they would be potentially affected by this event and would have to justify their decisions in this particular case. According to Stenning (1995), negative consequences happen to people who do not provide a satisfactory justification for their actions. Frink and Klimoski (1998) argued that the entity able to judge the accountability of a

person can punish or reward this person. Thus, three dimensions emerge from this concept: responsibility, justification for one's actions and sanctions and rewards.

The definition used by Lerner and Tetlock (1999) may be fitting for caregiving and law enforcement: "Accountability refers to the implicit or explicit expectation that one may be called to justify one's beliefs, feelings and actions to others" (p.255). However, this thesis will use the definition provided by Hall et al. (2006) since it adds the notion of "*Felt"*, which allows the for the consideration of a subjective process when a worker deals with this aspect of his or her profession: "*Felt accountability* refers to an implicit or explicit expectation that one's decisions or actions will be subject to evaluation by some salient audience(s) (including oneself), with the belief in the potential for either rewards or sanctions based on these evaluations" (p.88). This definition is embedded in a phenomenological perspective, which views accountability as a state of mind, or subjective interpretation of reality, rather than exclusively as an objective condition (e.g., Frink & Klimoski, 1998).

2.1.3.1 Consequences

Previous research has found that felt accountability was associated with many positive behavioral and psychological outcomes at work (Hall et al., 2003). For example, Fandt (1991) found that workers who felt accountable were more likely to be high performers, improve accuracy, and pay greater attention to others' needs than workers with lower levels of felt accountability. Thoms, Dose, and Scott (2002) reported that felt accountability (e.g., to both coworker and management) was associated with heightened levels of job satisfaction.

Despite these positive outcomes, considerable research has reported adverse effects of felt accountability on job satisfaction (Ito & Brotheridge, 2007). Indeed, felt accountability

may lead to negative outcomes due to increased pressure or tension (Ferris et al., 1995). Hall et al. (2003) reported that felt accountability was directly associated with tension and the exertion of emotional labor. The more workers feel accountable, the more they experienced tension (W. A. Hochwarter, Perrewé, Hall, & Ferris, 2005). Thus, felt accountability may represents a stressor because of its potentially anxiety-provoking effects (Siegel-Jacobs & Yates, 1996).

In this vein, Ferris et al. (1995) provided evidence suggesting that felt accountability has the potential to act as a workplace stressor with associated strain reactions (e.g. job tension and emotional exhaustion). Similarly, Hall et al. (2003) found that felt accountability was associated with higher levels of job tension and emotional labor. Moreover, when increased accountability leads to heightened levels of scrutiny (Lerner & Tetlock, 1999), anxiety is a possible consequence especially when coupled with evaluation apprehension (White, Mitchell, & Bell, 1977). Therefore, felt accountability can be characterized as a potential workplace stressor, with associated strain reactions (W. Hochwarter, Kacmar, & Ferris, 2003).

As mentioned, caregivers and law enforcers must compose with different levels and instances of accountability. Consistent with role theory (Katz & Kahn, 1978), which is embedded in identity theory, navigating through a "web of accountabilities" may cause anxiety, conflict and overload since workers must face different accountabilities to different individuals and groups (Frink & Klimoski, 1998). Moreover, accountabilities often clash with one another and often require prioritization and may result in role conflict (Hall et al., 2006). Child protection work may serve as an example of this role conflict – these workers are accountable for care and control simultaneously (Orsi, Lafortune, & Brochu, 2010). This may

therefore heighten the stress experienced through felt accountability and thus, impact their mental health at work.

Finally, Schlenker, Weigold, and Doherty (1991) argued that accountability may be perceived as a threat and thus as a potential stressor when workers believe that demands extend beyond their own capabilities. This may thus refer to negative felt accountability. Moreover, they affirmed that "problems with accountability are at the core of most dysfunctional behaviors" (1991, p.96). According to these authors, many clinical disorders are attributable to an individual's failure to cope with stress emanating from felt accountability. In a more general sense, much of the literature addressing exposure to workplace aggression, exposure to traumatic material as well as felt accountability has emphasized the mental health outcomes of these stressors.

2.2 Mental health at work

Psychological wellbeing and psychological distress are recognized as the two main components of mental health, one positive and the other negative (Keyes, 2003; Massé et al., 1998). The majority of studies have focused on the negative consequences of psychological distress (e.g. burnout, anxiety, stress, etc.) rather than focusing on the positive outcomes of psychological wellbeing (e.g. sense of accomplishment, self-efficacy, etc.) (Genoud, Brodard, & Reicherts, 2009; Gilibert & Daloz, 2008; Laugaa, Rascle, & Bruchon-Schweitzer, 2008). However, the results of some studies showed that psychological wellbeing and psychological distress are negatively related distinct concepts (Karademas, 2007; Massé et al., 1998; Veit & Ware, 1983) . In this vein, two articles within this thesis focus on both positive and negative psychological consequences of work-related stress through the concepts of compassion fatigue

and compassion satisfaction. Moreover, a conceptual model comprised of these two concepts, the *Professional Quality of life* model (Stamm, 2009a), is empirically tested. In another article, mental health refers to the presence or absence of symptoms related to PTSD following violent victimization in the workplace.

2.2.1 Compassion fatigue

This thesis draws on general literature on compassion fatigue in order to further extend the understanding of this phenomenon in child protection settings. Thus, depending on their area of study, researchers have used the terms burnout, compassion fatigue, vicarious trauma, secondary trauma and secondary traumatic stress in their study of the negative impact of providing social services (Bride, 2007; Figley, 1999; Jenkins & Baird, 2002; Stoensen, 2007). Consequently, no single accurate conceptualization currently defines the extent of the impact of providing social services to clients in difficulty (Kadambi & Ennis, 2004; Lonne, 2003). The concept of compassion fatigue as proposed by C.R. Figley (1995), however, brings together several of these concepts. Indeed, compassion fatigue, defined as cumulative traumatic stress by C.R. Figley (1995), encompasses the notion of primary traumatic stress, secondary traumatic stress and vicarious traumatization. Figure 1 illustrates the compassion fatigue model as proposed by Charles R Figley (1995). Primary traumatic stress added to secondary and vicarious traumatization cover the components of compassion fatigue.

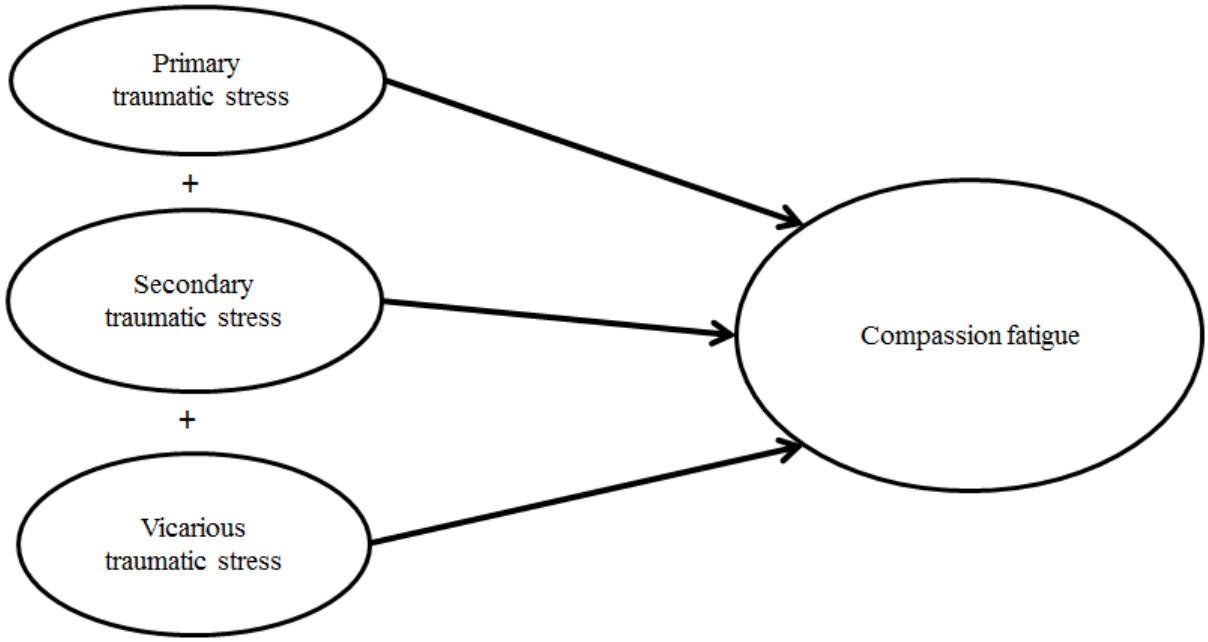


Figure 1 – Figley's (1995) compassion fatigue model.

The majority of studies on compassion fatigue have focused on correlations between work-related stress and the psychological distress of workers (Alderson, 2004). These studies have therefore relied on environmental factors in order to explain the mental state of therapists. Consequently, they objectively addressed the impact of providing social support or care, interpreting workers' suffering as a response to stimuli. Based on a deterministic approach, this model then omits to consider the role of cognition *a priori* and *a posteriori* in the understanding of the impact of caregiving or providing social support such as child protection services. By integrating the notion of professional identity in Figley's (1995) model, this thesis adds a subjective perspective to the compassion fatigue model allowing for the consideration of compassion satisfaction while taking into account the influence of stress caused by felt accountability. This therefore corresponds to the first objective of this thesis, which is addressed in chapter 4.

2.2.2 Compassion satisfaction

Other studies have showed that providing caring or helping services to vulnerable others engenders many personal benefits for the caregiver (Lonne, 2003). The satisfaction derived from protecting vulnerable people from violence even seems to protect caregivers from some negative consequences of their work (Richardson, 2001). Thus, Stamm (2002) proposed the concept of compassion satisfaction, which is the inverse of compassion fatigue. According to this author, this concept refers to the sense of personal fulfillment and social recognition one derives from his professional actions. The personal satisfaction that comes from this kind of work is found to be a protective factor from the adversity inherent to this work (Pottage & Huxley, 1996; Poulin, 1994; Powell, 1994). In this vein, Lonne (2003) argued the level of stress, anxiety and distress of the worker providing social services would be relatively low when compared to the satisfaction of helping, caring and protecting others.

2.2.3 The Professional Quality of Life Model

Combining compassion satisfaction and compassion fatigue in a single model, Stamm (2009b) proposed the Professional Quality of Life Model, which refers to the quality of life one feels in relation to their work as a helper. In addition to incorporating both compassion fatigue and compassion satisfaction as possible outcomes of work-related stress, it also includes characteristics of the work environment (organizational and task-wise) as well as the characteristics of the worker and his or her exposure to potentially traumatic situations. Further pushing the study of compassion fatigue, this author argued that this concept is divided into two dimensions: secondary traumatic stress and burnout.

Secondary traumatic stress, which is associated with work-related exposure to traumatic events and persons, is driven by fear and manifests itself through symptoms similar to those of PTSD. Indeed, secondary traumatization in helpers includes many of the symptoms reported by trauma victims themselves (Chrestman, 1999; Kassam-Adams, 1999). This aspect of compassion fatigue may therefore suddenly develop following particular situations.

According to Maslach (2003), burnout is characterized by physical and emotional exhaustion, cynicism and a decreased sense of self-efficacy that builds up over time. Indeed, unlike secondary traumatic stress, burnout has a gradual onset (Beck, 2011). Mental signs of burnout may be feelings of powerlessness, hopelessness, emotional exhaustion, detachment, isolation, irritability, frustration, being trapped, failure, despair, cynicism and apathy. Common physical symptoms are headaches, sleep problems, gastrointestinal problems, chronic fatigue, muscle aches, high blood pressure, frequent colds and sudden weight loss or gain (Maslach & Leiter, 2008). Burnout is often related to a very high workload, an unsupportive work environment, the cumulative effects of stress as well as strain that results from insufficient resources and excessive demands or incongruence between individuals and the work they do (Maslach, 2003).

In sum, the ProQol model is a generic model that allows for the integration of work-related stressors and factors that amplify or mitigate these stressors in our understanding of what influences compassion satisfaction and compassion fatigue. However, it needs to be adapted to the specificities of the child protection profession since some stressors are not considered, such as accountability. This adapted model will be tested empirically in this thesis (chapter 5) for a better assessment of the stressors that impact ProQol for child protection

workers. Moreover, this thesis will also examine the effects of factors known to influence ProQol in multivariate models. This will therefore address the second objective of this thesis.

2.2.4 Post-traumatic stress and chronic stress

Theories of traumatic stress and chronic stress may also shed light on the inherent adversity of caregiving and law enforcement. When taken together, post-traumatic stress and chronic stress may be akin to the notion of compassion fatigue as described by Stamm (2009b).

Post-traumatic stress may occur when a caregiver or law enforcer experiences an intense stress. If so, this worker may be affected by one or several symptoms associated with post-traumatic stress disorder (PTSD). According to the American Psychiatric Association (2013), PTSD is a psychiatric disorder that develops when (1) someone directly experiences a traumatic event such as a natural disaster or an assault, or (2) when someone directly witnesses the event as it occurred to another individual, or (3) when someone learns that the traumatic event happened to a close family member or friend or, finally, (4) by experiencing repeated or extreme exposure to aversive details of the traumatic event (however, this does not apply to exposure through media such as television, movies, or pictures). This exposure then results in a feeling of threat to the physical integrity of the self or others inducing intense reactions of fear, helplessness or horror in the individual. Many symptoms are therefore associated with this disorder: intrusive thoughts, feelings of intense psychological distress, physiological reactivity, persistent avoidance of stimuli associated with the trauma, hypervigilance, numbing, sleeping difficulties, concentration problems and anger. In the fourth article of this

thesis (chapter 7), these symptoms are utilized in order to assess the mental health of caregivers and law enforcers who were victims of workplace aggression.

Chronic stress, on the other hand, can occur in response to everyday stressors that are ignored or poorly managed, as well as to exposure to traumatic events (APA, 2013). In the long term, these types of stressors may cause negative consequences for workers (e.g. anxiety, fear of some customers, decreased motivation, etc.). Lazarus and Folkman (1984) and Lazarus (2006) argued that each episode of violence would have an additive effect that would eventually carry significant consequences for the victim (i.e., in this thesis, for the child protection worker). Nevertheless, they suggested that the victim's cognitive assessment or interpretation of the events has considerable mediating effects on the psychological impact of this event. Indeed, chronic stressors may be perceived as negative and offensive or as positive and challenging. The subjective assessment of these stressors rather than their objective and observable nature would therefore dictate the consequences, positive or negative. In the spirit of considering the subjective interpretation of stressors, examining sex and gender influences also seems essential.

2.3 Sex and gender influences

In all articles, the assessment of sex and gender differences plays an important role. Indeed, recent studies on sex and gender have shown that it is important to consider these characteristics in the understanding of stress reactions. For example, studies on stress and gender have shown that men and women differently perceive, experience, report and cope with workplace aggression (Barnett, Biener, & Baruch, 1987; He et al., 2002; Johnson, Greaves, & Repta, 2007; Wells et al., 2006). Therefore, literature that has guided the gender-

differentiated approach of this thesis that is not covered in the articles is briefly reviewed in this section.

According to Johnson et al. (2007), gender refers to the set of roles and relationships, personality traits, attitudes, behaviors, values as well as the relative power and influence that society ascribes to women and men. Biological sex refers to the biological characteristics such as anatomy (e.g. height and body shape) and physiology (e.g. hormonal activity or functioning of organs) that distinguish people, identifying them as "women" or as "men."

Studies in public service settings showed that men were more often victims of workplace aggression than women (Shields & Wilkins, 2009; Whittington, 2002). Tragno, Tarquinio, Duveau, and Dodeler (2007) argued that this difference is attributable to each gender's preferred method of solving conflict. More compassionate and less rigid than men, women are more likely to bypass the violence of users by their interventions that are more accommodating and empathetic. Men, on the other hand, tend to be more directive and aggressive in responses to their violent clients. In short, men are more easily engaged in power struggles while women rather promote dialogue and interaction. It is therefore not biological sex that is responsible for the victimization of workers, but rather the preferred type of intervention with clients. However, Tolin and Foa (2006) demonstrated that even though they are less often victims, the risk of developing PTSD following an act of violence is twice as high for women than for men.

Olff, Langeland, Draijer, and Gersons (2007) reviewed epidemiological studies that found gender differences in PTSD in order to further understand the particular vulnerability of women to this syndrome. Thus, explanations reviewed within a psychobiological model of PTSD suggest that women's higher PTSD risk may be due to the type of trauma they

experience, their younger age at the time of trauma exposure, their stronger perceptions of threat and loss of control, higher levels of peritraumatic dissociation, insufficient social support resources, and greater use of alcohol to manage trauma-related symptoms like intrusive memories and dissociation, as well as gender-specific acute psychobiological reactions to trauma. This therefore emphasizes the need to consider gender when studying PTSD.

Bem (1981) proposed a differential approach based on the psychological and behavioral characteristics of males and females. This author distinguished four types of gender identities: masculine, feminine, androgynous and undifferentiated. The masculine identity brings together individuals perceived as independent, authoritarian and task-oriented. Feminine individuals are perceived as sensitive, warm, dependent and people-oriented. Those with androgynous identities, reporting as many female as male characteristics, are seen as competitive, sensitive, more psychologically adapted and caring. Finally, undifferentiated individuals, reporting few characteristics of both sexes, are perceived as having low self-esteem and poorer psychological adjustment than others. These differences are then likely to influence how caregivers and law enforcers perceive and cope with work-related stressors.

Tragno et al. (2007) then pushed further and tested whether gender identity had an influence on the development of psychological consequences as a result of victimization at work. They recruited 367 employees (30.8% men and 69.2% women) from various professional sectors and asked them to complete three questionnaires: one on their individual characteristics (e.g. gender, age, marital status, and educational level), another on their level of traumatic stress (*Impact of Event Scale - Revised, IES-R*) and another on gender identity (*Bem Sex Role Inventory; BSRI*). They discovered that feminine workers were less vulnerable than

others, because they possessed the necessary assets to cope with their victimization. Indeed, they positively coped with the experienced aggression. Androgynous workers were also less vulnerable since they had a greater identity plasticity and adaptability. Workers demonstrating masculine or undifferentiated identities were, in turn, more psychologically affected by violence. When masculine workers were a victim of an act of violence, they became aware that they were not "the strongest". This acknowledgment then caused a decrease in self-confidence, especially if the individual had to deal with a feeling of helplessness during the attack. Undifferentiated workers perceived themselves as helpless when faced with violence. Not possessing any specific characteristic or belief system as an anchor for their own individuality, they experienced difficulty in coping with their victimization.

In light of this knowledge on gender-differentiated perceptions or reactions to stressors, it is imperative to include sex and gender in the present research. Moreover, few studies have compared differences in perceptions of workplace aggression and felt accountability according to sex and even fewer have included gender role as an intervening variable. Thus, sex and gender role are integrated in the assessment of the ProQol model for child protection workers (chapter 5). Sex differences regarding predictors of trivialization of workplace aggression will be investigated among caregivers and law enforcers (chapter 6). Gender-differentiated psychological consequences of trivialization of workplace aggression for caregivers and law enforcers who experienced a severe violent act are also assessed (chapter 7).

Chapter 3 - Methodology

The current section presents the methodology of this thesis. Because it combines two different studies, the samples, sampling procedures, measures and analyses of these studies will be described throughout this section as a function of their pursued objectives. Before presenting this conventional methodology section, explanations on how this research was made possible and how "scientific distance" was managed are provided. Indeed, two aspects of this thesis are in rupture with "conventional" research design and tradition. First, I (the author; the first pronoun will be used for this subsection) studied my own work environment. Metaphysically speaking, this research could be framed as a personal journey to understand oneself. Then, I combined a quantitative methodology with a traditional subjective theoretical framework, which mostly relied on qualitative methods, and made this combination a particular epistemological feature of this doctoral thesis. Both aspects are discussed in the following section.

3.1 From subjective to objective

As described in the foreword, the research questions that drove this doctoral thesis emerged from a personal experience. However, prior experiences, affiliations, procedures and analytical strategies allowed me to take a 'scientific distance' to study my object.

3.1.1 Prior research experiences

This is not the first time I studied my own work environment. In fact, the first time was when I worked as a bouncer in a Montreal barroom. Using the "bouncer-ethnographer" methodology (Winlow, Hobbs, Lister & Hadfield, 2001), I investigated the emergence of incivilities and aggression in a barroom setting and the ways in which bouncers handled these behaviors. The data collection took place over a period of one year. After the data collection, I left this job and ask for the collaboration of three professors that had never worked in such an environment. These collaborations and the use of mixed methods helped to "objectivise" the research. To this date, three articles have been published with this data and have proven that one can study one's own work environment (Boivin, Geoffrion, Ouellet & Felson, 2014; Geoffrion, Felson, Boivin & Ouellet, 2014; Geoffrion, Sader, Ouellet & Boivin, 2015).

My second experience of studying my own work environment came about 3 years after I started working as an educator for the Monteregie Youth Center. As mentioned in the foreword, I wondered how workers cope with their clientele's aggressive behaviors. With the help of the union of educators, I managed to collect victimization surveys from more than 500 educators all over the province of Quebec. Seeking collaboration with a professor that was not working for such institutions, we analyzed the data and published an article that identifies individual and organizational predictors of violence towards educators (Geoffrion & Ouellet, 2013). This study inspired the present research and demonstrated once again that studying one's own environment with 'scientific objectivity' is possible.

3.1.2 Affiliation

As soon as I started my doctoral studies, I knew from these past experiences that I had to affiliate myself with professors that will help me to take distance from the field. At this time, Dr. Stéphane Guay was the director of the Trauma Studies Center of the Research center of the Institut universitaire en santé mentale de Montréal. Moreover, he was the principal investigator of a CIHR team grant on violence in the workplace. Thus, seeking direction from Dr. Guay was the logical choice.

Accepted within his research team, I then benefited mainly from financial, human and research resources that helped me take a distance from the field I was studying and working in simultaneously. On the financial level, I first obtained a scholarship from a team grant on workplace violence. This allowed me to take a six-month leave from my work at the Monteregie Youth Center. Moreover, this significantly enhanced my academic record and I subsequently obtained more than four scholarships from other research centers and organization grants. Consequently, I quit my job at the Monteregie Youth Center and fully focused on my research. This was really helpful to increase the 'scientific distance' with my research object. On the human level, I had the opportunity to discuss and present my project and findings with other researchers as well as clinicians. Being part of a multidisciplinary research team was therefore beneficial since it allowed seeing my doctoral project from different perspectives, which in turn increased the distance I took with my study object. On the research level, I had the opportunity to collaborate on other projects investigating workplace violence in other sectors of employment. Therefore, I used data that had been collected, prior to my arrival in this team, among healthcare workers and law enforcers. With these data, I was able to verify if the proposed theoretical framework and findings from the Monteregie Youth Center workers could also be applicable within datasets I was not involved in collecting from

milieus I had never worked in myself. All in all, this affiliation increased the objectivity I had with the topic of my doctoral research.

3.1.3 Formal procedures to conduct research in the Monteregie Youth Center

If a researcher wants to conduct a research project in the Monteregie Youth Center, several procedures are to be followed. First, I had to submit the project to the research committee for assessment. Simultaneously, I had to find a member of the direction team to act as the representative for the institution responsible of the research. Mario Morisette, adjunct to the human resources director, took on this role. After the research committee accepted the project, I had to present it to the board of directors. There, all directors had to accept the project to pursue it, which they did. After these procedures, I had to submit the project to the Quebec Youth Center – Institut Universitaire research department to obtain ethics approval. After revision of the project, which was mainly aimed to ensure transparency regarding my position as a researcher studying my own work environment and colleagues, the 'scientific distance' needed to realize the research was attained. Unfortunately, Université de Montréal did not recognize this ethical approval and requested that I seek approval with their ethical team. Using the same ethical demand forms, Université de Montréal granted me ethical approval, confirming that 'scientific distance' was well managed in the project.

3.1.4 Analytical strategies

Since the research questions emerged from personal experience, a subjective theoretical framework was the natural choice. Symbolic interactionism fitted perfectly with the project. However, to increase 'scientific distance', I decided to use quantitative data and analyses with this framework. I therefore had to rely on the few researchers that have done the same. Here, I describe the two schools of this theoretical framework in order to clarify the epistemological position I took for my research.

3.1.4.1 Quantitative methods and symbolic interactionism

The theoretical framework that drives this thesis is rooted in symbolic interactionism. After Mead, this sociological current split into two, with two different places, two different schools, but mostly two different interpretations. These discrepancies are briefly summarized based on Stryker (1980).

The most known school of symbolic interactionism is without a doubt the School of Chicago with famous tenants such as Blumer, Becker and Hughes. This interpretation of symbolic interactionism starts from the point of view of the individual. More specifically, it emphasizes that interpretation and understanding of social events must be studied through the analysis of meanings given by human participants in interaction, which refers to the hermeneutics of social interactions. Thus, this school focuses on the subjective input of individuals in interaction. Since every individual is free to interpret situations as they want, the use of conventional methods of science in not adequate according to this school, since interactions and interpretations are in constant change and vary from an individual and a situation to another. The number of possible interpretations is therefore infinite, strengthening

the relativist perspective of this symbolic interactionism. The introspection and deep understanding offered by qualitative methods are thus most able to capture the dynamic aspect of the studied phenomena, as their continuous change prevents any generalization. The scope of this interpretation of symbolic interactionism is idiosyncratic, adopting ethnography as the "championed" method because it allows for some introspection about the phenomena studied in addition to generating an in-depth description. Pushing this idea to an extreme, Blumer claims that symbolic interactionism reveals the Truth. It therefore does not have to submit itself to conventional scientific testing. This interpretation of symbolic interactionism is embedded in a vision in which science develops through revolutions rather than through a cumulative dialectical process. This perception further supports the rejection of conventional methods and encourages the use of less common methods (eg. auto-ethnography). For Stryker, this version of symbolic interactionism is more metaphysical than scientific (1980, p.93).

The lesser known school of symbolic interactionism is the School of Iowa where Kuhn, Stryker and Reynolds developed a different interpretation of this theoretical framework. Contrasting the School of Chicago, the School of Iowa takes as its starting point the influence of society on the individual. Social structures constrain hermeneutic, which restrains the number of meanings possible for a given situation, and thus provide some stability in terms of interactions - not everything is in a constant state of flux. This therefore allows for the measure of certain parameters, the use of conventional methods of social sciences, and the generating of hypotheses and laws that will be put to the test of experimentation and falsification. The scope of this version of symbolic interactionism is nomothetic rather than idiosyncratic. The evolution of science thus emanates from an iterative process.

This thesis holds this interpretation of symbolic interactionism. Since professional identity is shaped through professional socialization, encompassing occupational culture and the influence of organization (Dick, 2000; Åkerström, 2002), it takes into account the impact of social structures on meanings given to work-related stress. The number of possible meanings is therefore constrained, making it possible for it to be measured using conventional methods of social science. Therefore, self-reported measures of perceptions have been used in order to remain in accordance with the subjective outlook of symbolic interactionism.

Even though qualitative methods could also ascertain a certain level of objectivity, the use of quantitative data and analysis avoided the use of personal experiences as explanations for the findings. In sum, this strategy, in addition to past experiences, affiliations and procedures to pursue research, ensured the 'scientific distance' of the researcher with his research object.

3.2 Conventional methodology section

3.2.1 Objective 1. Integrating professional identity into the compassion fatigue model.

The first objective is addressed in a theoretical article. To begin, the theoretical background of compassion fatigue and professional identity are presented. These concepts are then discussed in reference to four stressors specific to child protection work: direct violent victimization, witnessing violent behaviors, exposure to the traumatic experiences of children and felt accountability. At the outcome of this exercise, an enhanced version of Figley's (1995) compassion fatigue model is proposed, which integrates felt accountability while considering the role of cognitions in the development of compassion fatigue. This article did

not include analysis other than an extensive review of the literature in order to make propositions for amendments to the existing theory based on hypothetical-deductive reasoning (Bélanger, 1998).

3.2.2 Objective 2. A quantitative examination of the *Professional Quality of Life* model among child protection workers.

The second objective is a quantitative examination of an adapted version of the *Professional Quality of Life* model, which is based on the theoretical argument developed in the first objective. To achieve this, this article relies on study 1.

3.2.2.1 Participants.

Study 1's sample is composed of 310 child protection workers who answered an online victimization survey. All participants were French-speaking residents from the province of Quebec in Canada and worked in Monteregie's Youth Center[1] situated in the southern Montreal area. Of these respondents, 46.5% were educators working in juvenile facilities or foster care centers, 10.0% were educators working within family settings and 43.5% were human relation agents[2]. Of all the respondents, 84.5% were women. Study 1 also included 30 semi-directed interviews with child protection workers from this institution. However, the qualitative perspective of this project was not used for the present thesis. This study was approved by the Ethics committee of the Université de Montréal.

[1] In Quebec Canada, Youth Protection Services are operated by Youth Centers, which are divided geographically. Monteregie covers the territory south of Montreal and extending to the U.S. border.
[2] In Quebec Canada, social services within Youth Protection Services are multidisciplinary. Social workers, criminologists and psychoeducators act as human relation agents.

3.2.2.2 Educators.

According to the Association of Quebec's Youth Centers[3], an educator is a person who immediately provides education and rehabilitation to beneficiaries in institutional or external environments according to professionally established intervention programs for the rehabilitation of beneficiaries or their reintegration into society. Educators apply education techniques using acts of daily life, organizing, coordinating and animating the activities planned by the service program, to ensure the learning and acquisition of attitudes and appropriate behavior. Educators also observe and analyze the behavior of beneficiaries in order to assess their needs and capabilities while recording their progress in drafting the appropriate documents. They also provide the programming of educational activities. To be an educator, one has to have a college degree in special education or in delinquency intervention. Some also have undergraduate training in psychoeducation, criminology, psychology or sexology.

3.2.2.3 Human relation agents.

According to the Association of Quebec's Youth Centers[4], human relation agents perform professional activities of a social nature in order to help young people, their parents and their families struggling with major difficulties in terms of their personal, family or social functionning under the Youth Protection Act of the Youth Criminal Justice Act. Human relation agents spend almost 60% of their time in the community to interact with families, to

[3] In March 2015, this association was dissolved after a reform in the health and social services of the Quebec province. Information on job descriptions was taken in November 2013 from the website of the Association (www.acjq.qc.ca).
[4] Ibid

report to the Youth Court, to visit the Health Center and Social Services and to visit schools. The rest of their time is devoted to administrative follow-up. Human relation agents necessarily have a bachelor's degree in psychoeducation, social work, criminology or sexology since the adoption of Bill 21 (An Act to amend the Professional Code and other legislative provisions in the field of mental health and human relations).

3.2.2.4 Recruitment and sampling procedure.

Study 1 was a research project designed by the author of this thesis that aimed to assess the impact of workplace aggression and felt accountability on youth protection workers. Given that gender differences are emphasized in this thesis, a randomized sample stratified by gender was recruited to complete this study.

The researcher was provided with a complete list of the child protection workers employed by Monteregie's Youth Center. From this list, selected workers were invited to participate in the study via email by a VISAGE (Violence at Work According to Sex and Gender) research team member. They were informed of the purpose of the study and of the anonymity of their answers. In addition, this email explained that Monteregie's Youth Center was excusing them for one hour of work in order to fill out the questionnaire. Participants were asked to return their consent form in order to receive a personal identification number that would give them access to the online questionnaire. Participants who had not been in contact with the clientele in the year prior to their completion of the survey as well as those on maternity leave were excluded from the sample. Others were asked to answer anonymously and on a voluntarily basis. The data collection took place between November 2013 and July 2014. The valid response rate was 40.9% (see appendix 1 – flow chart). The sample is

representative of the Monteregie's Youth Center child workers population with a margin of error of 4.9% (19 out of 20 repeated polls).

3.2.2.5 Measures.

The online victimization survey, hosted by *survey monkey*, was composed of 16 valid measurement tools but only 8 were used for the present thesis: Perception of Prevalence of Aggression Scale (POPAS), Felt Accountability (FA), Perception of Organizational Support (POS), Professional Identity Scale (PIS), Clinician confidence in coping with patient aggression instrument (CONF), Bem Sex-Role Inventory (BSRI), Ways Of Coping Questionnaire (WCQ) and Professional Quality of Life (ProQol). In addition, information was collected concerning years of experience in child protection work, work environment (i.e. inpatient or outpatient), time spent conducting therapeutic interviews with the clientele and time reading reports of clients' problems and psychosocial situations.

Considering the language spoken by the assessed sample, the POPAS, the FA, the PIS and the CONF were translated since their French-Canadian versions were non-existent. Following the procedure recommended by Brislin (1980), these questionnaires were translated and subsequently revised by a professional linguist specialized in psychosocial studies. Following this, they were independently back-translated into English by a second professional translator and then revised by a third professional linguist specialized in psychosocial research.

3.2.2.6 Analysis.

In order to test the adapted model using path modeling analyses, nine variables from the victimization survey were used; exposure to workplace aggression, time exposed to traumatic stories, felt accountability, perception of organizational support, adherence to one's professional identity, confidence in coping with patient aggression, gender role, coping strategies and *Professional Quality of Life* (ProQol). Exposure to workplace aggression, time exposed to traumatic stories and felt accountability were treated as exogenous variables, while the ProQol was treated as endogenous. All other measures were inserted into path analysis models as mediating variables. Path analysis modeling has been recognized a useful analytical method for longitudinal and cross-sectional data, as it permits testing both the fit of hypothesized directional relations between variables and the structure of relationships with the observed data (Hoyle, 2012). Indirect effects with intervening variables were tested using bootstrapping (with $n = 5\,000$) procedures as instructed by Preacher and Hayes (2008). Moderation effects were tested using multi-group method (years of experience). Level of significance was $p < .05$. *MPlus 7.3* was used to compute the analyses of this study.

3.2.3 Objective 3. Predictors of trivialization of workplace aggression among caregivers and law enforcers.

To address the third objective, a convenience sample was extracted from a study (representing study 2) carried out by the VISAGE (Violence in the workplace according to sex and gender) research team in Quebec, Canada. Funded by the Institute of Gender and Health of the Canadian Institutes of Health Research, the VISAGE research team of the Trauma Studies Centre of the *Institut universitaire en santé mentale de Montréal* develops partnerships with targeted professional sectors in order to enhance clinical and organizational aspects of

care for workers exposed to, or at high risk of being exposed to, serious violent acts. The team's goal is to develop and share knowledge on workplace violence in the hopes of recommending strategies that take into account differences in gender-based needs. With their collaborators, *Association paritaire pour la santé et la sécurité du travail du secteur des affaires municipales* (APSAM), *Association paritaire pour la santé et la sécurité du travail du secteur des affaires provinciales* (APSSAP), and *Association paritaire pour la santé et la sécurité du travail du secteur des affaires sociales* (ASSTSAS), they carried out a survey between January 2011 and October 2012. It sampled 2,889 workers in seven categories of employment: managers, peace officers, healthcare professionals, nursing staff, administrative workers, skilled and service industry workers, and public transportation workers. The questions related to the acts of violence they might have been victims of or witnessed during the past 12 months as well as their repercussions. The survey also examined workers' perceptions with regard to violence and the support received at work to counter this reality. This study was approved by the Ethics committee of the Institut universitaire en santé mentale de Montréal (Montreal Mental Health University Institute).

3.2.3.1 Participants.

For the purpose of the present thesis, only caregivers and law enforcers were selected. Security agents, park rangers, law officials and police officers make up the law enforcers group. The caregivers group is represented by orderlies, nurses and other health professionals. As a result, we obtained a sample of 1141 workers of which 61.2 % were women and 67.3% were caregivers.

3.2.3.2 Sampling procedure.

As mentioned, the study was conducted among French-speaking workers from the province of Quebec in Canada. Workers were recruited by three organizations that collaborate with the VISAGE research team. Workers were reached by email or on-site to complete a survey in an online (hosted by *survey monkey*) or printed format. All workers were informed of the purpose of the study and the anonymity of their answers through the website. A majority of participants completed the survey online (85.7 %), vs. on paper (14.3 %). All questionnaires were answered anonymously and on a voluntary basis. This represents a convenience sample.

3.2.3.3 Measures.

In order to address the third objective, individual and organizational factors were measured. On the individual level, sex and age of the participants were controlled while the nature of the job (e.g. caregiver or law enforcer) was considered. A victimization measure was included that could reflect direct victimization of being a witness of workplace aggression**.** Also, inspired by the *POPAS*, a distinction was made between *severe violent acts* (SVA) and *mild violent acts* (MVA). Questions related to perceptions of workplace aggression were computed in order to measure trivialization of violence; one variable measured perceptions of normalization of violence while the other measured perceptions of the taboo surrounding workplace aggression.

As for the organizational factors, five items from the questionnaire explored the perceptions of workers regarding different organizational attitudes towards violence in the workplace. These variables made it possible to measure the degree of "presence" of (1) the

necessary tools to cope with violence (training, procedure, guidelines, etc.), (2) a "zero tolerance" policy, (3) safe physical environments (cameras, bulletproof glass, etc.), (4) colleagues' support, and (5) employer's support.

3.2.3.4 Analyses.

Chi-squared *(x^2)* tests were used to make gender comparisons of normalization and tabooing of violence. X^2-tests were also run to compare normalization and tabooing between caregivers and law enforcers. Logistic regression was used to find predictors of normalization and then, to identify predictors of tabooing. In order to test gender differences, both models were tested separately for men and women. Post-hoc comparison to test regression estimates differences between male and female respondents were performed as instructed by Paternoster, Brame, Mazerolle and Piquero (1999). *SPSS 22.0* was used to compute the analyses of this study.

3.2.4 Objective 4. Trivialization of workplace aggression and psychological consequences.

The fourth objective also relies on study 2 conducted by the VISAGE research team. However, only the caregivers and law enforcers who had been victims or witnesses of at least one severe violent act (e.g. violent acts that are more likely to result in harm or injury and consequently are more likely to lead to sick leaves) in the workplace in the past 12 months were selected.

3.2.4.1 Participants.

We obtained a sample of 376 workers of which 54.3% were women and 70.5% were healthcare providers. Security agents (29.7%), park rangers (14.4%) and police officers (55.9%) constitute the law enforcers group. Orderlies (12.5%), nurses (61.9%) and healthcare professionals (25.6%) represent the healthcare providers group.

3.2.4.2 Sampling procedure.

The same sampling procedure as objective 3 was used since the same data set was utilized. Within this subsample, a majority of the participants completed the survey online (74.2%), vs. on paper (25.8%).

3.2.4.3 Measures.

The same individual and contextual factors were input to predict psychological consequences. However, injuries following victimization were inserted in the model. Psychological consequences were measured with a scale of post-traumatic stress reactions based on the DSM-IV symptoms of PTSD developed by the VISAGE research team.

3.2.4.4. Analysis.

A general path analysis model, including gender, was used to answer the first objective and to test the formulated hypotheses in a multivariate model. This technique allowed for the verification of direct and indirect effects. Consequently, it made it possible to consider how individual and organizational factors were associated with the endogenous variable as well as to test the indirect effect of normalization and tabooing. Indirect effects with multiple

intervening variables were tested using bootstrapping (with $n = 5\,000$) procedures as instructed by Preacher and Hayes (2008). Level of significance used was $p \leq .05$. *MPlus 7.3* was used to compute the analyses of this study.

Chapter 4 - Rethinking Compassion Fatigue through the Lens of Professional Identity: The Case of Child Protection Workers

Within research on compassion fatigue and child protection work, subjective features such as meanings given to work-related stress are inconsistently addressed. Relying on identity theory, this article draws on general literature on compassion fatigue and professional identity (PI) to further extend the understanding of compassion fatigue in child protection settings. Thus, a subjective perspective is introduced into Figley's (1995) compassion fatigue model. Moreover, the integration of PI into Figley's (1995) model allows for the consideration of positive outcomes of performing child protection work, such as compassion satisfaction, and takes into account the influence of stress caused by accountability. Our demonstration specifically relies on child protection workers since many studies have suggested that compassion fatigue is a serious issue within this profession and can impact the mental health of these workers, leading to high turnover rates (Anderson, 2000; Cerney, 1995; Horwitz, 1998; Meyers & Cornille, 2002). This article then expands upon sociological studies, particularly Thoits's work (1999), that links psychological states to self-conceptions, while contributing to the sophistication of the concept of compassion fatigue.

To do so, we first present the theoretical background of compassion fatigue and the PI concept. We then articulate the interaction between these concepts in regards to four stressors specific to child protection work: direct violent victimization, witnessing violent behaviors, exposure to the children's traumatic experiences and responsibility for professional actions. The three first stressors appeared in Figley's (1995) model of compassion fatigue. The use of

PI allows us to incorporate accountability as a fourth type of stressor in the compassion fatigue model. After all, child protection workers must adopt and apply various codes of conduct that guide their counseling while making them accountable for their professional actions (Osofsky, Putnam, & Lederman, 2008). In addition, the integration of identity theory will consider the possibility of positive reactions to work-related stress, in contrast to exclusively examining fatigue or distress. As argued by Stamm (2002), compassion satisfaction, which refers to the pleasure one derives from helping others, is a possible outcome of providing social support or caregiving services.

4.1 Background

Public service professions, such as child protection work, involve constant interaction with individuals who have a wide array of needs and demands (Hawkins, 2001). On a daily basis, child protection workers must face and deal with child abuse, neglect, family violence and various traumas. These circumstances may lead to stressful encounters with the clientele (Littlechild, 2005a, 2005b), all while child protection workers are being held accountable for the professional decisions they make (Osofsky et al., 2008). Because the encountered problems are complex, clients have difficulties in their interpersonal relationships and situations are highly emotional, providing social services in this context may generate anxiety (Strozier & Evans, 1998). Nevertheless, social interactions in this professional relationship are constrained by the needs of the patient and the mandate of the professional. As such, the inherent adversity of this type of work occurs in micro situations and is closely linked to the meanings that participants assign to them. Examples of such situations include social workers getting verbally harassed (Macdonald & Sirotich, 2001), behavior technicians in juvenile

facilities being exposed to violent tantrums (Geoffrion & Ouellet, 2013), and child protection workers listening to children's recounting of traumatic experiences (Ferguson, 2005). Such workplace features result in child protection work imposing considerable demand on the worker.

Figley's (1995) compassion fatigue is currently the dominant model in work-related stress studies that examine the consequences of caring for others on therapists. Figley (1995) defined this concept as the accumulation of primary, secondary and vicarious traumatic stress caused by exposure to work-related stressful interactions. If stress becomes excessive, the therapist may develop compassion fatigue which, in turn, may jeopardize his or her professional sense of self while negatively impacting on psychological wellbeing (Craig & Sprang, 2010). Thus, many studies have shown that providing social support and care may cause a profound change in a worker's personal and professional identity (Figley, 2002; Jenkins & Baird, 2002; Kadambi & Truscott, 2004; McCann & Pearlman, 1990). Pearlman and Saakvitne (1995) described a profound shift in personal outlooks that altered and possibly damaged helping professionals' fundamental beliefs about the world by being repeatedly exposed to traumatic material. A negative transformation of self-perception and environment-perception is often associated with psychological distress (Thoits, 1999).

However, child protection workers are not automatically traumatized by their daily encounters with abused children or reluctant parents. In other words, child protection workers give meaning to work-related stressful situations, and then act accordingly to these interpretations. Meanings given to these stressors are thus pivotal to the experience of distress in a given work environment (Dewe, 1991, 1992; Dick, 2000; Eden, 1990; Large & Marcussen, 2000; Marsella, 1994). Influenced by identity, these meanings can dampen or

amplify the impact of stressors on the person experiencing them (Thoits, 1999). Therefore, individuals can frame their interpretation of the situation in order to maintain psychological wellbeing; they are not condemned to suffer from a stressful situation. A cognitive process must then be considered in assessing compassion fatigue since identity and meaning are crucial to understand compassion fatigue. In this vein, the present article aims to improve upon the compassion fatigue model by accounting for subjective experiences as well as considering external factors.

The majority of studies on compassion fatigue have focused on correlations between work-related stress and the psychological distress of workers (Alderson, 2004). These studies have therefore relied on environmental factors in order to explain the mental state of therapists. Consequently, they objectively addressed the impact of providing social support or care, interpreting workers' suffering as a response to stimuli. Since the identification of external causes on its own does not explain the psychological impact of stressors, an increasing number of researchers are including self and identity concepts in their studies on mental health (Thoits, 1999). In the present article, the notion of professional identity (PI) is introduced in order to consider the impact on meaning in the understanding of the development of compassion fatigue among child protection workers.

PI refers to a system of meanings associated with worker roles (Skorikov & Vondracek, 2011). Shaped trough professional socialization, it encompasses the worker's past experiences, the occupational culture, as well as the influence of organization (Åkerström, 2002; Dick, 2000). It guides the way in which workers think, act and interact in their professional settings (Fagermoen, 1997). In other words, PI provides a framework of meaning

specific to a profession and a work environment that a worker can then adapt in order to define a work-related situation. Thus, the notion of meaning is at the heart of this concept.

According to Dick (2000), the few studies that have emphasized the role of meaning associated to work-related stress all agreed that the meaning of stressors varies across individuals and circumstances. Even though meanings are subjective, Dick (2000) evoked that they are nevertheless influenced by social structures. Thus, meanings are located within and influenced by a broader social and specifically context and are therefore at least partly socially constructed.

Hence, this article proposes a framework that encompasses the worker's subjective perspective as well as organizational and occupational influences. By doing so, we will be able to understand how meanings given to stressful situations, which are guided by PI, differentially affect the development of compassion fatigue and thus, the psychological wellbeing of child protection workers. Derived from identity theory, the concept of "professional identity" is incorporated in the compassion fatigue model (Figley, 1995). It is proposed that PI acts as a modulator of child protection compassion fatigue as it guides how workers define and act towards work-related stress.

Put simply, integrating identity theory into compassion fatigue will enhance Figley's (1995) model by considering the role of cognitions. Indeed, identity serves as a subjective interpretative framework that guides the interpretation of work-related situations. Shaped and developed through work-related experiences and interactions, PI also incorporates the influences of contextual factors such as occupational culture and organizational context. Therefore, compassion fatigue is not only a simple reaction to external stimuli. It is influenced by meaning given to the situation.

4.2 Compassion fatigue

Compassion fatigue refers to the cumulative effect of working with survivors of traumatic life events, or perpetrators, as part of everyday work (Osofsky et al. 2008, p.91). Figley (1982) affirmed that compassion fatigue is the "cost of caring" and the accumulation of primary and secondary traumatic stress and vicarious trauma (Figley, 1995). Primary traumatic stress refers to direct trauma experienced by the child protection worker. Here, he can be the direct victim or witness of an extreme event such as being assaulted by a patient or experiencing an uprising in a facility. Secondary traumatic stress occurs when the child protection worker is overwhelmed by exposure to an extreme event directly experienced by another person. The difference with primary traumatic stress is that, in this situation, the child protection worker is exposed to another person experiencing a potentially traumatic event. Vicarious traumatization is bearing witness to another person's traumas through listening to their stories. Compassion fatigue is therefore a reaction that emerges from the child protection worker's overexposure to human suffering. Building up over time, the child protection worker will feel less empathy for his clients as well as less compassion in other spheres of life.

4.2.1 The consequences of compassion fatigue

Compassion fatigue has a wide array of consequences (Figley & Stamm, 1996). Preoccupation with the recounted traumatic events, avoidance and numbing, an increase in negative arousal, lowered frustration and tolerance, intrusive thoughts of client's material, dread of working with certain clients, a decrease in the subjective feeling of safety, a sense of therapeutic impotence, a diminished sense of purpose and a decreased level of functioning in a number of areas are examples of symptoms.

Berzoff and Kita (2010) listed some other consequences based on cognitive, emotional or behavioral impacts on the therapist. On a cognitive level, compassion fatigue can result in the therapist's lowered concentration, decreased self-esteem, apathy, negativity, depersonalization, minimization and thoughts of harm to the self or others. On an emotional level, therapists may feel powerlessness, guilt, rage, fear, survivor guilt, depression, an emotional rollercoaster, and depletion. On the behavioral level, this may result in impatience, irritation, sadness, moodiness, sleep disturbances, nightmares, hyper-vigilance, accident proneness, and the tendency to lose things.

Some studies have also shown that exposure to stressors can alter neuroendocrine and hormonal systems (Boscarino, 1997) as well as neuropsychological process by down-regulating the sensory processing elicited by the perception of pain in others (Decety, Yang, & Cheng, 2010). Ultimately, the therapist who suffers from compassion fatigue has absorbed the emotional weight of his clients' traumatic experiences in ways that have negatively affected his or her PI, personal self and existential state (Berzoff & Kita, 2010; Figley, 2002). Compassion fatigue is therefore associated with psychological distress (Adams, Boscarino, & Figley, 2006).

4.2.2 Only negative effects?

Other authors have argued that caring for others as a job does not only result in negative outcomes. In fact, providing such care can be both highly rewarding and highly stressful (Ohaeri, 2003). Stamm (2005) reported that compassion satisfaction refers to the pleasure one derives from being able to do his or her work as a therapist effectively; it is the pleasure and fulfillment that one gets from helping others and a sense of making a contribution

to the welfare of others and society (Stamm, 2002). In this vein, some studies revealed that supporting or caring for people in need provides more beneficial outcomes than negative consequences for social workers, human service practitioners and child protection workers (Lonne , 2003; Conrad & Keller-Guenther, 2006). In addition, compassion satisfaction may mitigate the impact of work-related stressors (Pottage & Huxley, 1996). Therefore, some researchers have questioned whether negative effects have been overestimated or overgeneralized at the expense of positive outcomes (Minnen & Keijsers, 2000; Kadambi & Ennis, 2004).

4.2.3 Conceptual confusion and the ambiguity of prevalence

Depending on their field of study, researchers have synonymously used the term compassion fatigue, burnout, secondary trauma, secondary traumatic stress and vicarious trauma in order to depict the negative consequences of providing social support or care (Bride, 2007; Figley, 1999; Jenkins & Baird, 2002). Consequently, no uniform conceptualization currently defines the extent of compassion fatigue and this leads to considerable variability in the prevalence of compassion fatigue from one study to another (Sabin-Farrell & Turpin, 2003). In healthcare professions, for example, the conceptual confusion of compassion fatigue results in prevalence ranging from 16 % to 85 % (Beck, 2011). In a study with child protection workers, Cornille and Meyers (1999) found that 37 % of them manifested clinical levels of emotional distress associated with compassion fatigue. In their research with humanitarian aid workers who work on the frontlines of trauma treatment, Shah, Garland, and Katz (2007) reported that 100 % (N=76) of their respondents reported compassion fatigue.

Facing these discrepancies, recent studies have clarified some aspects of this concept. Adams et al. (2006) argued that compassion fatigue is specific to work-related stress; it is not another designation for negative life events, past trauma, lack of social support or low mastery. It is then a hazard associated with therapy work (Adams et al. 2006, Berzoff & Kita, 2010). Berzoff & Kita (2010) also contributed to a more precise definition of compassion fatigue by contrasting it to countertransference. First, compassion fatigue emerges from the experience of providing caring services to those who suffer, while countertransference arises from the intersubjective relationship between the client and the clinician unveiling the therapist's unconscious worlds and past psychic wounds. Second, compassion fatigue develops over time while countertransference is immediate and ubiquitous. Third, compassion fatigue tires the therapist by undermining his ideals and disturbing his hope and meaning resulting in emotional exhaustion, while countertransference does not necessarily fatigue the clinician. Fourth, compassion fatigue is not essential to therapeutic work where countertransference is; actually, compassion fatigue can interfere with the therapist's ability to help his client. For Mathieu (2007), compassion fatigue must be seen as a continuum, meaning that at various times in a therapist's career, they may be more or less vulnerable to its effects.

4.2.4 Why do some child protection workers develop compassion fatigue?

Osofsky et al. (2008. p.92) cites Figley (1995), who identified risk factors of compassion fatigue: "Measuring your self-worth by how much you help others; having unrealistic expectations of yourself and others; being self-critical and a perfectionist; fearing others will judge you if you show "weakness" (e.g., seek help or express your feelings); being unable to give or receive emotional support, overextending yourself; and letting work bleed

over into your personal time." Saakvitne and Pearlman (1996) have also proposed personal and situational factors that contribute to the appearance of compassion fatigue. From an individual perspective, current life circumstances, personal history, coping style and personality type will influence the development of compassion fatigue. Doing work that others avoid, helping people that are not valued in our society such as sexual delinquents, the glamorization of violence, workplace negativity as a result of burnout and general unhappiness represent some of these situational factors. The problem with these factors proposed by Saakvitne and Pearlman (1996) is that they confound conceptual elements, bringing back countertransference predictors in the prediction of compassion fatigue.

Craig & Spang (2010) identified several studies that revealed different variables associated to the emerge of compassion fatigue: working on the frontlines (Shah et al., 2007), female gender (Kassam-Adams, 1999; Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007), younger age (Ghahramanlou & Brodbeck, 2000), increased exposure to traumatized clients (Kassam-Adams, 1999; Schauben & Frazier, 1995), longer length of time providing sexual abuse treatment (Cunningham, 2003), occupational stress (Badger, Royse, & Craig, 2008) and clinician's own maltreatment history (Nelson-Gardell & Harris, 2003). Craig & Sprang (2010) also mention studies that revealed variables which dampen compassion fatigue, such as access to clinical supervision (Rich, 1997), training for new and experienced clinicians (Chrestman, 1999), perceived coping ability (Follette, Polusny, & Milbeck, 1994), emotional separation (Badger et al., 2008), disengagement (Figley, 2002), amount of clinician experience (Cunningham, 2003), self-care strategies, and social support (Chrestman, 1999; Rich, 1997; Schauben & Frazier, 1995). In addition, Schauben & Frazier (1995) found that active coping strategies like problem-solving, humor and asking for emotional support and

advice lead to fewer symptoms. Finally, it seems that therapists who assimilate traumatic material as told by their patients in their cognitive schemata or adapt their cognitions to the reported stories better cope with traumatic stress related to their work (Minnen & Keijsers, 2000).

Craig and Sprang (2010) have also investigated factors which lead to burnout, compassion fatigue and compassion satisfaction in a random, national sample of 532 self-identified trauma therapists. Overall, only 5 % of their respondents were at high risk for compassion fatigue. Their results showed that increased percentages of individuals with PTSD on the caseload predicted compassion fatigue. According to these authors, this finding supported the idea that the "dose of exposure" is what matters when trying to understand who will develop negative consequences from his or her helping professional relationships (Galea, 2007). In the same vein, an increase in the number of years of clinical experience and use of evidence-based practices were significant predictors of compassion satisfaction. Craig and Sprang (2010) therefore suggested that maturity and professional experience may act as buffers to compassion fatigue. Consistent with the findings of Walsh and Wigens (2003), evidence-based practices seem to increase compassion satisfaction by strengthening the therapist's self-confidence in his or her professional decisions and interpretations of work-related situations. Relying on Fonagy (1999), Craig and Sprang (2010, p.335) stated, "the use of evidence-based practices may, in fact, improve therapist confidence and competence by creating the necessary boundaries and structure for the therapeutic work to be successful."

Other researchers have focused on the organizational factors that influence compassion fatigue. Meadors and Lamson (2008) found that a "culture of silence" in which stressful events are not spoken of, lack of awareness of symptoms and poor training regarding the risks

of high stress jobs are all associated with high rates of compassion fatigue. Supervision, on the other hand, decreased the impacts of compassion fatigue (Foy, Kagan, McDermott, Leskin, Sipprelle & Paz, 1996; Litz & Roemer, 1996; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Regehr, Hemsworth, Leslie, Howe, and Chau (2004) claimed that organizational factors are the strongest predictors of compassion fatigue.

Osofsky et al. (2008) in their review article listed these organizational factors as playing a role in compassion fatigue for child welfare workers: high case load, little support from supervisors, being placed in situations with conflicting roles, expectations or values, lack of peer support, inadequate resources to meet demands, being forced to assume personal liability for job-related decisions and actions, excessive workload or paperwork, too many interruptions during critical or demanding tasks, physical risks or concerns about personal safety, limited job recognition and shift work.

4.2.5 Introducing accountability stress, positive consequences and subjective input

Child protection workers are accountable for the decisions and actions they take in the course of their work (Osofsky et al. 2008). Accountability for decision-making and risk management (e.g. granting provisional release to a juvenile delinquent, removing a child from is family, etc.) adds to the complexity of social work (Bennett, Evans & Tattersall, 1993; Dollard, Winefield & Winefield, 2001; McLean & Andrew, 1999). If the decisions of child protection workers result in serious consequences for the client, such as suicide, they may have to justify their decisions in these particular cases. However, the actual compassion fatigue model does not consider this work-related stressor. This additional stressor should be

incorporated in our understanding of compassion fatigue, at least for therapists who work in the context of authority, such as child protection workers. Stress coming from accountability is, to this day, a phenomenon sparsely studied in social work.

The compassion model should also include positive outcomes since many studies have demonstrated that cumulative exposure to work-related situations may result in satisfaction for a child protection worker and fatigue for another. In order to understand how providing social support or caring affects the child protection worker, we need a model that covers a response continuum ranging from fatigue to satisfaction.

The common denominator of studies on compassion fatigue is that they take a deterministic approach, focusing mainly on external factors (Alderson, 2004). Even the study of cognitive aspects only refers to the consequences of compassion fatigue on cognition or the adaptation of cognitions in order to cope with traumatic exposure. As such, they do not consider the subjective view *a priori* of the child protection worker that gives meaning to the adverse experiences in his or her work. They do not mention the role of cognition *a posteriori* in the appraisal and management of stressful situations. Only few studies have considered the use of active cognitive coping strategies such as Problem Solving and Cognitive Restructuring by child protection workers (Anderson, 2000; Parry, 1989). These studies demonstrated that child protection workers are more likely to cope well with the use of these strategies. Therefore, subjective input must be included in the understanding of compassion fatigue among child protection workers.

In light of this literature review, three limits of Figley's compassion fatigue model appear: it omits the stress engendered by accountability, it excludes positive outcomes and it ignores the influence of subjective appraisal of work-related stressors. Therefore, we argue

that meanings given to work-related stressors must be included in the compassion fatigue/satisfaction continuum in order to understand differential responses to the "cost of caring".

4.3 Identity

Mead's (1934) symbolic interactionism is the starting point for creating the foundations of identity theory. First and foremost, the individual is seen as a pragmatic actor rather than a determined person. Society and self are then created through the process of communication and interaction. In this process, the human being is a symbol-user. Indeed, his mind allows him to manipulate significant symbols. These symbols represent common meanings about "objects" shared by participants of an interaction which allow them to behave according to the definitions given to this "object". Blumer (1969) summarized the three premises of this perspective. First, humans act and behave towards things on the basis of meanings they attribute to them, on how they come to define them. Second, meanings are derived from and arise out of social interactions that an individual has with other, with himself and with society. Third, these meanings are dynamic: they can be modified through an interpretative process used by individuals while dealing with a given situation. By this reflexive process and the symbolic character of social interactions (shared meanings), individuals are able to "take the role of the other" that allows individuals to think reflexively about themselves making the self an object to itself (Mead, 1934). This way, they also internalize the responses of others with whom they interact. These social processes are crucial in shaping one's self-conceptions.

More recently, Serpe and Stryker (2011) summarized the basic tenants of identity theory. Identity theory is based on the premise of structural symbolic interactionism that stated that "society" impacts "self" which impacts "social behaviors". Social action takes place in a reflexive process of developing shared meanings from society, person, and others. The self is a complex structure of multiple identities or internalized role expectations (father, husband, scholar, marathoner, fly fisher, etc.) which are determinants of social behavior. The link between identities and behavior is seen as both facilitated and constrained by the location of persons in the social structures constituting organized society. Human experiences are thus socially organized, not randomly distributed.

Human beings have many identities structured in oneself. Some of these identities are central to the individual while others are more peripheral and easily malleable. Depending on salience and commitment to a particular identity, it will be more or less central, consistent or changing from one situation to another (Stryker, 1980). These identities may be independent, aligned with or, in conflict with one another (Serpe & Stryker, 2011). In this way, expectations or roles linked to identities may be compatible or conflicting. Role and identity conflicts may then emerge from the interaction with others or with the self.

Serpe and Stryker (2011) and Thoits (1999) likened identity to cognitive schemata that have the capacity to affect behaviors and that can be applied in different situations, as defined by Markus (1977). The self is therefore seen as a structure of identities that are cognitive representations of positions in which persons are embedded. Once again, roles are attached to these positions and guide social behaviors. Identities are thus internalized meanings of structural positions in the form of role expectations. Self-descriptive and self-defining (Thoits, 1999), identities guide life paths and decisions (Kroger, 2006). They do not only answer the

question “whom you think you are” but also “who you act as being” (Vignoles, Schwartz, & Luyckx, 2011). Therefore, identity encompasses a subjective and objective perspective: “Viewed through the lens of an individual person, identity consists of the confluence of the person’s self-chosen or ascribed commitments, personal characteristics, and beliefs about herself; roles and positions in relation to significant others; and her membership in social groups and categories (including both her status within the group and the group’s status within the larger context)” (Vignoles et al., 2011, p.4).

Where these propositions differ from structural symbolic interactionism is that they incorporate the notion of emotion. For Stryker (2008, p.20), “persons are seen as having multiple identities [self is understood to include affective and conative as well as cognitive aspects (Stryker, 1968)], with persons having, potentially, as many identities as there are organized systems of role relationships in which they participate”. Thus, when studying role distancing, role involvement and role satisfaction, Stryker and Staham (1985) found that identities carry an emotional freight. Sentiments and emotions are important to an individual during interactions, thus to the self, and may amplify how stimuli are perceived and experienced. Meanings associated to the experience of these affects can play a significant role in the way an individual will define the situation, how the self will be organized and how the person will act (Stryker, 2004) Consequently, identity theory recognizes the importance of affect in the contribution to commitment to the hierarchical ordering of identities since emotions may amplify commitment (Serpe, 1987; Stryker, 1987; Stryker & Serpe, 1982; Stryker, 2004). Therefore, commitment is not only based on rational thought; it has an affective component that ties the person to an identity. Consequently, the theory proposes that

commitment impacts identity salience, which in turn impacts role choice behaviors (Serpe & Stryker, 2011).

Identities are then both personal and social in their content as well as in their processes; in the way they are formed, maintained and changed over time (Vignoles et al., 2011). Since they are social constructs, they can be deconstructed and revised. Even though identity processes are influenced by contextual factors, the active role of the person in this process must not be ruled out (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987).

4.3.1 Professional identity

PI is used synonymously in the literature with the concept of occupational identity in order to refer to a system of meanings associated with worker roles (Skorikov & Vondracek, 2011). Brown, Kirpal, and Rauner (2007) have identified important features of occupational identities: they are both in continuity and change; they are shaped by the changing system of interpersonal relationships around which they are constructed; individuals make a significant contribution to the construction of their occupational identity while they are constrained by social structures and processes; there is considerable variation in the salience of occupational identity within the person's overall sense of identity.

According to Schwartz (2001), occupational identity is often a central identity for individuals. In this vein, theorists have argued that a strong occupational identity contributes to psychosocial adjustment, wellbeing, and life satisfaction (Christiansen, 1999; Kroger, 2006; Vondracek, 1995). In empirical studies with working adults, the strength (or commitment) of occupational identity was found to be a strong predictor of lower levels of depression and

anxiety while predicting higher levels of life satisfaction (McKeague, Skorikov & Serikawa, 2002; Skorikov, 2008).

Fagermoen (1997) proposed in a study with nurses that PI guides nurses' thinking, actions and interactions related to their profession. Thus, it plays a critical role in the way an individual interprets and acts towards work-related stressors. Moreover, studies have found that the more individuals are committed to their organization or profession, the more they will interpret work-related situations according to the organization's ideology, values and culture (Mael & Ashforth, 1992; Rousseau, 1998).

The concept of PI, or its synonym occupational identity, has been articulated in study with police officers and caregivers in order to explain how these workers deal with workplace violence. Dick (2000) found that policing identity operates at the collective level to "normalize" some emotional responses and "pathologize" others that are contrary to police organizational culture. Graef (1990) argued that police culture promotes so-called masculine values such as being able to handle potentially violent situations and thus cope with the negative impact of exposure to such stressors. As for caregivers, Åkerström (2002) observed that caregivers will downplay violence from the patients in order to preserve their identity as caregivers and the boundary of their work. In fact, they reframe these stressful situations according to the framework of their job, restoring the normalcy of these aggressive behaviors and allowing them to keep on offering caregiving services to their patients.

4.3.2 Work-Related Stress

A number of researchers have studied the influence of identity on the psychological health of workers. Based on symbolic interactionism, Kelchtermans (1999) conducted

qualitative interviews with several teachers. Analyses of these interviews revealed that identity is actually a subjective interpretative framework, such as glasses, which protects teachers from or precipitates them towards burnout. The outcome depends on how they define their occupational stressors. While teachers do experience exposure to traumatic stressors via students, they are not trained the same as child protection workers. However, this study demonstrated that psychological impact of stressors depends on meanings given to the situations, and on how identity will lead a person to appraise the stressor (Thoits, 1999).

Thoits (1999) explained different ways in which identity may affect the impact of stressors on mental health. Initially, she recognized that stressors that damage or threaten self-conceptions, or identities, are likely to predict emotional problems since one's self-conception is closely linked to his psychological state. However, obstacles faced by individuals become problematic only if they threaten their central identities. Simply put, the effect will depend on the salience of the identity threatened. She then argued that identity negotiation, such as change in the hierarchical ordering within the self, may become a stress-coping strategy. In this way, if an individual has other identities in which they may invest themselves and experience positive affect, the impact of a stressor on the self may be countered. The abandonment of a problematic identity can then be the ultimate way of relieving chronic stress. However, if identity loss may be a coping strategy, it may also be a stressor in itself since it impacts the self. Still, identity loss or abandonment is often caused by cumulative exposure to stress.

Emotions should also be considered in these relations. The more the identity is salient, the more the emotional reactions to stressors will be intense and, the more it may impact mental wellbeing (Thoits, 1994). Extreme events such as physical assaults can then be serious

threats to the integrity of identity and eventually, to the self (Stryker, 2004). According to Stryker (2004), role performance assessments also generate emotions. Performances meeting role expectations may create positive affect for the performer, and the other person involved in the interaction which will strengthen the commitment to this identity. On the other hand, performances failing to meet expectations may produce negative effects for both the performer and the other. This bad performance may jeopardize commitment to the related identity, compromise the psychological wellbeing of the performer while undermining the relationship between the antagonists; Stryker (1980) then refers to interpersonal role conflict. In other cases, some persons may face cognitive and emotional dissonance if their structural positions generate identity or intrapersonal role conflict (Stryker, R. 2000; Stryker, 1980).

4.4 Child protection workers, professional identity and the structuring of compassion fatigue

In this section, it is suggested that PI modulates the experience of work-related stress on compassion fatigue of child protection workers and thus, on their psychological wellbeing as reviewed. First, integration of PI in Figley's (1995) compassion fatigue model will be discussed. Second, possibilities offered by the import of identity theory into the understanding of occupational stress will be addressed. In order to make these propositions clearer, possible relations and extensions will be applied to the child protection work context.

4.4.1 Professional identity and compassion fatigue

First, PI introduces a subjective dimension to stressor outcomes on compassion state. PI will influence *a priori* how significant the stressor is to the worker. If the stress is important to the individual, it will then be appraised *a posteriori* according to PI. Depending on this appraisal, it will or will not impact compassion state. This is represented in Figure 2 as a continuum going from compassion fatigue to compassion satisfaction.

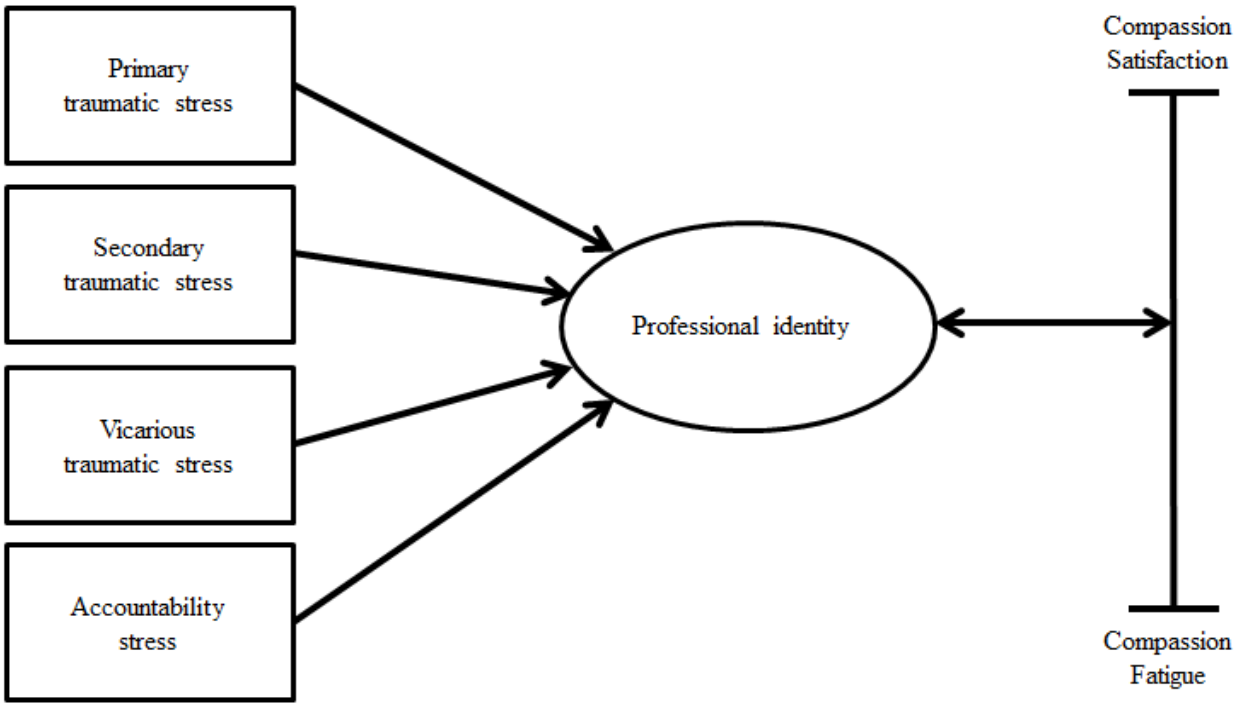


Figure 2 – Professional and compassion model.

However, even if they contain a subjective component, organizational and cultural factors related to the work environment considerably influence how workers will define what they are experiencing. As such, a child protection worker may have been assaulted by different clients in the course of his or her career without developing compassion fatigue. Depending on past experiences with aggressive patients, training in such situations, his or her clinical

interpretation of the situation, employer support facing aggressive patients, the presence of a supporting colleague with whom to debrief, and the shared meanings given to violence in the workplace, the child protection worker will interpret the stress experienced. If, like Åkerström's (2002) nurses, he or she frames this experience according to the boundaries of the profession, he or she will put the situation in context and interpret it in a way that will not affect compassion state. For example, he or she will see this assault as a result of impulsivity, lack of social skills, a conflictual personality and all other clinical assessments focusing on the client's difficulties instead of seeing this as a direct assault to his or her person. Defining oneself as a child protection worker trained to handle such behaviors will allow one to help the client, whereas defining oneself as a victim may lead to completely different emotions and behaviors such as initiating legal proceedings or simply ceasing to provide this client with caregiving services. If a child protection worker can reframe stressors in coherence with his or her PI, he or she may be less likely to develop compassion fatigue and thus, maintain compassion satisfaction. This relation can then be applied to secondary, vicarious and accountability stress. Thus, by determining possible meanings given to work-related stressors, PI modulates compassion fatigue.

Since the notion of PI involves social structures, accountability stress may be easily introduced in the compassion model. Many codes and regulations influence how a child protection worker may provide social support and security. Laws restrain what he or she can do and what he or she cannot do. Laws not only restrain what, but also where, when, how and for how long. Professional orders as well as institutions to which the worker belongs will control the way he or she provides help through codes of conduct, supervision and demands for the justification of clinical decisions. Ultimately, a child protection worker must report to

the Youth Chamber. He or she must respect the boundary of the profession or face sanctions by different instances. Once again, the way the worker will interpret this accountability may affect his or her compassion potential since it can be perceived as another obstacle or as a reasonable way to control use of legal power. In this vein, and especially in child protection work, PI in itself and the role expectations attached to it may lead to compassion fatigue. This adds another variable to Figley's (1995) model. Child protection workers must help their clients while controlling them. They have the authority to restrain contact between parents and their children but must at the same time help these parents resolve the problematic situation. Caring and controlling at the same time may then lead to intrapersonal or interpersonal conflicts that may create additional stress which in turn, amplify compassion fatigue (Boyd & Pasley, 1989). Thus, caregiving and policing may be two identities that are difficult to combine within oneself. It may also be hard for the parents to accept that the one who took their child away from them is actually trying to provide help. In the same vein, studies have shown that caregivers who trespass the boundaries of their work in interaction with their clients are more likely to be assaulted by their clients since they do not act according to their role; they diverge from role expectations (Morrison, Morman, Bonner, Taylor, Abraham & Lathan, 2002; Yassi, Tate, Cooper, Jenkins & Trottier, 1998).

Another proposition derived by the integration of PI to the compassion model is that the outcome may be satisfaction or fatigue. Figure 2 presents a continuum that ranges from fatigue to satisfaction. Depending on circumstances, the position of a person on this continuum may change through time. An important aspect of this proposition is that the relation is bidirectional. Thus, compassion state will also have an influence on PI. Compassion

fatigue can undermine how a child protection worker assesses his professional efficacy, which may in turn affect meanings given to stressors.

Therefore, the main proposition derived from our model states that the PI of a worker modulates his compassion state. If his PI is consistent with the interpretive framework proposed by occupational culture, organizational values and role expectations, it allows the child protection worker to face the adversity inherent to his work and keep the satisfaction of compassion. On the other hand, if it is inconsistent with this interpretative framework thus misinterpreting his role and the needs of his clients, it can amplify the negative consequences of his work. In other words, the boundaries defined by the social structures in such a workplace promote a PI adapted to the constraints of the job and allows workers to cope with these constraints. Still malleable, it then depends on how work-related meanings are incorporated in this PI and impact professional interactions. Negotiating the "fit" of this particular identity is therefore at the heart of maintaining compassion satisfaction. Hence, the proposed framework may account for how child protection workers differentially deal with the inherent adversity of their profession.

4.4.2 Compassion fatigue, identity and psychological wellbeing

The richness of associations derived from identity theory also reveals possible links between compassion fatigue and psychological wellbeing. As mentioned by Adams et al. (2006), compassion fatigue is often associated with psychological distress. Just as work-related stressors are modulated by PI, the impact of compassion fatigue or satisfaction on psychological wellbeing is modulated by the self. According to identity theory, we must first assess how committed the person is to his or her PI in order to know how salient an identity is

to the self. Being aware o this salience, we may then evaluate how it will impact the self and his psychological state. Like Thoits (1999) argued, only adversity that threatens core identities will impact psychological wellbeing. Still, the outcome is not necessarily negative. Compassion satisfaction may increase a commitment to PI which promotes psychological wellbeing. Figure 3 summarizes the possible relations between compassion state, the self and psychological wellbeing.

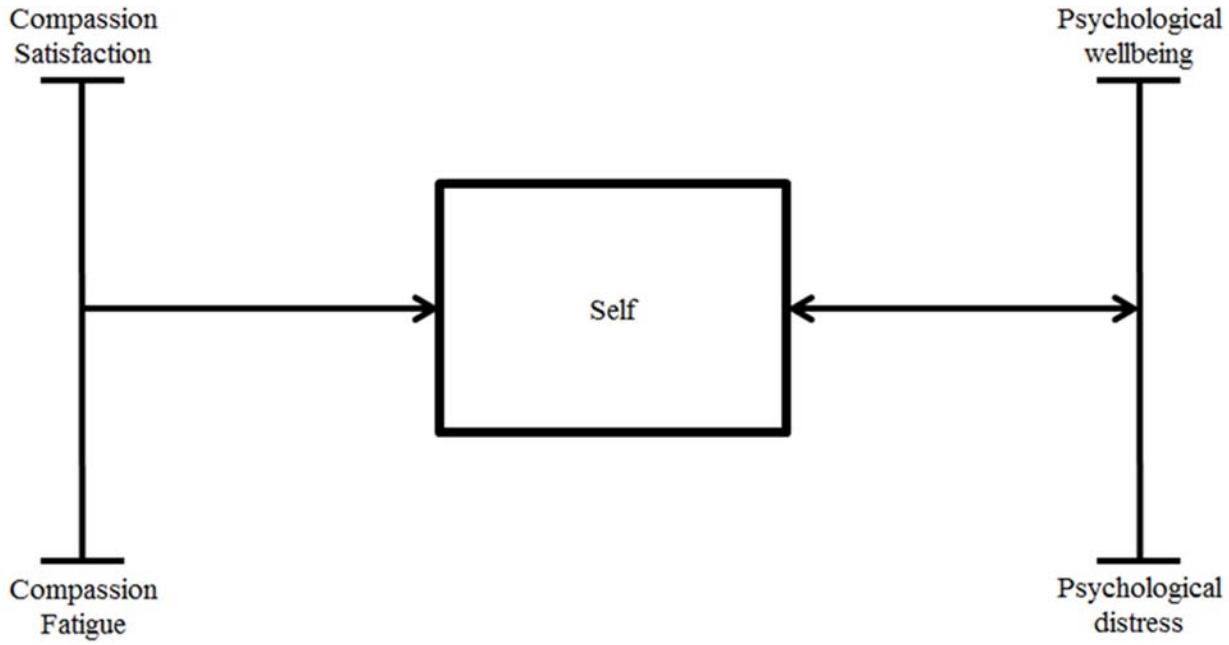


Figure 3 – Compassion on psychological state.

Another way the self may moderate the impact of adversity is by restructuring the hierarchical order of identities. For example, a child protection worker may suffer from compassion fatigue but have positive role performances and positive affect in his identity as a father. In order to diminish the impact of compassion fatigue on the self, he or she may relegate his PI to a peripheral status and increase commitment to his identity as a parent.

Figley (2002) has already suggested that disengagement, which refers to the capacity of the therapist to distance himself from the misery of his client between sessions, may diminish or prevent compassion stress. Thoits (1999) explained that psychological distress is often caused by the absence of other positive self-conceptions generated by other identities.

Once again, the relation between the self and psychological state is bidirectional. If the self can modulate compassion state, psychological state can influence self-conceptions. Thus, in a situation of psychological distress, one may be more vulnerable to compassion fatigue or resistant to compassion satisfaction. In this way, psychological state affects self-conception, which in turn influences meanings given to the situation.

4.4.2.1 The impact of highly emotional events

Child protection workers may experience extreme events that are highly emotional. For example, a worker may grant a teenager weekend leave permission from foster care. During the weekend, the worker receives a call stating that the teenager has committed suicide, or that he is in the hospital following an assault by gang members. The resulting guilt and emotional freight of this situation may exacerbate the commitment to PI and therefore affect psychological wellbeing. Thus, even if he tries to give meaning to the situation in such a way that would dampen the impact of the work-related stress, the emotional freight could be so high that it jeopardizes the organizations of identities and thus the self (Serpe, 1987; Stryker, 1987; Stryker & Serpe, 1982; Stryker, 2004). The child worker will then question the adequacy of his or her decision and assessment of the situation, whether he or she intervened enough towards this youth, or whether he or she misinterpreted certain behaviors. In addition, his or her employer, his or her colleagues, the parents of the youth, lawyers, judges, and others

will demand an explanation for his or her decision. Was he or she sufficiently aware of the situation before he granted the leave? Did he or she respect the boundaries of his legal authority? Did he or she forget a step in the procedure? Is he or she still competent for the job? All these stressors within a single situation may therefore disorganize the self and create psychological distress.

4.5 Conclusion

This article revisited Figley's (1995) compassion fatigue model. It has been argued that the deterministic approach present in this model excludes the role of cognitions *a priori* and *a posteriori* in the understanding of compassion fatigue. It also exclusively focuses on external factors and omits the role of subjective stress appraisal. Moreover, it only considers the negative results of providing social support and care. Consequently, this model cannot explain the fact that some individuals develop compassion satisfaction instead of compassion fatigue.

We have proposed the integration of notions from identity theory into Figley's (1995) model. Conceptualized as a subjective interpretational framework, identity adds a subjective perspective to this model. Specifically, identity guides how workers define their work-related stressors, which in turn guide their actions. Thus, workers possess a certain level of control on how they experience these stressors as they may interpret them positively or negatively. Meanings given to situations may protect or accelerate the development of compassion fatigue or compassion satisfaction. Implicitly, we argued that a compassion model should consider negative outcomes (fatigue) as well as positive consequences (satisfaction). Furthermore, compassion must be understood as a continuum.

By considering the impact of specific aspects of social structures, such as codes and regulations, on the self, PI suggested the integration of a fourth variable in the compassion model: accountability stress. Since compassion fatigue is specific to work-related situations (Adams et al., 2006), we proposed that this type of stress can affect child protection workers as much as other traumatic stress present in Figley's (1995) model. In this vein, PI showed that role conflicts might emerge for certain child protection workers who have two different and incompatible mandates. Whether these experiences are intrapersonal or interpersonal, these conflicts may lead to compassion fatigue.

Finally, based on identity theory, we have proposed that the self modulates the impacts of compassion state on psychological wellbeing. Once again, a bidirectional relation was demonstrated. The way workers negotiate their identities may soothe or exacerbate the impact of compassion on their mental health. On the other hand, psychological state may affect the organization of the self and how individuals perceive encountered situations, making them more vulnerable or resistant to compassion fatigue.

These propositions were articulated around child protection work since this type of profession allows for the integration of all suggested concepts and relations. Implicitly, we have proposed that the influence of social structures specific to the child protection profession helps workers face the adversity of their job. By influencing the meanings given to work-related stressors and interactions, child protection workers can interpret difficult situations in such a way that they foster compassion satisfaction while dampening compassion fatigue. However, it has been acknowledged that extremely emotionally charged events may mitigate the effects of positive appraisal by jeopardizing salience and commitment to PI and thus, to self-equilibrium.

In addition, the focus on child protection workers allowed for the adaptation of compassion fatigue to the contingencies of this profession. Although the generalization of this paper to other professions is limited, the suggested model might be adapted to other occupations sharing similar issues. PI and our proposed model of compassion may therefore be useful for other types of work involving care or support for others. In fact, all therapists develop a PI that allows them to offer their services. Even if they are not constrained in their work as much as are child protection workers, they are still to some degree accountable for the services they offer. Furthermore, the integration of meanings and the notion of PI may explain the high variance of prevalence in compassion fatigue from one study to another by unravelling the conceptual vagueness that hinders this phenomenon. On a more practical level, this finding suggests that cognitive-behavioral therapy may be relevant to help child protection workers who develop compassion fatigue by reframing meanings given to work stressors in a way that is consistent with professional boundaries. Therefore, since compassion fatigue affects helping professionals, it is crucial that researchers pursue the development of our understanding of this problem.

Chapter 5 - Compassion fatigue among child protection workers: An examination of an adapted version of the Professional Quality of Life model

Public service professions, such as child protection work, involve constant interaction with individuals who have a wide array of mental health needs and demands (Hawkins, 2001). On a daily basis, child protection workers must deal with child abuse, neglect, family violence and trauma. These circumstances may lead to stressful and aggressive interactions with the clientele (Littlechild, 2005a, 2005b), all while child protection workers are being held accountable for the professional decisions they make (Osofsky, Putnam, & Lederman, 2008). Figley (1995)'s compassion fatigue (CF) is currently the dominant conceptual model of the potential negative consequences of caring for others. Caused by the accumulation of primary, secondary and vicarious traumatic stress, CF appears as the inevitable cost of caregiving (Figley, 1982). Affected by CF, caregivers are likely to be afflicted by a loss of empathy in their professional and personal life and may develop traumatic symptoms similar to those experienced by their clients (Figley, 1995).

Still, Cornille and Meyers (1999) found that not all child protection workers are affected by CF. In their study with 360 American child protection workers, only 37 % of them manifested clinical levels of emotional distress associated with CF. In parallel, Stamm (2002) suggested that workers may develop compassion satisfaction (CS) instead of fatigue, which refers to the pleasure one derives from helping others. Consequently, Stamm (2009) proposed the Professional Quality of Life model (ProQol) which encompasses CF and CS as possible

outcomes of work-related stress. The current study provided a quantitative examination of this model. To do so, we first present the theoretical background of CF and ProQol while articulating these concepts in the setting of child protection work. Selected factors known to influence CF and CS are developed and introduced in the studied model in order to empirically test the ProQol model. Clinical and policy implications are then discussed following the quantitative examination.

5.1 Theoretical foundations

5.1.1 Compassion fatigue

Depending on their field of study, researchers have synonymously used the term CF, burnout, secondary trauma, secondary traumatic stress and vicarious trauma to depict the negative consequences of providing social support or care (Bride, 2007; Figley, 1999; Jenkins & Baird, 2002; Stoensen, 2007). Facing these discrepancies, recent studies have aimed to clarify some aspects of this concept. R. E. Adams, Boscarino, and Figley (2006) argued that CF is specific to work-related stress; it is not another designation for negative life events, past trauma, lack of social support or low mastery. It is then a hazard associated with therapist work (R. E. Adams et al., 2006; Berzoff & Kita, 2010). For Berzoff and Kita (2010), CF emerges from the experience of providing caregiving services to those who suffer, develops over time, tires the therapist by undermining his ideals and disturbing his hope and meaning, and leads to emotional exhaustion that interferes with his ability to help his clients.

5.1.1.1 Causes of compassion fatigue

According to Figley (1995), CF is the convergence of primary, secondary and vicarious traumatic stress. Primary traumatic stress refers to direct trauma experienced by the caregiver. Here, caregivers can be the direct victim or witness of an extreme event such as being assaulted by a patient or experiencing an uprising in a facility. Secondary traumatic stress occurs when the caregiver witnesses another person experiencing a potentially traumatic event. The difference with primary traumatic stress is that the caregiver is overwhelmed by exposure to an extreme event directly experienced by another person, not by himself. Vicarious traumatization occurs when bearing witness to other individuals' traumas through listening to or reading their stories. CF then refers then to "cumulative effect of working with survivors of traumatic life events, or perpetrators, as part of everyday work" (Osofsky et al. 2008, p.91).

Examples of such situations that may result in traumatic stress in child protection settings include social workers getting verbally harassed (Macdonald & Sirotich, 2001), behavior technicians in juvenile facilities being exposed to violent tantrums (Geoffrion & Ouellet, 2013), and child protection workers listening to children's stories of traumatic experiences (Ferguson, 2005). Thus, exposure to workplace aggression may encompass primary and secondary traumatic stress for child protection workers. Defined as "any behavior intended to harm an individual in an organization" (Dupré & Barling, 2006, p.19), workplace aggression includes physical assault, threats of assault and psychological aggression (Barling, Dupré, & Kelloway, 2009). Time spent in interview with clients and reading reports on the family's situation may lead to vicarious traumatic stress. As reported by Kassam-Adams

(1999) and Schauben and Frazier (1995), high frequency exposure to traumatized clients is found to be a positive predictor of CF.

5.1.1.2 Consequences of compassion fatigue

CF has a wide array of negative consequences on cognitive, emotional, behavioral and biological levels (Berzoff & Kita, 2010; Boscarino, 1997; Decety, Yang, & Cheng, 2010; Figley & Stamm, 1996). According to Stamm (2005), CF manifests itself through symptoms associated to secondary traumatic stress and burnout. For example, a child protection worker suffering from CF may experience sleep difficulties, overwhelming intrusive images of the traumatic event, avoidance of any reminders of the traumatic event or could be submerged by feelings of hopelessness and therapeutic helplessness.

On the other hand, Stamm (2002) also argued that caring for others as a profession while being exposed to potentially traumatic material may not exclusively result in negative outcomes. Even though it may be highly stressful, such a situation may simultaneously be highly rewarding (Ohaeri, 2003). Thus, Stamm (2002, 2005) proposed the concept of CS, which arises from the pleasure derived from being able to perform the work of a therapist effectively; it is the pleasure and fulfillment that one gets from helping others and from the sense of making a contribution to the welfare of others and society. Some studies have revealed that supporting or caring for people in need with health or behavioral problems provides more beneficial outcomes than negative consequences for the therapist (Lonne, 2003; Conrad & Keller-Guenther, 2006). In sum, it appears that certain factors may contribute to CF while others enhance CS, thus intervening in the compassion state. However, the empirical

basis of these relations remains questionable since they have rarely been assessed in an integrated multivariate approach.

5.1.2 The Professional Quality of Life (ProQol) Model

Stamm (2009) proposed the ProQol model, which refers to the quality of life one experiences in relation to one's work as a helper. Associated with characteristics of the work environment (organizational and task wise) as well as with characteristics of the worker and his exposure to potentially traumatic situations, it incorporates two possible outcomes: CS and CF. The positive outcome, CS, represents the positive feeling associated with caring for those affected by health or behavioral problems. The negative endpoint, CF, is associated with negative consequences of caring for others and is divided into two dimensions: secondary traumatic stress and burnout.

Secondary traumatic stress, which is associated to work-related exposure to traumatic events and traumatized persons, is driven by fear and manifests itself through symptoms similar to those of PTSD. Indeed, secondary traumatization in helpers includes many of the symptoms reported by direct trauma victims (Chrestman, 1999; Kassam-Adams, 1999). This aspect of CF may then develop suddenly and is linked to particular situations.

According to Maslach (2003), burnout is characterized by physical and emotional exhaustion, cynicism and a decreased sense of self-efficacy that builds up over time. Indeed, unlike secondary traumatic stress, burnout has a gradual onset (Beck, 2011). Mental signs of burnout include feelings of powerlessness, hopelessness, emotional exhaustion, detachment, isolation, irritability, frustration, being trapped, failure, despair, cynicism and apathy. Common physical symptoms are headaches, sleep problems, gastrointestinal problems,

chronic fatigue, muscle aches, high blood pressure, frequent colds and sudden weight loss or gain (Maslach & Leiter, 2008). Burnout is often related to a very high workload, a non-supportive work environment, the cumulative effects of stress, and strain that results from insufficient resources and excessive demands or incongruence between individuals and their work (Maslach, 2003). Thus, accountability may contribute to this aspect of CF.

5.2 Introducing accountability stress as a fourth stressor

The actual CF model does not consider accountability as a stressor that influences compassion fatigue. Yet, child protection workers are accountable for the decisions and actions they take in the course of their work (Osofsky et al. 2008). In their review article, Osofsky et al. (2008) found that in addition to physical risks or concerns about personal safety, being forced to assume personal liability for job-related decisions and actions plays a significant role in CF for child protection workers. Accountability for decision-making and risk-management (e.g. granting provisional release to a juvenile delinquent, removing a child from a family, etc.) adds to the complexity of social work (Bennett, Evans, & Tattersall, 1993; Dollard, Dormann, Boyd, Winefield, & Winefield, 2003; McLean & Andrew, 1999).

The definition of felt accountability provided by Hall et al. (2006) is applicable to child protection work: "*Felt accountability* refers to an implicit or explicit expectation that one's decisions or actions will be subject to evaluation by some salient audience(s) (including oneself), with the belief in the potential for either rewards or sanctions based on these evaluations."(p.88). Child protection workers must abide to codes of conduct and laws that guide their counseling while making them accountable for their professional actions. If their decisions result in serious consequences for the client, such as suicide, they may be called to

justify their decisions in this particular case. Thus, accountability may represent a stressor because of its potentially anxiety-provoking effects (Siegel-Jacobs & Yates, 1996). In this vein, Ferris, Mitchell, Canavan, Frink, and Hopper (1995) have provided evidence suggesting that accountability has the potential to act as a workplace stressor with associated strain reactions (e.g. job tension and emotional exhaustion). Similarly, Hall et al. (2003) found that felt accountability was associated with higher levels of job tension and emotional labor.

Therefore, it is argued that this additional stressor should be incorporated in our understanding of CF among child protection workers. Research on these stressors, including accountability stress, is needed since CF may jeopardize a worker's sense of self while negatively impacting on his psychological wellbeing (Craig & Sprang, 2010).

5.2.1 An adapted and integrated model for child protection profession

Stamm (2009) ProQol is a generic model that allows for the integration of work-related stressors and factors that influence CS and CF. However, it needs to be adapted to the specificities child protection profession since some stressors are not considered, such as accountability. Thus, this adapted model needs to be tested empirically for a better assessment of the stressors that impact ProQol for child protection workers. Moreover, it needs to be examined in multivariate models, which allow for the integration of factors that influence ProQol.

5.3 Factors influencing compassion state

Many factors have been found to affect CF and CS. Gender, social support, professional identity, coping strategies, and confidence in coping with client aggression will

be discussed. Thus, these factors may have direct effects on ProQol or may allow indirect effects of stressors.

5.3.1 Gender

In studies with psychotherapists, social workers and child protection workers, being a female has been associated with higher risk of developing CF (Kassam-Adams, 1999; Meyers & Cornille, 2002; Sprang, Clark, & Whitt-Woosley, 2007). However, these studies focus on the biological sex of respondents rather than on their gender role, which refers to "expectations of what is appropriate behavior for each sex" (Weiten, 1997, p.325). Johnson, Greaves, and Repta (2007) argued that gender role can also directly affect men and women's behaviors and perceptions by ascribing expected roles, responsibilities, and activities to individuals based on their gender. Using the Bem Sex-Roles Identity scale (Bem, 1981), Tragno, Tarquinio, Duveau, and Dodeler (2007) found gender-differentiated consequences to work-related stressors among 367 workers from different professional sectors. For example, workers expressing more masculine traits were more psychologically affected by workplace aggression victimization than those with more feminine traits. When a worker with masculine traits and attitudes is a victim of a violent act, he/she might interpret it as a sign of weakness, which goes against the expected role of masculinity. Consequently, he/she might feel a decrease in self-confidence as well as increased self-doubt.

5.3.2 Social support

Figley (1995) identified that being unable to receive emotional support was a risk factor for CF. Osofsky et al. (2008) also found that limited job recognition, thus poor

organizational support, contributes to the development of CF for child protection workers. On the other hand, social support has been found to reduce CF (Chrestman, 1999; Rich, 1997; Schauben & Frazier, 1995).

5.3.3 Professional identity

Professional identity, which refers to a system of meanings and values associated with the worker's roles (Skorikov & Vondracek, 2011), may also intervene in the relation between stressors and compassion state for child protection workers. Identity guides a person's appraisal of stressful situations and, depending on this appraisal, the stressor may or may not psychologically impact the individual (Thoits, 1999). In a qualitative study with nurses, Åkerström (2002) found that these caregivers rely on their profession values and identity to interpret patient aggressions. In doing so, they reframe these stressful situations according to the framework of their job, restoring the normalcy of these aggressive behaviors and allowing them to keep on offering care services to their patients. In empirical studies with working adults, commitment to professional identity was found to be a strong predictor of lower levels of depression and anxiety while predicting higher levels of life satisfaction (McKeague, Skorikov & Serikawa, 2002; Skorikov, 2008). Moreover, studies have found that the more an individual is committed to his or her organization or profession, the more he or she will interpret work-related situations according to the organization's ideology, values and culture (Mael & Ashforth, 1992; Rousseau, 1998). Consequently, adhering to professional identity may reduce the impact of work-related stressors and workplace aggression.

5.3.4 Coping strategies

Saakvitne and Pearlman (1996) found that coping style may contribute to the rise of CF. Coping here refers to cognitive and behavioral efforts made by an individual to escape, tolerate or minimize stress (Lazarus & Folkman, 1984). Other studies have demonstrated that coping ability (Follette, Polusny, & Milbeck, 1994), emotional separation (Badger et al., 2008) and emotional disengagement (Figley, 2002) are factors that are negatively associated with CF. In addition, Schauben & Frazier (1995) found that active coping-strategies like problem-solving and asking for emotional support lead to fewer symptoms of CF. It also seems that therapists who assimilate traumatic material as told by their patients in their cognitive schemata or who adapt their cognitions to the stories report better coping with traumatic work-related stress (Minnen & Keijsers, 2000).

5.3.5 Confidence in coping with client aggression

Confidence in coping with patient aggression may also impact compassion state. O'Connell, Young, Brooks, Hutchings, and Lofthouse (2000) found that among nurses, poor confidence in skills to manage patient aggression amplified the stress of managing aggressive behaviors and was associated with more sick leaves, burnouts and a higher turnover rate. In a phenomenological study with caregivers in psychiatric settings, Carlsson, Dahlberg, Ekebergh, and Dahlberg (2006) found that confidence in managing potentially aggressive patients affects how a staff member interacts with patients. Lee (2001) found that nurses demonstrating confidence while managing difficult situations such as patient aggression were more likely to produce positive outcomes. Thus, confidence in coping with workplace aggression may reduce the odds of victimization while helping caregivers to cope with stressful situations.

5.3.6 Clinical experience

Cunningham (2003), in his study with social workers, found that the amount of clinical experience reduces CF. In the same vein, Galea (2007) demonstrated that years of experience were positively associated with CS. It then appears that professional maturity may protect helpers from CF.

5.4 Aims of the study

The present study, conducted among child protection workers, expands on the *Professional quality of life* model proposed by Stamm (2010). The main objective is to evaluate the effects of stressors, including accountability, and factors known to influence ProQol in path analysis model. More specifically, gender roles, perceived organizational support, adherence to the professional identity, coping ability and confidence in coping with client aggression will be used in the present study as intervening variables between stressors and ProQol. Findings from the present study could then inform the emergence of CF while promoting management and policy implications that decrease CF.

5.5 Hypotheses

Derived from the literature, a conceptual model was created (Figure 4) and six hypotheses were formulated:

(1) Exposure to workplace aggression, time of exposure to traumatic material and accountability are positively associated with CF and negatively associated with CS;

(2) Female gender role is positively associated with CF and partially accounts for indirect effects of stressors;

(3) Perceived organizational support is negatively associated with CF and positively associated with CS while contributing to indirect effects of stressors;

(4) Adherence to professional identity is negatively associated with CF and positively associated with CS while contributing to indirect effects of stressors;

(5) Use of coping ability is negatively associated with CF and positively associated with CS while contributing to indirect effects of stressors;

(6) Confidence in coping with patient aggression is negatively associated with CF and positively associated with CS while contributing to indirect effects of exposure to workplace aggression.

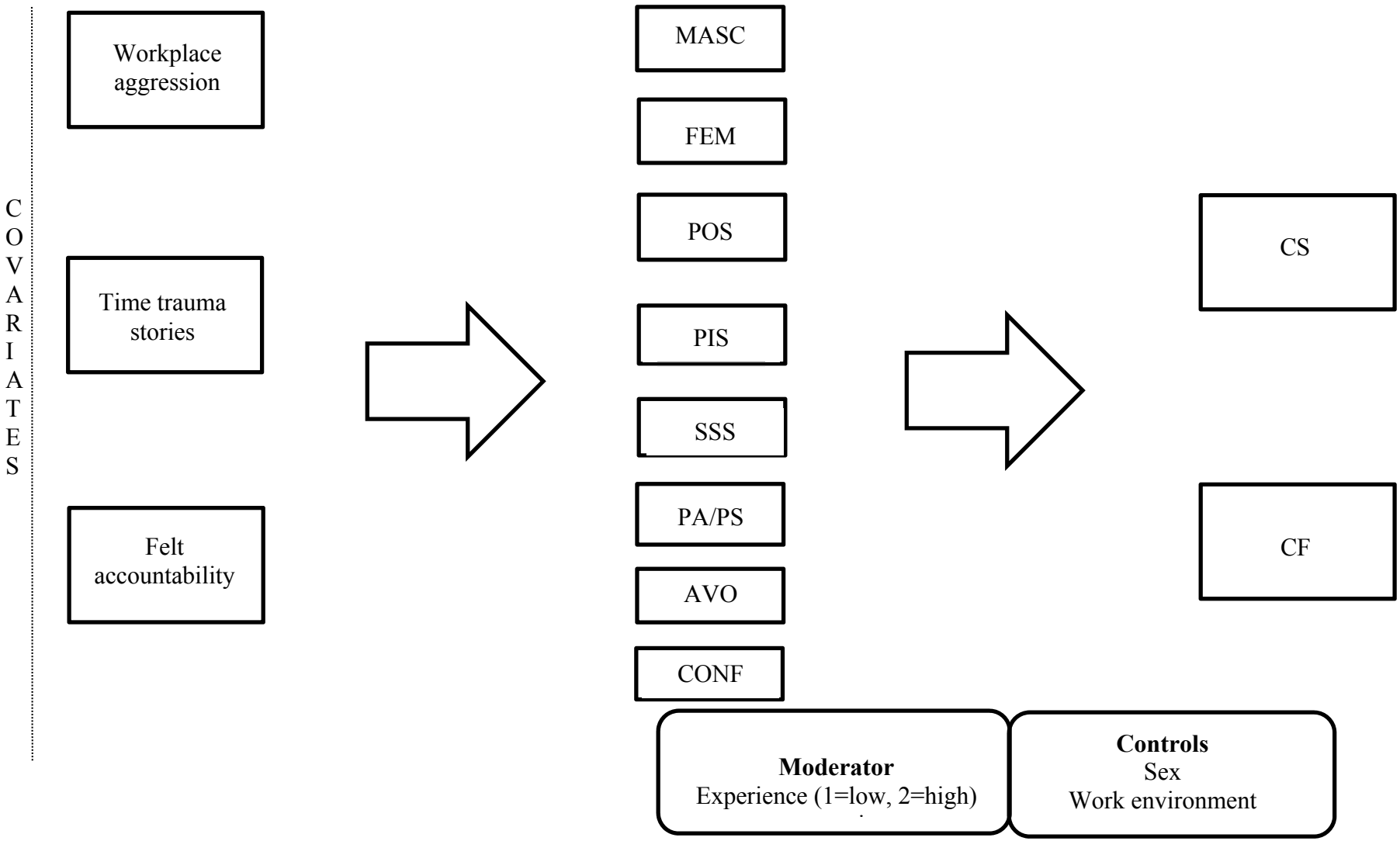


Figure 4 – Conceptual model**.**

5.6 Method

5.6.1 Participants

The current sample included 301 child protection workers. All participants were French-speaking residents from the province of Quebec (Canada) who worked in Monteregie's Youth Center[5] situated south of Montreal. Of these respondents, 46.5% were educators working in juvenile facilities or foster care centers (inpatient), 10.0% were educators working within family settings and 44.2% were human relation agents[6] (outpatient).

5.6.2 Sampling procedure

A randomized sample stratified by sex was recruited, which led to a proportion of 84.4% female respondents and 15.6% male respondents. Participants who have not been in contact with the clientele in the year prior to their completion of the survey and those on maternity leave were excluded from the sample.

The researchers were provided with a complete list of the child protection workers employed by Monteregie's Youth Center. From this list, selected workers were invited to participate in the study via email by a VISAGE (Violence at Work According to Sex and Gender) research team member. They were informed of the purpose of the study and of the anonymity of their answers. In addition, this email explained that Monteregie's Youth Center was excusing them for one hour of work in order to fill out the questionnaire. Participants were asked to return their consent form in order to receive a personal identification number

[5] In Quebec Canada, Youth Protection Services are operated by Youth Centers, which are divided geographically. Monteregie covers the territory south of Montreal and extending to the U.S. border.
[6] In Quebec Canada, social services of Youth Protection are multidisciplinary. Social workers, criminologists and psychoeducators act as human relation agents.

that would give them access to the online questionnaire. Participants answered anonymously and on a voluntarily basis. The data collection took place between November 2013 and July 2014. The valid response rate was 40.9%. The sample is also representative of Monteregie's Youth Center child worker population with a margin of error of 4.9% (19 out of 20 repeated polls). Post-hoc comparisons were made between respondents and non-respondents based on the institution's human resources data in regards to age, gender, type of work and years of experience. No statistically significant differences were found.

5.6.3 Measures

In order to test the ProQol model and hypotheses, a survey was developed and included 8 reliable measurement instruments: Perception of Prevalence of Aggression Scale (POPAS), Felt Accountability (FA), Perception of Organizational Support (POS), Professional Identity Scale (PIS), Clinician confidence in coping with patient aggression instrument (CONF), Bem Sex-Role Inventory (BSRI), Ways Of Coping Questionnaire (WCQ) and Professional Quality of Life (ProQol). In addition, information were collected concerning years of experience in child protection work, work environment (inpatient or outpatient), time spent in therapeutic interview with the clientele and time spent reading reports of clientele's problematic psychosocial situations.

Considering the spoken language of the assessed sample, the POPAS, the FA, the PIS and the CONF were translated since their French-Canadian versions were non-existent. These questionnaires were first translated and were subsequently revised by a professional linguist specialized in psychosocial studies. Following this, they were independently back-translated into English by a second professional translator and then revised by a third professional

linguist specialized in psychosocial research, following the procedure recommended by Brislin (1980).

5.6.3.1 Exposure to workplace aggression

The POPAS (Oud, 2001) is a 16-item self-report questionnaire designed to measure aggressive patient behaviors experienced by helpers in the past twelve months (Nijman, Bowers, Oud, & Jansen, 2005). It defines violence as *workplace aggressions*, which encompass any behavior by an individual who means to physically or psychologically as well as directly or indirectly harm a worker in a work-related context (Schat & Kelloway, 2005). Thus, it measures primary (e.g. "To what extent have you been confronted with severe physical violence (with major injury as result) during the last year in the course of your work?") and secondary traumatic stress (e.g. "To what extent have you been confronted with severe violence against self and with major injury as a result) during the last year in the course of your work?"). For each of the first 15 items, respondents first had to rate the frequency of perceived aggressive acts they experienced in the past twelve months on a five-point Likert scale (1 = never, 2 = occasionally, 3 = sometimes, 4 = often, 5 = frequently). Next, they are asked to provide an estimated number of times they experienced that type of aggression in the assessed year. The sixteenth item counted the number of days workers missed due to client aggression. For the present study, the 15 Likert-scale items that measured frequency of perceived exposure to different types of aggression were used and computed into a total score as suggested by Gale et al. (2009).

The POPAS has been recognized as a reliable instrument. In fact, those that tested the internal consistency of the scale obtained a Cronbach's Alpha ranging between 0.70 and 0.91

(Brown, Loh, & Marsh, 2012; Gale et al., 2009; B. James, Isa, & Oud, 2011; Jonker, Goossens, Steenhuis, & Oud, 2008; Nijman et al., 2005). In the present study, the POPAS showed good internal consistency ($\alpha = 0.85$).

5.6.3.2 Time of exposure to potentially traumatic material

In order to measure the time of exposure to potentially traumatic material, two questions were asked. The first was: "In the past 12 months, how many hours per week on average did you spend in meetings with your clients during which they were called on or were likely to talk about their problematic experiences?". The second was: "In the past 12 months, how many hours per week on average did you spend reading your clients' files?". The number of hours for both questions was summed up to measure the time of exposure to potentially traumatic material.

5.6.3.3 Felt accountability

In order to measure felt accountability**,** an eight-item self-report questionnaire utilizing Likert scales developed by Hochwarter, Kacmar, and Ferris (2003) was used (e.g. "I often have to explain why I do certain things at work). Studies relying on this instrument have demonstrated good psychometric properties of the FA questionnaire in terms of internal consistency ($\alpha = 0.74$ to $\alpha = 0.90$) and revealed the unidimensionality of the tool (Breaux, Munyon, Hochwarter, & Ferris, 2009; Hall et al., 2003; Hochwarter et al., 2007; Hochwarter, Perrewé, Hall, & Ferris, 2005). The scale utilized a 7-point response format with strongly disagree (1) and strongly agree (7) as endpoints. One item was not used within the present sample since it did not apply to the participants' situation (e.g "The jobs of many people at

work depend on my success or failures"). The seven-item translated instrument presented good internal consistency within the present study (α = 0.75).

5.6.3.4 Gender role

To measure gender role perceptions, a French version of the BSRI 20-item was used (Alain, 1987). Each item represented a gender-stereotype attitude/trait (e.g. "willing to take risks" for masculine, "eager to sooth hurt feelings" for feminine"). Respondents had to rate, from 0 to 7, the extent to which they self-identified to these attitudes/traits. A masculine score and a feminine score was then computed. Internal consistency for the masculine scale (MASC) in the present study was 0.82, while the feminine scale (FEM) was 0.86.

5.6.3.5 Perceived organizational support

To measure child protection workers' perception of organizational support, a high-loading 8-item scale was extracted from Eisenberger, Huntington, Hutchison, and Sowa (1986)'s 36-item instrument (e.g., ''My organization is willing to help me when I need a special favor"). The French version translated by Vandenberghe and Peiro (1999) was used. This translated instrument has shown good reliability (α = 0.89, α = 0.93) as well as discriminant validity (Vandenberghe et al., 2007; Vandenberghe & Peiro, 1999). Respondents had to rate on a 5-point Likert scale to what extent they agreed with each item (1 = not at all, 5 = completely). In the present, the 8-item scale showed good internal consistency (α = 0.92).

5.6.3.6 Adherence to professional identity

PIS (K. Adams, Hean, Sturgis, & Clark, 2006) was used to measure identification to professional identity. This instrument is a one-dimensional 9-item Likert scale questionnaire (e.g. “I feel I share characteristics with other members of the profession”;” I feel like I am a member of this profession.”) that showed good internal consistency (α = .79) in K. Adams et al. (2006)’s study among British students. Respondents had to rate on a 6-point Likert scale to what extent they agreed with each item (1 = highly disagree, 6 = highly agree). The translated instrument also presented good internal consistency within the present study (α = .89).

5.6.3.7 Coping strategies

A 21-item shortened French version (Bouchard, Sabourin, Lussier, Richer, & Wright, 1995) of the WCQ (Folkman & Lazarus, 1988; Mishara, 1987) was used to measure coping strategies. Each item was ranked on a 4-point Likert scale from 0 (not used) to 4 (very used). This version, tested with 1012 French Canadian adults, yielded a 3-factor structure: social support seeking (SSS), positive appraisal/problem-solving (PA/PS), and avoidance (AVO). Alpha reliabilities were .85, .80, and .76, respectively. In the present study, alpha reliabilities were .76, .82, and 76, respectively.

5.6.3.8 Confidence in coping with client aggression

The CONF instrument was used to measure “self-attributed ability, preparation and comfort in safely and effectively intervening psychologically and physically with the aggressive patient for purposes of self-preservation and therapeutic intervention” (Thackrey, 1987, p. 58). This one-dimensional instrument is composed of 10 items on a Likert scale

ranging from 1 to 11. The instrument showed good internal consistency in Thackrey (1987) first use with 183 clinicians (α = .92) as well as in the present study (α = .93).

5.6.3.9 Compassion satisfaction and compassion fatigue

The French version of the Professional Quality of Life Scale: Compassion Fatigue and Satisfaction Version 5 (ProQol) (Stamm, 2009) was used to measure the two endogenous variables of the present study. Composed of 30 items, this self-report instrument contained three 10–item subscales assessing burnout, secondary traumatic stress and compassion satisfaction. Each question assessed how frequently the respondents experienced the item captured within the scale, in the last 30 days using a 5-point Likert scale from 1= never to 5 = very often. The developer reports that Cronbach's α for the subscales are .88 for compassion satisfaction, .81 for secondary traumatic stress, and .75 for burnout (Stamm (2009). However, in the present study, the burnout subscale did not have satisfactory internal consistency. Since Figley (2002) and Stamm (2009) argued that burnout and secondary traumatic stress are two latent concepts of compassion fatigue and that have not been proven empirically separable (Figley & Stamm, 1996; Stamm, 2005), we computed the two subscales to measure compassion fatigue. The internal consistency of compassion satisfaction and fatigue were good with Cronbach's α of .90 and .76 respectively.

5.6.3.10 Control and moderator variables

Sex of the respondents and work environment were controlled for in the present study. Indeed, work environment (inpatient vs. outpatient) influenced the number of hours directly spent with the clientele and thus, the odds of being exposed to workplace aggression.

Educators working in juvenile facilities constituted the inpatient group while educators and human relation agents working within family settings comprised the outpatient group. Of the respondents, 46.5% worked in inpatient settings while 53.5% in outpatient.

Years of experience was used a moderator variable in the present study since reviewed literature demonstrated that this factor may influence the impact of stressors on compassion state. Using the median (7.21) as a cut-off, two groups were formed: low and high experience.

5.6.4 Analyses

Spearman rho was used to assess the correlation among variables. According to Bobko (2001), Spearman rho should be privileged, rather than Pearson, when correlations between self-report ordinal scales are assessed since they are more conservative and help compensate the possible inflations due to self-report. Path analysis was used to test the hypotheses and the proposed integrated model. Indirect effects were tested using bootstrapping (with n = 5 000) procedures as instructed by Preacher and Hayes (2008). Moderations effects were tested using multi-group method (years of experience). Level of significance used was $p < .05$. Figure 1 shows the conceptual path model.

Including paths from identified stressors to intervening factors has the added advantage of testing indirect associations from stressors to CS-CF. Using structural equation modeling is appropriate for observing indirect effects between X → Y through an intervening variable (M) (Mathieu & Taylor, 2006). However, indirect associations will be discussed rather than mediated causal effects. *MPlus 7.3* was used to run these analyses.

5.7 Results

Table I shows the mean total score and standard deviation for each variable. The correlation matrix is also represented in Table I. The association between CS and CF was negative and significant (Spearman's rho = -.414; $p < .001$), thus proving evidence of convergent validity. According to Haynes (2001, p.75), convergent validity refers to "the degree to which the data form the assessment instrument are coherently related to other measures of the same construct as well as to other variables that they are expected, on theoretical grounds, to be related to the construct".

Table I

Descriptive Statistics and Correlations Among Variables

Variable	*Scale range*	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12
1. POPAS	15-75	31.49	7.35	-											
2. Traumatic Material	-	11.89	9.72	-.34	-										
3. FA	7-35	20.60	4.84	-.06	.26	-									
4. MASC (BSRI)	7-70	47.68	7.20	.18	-.01	.13	-								
5. FEM (BSRI)	7-70	57.87	6.08	.07	.09	.01	.11	-							
6. POS	8-40	24.68	6.15	.08	-.17	-.21	.05	.12	-						
7. PIS	9-54	46.39	6.52	.18	-.14	-.16	.17	.29	.53	-					
8. SSS	0-18	8.61	3.46	.11	.05	.00	.03	.20	.11	.15	-				
9. PA/PS	0-27	11.46	4.75	.09	.08	.06	.20	.19	.17	.13	.48	-			
10. AVO	0-18	3.87	3.11	.10	-.04	.26	-.09	-.08	-.18	-.17	.11	.10	-		
11. CONF	10-110	61.81	17.52	.30	-.24	-.10	.26	.05	.30	.18	.00	.16	-.11	-	
12. CS (ProQol)	10-50	38.05	5.35	.20	-.08	-.07	.29	.22	.39	.55	.21	.35	-.18	.32	-
13. CF (ProQol)	20-100	43.82	7.72	.08	.18	.35	-.20	-.08	-.21	-.29	.07	-.04	.44	-.33	-.41

Note. N=301. Scale range = scale possible range. POPAS = workplace aggression exposure; Traumatic material = Time exposed to traumatic material; FA = Felt accountability; MASC = masculine traits; FEM = feminine traits; POS = Perceived organizational support; PIS = Adherence to the professional identity; SSS = Social support seeking; PA/PS = Positive appraisal/problem-solving; AVO = Avoidance; CONF = Confidence in coping with clients' aggression; CS = Compassion satisfaction; CF = Compassion fatigue. $r = .12–.15$, $p < .05$; $r = .16–.20$, $p < .01$; $r > .21$, $p < .001$.

The path diagram is shown in Figure 5. According to Hu and Bentler (1999), the results of various goodness-of-fit measures suggested that this model was acceptable (x^2=33.46, *df* = 24, *p* > .05; RMSEA =.04; CFI = .99; SRMR =.05). Consequently, it was possible to test the five formulated hypotheses while answering our objective; to test ProQol in an integrated model. D1 and D2 represent errors of endogenous variables.

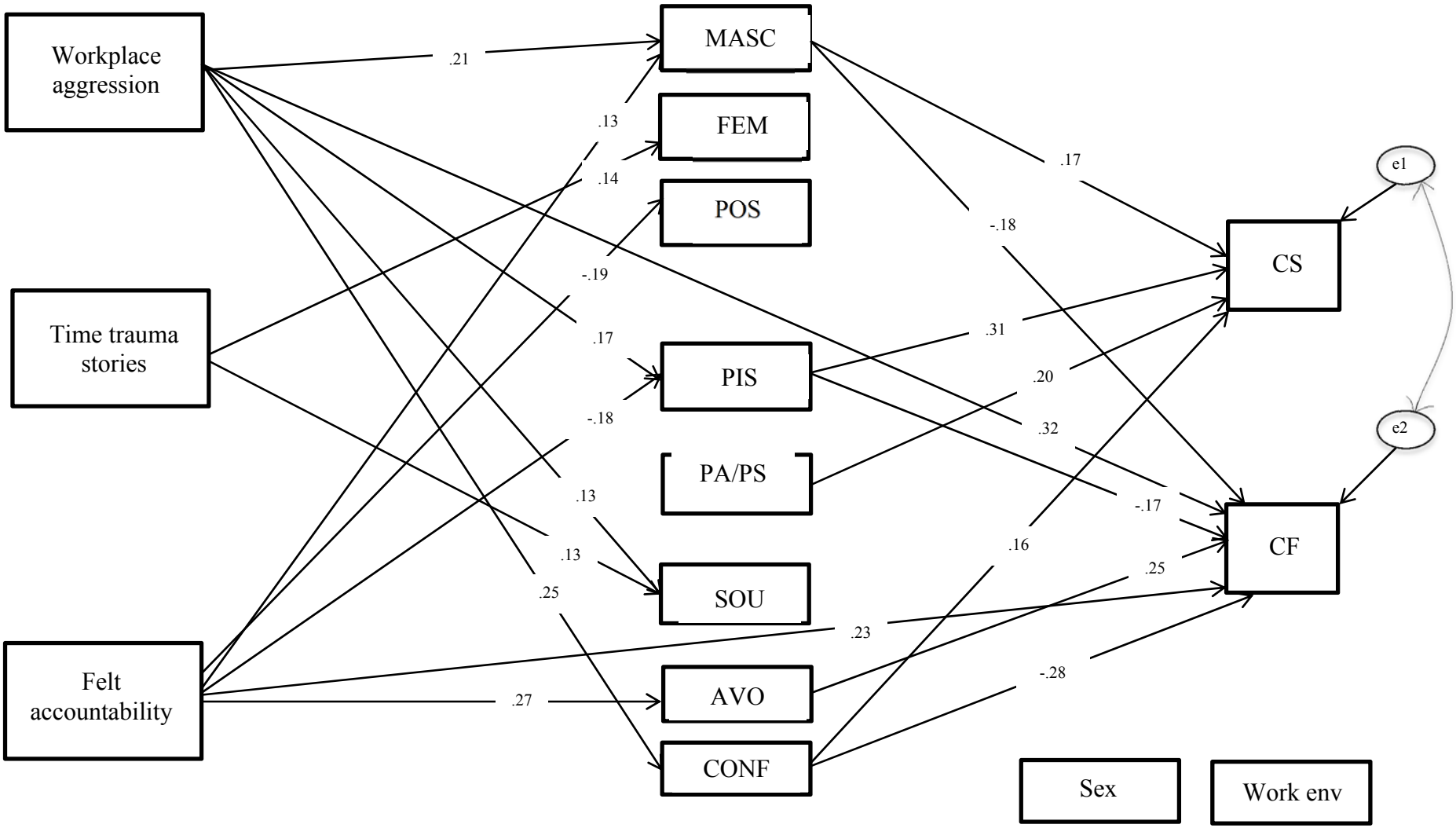


Figure 5 – Path diagram.

5.7.1 Compassion satisfaction

R^2 for CS was equal to 0.35. If this revised model accurately reflected reality, POPAS, the time of exposure to traumatic material and FA had no direct effect on CS. However, some factors had positive direct effects on CS as expected. In an ascending order of strengths and statistical weights, they were PIS, PA/PS, MASC and CONF. Still, multi-group moderations tests revealed that the number of years of experience reduced the effect of PIS on CS (t =-*2.06, $p < .05$*). Infirming *hypothesis 3*, POS was not associated to CS.

Table II shows tests of indirect effects. These analyses confirmed the significance of the indirect effects of MASC, PIS and CONF in the relation between POPAS and CS. All these indirect effects were positive and all accounted for 100% of the total effect of POPAS on CS. PIS also had a negative indirect effect in the relation between FA and CS and accounted for 12% of the total effect. MASC had no indirect effect in this relation.

Table II

Indirect effects for multiple intervening variables on CS and CF (n = 301, 5 000 Bootstrap sample)

	Indirect effect	S.E.	Indirect effect 95% CI
Predictor : POPAS			
Trough MASC on CS	0.02*	0.01	0.00 – 0.05
Trough MASC on CF	-0.04*	0.02	-0.07 – -0.01
Trough PIS on CS	0,04**	0.01	0.01 – 0.06
Trough PIS on CF	-0.03*	0.01	-0.06 – -0.00
Trough CONF on CS	0.03*	0.01	0.0 – 0.05
Trough CONF on CF	-0.07**	0.02	-0.12 – -0.04
Predictor : FA			
Trough MASC on CS	0.02	0.01	-0.00 – 0.05
Trough MASC on CF	-0.04	0.02	-0.08 – -0.00
Trough PIS on CS	-0.06*	0.01	-0.11 – -0.02
Trough PIS on CF	0.05*	0.02	0.00 – 0.09
Trough AVO on CF	0.10**	0.03	0.04 – 0.15

Note. The heading "Indirect" refers to the magnitude of the effect of the predictor that is attributed to the corresponding intervening variable for that row. Models with multiple indirect effects used a 95% CI. $* p < .05$. $** p < .01$.

5.7.2 Compassion fatigue

R^2 for CF was equal to 0.39 . If this model accurately reflected reality, POPAS and FA had positive direct effects on CF. Of these two stressors, POPAS was the strongest in terms of the statistical strength of the relation and weights in the multivariate model. AVO also appeared as a positive predictor of CF. On the other hand, MASC, PIS and CONF were negatively related to CF. In terms of strength of relation between these factors and CF, CONF

was the strongest, followed by AVO, PIS and MASC. FEM was not related to CF, thus infirming *hypothesis 1*.

Tests of multivariate indirect effects showed that MASC, PIS and CONF contribute to the indirect relation between POPAS and CF. MASC accounted for 14% of the total effect, PIS for 10% and CONF for 22%. These indirect effects were negative, thus contrary to the direct effect. According to MacKinnon, Fairchild, and Fritz (2007), this refers to inconsistent associations where the intervening variable may act as a suppressing variable. As such, when considering MASC, PIS and CONF, the total effect of POPAS on CF is then likely to be smaller than because the direct and indirect effects will tend to cancel each other out. MASC did not contribute to indirect relation between FA and CF. However, PIS (12% of the total effect) and AVO (23% of the total effect) did for the relation between FA and CF.

5.8 Discussion

The aim of the present study was to provide a quantitative examination of the ProQol model (Stamm, 2009) in a representative sample of 301 child protection workers. Using path analysis modeling, masculine attitudes, adherence to professional identity, positive appraisal/problem-solving coping strategies, and confidence in coping with client aggression were found to be positively associated with CS. Furthermore, exposure to workplace aggression had positive indirect effects on CS through masculine attitudes, adherence to professional identity and confidence in coping with client aggression. As for CF, exposure to workplace aggression, felt accountability, and avoidant coping strategies had positive direct effects while masculine attitudes, adherence to professional identity and confidence in coping with client aggression had negative direct effects. Consequently, inconsistent associations

were found in the relation between workplace aggression and CF through these three factors. Finally, adherence to professional identity and avoidance were found to contribute to the indirect effect between felt accountability and CF. In light of the results and to answer the objective of this paper, the results for each hypothesis will be discussed.

5.8.1 Hypothesis 1: The impact of stressors

The first hypothesis was partially supported since all stressors did not influence CS and CF. When comparing correlations among variables and the results of multivariate path analysis modeling, it is possible to observe how different factors influence CS and CF when other variables are controlled for. Thus, the multivariate model allowed for the findings of the present study to emerge.

With regard to the impact of exposure to workplace aggression, the time of exposure to traumatic material and accountability stress on CS, path analysis revealed no significant relations in the integrated model. These findings suggest that these stressors do not directly alter the satisfaction associated with the task of helping children and families in need. In a sense, it reflects the current state of the literature since previous studies have demonstrated that factors associated with CS are individual and organizational characteristics that promote satisfaction, not stressors that hinder it. For example, Craig and Sprang (2010), in a study among 532 American trauma therapists, suggested that clinical experience and use of evidence-based practices were significant predictors of CS. Thus, CS may be influenced by factors that impact work success (e.g. using evidence-based practices) to a greater extent than by consequences of work-related stressors (e.g. exposure to workplace aggression).

However, exposure to workplace aggression and felt accountability were found to have indirect effects on CS in the integrated model through self-identification to masculine stereotyped attitudes, adherence to professional identity and confidence in coping with client aggression. These stressors therefore influenced CS through the individual characteristics of the child protection workers. The same applied to accountability since it had an indirect effect through professional identity.

On the other hand, exposure to workplace aggression had direct effect on CF. The more child protection workers perceived that they were frequently exposed to workplace aggression, the higher they scored on CF. This supports studies that have provided evidence of the positive association between exposure to workplace aggression and psychological consequences (AbuAlRub & Al-Asmar, 2011; Arnetz & Arnetz, 2001; Demir & Rodwell, 2012; Gates, Gillespie, & Succop, 2011; Whittington, 2002). Consistent with the ProQol model (Stamm, 2009), it demonstrates that even in an integrated model accounting for sex, work environment, work-related stressors and intervening factors, exposure to workplace aggression still impacts CF.

The time of exposure to traumatic material emerging from interviews with clients or their records was not associated to CS or CF in an integrated model. These results are inconsistent with Figley (1995)'s and Stamm (2009)'s models. Bivariate analysis revealed a significant and positive relation between this measure of potentially vicarious traumatic stress and CF. However, in the multivariate model used, this type of traumatic stress did not impact CF. This absence of relation may be attributable to multivariate analysis or to the measure used for this concept. Indeed, only counting the hours spent with clientele or reading reports may not have adequately evaluated the reality of vicarious traumatic stress.

Accountability also had a direct and positive effect on CF; the more child protection workers felt accountable for their clinical work, the more they were affected by CF. Consistent with Osofsky et al. (2008), this finding supports the inclusion of accountability as a stressor in Figley (1995)'s and Stamm (2009)'s models. Indeed, felt accountability adds to the complexity of the work while increasing occupational stressors that are associated to CF (Badger, Royse, & Craig, 2008; Dollard et al., 2003). This finding then bolsters the current study's proposition that the ProQol needs to be adapted in order to consider the specificities of child protection work.

5.8.2 Hypothesis 2: The impact of sex and gender

The integrated model showed no significant differences in CS and CF according to the sex of the child protection workers. Thus, it is inconsistent with Tolin and Foa (2006)'s meta-analysis that revealed that women were more likely than men to meet diagnostic criteria for PTSD after experiencing a potentially traumatic situation. However, gender roles had an impact on CS and CF. Self-identification to masculine stereotyped attitudes was found to be positively associated with CS of the child protection workers while negatively associated with CF. Moreover, this self-identification to masculinity contributed to indirect effects between exposure to workplace aggression on both CS and CF; it partially accounted for the relation between these variables. However, the indirect effect on CF was negative whereas the direct effect was positive. Concretely, this means that the more child protection workers were exposed to workplace aggression, the more they self-identified to masculine stereotyped attitudes. Then, the more they self-identified to masculine attitudes, the less they developed CF. In other words, high exposure to workplace aggression was associated with high

masculinity, and in turn to low CF. As mentioned, this reflects an inconsistent association in which the intervening variable acts as a suppressing variable (MacKinnon et al., 2007). It could therefore be hypothesized that masculinity, in the way that it was measured, had this suppressing effect since it reflects the child protection worker's propensity to engage in risk-management and take a stand in stressful situations, which characterizes the work of a caregiver in a context of authority.

Since feminine stereotyped attitudes had no significant relations with CS or CF in the integrated model, the second hypothesis was infirmed. Nevertheless, by including gender role in the proposed model of CS-CF, it was possible to find that masculinity suppressed a part of the positive association between exposure to workplace aggression and CF. Therefore, it demonstrates that considering gender role is relevant to the study of CF since it specifies the relation between these variables and may therefore explain why some workers are less affected by workplace aggression. Thus, men and women manifesting masculine stereotyped attitudes may be more suited for this profession, in which one has to deal with an aggressive clientele.

5.8.3 Hypothesis 3: The impact of organizational support

The hypothesis regarding the effect of perceived organizational support on CF and CS was infirmed. This type of support lost its significance in the multivariate model. Consequently, it did not contribute to indirect effects of stressors on compassion state. Inconsistent with studies that have shown a relation between support and CF, these findings highlight once again the necessity of using an integrated model in order to assess the impact of intervening variables, which accounts for the total effect of stressors on CS-CF. Another

explanation may also refer to the type of support assessed. In fact, previous studies have focused on social support or emotional support (K. Adams et al., 2006; Berzoff & Kita, 2010; Figley, 1995; Schauben & Frazier, 1995), not organizational support.

5.8.4 Hypothesis 4: Adherence to professional identity

Adherence to professional identity had a positive effect on CS and a negative effect on CF. Moreover, it partially accounts for the effect of workplace aggression exposure on CF while contributing to the indirect effect of felt accountability on CF. However, the number of years of experience moderated this effect of professional identity on CS and CF. Indeed, highly experienced child protection workers benefited from the positive link between PIS and CS to a lesser extent than less experienced workers. However, even though they had more experience, the more child protection workers positively identified themselves with this profession, the more they had CS and the less they developed CF.

These findings are consistent with studies that demonstrated that a strong professional identity contributes to psychosocial adjustment, well-being, and life satisfaction while decreasing levels of depression and anxiety (Christiansen, 1999; Kroger, 2006; McKeague et al., 2002; Skorikov, 2008; Vondracek, 1995). Therefore, management should promote the professional identity of child protection work in order to increase the sense of belonging of their workers. Since this variable only contributed to indirect effects of workplace aggression and felt accountability, the hypothesis related to professional identity was partially confirmed.

5.8.5 Hypothesis 5: Coping strategies

Three types of coping strategies were included in the integrated model proposed in this study. Only two were found to impact the ProQol. Avoidance increased CF while positive appraisal/problem-solving augmented CS. Avoidance also partially accounted for the indirect effect between accountability and CF. Once more, support was not associated with compassion state in an integrated model. Nuancing findings of Schauben and Frazier (1995) and van Minnen and Keijsers (2000), positive appraisal was positively associated with CS, but not negatively linked to CF. In addition, contrary to Badger et al. (2008) and Figley (2002), avoidance was a positive predictor of CF, not a negative one. Therefore, the hypothesis regarding coping strategies was partially confirmed and highlighted the need for more research on coping strategies as intervening variables of the ProQol of caregivers.

5.8.6 Hypothesis 6: Confidence in coping with client aggression

In addition to positively impacting CS and negatively impacting CF, confidence in coping with client aggression contributed to indirect associations between exposure to workplace aggression and both CS and CF. Confirming this hypothesis, it supports the reviewed literature on the impact of confidence in one's ability to manage aggressive behaviors. More precisely, these findings specified how confidence impacts both aspects of the ProQol. Thus, it strengthens the value of self-confidence when managing client aggression.

5.8.7 Policy and clinical implications

The findings of this study lead to multiple policy and clinical implications. First, results showed that gender role identity must be considered in child protection work settings. Since management can hardly influence gender traits and attitudes, they may be screened for

during hiring procedures. For example, individuals demonstrating masculine traits such as self-confidence and ability to deal with risk-taking and to defend their decisions may be privileged. Also, management can accompany others who correspond to those traits to a lesser extent with risk-management and decision-making through clinical supervision or by providing standardized clinical tools.

Second, professional identity should be reinforced since it is positively associated with CS and negatively associated with CF. Management could conduct a promotional campaign to enhance the sense of belonging to the profession. Management can also remind their workers of the mission of child protection work and its impact on society since adherence to professional identity also means that the worker embraces the mandate of his profession.

Third, positive appraisal and problem-solving should be emphasized through clinical supervision. Disturbed by a work-related incident or a difficult case, child protection workers should be helped by supervisors in order to reappraise this difficulty and to work with a problem-solving approach. In this vein, management should identify the difficulties encountered by their employees in order to diminish avoidance.

Fourth, findings confirmed the positive effect of self-confidence in managing workplace aggression. This result endorses the dissemination of violence minimization and de-escalation training programs. Indeed, studies have shown that training increased self-confidence (Allen & Tynan, 2000; Collins, 1994; Farrell & Cubit, 2005).

Finally, CS was found to be negatively related to CF. Thus, all factors found to increase CS should inspire management strategies. By privileging individuals with masculine traits, enforcing professional identity and promoting confidence and coping with client aggression, management may increase CS while decreasing CF; two birds with one stone.

5.8.8 Study limitations and directions for future research

This study has some limitations. First, the cross-sectional nature of the design limits the possibility of making causal links. Next, the measure of vicarious traumatic stress may not have been accurate enough to adequately capture the phenomenon. Self-reporting may not truly represent the real exposure to workplace aggression or the real magnitude of accountability. Still, this did not interfere with the study since the focus was put on subjective perceptions and how they affect the ProQol of helpers. Similarly, the measure of organizational support may not have been appropriate. However, support-seeking coping strategies did not appear as a significant factor. Response rate may also suggest that respondents were the most preoccupied with the subject while the one who did not participated were too affected by the stressors or their work or were on sick leaves making it impossible to respond to the invitation.

Since only survey instruments were used to collect all of the data, it can raise immediate concerns regarding common method variance. However, common method variance would be a legitimate concern if spuriously high relationships between independent and dependent variables were evident in this study (L. R. James, Gent, Hater, & Coray, 1979). An examination of the correlation matrix fails to suggest such a generally inflating mechanism (*rho*=.55 for PIS and CS was the highest correlation). Although it is impossible to completely rule out common method variance effects, they do not appear to be overly influential in the current study.

Still, more research is needed in order to assess the effects of other variables known to influence CS and CF. Bureaucratic constraints and institutional contingencies, for example,

are included in the ProQol model and may create work-related stress. These features have not been treated in this study, but should be the focus of additional research. Furthermore, future studies should employ prospective and longitudinal methods to evaluate the fluctuation through time of the ProQol since CS and CF are dynamic concepts. Indeed, Mathieu (2007) proposed that CF must be seen as a continuum, meaning that at various times in the helper's career, he may be more or less vulnerable to its effects. A longitudinal design would also enable mediation analysis. Finally, the present study demonstrated the importance of using multivariate models in future research.

5.9 Conclusion

Findings of the present study pointed towards the integration of a fourth variable in Figley (1995)'s compassion fatigue model and Stamm (2009)'s ProQol model: accountability stress. Since CF is specific to work-related situations (Adams et al., 2006), it was proposed that this type of stressor can affect child protection workers as much as other traumatic stress. The present paper also demonstrated the need for integrating all stressors and intervening variables in one model. Factors known to decrease or increase compassion state such as exposure to workplace aggression were confirmed in the proposed model while others were infirmed, losing significance in the multivariate analysis. Finally, findings revealed factors that management can target in order to mitigate compassion fatigue: masculine traits, adherence to professional identity, positive appraisal/problem-solving, confidence in coping with patient aggression and CS. This study should be replicated in other caregiving settings to validate its findings.

Chapter 6 - Predictors of trivialization of violence among workers of two at-risk sectors

6.1 Introduction

Some workers are at higher risk of being exposed to violence in their workplace as their duties involve different risk factors such as having contact with emotionally distressed individuals, supporting people in crisis and enforcing rules and regulations. In fact, public service professions involve constant interaction with people who have a wide array of needs and demands (Hawkins, 2001). Consequently, several studies highlighted the high prevalence of assaults directed against caregivers, especially in healthcare settings (Erickson & Williams-Evans, 2000; Isaksson, Åström, & Graneheim, 2008; Nachreiner, Gerberich, Ryan, & McGovern, 2007). Other studies showed that law enforcers are particularly exposed to violent behaviors during the course of their daily work (Brown, Fielding, & Grover, 1999; Dick, 2000; McCarty, Zhao, & Garland, 2007; Wells, Colbert, & Slate, 2006). Therefore, caregiving and law enforcement represent two categories of workplaces that are particularly at risk of worker victimization. In both work environments, violence has been associated with negative outcomes such as burnout, turnover, post-traumatic stress disorder (PTSD), loss of empathy, poor service delivery, depression, anxiety, psychosomatic disorder and absenteeism (Aquino & Thau, 2009; Arnetz & Arnetz, 2001; Brown et al., 1999; He, Zhao, & Archbold, 2002; Jackson, Clare, & Mannix, 2002; Pich, Hazelton, Sundin, & Kable, 2011).

6.1.1 Trivialization of violence

Nevertheless, caregivers and law enforcers tend to trivialize violence in the workplace (Åkerström, 2002; Dyrkacz, Mak, & Heck, 2012; Erickson & Williams-Evans, 2000; Macdonald & Sirotich, 2001). Currently, the term "trivialization of violence" is not clearly defined in the literature. Still, two aspects are repeatedly evoked when this concept is directly or indirectly discussed. The first is normalization of violence. The second is avoiding an open discussion of workers' discomfort with workplace violence, because such a discussion would lead to negative peer judgments. In the present study, trivializing violence will therefore refer to normalizing violence or to muting emotional discomfort about it. It is precisely on such features that this article is centered: what contributes to *normalization* and the perceived *taboo* of workplace violence. Hence, violence will refer to any aggressive behavior that threatens the safety and wellbeing of the worker (Nijman, Allertz, Merckelbach, A Campo, & Ravelli, 1997).

In healthcare settings, violence is often considered to be an unavoidable aspect of the profession and has been integrated in the caregivers' culture (Åkerström, 2002; Menzel, Brooks, Bernard, & Nelson, 2004; Rippon, 2000). Many nursing studies have shown that the majority of nurses believe that getting assaulted by a patient "goes with the job" (Erickson & Williams-Evans, 2000; Nachreinel et al. 2007). It seems that caregivers tend to justify their patients' aggression, attributing it to their medical condition in order to maintain the therapeutic bond or to preserve the morale of the team (Svendrup-Phillips, 2003). By doing so, they normalize their patients' violence. Moreover, they may excuse these aggressive behaviors and take the blame, arguing that their victimization reflects their own bad performance (Isaksson et al., 2008; Trossman, 2006). As for law enforcers, they are expected to deal with

violent behaviors; it is part of their routine and curriculum. In a qualitative study conducted among 35 police officers, Dick (2000) found that police officers were often shocked by their own psychological reactions when facing violent events that they did not perceive as out of the ordinary by any means. These results suggest that violence in the workplace is so inherent and normal to the job that a negative reaction towards it is considered to be abnormal.

Caregivers and law enforcers also tend to mute their discomfort with violence for fear of being stigmatized as "being incompetent" or "not fit" for their jobs (Åkerström, 2002; Dick, 2000; Macdonald & Sirotich, 2001; Norris & Kedward, 1990). Complaining about violence is depicted as contrary to the nature of healthcare professions (Jones & Lyneham, 2001). For example, based on the nature of their role, nurses are expected to deal with conflicts (Trossman, 2006). Thus, complaining about violent conflicts goes against expected roles and attitudes. For law enforcers, this phenomenon may be amplified by the insular nature of "policing" work and its occupational culture and values (Heidensohn, 1992; Reiner, 2010; Waddington, 1999). Like Brown et al. (1999) mentioned, making feelings explicit is not endorsed by the police occupational culture. Furthermore, officers will suppress emotional reactions or feelings of distaste because "part of their work is to be tough, to suppress emotions", (Gersons, 1989, p.252). That is, they will block feelings in stressful situations for fear of not performing well in the eyes of their peers (Mann & Neece, 1990). It is then erroneous to think that they will openly discuss their discomfort towards violence in the workplace.

6.1.2 Culture of silence

Thus, defining violence as being normal in the workplace and refraining from complaining about it creates a culture of silence. According to Dragon (2006), this culture of silence contributes to underreporting victimization incidents in the workplace. For MacDonald & Sirotich (2001), underreporting is a product of professional socialization. So, while violence in the workplace is trivialized, work-related threats and violence are not reported accurately (Dyrkacz et al., 2012; Jonker, Goossens, Steenhuis, & Oud, 2008). Consequently, this problem cannot be addressed appropriately, leaving workers at risk of being victims of workplace violence (Dyrkacz et al., 2012). As noted by Littlechild (1995), underreporting violence impairs the capacity of researchers and policy makers to assess the real prevalence and severity of workplace violence. Therefore, strategies developed to deal with violence in the workplace or to help workers cope with it are not optimal (MacDonald & Sirotich, 2001). Hence, understanding factors that contributes to the trivialization of violence in the workplace and developing strategies to counter underreporting may help to prevent physical and psychological harm.

6.1.3 Professional identity

The notion that the nature of the job influences perceptions and attitudes of workers is recurrent when studying trivialization of violence in the workplace. Indeed, authors like Dick (2000) and Åkerström (2002) argued that the insular nature of the job and its occupational culture construct the worker's identity and influence his perceptions of himself and his work environment. For Dick (2000), policing identity operates at the collective level to "normalize" some emotional responses and "pathologize" others that are contrary to the police

organizational culture. Graef (1990) also argued that police culture promotes so-called masculine values, such as being able to manage potentially violent situations. For Åkerström (2002), caregivers will downplay violence from the patients in order to preserve their identity as caregivers and the boundary of their work.

This interaction between occupational culture and perceptions of violence in the workplace supports the concept of "professional identity". In a study with nurses, Fagermoen (1997) suggested that there is an institutionalized set of values inherent to the nursing profession that influences the development and sustainment of professional identity, which is shaped trough professional socialization and work experiences. Professional identity is then defined as a set of values and beliefs held by the nurse that guides his/her thoughts, actions and interactions related to his/her profession; it serves as a subjective interpretative framework which guides the understanding of work-related situations. Since this identity plays a critical role in the perceptions of what is trivial and what is not in the workplace, this concept will serve as a theoretical framework for the present study.

6.1.4 Individual factors

Studies on stress and gender have shown that men and women differently perceive and experience their occupational accurate stressors (Barnett, Biener, & Baruch, 1987; Johnson, Greaves, & Repta, 2007; Wells et al., 2006). In fact, women are more likely to make sense or rationalize violence, while men tend to see it as a power-struggle (Tragno, Tarquinio, Duveau, & Dodeler, 2007; Vartia & Hyyti, 2002). Johnson et al. (2007) argued that individuals' every day actions are influenced by their gender role. Gender roles refer to the behavioral norms and expectations applied to men and women in society. Consequently, gender can directly affect

men and women's behaviors and perceptions by ascribing different roles, responsibilities, and activities to individuals based on their gender. Thus, gender roles may often serve to categorize individuals within an institution. These authors give the example of masculinity, which is often associated with toughness in our society (Johnson et al., 2007). As a result, masculine individuals may be less likely to seek help for health concerns as they prefer to "tough it out".

Victimization can also increase one's trivialization of violence in the workplace. Nachreiner et al. (2007) demonstrated that nurses who experienced physical assaults were more likely to accept violence as "part of the job" than those who had not experienced such victimization. In a study of violence towards educators in foster care homes, Geoffrion and Ouellet (2013) found that the proportion of workers who thought that violence was trivialized in their workplace was greater for the group who had been victim of physical assault than for the group who had never experienced such an assault. In this sense, some studies report a "habituation" phenomenon, which contributes to normalization of violence in the workplace (Dyrkacz et al. 2012; Erickson & Williams-Evans, 2000). For Erickson & Williams-Evans (2000), habituation to at-work violence refers to a process whereby a worker who may initially experience emotional responses towards violence responds less and less as he or she gets exposed to it. At some point, the worker will not even recognized that he or she is being assaulted.

6.1.5 Organizational factors

Individual characteristics are not the only factors involved in trivialization of violence in the workplace. In fact, when people join organizations, they acquire not only new skills but

also new identities and ways of thinking (Dick, 2000; Hill, 1992). So far, the response to violence in the healthcare sector has ranged from ignoring the problem to instating aggression minimization training and more recently, a "zero tolerance" policy (Holmes, 2006). With the introduction of these "zero tolerance" policies by organizations in the nursing environment, violence was expected to be perceived as unacceptable and liable to some sort of sanctions (Whittington, 2002).

The literature on both work environments has addressed the importance of colleagues' and supervisors' support in buffering the effects of violence in the workplace (Brown et al., 1999; Littlechild, 2005). However, in a trivialization context, habituation and acceptance of violence in the workplace have been depicted as a result of professional socialization (Brown et al., 1999; Dick 2000).

6.1.6 Aims of the study

The present study aims to fill a part of the gap in the literature about the trivialization of violence in workplaces characterized by high rates of aggressive behaviours from the clientele. Whether workplace violence is perceived as being "part of the job" or muted by the worker in order to avoid being stigmatized as "incompetent", individual and organizational factors seem to contribute to the minimization of violence in the workplace. Consequently, trivialization of workers' victimization leads to under-reporting, thus affecting the capacity of organizations to appropriately address work-related threats (Dragon, 2006; Dyrkacz et al., 2012; Erickson & Williams-Evans, 2000; Macdonald & Sirotich, 2001). Before assessing the consequences of characterizing violence as trivial, we must further investigate what factors lead to this perception. This study, conducted among men and women working as caregivers

or law enforcers, focuses on individual and organizational predictors of trivialization of violence in the workplace. The distinction between two work environments will also allow us to evaluate the influence of the nature of the job – and the values integrated in the professional identity - on the perception of violence. Moreover, we will assess these predictors depending on the gender of the worker. Based on our literature review, four hypotheses are formulated.

Hypothesis 1: Male workers are more likely than female workers to trivialize violence in the workplace.

Hypothesis 2: Law enforcers are more likely than caregivers to trivialize violence in the workplace.

Hypothesis 3: Workers who have been victims of multiple violent acts in the workplace are more likely than workers who have not been victims of violence to trivialize violence in the workplace.

Hypothesis 4: (a) Workers who feel supported by their colleagues and employers are less likely to trivialize violence in the workplace.

(b) Individuals working in organizations that have violence management strategies are less likely to trivialize violence in the workplace.

6.2 Method

6.2.1 Participants

The current convenience sample is extracted from a study carried out by the VISAGE research team in Quebec, Canada. VISAGE's study sampled 2,889 Quebec workers in seven categories of employment: managers, law officials, health care professionals, nursing staff, administrative workers, skilled and service industry workers, and public transportation

workers. For the purpose of the present study, we only selected peace officers, healthcare professionals and nursing staff. Security agents (10.7%), park rangers (26.8%), law officials (3.5%) and police officers (59.0%) constitute the law enforcers' group. Orderlies (14.8%), nurses (46.5%) and health professionals (38.7%) represent the caregivers' group. As a result, we obtained a sample of 1141 workers of which 61.2 % were women and 67.3% were caregivers.

6.2.2 Sampling procedure

The study was conducted among French-speaking workers from the province of Quebec in Canada. Workers were recruited by three organizations that depend on the Agency for Health and Safety at Work, which is dedicated to preventive health and safety in different industries. The first organization (Municipal Affairs) works with blue and white collar workers, firefighters, police officers and bus drivers. The second one (Provincial Affairs) works with employees from the provincial government. The third one (Health and Social Services) works with health and social workers.

Between January 2011 and October 2012, workers were reached by email or on-site to complete a survey in an online or printed format. All workers were informed of the purpose of the study and the anonymity of their answers through the websites. A majority of participants completed the survey online (85.7 %), vs. on paper (14.3 %). All questionnaires were answered anonymously and on a voluntarily basis.

6.2.3 Measures

The questionnaire was a victimization survey developed by the VISAGE research team derived from the Perceptions of Prevalence of Aggression scale (*POPAS*) (Oud, 2001). The questions were related to episodes of workplace violence that the respondents might have had either as a victim or as a witness during the past 12 months, and their repercussions. The survey also looked into workers' perceptions with regards to violence and the support received at work to cope with this reality.

6.2.3.1 Individual factors

Two sociodemographics characteristics were controlled in the present study. First, participants had to indicate if they were a man or a woman. Second, they had to reveal their age. Five categories were made for this variable (see Table III). Another individual factor referred to the nature of the job occupied by the worker. As mentioned, the grouping of different occupations led to the creation of a variable that describes the nature of the job: caregiver and law enforcer.

6.2.3.2 Victimization

A distinction was made between two kinds of violent victimizations: being a *direct victim* or being a *witness*. Respondents were asked on a scale from "0 to 10 and more" how many times they have been a direct victim of or a witness to 11 different types of violent acts. These categories were mutually exclusive.

Inspired by the *POPAS* (Oud, 2001), a distinction was made between *severe violent acts* (SVA) and *mild violent acts* (MVA). SVA are more likely to result in harm or injury and consequently are more likely to lead to sick leaves, while MVA have minor to no

consequences. Assaults, robbery, armed robbery, sexual contact, sexual aggression and death threats were grouped as SVA for the purpose of the study. Verbal abuse, threats, intimidation, harassment and vandalism form the MVA group. Victimization had to be work-related; the violent act had to have occurred in the workplace or during an activity directly related to the job.

6.2.3.3 Trivialization of violence

Trivialization is the act of making something appear trivial, unimportant, and insignificant. Our definition of trivialization of violence in the workplace includes two aspects: normalizing and tabooing aggressive behaviors. Three items from the survey were selected to represent these two aspects. First, respondents were asked if they believed that "severe violence is normal in (their) workplace, it is part of the job." On a 4 point likert-scale, workers could answer "not at all, slightly, highly or completely". Based on the distribution of this item and on conceptual grounds, we dichotomized it to measure *normalization* of violence in the workplace; "not at all" was coded as "no" while all other responses were coded as "yes". Second, respondents were asked on the same 4 point-likert scale (0 to 3) if they think that (1) "(they) would be judged by their colleagues if they complained about severe violence in (their) workplace" and (2) "(they) would be judged by their employer[7] if they complained about severe violence in (their) workplace". These two items were computed producing a scale with high reliability (α = .81). For conceptual purposes, and because the distribution was skewed, we dichotomized this variable in order to measure *tabooing* violence in the workplace. Scores of 0 were coded as "no" while all other scores were coded as "yes".

[7] Employer refers to immediate supperior.

6.2.3.4 Perceived organizational characteristics

Five different items from the questionnaire explored the perceptions of workers on different organizational characteristics towards violence in the workplace. On a 4 point likert-scale ranging from "not at all (0)" to "completely (3)", respondents had to state the level to which the following features were "present" in their work environment: (1) "to what extent do you have necessary tools to cope with violence (training, procedure, guidelines, etc) in your workplace", (2) "to what extent do you have a "zero tolerance" policy in regards to violence in your workplace, (3) " to what extent do you have safe physical environments (cameras, bulletproof glass, etc)", (4) "to what extent can you benefit from colleague support in your workplace", and (5) "to what extent can you benefit from employer support in your workplace".

6.2.4 Analyses

First, chi-squared *(x^2)* tests were used to make gender comparisons of normalization and tabooing of violence. X^2-tests were also run to compare normalization and tabooing between caregivers and law enforcers. Logistic regression was used to find predictors of normalization and then, to identify predictors of tabooing. In order to test gender differences, both models were tested separately for men and women. Post-hoc comparison of regression estimates were performed to assert these differences as instructed by Paternoster, Brame, Mazerolle and Piquero (1998). In order to meet the assumptions of a linear model and to minimize errors engendered by outliers, victimization variables were transformed in Z score. Age was used as a continuous variable even though it is categorical. The objective is to assess

if aging predicts trivialization, not to target a specific age as a predictor. SPSS 22.0 was used to perform these analyses.

6.3 Results

6.3.1 Descriptive results

Of the respondents, 29.9% reported being the victim of at least one SVA in the year prior to their completion of the questionnaire, while 57.4% reported being the victim of at least one MVA in the assessed year. On the other hand, 43.2% recalled witnessing at least one SVA, while 62.6% stated having witnessed at least one MVA. Respondents were therefore more often witnesses than they were victims. Overall, our victimization variables were all positively skewed (see Table III).

Table III
Sample descriptive results

	n	%	*M*	*SD*
Gender				
Man (1)	442	38.8		
Woman (2)	696	61.2		
Age				
15 to 25 (1)	99	8.7		
26 to 35 (2)	327	28.8		
36 to 45 (3)	253	22.3		
46 to 55 (4)	362	31.9		
56 to + (5)	95	8.4		
Nature of the job				
Caregiver (1)	768	67.3		
Law enforcer (2)	373	32.7		
Frequency of SVA direct victim	1141		1.53	3.79
Frequency of MVA direct victim	1141		4.57	6.37
Frequency of SVA witness	1141		3.97	8.07
Frequency of MVA witness	1141		5.54	6.97
Necessary tools to cope with violence (0 to 3)	1135		1.43	0.85
Presence of a “zero tolerance” policy (0 to 3)	1136		1.66	0.91
Safe physical environments(0 to 3)	1134		1.25	0.92
Colleagues’ support (0 to 3)	1137		1.78	0.83
Employer’s support (0 to 3)	1136		1.42	0.88
Violence is normal				
No (0)	792	69.4		
Yes (1)	349	30.6		
Violence is taboo				
No (0)	575	50.8		
Yes (1)	558	49.2		

Based on the respondents' perceptions about their workplace, 88.8% reported that necessary tools to cope with violence were slightly to completely "present", 90.2% stated that a "zero tolerance policy" was slightly to completely "present" and 77.4% acknowledged that a safe physical environment was slightly to completely "present". As for their perceptions of support in the workplace, 94.5% reported that colleagues' support was slightly to completely "present" and 86.6% indicated that employer's support was slightly to completely "present". Table III shows the mean and standard deviation of these 5 Likert-scales. Of our 1141 workers, 30.6 % thought that violence is normal in their work environment, while 49.2 % believed that they would be judged by their colleagues or employer if they complained about violence in their workplace (Table III).

6.3.2 Bivariate results

In a preliminary analysis, the link between normalization and tabooing was tested with Pearson's R test. The correlation was statistically significant and showed a positive association ($r = .11$, $p < .001$). The results of a comparison of male and female workers are presented in Table IV. Overall, the proportion of male respondents who think that "violence is normal" (38.2%) and that "they would be judged if they complained about violence" (53.5%) was significantly higher than that of women (25.7% and 46.6%, respectively). In addition, a greater proportion of law enforcers than caregivers define violence as normal (39.9% vs. 26.0%) and taboo (57.8% vs.45.1%). The X^2-test was also specified to the nature of the job, and men and women's perceptions were compared within each work environment. For caregivers, a greater proportion of male workers than female workers normalize (34.1%) and taboo (54.4%) violence in the workplace (vs. 23.0% and 41.7%, respectively). As for law enforcers, more

women than men (66.7% vs. 52.8%) thought that complaining about violence would lead to judgments from colleagues and their employer. Gender was not associated with normalization of violence for law enforcers.

Table IV

Prevalence of trivialization of violence in the workplace according to gender and nature of the job

	Men		Women			
Trivialization	*N*	%	*n*	%	$\chi^2(1)$	*P*
Normalization	169	38.2	179	25.7	19.95	<.001
Tabooing	235	53.5	322	46.6	5.16	.023
	Caregivers		Law Enforcers			
Trivialization	*N*	%	*n*	%	$\chi^2(1)$	*p*
Normalization	200	26.0	149	39.9	22.86	<.001
Tabooing	344	45.1	214	57.8	16.21	<.001
	Male Caregivers		Female Caregivers			
Trivialization	*N*	%	*n*	%	$\chi^2(1)$	*p*
Normalization	70	34.1	129	23.0	9.62	.003
Tabooing	111	54.4	232	41.7	9.70	.002
	Male Law enforcers		Female Law enforcers			
Trivialization	*N*	%	*n*	%	$\chi^2(1)$	*p*
Normalization	99	41.8	50	36.8	.903	.342
Tabooing	124	52.8	90	66.7	6.80	.009

6.3.3 Multivariate results

6.3.3.1 Normalization of violence in the workplace

The first model shown in Table V examined the role of individual and organizational characteristics in the normalization of violence in the workplace. The general model ($p < .001$) explained 21.5% of the variance of normalization. Gender of the worker (OR = 0.74) and witnessing SVA (OR = 1.50) appeared as significant individual predictors of normalization. The presence of necessary tools to cope with violence (OR = 1.56), of a "zero tolerance" policy (OR = 0.70), of safe physical environments (OR = 1.29) and of colleagues' support (OR = 1.34) were significant organizational predictors of normalization. Tabooing violence (OR = 1.39) also significantly influenced the normalization of violence in the workplace.

Table V

Logistic regression predicting normalization of violence in the workplace

Predictor	*B*	*SE*	*OR*	95% CI	WS	*p*
Gender	-0.31	0.16	0.74	[0.54, 1.00]	3.94	.047
Nature of the job	0.24	0.16	1.27	[0.92, 1.76]	2.19	.139
Age	-0.08	0.07	0.93	[0.81, 1.06]	1.30	.254
SVA direct victim[1]	0,07	0.09	1.08	[0.90, 1.29]	0.62	.432
MVA direct victim[1]	0.03	0.12	1.03	[0.82, 1.29]	0.04	.833
SVA witness[1]	0.40	0.11	1.49	[1.19, 1.86]	12.19	.000
MVA witness[1]	0.16	0.12	1.17	[0.92, 1.48]	1.65	.199
Necessary tools	0.44	0.10	1.56	[1.27, 1.91]	18.35	.000
"Zero tolerance" policy	-0.35	0.10	0.70	[0.58, 0.86]	12.49	.000
Safe physical environments	0.25	0.08	1.29	[1.09, 1.52]	9.19	.002
Colleagues' support	0.30	0.11	1.34	[1.09, 1,66]	7.62	.006

Employer's support	-0.19	0.11	0.83	[0.67, 1,04]	2.75	.097
Violence is taboo	0.33	0.16	1.39	[1,02, 1.89]	4.45	.035
Predictor for men	*B*	*SE*	*OR*	95% CI	WS	*p*
Nature of the job	0.26	0.23	1.29	[0.82, 2,02]	1.24	.265
Age	-0.09	0.10	0.91	[0.74, 1.12]	0.80	.371
SVA direct victim[1]	-0.11	0.14	0.89	[0.68, 1.17]	0.70	.404
MVA direct victim[1]	0.09	0.18	1.10	[0.78, 1.55]	0.29	.590
SVA witness[1]	0.76	0.21	2.13	[1.42, 3.19]	13.34	.000
MVA witness[1]	-0.04	0.19	0.96	[0.66, 1.40]	0.04	.849
Necessary tools	0.22	0.16	1.25	[0.91, 1.70]	1.92	.166
"Zero tolerance" policy	-0.26	0.16	0.77	[0.57, 1.05]	2.70	.100
Safe physical environments	0.16	0.13	1.17	[0.91, 1.50]	1.48	.223
Colleagues' support	0.39	0.18	1.48	[1.04, 2.11]	4.72	.030
Employer's support	-0.23	0.18	0.80	[0.56, 1.41]	1.53	.215
Violence is taboo	0.29	0.24	1.33	[0.84, 2.12]	1.49	.222
Predictor for women	*B*	*SE*	*OR*	95% CI	WS	*p*
Nature of the job	0.24	0.24	1.27	[0.80, 2.05]	0.97	.324
Age	-0.05	0.09	0.95	[0.80, 1.13]	0.30	.582
SVA direct victim[1]	0.22	0.13	1.25	[0.96, 1.62]	2.70	.100
MVA direct victim[1]	-0.04	0.16	0.96	[0.71, 1.32]	0.06	.812
SVA witness[1]	0.21	0.14	1.23	[0.94, 1.61]	2.21	.137
MVA witness[1]	0.29	0.16	1.34	[0.99, 1.83]	3.48	.062
Necessary tools	0.60	0.14	1.81	[1.38, 2.38]	18.22	.000
"Zero tolerance" policy	-0.43	0.13	0.65	[0.51, 0.84]	10.60	.001
Safe physical environments	0.33	0.11	1.40	[1.12, 1.74]	8.66	.003
Colleagues' support	0.24	0.14	1.28	[0.98, 1.67]	3.26	.071
Employer's support	-0.13	0.15	0.88	[0.65, 1.17]	0.79	.375
Violence is taboo	0.35	0.21	1.42	[0.94, 2.16]	2.71	.100

Note. CI = Confidence interval for odds ratio (*OR*). WS = Wald Statistic. [1] Zscore.

In the second model, only male respondents were selected for the same set of logistic regression. Consequently, 22.0% of the variance of normalization of violence in the workplace ($p < .001$) was explained by only two predictors: witnessing SVA (OR = 2.13) and having colleagues' support (OR = 1.48). The more men reported to have witnessed SVA, the more likely they were to define violence as normal in the workplace.

Only organizational characteristics accounted for women's normalization of violence in the workplace (model 3). The presence of necessary tools to cope with violence and safe physical environments were positively associated with normalization of violence, while a "zero tolerance" policy was negatively related. This model explained 19.8% of the variance of normalization of violence in the workplace ($p < .001$).

Post-hoc comparison of these regression estimates were performed to test if these differences in main effects between men and women were statistically significant. Only witnessing SVA was found to statistically differ according to gender (beta = -0.76, se = 0.21 for men; beta = 0.21, se = 0.14 for women; corrected $z = 2.18$, $p = .003$) whereas witnessing SVA appeared as a significant predictor for male respondents, not for women.

Subsequent analyses were also performed in order to assess the sensitivity of these predictors to different levels of normalization. The initial 4-point Likert scale item was then introduced in a multinomial logistic regression. That enabled the comparison of predictors according to the level of normalization (1 on the Likert scale = low, 2 = moderate, 3 = high).

As illustrated in Table VI, predictors varied according to the level of normalization. For example, when compared to no normalization, gender was only a significant predictor for low level of normalization; it was not a predictor for moderate and high levels. Moreover, there was no predictor that remained significant across all three levels. Thus, these results

suggest that predictors are sensitive to the level of normalization predicted. However, to investigate which predictors predict low normalization and which others predict high normalization is not the objective of the present study. This article is focus on predictors of normalization, regardless of its level.

Table VI

Multinomial logistic regression predicting normalization of violence in the workplace according to the level of normalization

Predictor for low normalization	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	-0.43	0.18	0.65	[0.46, 0.91]	6.17	.013
Nature of the job	-0.06	0.19	0.95	[0.65, 1.37]	0.08	.769
Age	-0.05	0.08	0.95	[0.82, 1.10]	0.46	.497
SVA direct victim[1]	0.08	0.11	1.08	[0.87, 1.34]	0.46	.497
MVA direct victim[1]	-0.09	0.14	0.92	[0.70, 1.20]	0.42	.517
SVA witness[1]	0.26	0.14	1.29	[0.99, 1.69]	3.50	.061
MVA witness[1]	0.18	0.14	1.19	[0.91, 1.57]	1.64	.201
Necessary tools	0.38	0.12	1.46	[1.16, 1.83]	10.47	.001
“Zero tolerance” policy	-0.33	0.11	0.72	[0.58, 0.90]	8.53	.003
Safe physical environments	0.17	0.10	1.18	[0.98, 1.42]	3.06	.080
Colleagues’ support	0.24	0.12	1.27	[1.01, 1,62]	3.99	.046
Employer’s support	-0.21	0.13	0.81	[0.63, 1,05]	2.61	.106
Violence is taboo	0.07	0.18	1.07	[0.76 1.51]	0.15	.701
Predictor for moderate normalization	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	-0.31	0.29	0.73	[0.42, 1.29]	1.15	.283
Nature of the job	0.46	0.30	1.58	[0.88, 2.84]	2.39	.122
Age	-0.27	0.13	0.76	[0.59, 0.99]	4.19	.041

SVA direct victim[1]	-0.09	0.13	1.10	[0.85, 1.41]	0.50	.481
MVA direct victim[1]	0.17	0.20	1.18	[0.80, 1.75]	0.70	.401
SVA witness[1]	0.56	0.16	1.75	[1.28, 2.39]	12.21	.000
MVA witness[1]	0.02	0.22	1.02	[0.67, 1.55]	0.01	.931
Necessary tools	0.37	0.20	1.44	[0.99, 2.12]	3.41	.065
"Zero tolerance" policy	-0.53	0.19	0.59	[0.41, 0.85]	8.23	.004
Safe physical environments	0.66	0.16	1.93	[1.41, 2.63]	16.70	.000
Colleagues' support	0.42	0.20	1.51	[1.03, 2.29]	4.43	.035
Employer's support	-0.32	0.22	0.73	[0.48, 1.11]	2.16	.142
Violence is taboo	0.61	0.30	1.85	[1.02, 3.33]	4.12	.042
Predictor for high normalization	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	0.31	0.34	1.36	[0.70, 2.64]	0.82	.364
Nature of the job	1.31	0.36	3.70	[1.84, 7.44]	13.40	.000
Age	0.06	0.16	1.06	[0.78, 1.45]	0.14	.706
SVA direct victim[1]	0.13	0.14	1.13	[0.86, 1.50]	0.78	.377
MVA direct victim[1]	0.36	0.21	1.43	[0.96, 2.14]	3.06	.080
SVA witness[1]	0.42	0.16	1.52	[1.11, 2.08]	6.74	.009
MVA witness[1]	0.29	0.23	1.34	[0.86, 2.09]	1.67	.197
Necessary tools	0.93	0.23	2.54	[1.63, 3.95]	16.96	.000
"Zero tolerance" policy	-0.28	0.21	0.76	[0.51, 1.14]	1.75	.186
Safe physical environments	0.21	0.18	1.23	[0.87, 1.75]	1.35	.245
Colleagues' support	0.43	0.23	1.54	[0.99, 2.41]	3.60	.058
Employer's support	0.03	0.25	1.03	[0.63, 1.67]	0.10	.920
Violence is taboo	1.40	0.37	4.05	[1.96, 8.39]	14.18	.000

Note. CI = Confidence interval for odds ratio (*OR*). WS = Wald Statistic. Reference category = No normalization

[1] Zscore. Cox and Snell $R^2 = 0.23$, Nagelkerke $R^2 = 0.28$, McFadden $R^2 = 0.15$.

6.3.3.2 Tabooing violence in the workplace

Table VII shows the logistic regression models for tabooing violence in the workplace. In the general model (model 4), individual characteristics as well as organization features explained 23.5 % of the variance of tabooing ($p < .001$). On the individual level, the nature of the job (OR = 1.59), the age of the worker (OR = 1.22) and witnessing SVA (OR = 1.25) were all positive predictors of tabooing violence. Law enforcers were 1.6 times more likely to taboo violence in their workplace than caregivers. Unlike normalization, gender of the worker did not predict tabooing violence. Neither did being a direct victim of a violent act. However, the more a worker witnesses SVA, the more he/she is prone to refrain from complaining about violence in the workplace. On the organizational level, the presence of necessary tools to cope with violence (OR = 0.78), of a "zero tolerance" policy (OR = 0.78), of the support of colleagues (OR = .63) and of the employer (OR = 0.72) were all negative predictors of tabooing violence in the workplace. In short, all the organizational predictors confirmed the fourth hypothesis. However, the presence of necessary tools to cope with violence and colleagues' support go in the opposite direction of the normalization model. Finally, normalizing violence in the workplace contributed to tabooing violence in the workplace (OR = 1.39). If a worker thought that violence is part of the job, he/she was 1.4 times more likely to refrain from complaining about it, as this could lead to negative judgments from colleagues or the employer.

Table VII

Logistic regression predicting tabooing of violence in the workplace

Predictor	*B*	*SE*	*OR*	95% CI	WS	*p*
Gender	-0.09	0.15	0.91	[0.68, 1.22]	0.41	.523
Nature of the job	0.46	0.16	1.58	[1.17, 2.15]	8.61	.003

Age	0.20	0.06	1.22	[1.08, 1.38]	10.43	.001
SVA direct victim[1]	-0.08	0.09	0.92	[0.77, 1.10]	0.78	.378
MVA direct victim[1]	0.17	0.11	1.18	[0.94, 1.47]	2.10	.148
SVA witness[1]	0.22	0.11	1.25	[1.02, 1.54]	4.51	.034
MVA witness[1]	0.07	0.12	1.07	[0.85, 1.35]	0.36	.551
Necessary tools	-0.24	0.10	0.78	[0.65, 0.94]	6.56	.010
“Zero tolerance” policy	-0.26	0.09	0.78	[0.65, 0.92]	8.18	.004
Safe physical environments	0.07	0.08	1.07	[0.92, 1.25]	0.73	.394
Colleagues’ support	-0.46	0.10	0.63	[0.52, 0.77]	21.83	.000
Employer’s support	-0.33	0.10	0.72	[0.59, 0.88]	10.03	.002
Violence is normal	0.34	0.16	1.41	[1.03, 1.91]	4.73	.030
Predictor for men	*B*	*SE*	*OR*	95% CI	WS	*p*
Nature of the job	-0.04	0.22	0.96	[0.62, 1.48]	0.03	.855
Age	0.23	0.10	1.26	[1.03, 1.53]	5.07	.024
SVA direct victim[1]	0.01	0.12	1.01	[0.80, 1.28]	0.01	.941
MVA direct victim[1]	0.38	0.18	1.46	[1.03, 2.07]	4.60	.032
SVA witness[1]	0.07	0.14	1.07	[0.82, 1.41]	0.26	.609
MVA witness[1]	-0.08	0.19	0.92	[0.64, 1.34]	0.17	.676
Necessary tools	-0.29	0.15	0.75	[0.56, 1.00]	3.80	.051
“Zero tolerance” policy	-0.18	0.15	0.84	[0.63, 1.12]	1.47	.226
Safe physical environments	-0.10	0.12	0.90	[0.71, 1.15]	.070	.403
Colleagues’ support	-0.57	0.17	0.57	[0.40, 0.80]	10.76	.001
Employer’s support	-0.13	0.18	0.88	[0.62, 1.24]	.052	.470
Violence is normal	0.32	0.24	1.38	[0.87, 2.19]	1.83	.176
Predictor for women	*B*	*SE*	*OR*	95% CI	WS	*p*
Nature of the job	0.90	0.23	2.46	[1.56, 3.90]	14.78	.000
Age	0.17	0.80	1.19	[1.02, 1.39]	4.68	.030

SVA direct victim[1]	-0.22	0.14	0.81	[0.61, 1.07]	2.28	.131
MVA direct victim[1]	0.07	0.16	1.07	[0.78, 1.46]	0.17	.681
SVA witness[1]	0.48	0.18	1.62	[1.15, 2.28]	7.60	.006
MVA witness[1]	0.12	0.16	1.13	[0.83, 1.53]	0.56	.453
Necessary tools	-0.23	0.13	0.79	[0.62, 1.02]	3.33	.068
"Zero tolerance" policy	-0.33	0.12	0.72	[0.57, 0.90]	8.44	.004
Safe physical environments	0.18	0.11	1.19	[0.97, 1.47]	2.70	.100
Colleagues' support	-0.42	0.12	0.66	[0.52, 0.84]	11.82	.001
Employer's support	-0.43	0.13	0.65	[0.50, 0.85]	10.40	.001
Violence is normal	0.35	0.22	1.42	[0.93, 2.16]	2.62	.106

Note. CI = Confidence interval for odds ratio (*OR*). WS = Wald Statistic. [1] Zscore.

When the same logistic regression was performed only for male respondents, 20.2 % of variance of tabooing violence in the workplace ($p < .001$) was explained (model 5). Age (OR = 1.26) and being the victim of MVA (OR = 1.46) were significant individual predictors, while colleagues' support (OR = 0.57) was the only significant organizational predictor. As in the general model, colleagues' support appeared as a negative predictor of tabooing violence.

When the second set of models was specified for women (model 6), 28.7 % of the variance of tabooing violence in the workplace was explained ($p < .001$). When compared to the general model (model 4), this specification increased the capacity to explain the variance of tabooing by 5 % even though it reduced the number of respondents. First, it appeared that the nature of the job was positively associated with the dependent variable (OR = 2.46). Female law enforcers were 2.46 times more likely than female caregivers to avoid complaining about violence in their workplace. Still on the individual level, age (OR = 1.19) and witnessing SVA (OR = 1.62) were also significant positive predictors. On the organizational level, the presence of a "zero tolerance" policy (OR = 0.72), of colleagues'

support (OR = 0.66) and of the employer's support (OR = 0.65) were all negatively associated with tabooing violence.

Post-hoc comparison of these regression estimates were also performed to test if these differences in main effects between men and women were statistically significant. Only the nature of the job was found to statistically differ according to gender (beta = -0.04, se = 0.22 for men; beta = 0.90, se = 0.23 for women; corrected $z = 2.95$, $p = .003$). In this case, the nature of the job was a significant predictor for female participants, not for men.

Subsequent analyses were also performed in order to assess the sensitivity of the predictors to different levels of normalization. The computed 4-point Likert scale items that were used to measure tabooing were recoded in order to assess 4 different levels (0 = no tabooing, 1-2 = low tabooing, 3-4 = moderate tabooing and 5-6 = high tabooing). This recoded scale was then introduced in a multinomial logistic regression. That enabled the comparison of predictors according to the level of tabooing.

As for normalization, predictors varied according to the level of tabooing (see Table VIII). When compared to no tabooing, MVA direct victimization was significant for each level of tabooing. However, its statistical weight and rank of best predictor varied across each model (3rd for low tabooing, 3rd for moderate tabooing and 1st for high tabooing). The same distinction applied to colleague's support (1st in low, 1st in moderate, 2nd in high). Such examples demonstrate that predictors are sensitive to levels of tabooing. These specifications should be further investigated in future research.

Table VIII

Multinomial logistic regression predicting tabooing of violence in the workplace according to the level of tabooing

Predictor for low tabooing	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	-0.69	0.37	0.50	[0.24, 1.03]	3.56	.059
Nature of the job	-1.29	0.37	0.28	[0.13, 0.57]	12.02	.001
Age	-0.27	0.16	0.76	[0.55, 1.05]	2.80	.094
SVA direct victim[1]	0.19	0.16	1.20	[0.88, 1.66]	1.29	.256
MVA direct victim[1]	-0.97	0.24	0.42	[0.26, 0.67]	13.04	.000
SVA witness[1]	-0.59	0.18	0.55	[0.39, 0.79]	10.84	.001
MVA witness[1]	0.34	0.27	1.41	[0.84, 2.37]	1.68	.195
Necessary tools	0.23	0.25	1.26	[0.77, 2.07]	0.82	.365
“Zero tolerance” policy	0.27	0.22	1.31	[0.86, 2.00]	1.60	.207
Safe physical environments	-0.35	0.18	0.97	[0.67, 1.39]	0.04	.849
Colleagues’ support	1.27	0.24	3.58	[2.22, 5.77]	27.24	.000
Employer’s support	1.13	0.28	3.10	[1.79, 5,38]	16.18	.000
Violence is normal	-.030	0.36	0.74	[0.51, 2.08]	0.68	.414
Predictor for moderate tabooing	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	-0.90	0.36	0.41	[0.20, 0.82]	6.23	.013
Nature of the job	-0.93	0.37	0.40	[0.19, 0.81]	6.45	.011
Age	-0.86	0.16	0.91	[0.67, 1.26]	0.28	.596
SVA direct victim[1]	0.12	0.16	1.12	[0.83, 1.53]	0.59	.444
MVA direct victim[1]	-0.81	0.24	0.45	[0.28, 0.71]	11.85	.001
SVA witness[1]	-0.45	0.17	0.64	[0.46, 0.89]	7.62	.007
MVA witness[1]	0.43	0.26	1.54	[0.93, 2.57]	2.80	.084
Necessary tools	-0.12	0.25	0.99	[0.61, 1.62]	0.00	.963
“Zero tolerance” policy	0.41	0.21	1.04	[0.69, 1.58]	0.04	.846
Safe physical environments	0.40	0.18	1.04	[0.73, 1.48]	0.05	.823

Colleagues' support	0.93	0.24	2.54	[1.58, 4.07]	15.00	.000
Employer's support	0.94	0.28	2.56	[1.48, 4.42]	11.35	.001
Violence is normal	0.30	0.36	1.03	[0.41, 2.08]	0.01	.933
Predictor for high tabooing	*B*	*SE*	*OR*	95% CI	WS	*P*
Gender	-0.62	0.39	0.53	[0.25, 1.14]	2.61	.106
Nature of the job	-0.73	0.40	0.48	[0.22, 1.05]	3.38	.066
Age	-0.08	0.18	0.93	[0.66, 1.30]	0.20	.656
SVA direct victim[1]	0.07	0.16	1.07	[0.78, 1.47]	0.17	.680
MVA direct victim[1]	-0.60	0.25	0.55	[0.34 0.90]	5.67	.017
SVA witness[1]	-0.23	0.17	0.80	[0.57, 1.12]	1.71	.191
MVA witness[1]	0.49	0.28	1.64	[0.96, 2.81]	3.22	.073
Necessary tools	-0.46	0.28	0.96	[0.56, 1.64]	0.03	.866
"Zero tolerance" policy	-0.11	0.23	0.89	[0.57, 1.40]	0.24	.627
Safe physical environments	0.00	0.20	1.00	[0.68, 1.47]	0.01	.982
Colleagues' support	0.61	0.26	1.83	[1.11, 3.04]	5.51	.019
Employer's support	0.31	0.30	1.36	[0.75, 2.46]	1.02	.312
Violence is normal	0.21	0.38	1.24	[0.58, 2.61]	0.31	.580

Note. CI = Confidence interval for odds ratio (*OR*). WS = Wald Statistic. Reference category = No tabooing. [1] Zscore. Cox and Snell $R^2 = 0.27$, Nagelkerke $R^2 = 0.31$, McFadden $R^2 = 0.15$.

6.4 Discussion

The main aim of the present study was to provide a quantitative examination of how individual characteristics as well as organizational characteristics influence trivialization of violence in the workplace. A bi-dimensional definition of trivialization of violence was also proposed: normalization and tabooing. Using a victimization survey, perceptions of 1141 workers acting as caregivers and law enforcers revealed individual and organizational

predictors of trivialization of workplace violence. Additionally, specifications of these predictions depending on the gender of the worker were provided.

6.4.1 Hypothesis 1: Gender differences

Even though multivariate results do not entirely confirm the first hypothesis of the present study, gender differentiated analyses reveal important distinctions between male and female workers on trivialization of violence in the workplace. Based on the proposed bi-dimensional definition of trivialization, gender of the worker appears as an important predictor of normalization, but not tabooing. Men from the present sample were more likely than women to think that violence in the workplace is "part of the job". This finding is consistent with the literature on stress and gender, which suggests significant differences in the perceptions and coping skills of male and female workers (Barnett et al., 1987; Brown & Campbell, 1990; He et al., 2002). This result may also provide another explanation for the fact that men are less likely than women to seek professional help. Not only do men refrain from seeking help by fear of being perceived as being weak by their colleagues (Graf, 1986), men do not ask for help since they believe that violence is normal in their workplace.

6.4.2 Hypothesis 2: Caregivers vs. law enforcers

The nature of the job does not affect the perception of normalcy of violence in the workplace. As a result, law enforcers are not more likely than caregivers to normalize violence in the workplace. After all, both caregivers and law enforcers are trained and employed to deal with a problematic clientele. As mentioned by Åkerström (2002), if nurses labelled their patient's aggression as "violence", this would imply that they are "victims" and their patient is

an “offender”, which could defy the common cultural construct. At the same time, this definition would put their skills in question. As Åkerström’s study sampled nursing staff, Mann and Neece’s (1990) and Dick’s (2000) studies reported the same process for law enforcers: defining aggressions as abnormal in the workplace could jeopardize the worker’s ability to adequately perform the expected role.

However, although the nature of the job does not predict normalization, it does predict tabooing. This is even truer for law enforcers. In a study on the social construction of meanings of acute stressors, Dick (2000) argued that the police culture exerts an influence on the perceptions of these stressors. For example, police officers must remain emotionally detached and in control in front of death, distress or violent acts, all while intervening professionally (Pogrebin & Poole, 1991), even though they are affected by the situation. Thus, professional socialization requires the police officer to develop appropriate skills in controlling responses to tragic or unpleasant circumstances (Brown et al. 1999). Complaining about violence is then contrary to the insular nature of police culture, which advocates mental strength and emphasizes the importance of enacting appropriate attitudes and beliefs (Brown et al., 1999; Reiner, 2010; Waddington, 1999). Doing the opposite may result in difficulties to be accepted by colleagues (Heidensohn, 1992) since the expected professional identity is not displayed. Similarly, Norris and Kedward (1990) revealed that social workers refrain from reporting violent incidents because they did not want to be seen as poor social workers or incompetent by colleagues or their employer. Åkerström (2002), on her part, argued that caregivers avoid describing themselves as victims even though they are assaulted because this would suggest that they are not competent enough for the job. Complaining about violence in the workplace could symbolize the incapacity of a worker to properly handle the expected

work or to display the proper "professional identity". This behavior can then lead to stigmatization. Even though the "stigma symbol" (Goffman, 1963) can affect workers regardless of the nature of their job, the present study clearly indicates that tabooing violence is more likely to occur in the law enforcement environment than in the caregiver environment.

As shown by post-hoc comparison of gender-specific regression estimates, this fear of stigma is even more important for women working as law enforcers. This finding is consistent with Fielding's (1994) description of the police culture: competitive, preoccupied with the imagery of conflict and with exaggerated heterosexual orientation, misogynistic and patriarchal attitudes. Haarr (1997) found that female officers felt that their male partners often questioned their abilities. Martin (1990) has also shown that female officers may be subjected to gender discrimination from male officers and supervisors. Consequently, the current study revealed that women in law enforcement think that complaining about violence in their workplace could result in negative judgments from their peers. Women working as law enforcers can then be affected by two levels of stigmatization: being a woman in "man's" job (Breakwell, 1986; Johnson et al., 2007) and not adopting the proper professional identity (Åkerström, 2002; Dick, 2000; Macdonald & Sirotich, 2001; Norris & Kedward, 1990).

This is also consistent with research on women working in non-traditional occupations. Walshok (1981) argued that women working in traditionally male occupations, like in steel mills and mailrooms, might experience hostility from their male counterparts that may elevate reported levels of stress. More recently and in the police setting, researchers have also demonstrated that the gender of the officer is important in regards to work-related stress effects since female officers often feel additional pressure from their male colleagues to prove themselves on the job (McCarty et al., 2007; Goolkasian, Geddes & Delong, 1985). Therefore,

Kirk-Brown et al. (1999) reported that policewomen might be more vulnerable to a lack of social support than their male counterparts due to their status as a minority group and the overall masculine nature of police work. This may shed light on why female respondents in the present study were more likely to taboo their discomfort towards violence; to be accepted by their colleagues and to maintain their bonds in order to benefit from peer-support when needed.

The specification of the multivariate model showed that the nature of the job is not a significant predictor of tabooing violence in the workplace for male workers. Whether they work as caregivers or as law enforcers, men are expected to be "cool" in the face of violence, as shown in the bivariate analyses. This finding could refer to the John-Wayne syndrome, which implies that men are expected to maintain a high level of toughness and play things close to the chest (Wells et al., 2006). Even though this phenomenon is prevalent in criminal justice organizations (Bartol & Bartol, 1994; Wrightsman, Nietzel, & Fortune, 1994), the current study revealed that the nature of the job does not affect the John-Wayne syndrome. Overall, the bivariate results have demonstrated that male workers are more prone to trivialize violence in their workplace then females workers, regardless of the nature of the job. In sum, hypothesis two was partially confirmed but mostly nuanced.

6.4.3 Aging

Age was also a positive predictor in all models of tabooing violence in the workplace. These results suggest that, as they get older, male and female workers are less likely to talk about their discomfort about violence in the workplace. Considering the fact that the majority of the respondents were engaged in a caregiving or law enforcement career, age can be

interpreted as a proxy for work experience. This finding is consistent with Whittington (2002), who found that staff with more than 15 years of experience were more tolerant towards violence in the workplace than those with less experience. By being more tolerant, they are more likely to accept it as "part of the job" and, consequently, are less likely to complain about it.

6.4.4 Hypothesis 3: Victimization

There is scientific evidence supporting the fact that victimization in the workplace contributes to trivialization of violence in the workplace (Freyne & Wrigley, 1996; Jansen, Dassen, & Groot Jebbink, 2005; Jonker et al., 2008; Nijman et al., 1997). Through repeated victimizations, workers in these environments come to normalize or minimize the aggressions they experienced. This process suggests a habituation phenomenon that contributes to the perception that violence is "part of the job" (Erickson & Williams-Evans, 2000). However, the present study nuances this habituation phenomenon. Unlike previous studies (Erickson & Williams-Evans, 2000; Freyne & Wrigley, 1996; Jansen et al., 2005; Jonker et al., 2008; Rippon, 2000), the definition of victimization used in the current study includes witnessing an act of aggression. As shown by the descriptive statistics, respondents of the present study were more often witnesses than victims of violence. Including witnesses in the definition of victimization allowed for the consideration of the perceptions of people who have never been victims of assaults during their working hours, but were regularly exposed to it. Thus, the current models showed that normalization and tabooing of violence are associated with witnessing SVA, not necessarily being the direct victim of them. This suggests that habituation is more likely to settle in by observing multiple aggressions in the workplace.

Consequently, if a worker thinks that violence is part of the job and if he repeatedly witnesses violent acts, this worker is more likely to think that he or she would be judged by his or her colleagues and his employer if he or she complained about violence in his or her workplace.

Inconsistent with the third hypothesis, direct victimization did not predict normalization of violence, but witnessing SVA almost did in both general models. The distinction between severe and mild violent acts of victimization is thus relevant to identify predictors of trivialization of violence. At this point, it has been shown that trivialization of violence in the workplace is influenced by the nature of the job and by individual factors such as past experience or exposure to violent behaviors. This is consistent with findings related to the subjective nature of perceptions of violence (Abderhalden, Needham, Friedli, Poelmans, & Dassen, 2002; Ferns, 2006; Isaksson et al., 2008; Snowdon, Miller, & Vaughan, 1996). However, it is essential to consider organizational characteristics. Like Dick (2000) argued, organizations influence the beliefs, cognitions and attitudes of employees towards acute stressors, while shaping new identities and ways of thinking.

6.4.5 Hypothesis 4: Organizational influence

Generally, the presence of necessary tools to cope with violence, a safe physical environment and colleagues' support contribute to defining violence in the workplace as normal. Work environments that offer training in the management of violence and physical devices designed to enhance safety are sending out the message that aggressive behaviors from the clientele are normal and to be expected. On the other hand, a "zero tolerance" policy achieves its goal by decreasing the likelihood of violence being perceived as normal. Unexpectedly, colleagues' support increases the likelihood of perceiving violence as normal in

the workplace. This suggests that coworkers have an impact on the perception of violence and thus, supports the phenomenon of professional socialization that contributes to the normalization of violence in the workplace (Brown et al., 1999; Dick, 2000).

All statistically significant organizational characteristics were negative predictors of tabooing violence. A "zero tolerance" policy, organizations offering necessary tools to cope with violence like minimization training or post-intervention procedures, colleagues' support and employer's support encourage workers to talk about their negative feelings towards violence in the workplace. Meanwhile, all statistically significant individual characteristics were positive predictors of tabooing violence, regardless of the gender of the respondents. Therefore, no matter how hard organizations try to help their workers, the nature of the job and past victimization will deter people from talking about their discomfort. Nevertheless, it is important to note that the introduction of policies is relatively new in the assessed work environments (Whittington, 2002). It may then take some time for organizations to influence how workers define violence in their workplace.

Based on the bi-dimensional definition of trivialization of violence put forth by the present study, colleagues' support contributes to normalization of violence but decreases the likelihood of tabooing. This suggests that by normalizing violence, colleagues can encourage acceptance of this reality as inherent to the job, thus allowing coworkers to talk more openly about their discomfort. Also, based on the strength of the relation between colleagues' support and tabooing, colleagues seem to play a major role in promoting a professional identity that allows for the free discussion of workplace aggression instead of muting it. In sum, hypothesis 4 was partially confirmed.

6.4.6 Policy implications

If an organization wants to work on trivialization of violence in the workplace, it must consider the "professional" identity promoted by the job, the gender influence in this context, and the level of exposure to violence, all while accentuating the presence of management policies and the support from colleagues and the employer. This bolsters "peer-support" interventions in which workers are encouraged to talk about their traumatic experience with trained colleagues who are sympathetic and supportive (Stephens, Long, & Miller, 1997). Still, the findings of the present study show that organizations should not hesitate to adopt and disseminate strategies to counter workplace violence since these actions have an effect on the tabooing of violence.

6.4.7 Study limitations and directions for future research

This study has some limitations. Since the survey is based on a convenience sample, the findings are not generalizable to the caregiving and law enforcement populations. Furthermore, data may have been collected only from people willing to talk or complain about violence. It is also possible that the distribution of the questionnaire by a member of a joint association for health and safety at work in their work environment and the nature of the survey may have influenced the reported prevalence. This may then explain the low prevalence of respondents who think that violence is "part of the job"; workers who wanted to complete the questionnaire were the ones who wanted to denounce violence in the workplace, not the ones who accept it as a reality of their work. There is also a potential limitation stemming from the fact that caregivers and law enforcers self-reported their experience of workplace violence. In order to minimize recall bias, the questionnaire only focused on

victimization that occurred during the past year. Like mentioned by Nachreiner et al. (2007), this method has been used successfully in previous studies. Still, the number of respondents allowed a robust analysis of the data. Finally, organizational characteristics were measured through the eyes of the respondents. This was consistent with the focus on perceptions and their impact on attitudes towards violence in the workplace.

More research is needed in order to assess the consequences of trivialization of violence in the workplace. After an assault, a worker may become habituated to violence and assume the role of a victim (Erickson & Williams-Evans, 2000). What are the consequences of such trivialization? Does normalization provides acceptance and break the taboo? Research on the psychological consequences of trivialization of violence could answer this question. In this vein, further research should rely on random sampling while controlling other important individual characteristics, such as personal history of abuse. Moreover, level of trivialization could be used to assess if the consequences of normalizing and tabooing violence in the workplace vary proportionally to the intensity of trivialization. Thus, organizations could adjust their interventions proportionally and focus on the most problematic profiles.

6.5 Conclusion

Even though contextual factors influence individual perceptions, meanings given to violence in the workplace remain subjective. More specifically, this study reveals that, no matter how much an organization is perceived as trying to counter violence, the majority of workers still fear the stigma generated by complaining about violence in the workplace. Like Dick (2000) argued, concepts such as “identity” and “culture” are probably not ontologically independent. The present paper implicitly suggests that professional identity may be the nexus

between individual, organization and cultural factors that help understand trivialization of violence in the workplace. It also demonstrates that some of the predictors of trivialization are only relevant for men while others are only accurate for women. Furthermore, it has been argued that trivialization of violence in the workplace has two dimensions: normalization and tabooing. Thus, predictors of trivialization are different for normalization or tabooing of violence in the workplace.

Chapter 7 - The Effects of Trivialization of Workplace Aggression on its Victims: Is Gender an Issue?

7.1 Introduction

Workers within the healthcare and law enforcement sectors are among those most prone to experiencing workplace aggression (Piquero, Piquero, Craig, & Clipper, 2013). Such exposure has been associated with negative outcomes such as anger, burnout, turnover, post-traumatic stress disorder (PTSD), loss of empathy, poor service delivery, depression, anxiety, psychosomatic disorder and absenteeism (Aquino & Thau, 2009; Arnetz & Arnetz, 2001; Barling, 1996; Brown, Fielding, & Grover, 1999; Chapman, Perry, Styles, & Combs, 2009; He, Zhao, & Archbold, 2002; Jackson, Clare, & Mannix, 2002; Pich, Hazelton, Sundin, & Kable, 2011; Wilson, Douglas, & Lyon, 2011). Nevertheless, workers from the healthcare and law enforcement sectors tend to normalize or mute their victimization from workplace aggression (Åkerström, 2002; Dyrkacz, Mak, & Heck, 2012; Erickson & Williams-Evans, 2000; Macdonald & Sirotich, 2001). Moreover, studies on stress and gender have shown that men and women differently perceive, experience, report and cope with workplace aggression (Barnett, Biener, & Baruch, 1987; He et al., 2002; Johnson, Greaves, & Repta, 2007; Wells, Colbert, & Slate, 2006). Differing perceptions of this situation may then alter the impact of stress related to the aggression (Åkerström, 2002; Thoits, 1999). Thus, the focus of the current study was to assess the gender-differentiated effects of trivialization of workplace aggression on psychological consequences related to PTSD experienced by caregivers and law enforcers who were victims of a severe violent act (SVA) in their work environment.

Workplace aggression is defined as "any behavior intended to harm an individual in an organization" (Dupré & Barling, 2006, p.19). More specifically, SVA refers to violent acts that are more likely to result in harm or injury and consequently are more likely to lead to sick leaves. For example, assaults or death threats are more likely to qualify as SVAs, while insults are less so. Before defining trivialization of workplace aggression, factors that are known to be associated with psychological consequences following victimization from workplace violence will be discussed.

7.1.1 Workplace aggression and psychological consequences according to gender

Gender differences in psychological consequences following workplace aggression have been documented. Findorff, McGovern, Wall, and Gerberich (2005) found that women working in the healthcare sector experienced more psychological consequences (anger, stress, and frustration) than their male colleagues even though their exposure to violence was similar. In studies conducted among law enforcers, females have been found to be more susceptible to manifest greater job stress or mild psychological distress after being exposed to workplace aggression (DeCarlo & Gruenfeld, 1989; Van Voorhis, Cullen, Link, & Wolfe, 1991; Wells et al., 2006; Wright & Saylor, 1991). Yet, other studies among law enforcers or employees of the healthcare sector reported no gender differences in PTSD symptomatology after workplace aggression (Armstrong & Griffin, 2004; Fitzpatrick & Wilson, 1999; Lilly, Pole, Best, Metzler, & Marmar, 2009; Santos, Leather, Dunn, & Zarola, 2009). Since the results concerning psychological consequences according to gender are mitigated, further research is needed to understand gender-differential responses to workplace aggression.

7.1.2 Psychological consequences and workplace aggression exposure

Past experiences and exposure to workplace aggression have an impact on psychological consequences following victimization. Several studies have provided evidence of an association between exposure to workplace violence and psychological consequences, namely PTSD symptoms (AbuAlRub & Al-Asmar, 2011; Arnetz & Arnetz, 2001; Demir & Rodwell, 2012; Gates, Gillespie, & Succop, 2011; Whittington, 2002). In a study conducted with a sample of nurses, Lam (2002) found that high exposure to aggression in the workplace more than doubles the odds of psychological distress**,** as compared to workers who were less exposed. In their study with British police officers, Brown et al. (1999) found that low-frequency but high impact stressors related to policing, such as having to deal with death or disasters, were associated with higher PTSD symptoms for officers who had experienced these incidents. On the other hand, high exposure to low felt stress incidents that may be considered as routine were associated with low levels of psychological disturbances. Still, these findings showed that prior victimization and high exposure might weaken workers' psychological wellbeing, making them vulnerable to subsequent workplace aggression.

However, a few studies with mental healthcare workers did not find any significant differences between exposed and non-exposed workers in terms of PTSD (Ryan et al., 2008). Here again, associations between psychological consequences of workplace aggression and prior victimization are inconsistent and underline the need for further research (Ryan et al., 2008; Versola-Russo, 2006).

7.1.3 Organizational strategies to counter violence

Many organizations have put in place strategies to address workplace aggression and/or to help their employees cope with this problematic. In this vein, "zero-tolerance" policies have been introduced in many organizations in the healthcare sector but their effects are mitigated (Whittington, 2002). On the other hand, aggression minimization training programs have been identified as improving staff knowledge, skills, confidence and attitudes toward workplace aggression thus enhancing the perception of a safer workplace (Grenyer et al., 2004). Redesigning environmental features in order to provide safe physical environments that promote situational risk prevention has also been used in psychiatric wards and prisons (Cooke & Johnstone, 2010; Gadon, Johnstone, & Cooke, 2006).

At an interpersonal level, peer support has proved its efficacy in protecting workers from workplace aggression and helping them cope with its psychological impact. He et al. (2002) found that camaraderie dampens the impact of work-related stressors on male police officers. More broadly, Brown et al. (1999) showed that social support (including colleagues and supervisors) decreased the likelihood of suffering psychological distress for both men and women law enforcers, but only to a modest degree. Stephens, Long, and Miller (1997) found that police officers who benefit from "peer-support" interventions, in which workers are encouraged to talk about their traumatic experience with trained colleagues who are sympathetic and supportive, reported fewer PTSD symptoms. Similarly, healthcare worker who were victims of workplace violence tend to seek support mainly from colleagues rather than from professionals (Fernandes et al., 1999). In sum, perceived organizational efforts to counter the impact of violent traumatic events, and especially feeling supported, may reduce the psychological consequences of workplace aggression. However, many studies that did not

find this association have questioned the role of social support in the individual network within and outside the organization in terms of traumatic stress related to work duties (Leffler & Dembert, 1998; Regehr, Hill, & Glancy, 2000; Weiss, Marmar, Metzler, & Ronfeldt, 1995). Thus, more research on the influence of organizational strategies to counter workplace aggression is needed.

7.1.4 Perception of workplace aggression according to the nature of the job

The nature of the job may also play a significant role in the psychological wellbeing of workers who face workplace aggression. Nurses often consider workplace aggression from the clientele as an unavoidable aspect of the profession (Åkerström, 2002; Erickson & Williams-Evans, 2000; Menzel, Brooks, Bernard, & Nelson, 2004; Nachreiner, Gerberich, Ryan, & McGovern, 2007; Rippon, 2000). Concretely, nurses may justify their patient's aggression, attributing it to his or her medical condition, in order to maintain the therapeutic bond or to preserve the morale of the team (Svendrup-Phillips, 2003).

Workplace aggression is also a characteristic of policing and law enforcement work. In fact, law enforcers are expected to deal with violent behaviours; it is part of their routine and curriculum. Consequently, studies have demonstrated that law enforcers tend to inhibit their emotional reactions to violence (Brown et al., 1999; Dick, 2000). According to a study from Stephens et al. (1997), this inhibition of emotional expression was associated with psychological distress in their sample of New Zealand police officers. However, Brown et al. (1999) tested the same association within their sample of British police officers but did not find any significant relation between this coping strategy and psychological distress. Nevertheless, these findings underline the close relationship between the nature of the job,

perceptions of violence including trivialization, and psychological wellbeing. Still, more studies are needed to understand these relations.

7.1.5 Trivialization of workplace aggression

Trivialization is the act of making something appears trivial, unimportant, and insignificant. In the literature, the term "trivialization of workplace aggression" is not clearly defined. Still, normalization and tabooing of workplace aggression are repeatedly evoked when this concept is discussed. *Normalization* implies the belief that aggression from the clientele is "part of the job". *Tabooing* refers to workers who prefer avoiding open discussion regarding their discomfort with workplace aggression, because such a conversation would lead to negative peer judgment. Healthcare providers and law enforcers tend to mute their discomfort with violence for fear of being stigmatized as "incompetent" or "unfit" for their jobs by colleagues or supervisors (Åkerström, 2002; Dick, 2000; Macdonald & Sirotich, 2001; Norris & Kedward, 1990). As demonstrated by Stephens et al. (1997), defense mechanisms that foster emotional inhibition may increase the likelihood of psychological distress. With that being said, the influence of trivialization of workplace aggression on psychological wellbeing remains unexamined.

7.1.5.1 Trivialization and exposure to workplace aggression

Exposure to workplace aggression can also increase one's trivialization of workplace aggression (Freyne & Wrigley, 1996; Jansen, Dassen, & Groot Jebbink, 2005; Jonker, Goossens, Steenhuis, & Oud, 2008; Nijman, Allertz, Merckelbach, Campo, & Ravelli, 1997). Nachreiner et al. (2007) demonstrated that nurses who experienced physical assaults were

more likely to accept violence as "part of the job" than those who had not experienced such victimization. For law enforcers, violence is considered to be part of the routine and curriculum of the job (Brown et al., 1999; Dick, 2000). In both cases, exposure to workplace aggression seems to be associated with its normalization.

7.1.5.2 Trivialization and nature of the job

The nature of the job influences the perceptions and attitudes of workers towards workplace aggression. Dick (2000) and Åkerström (2002) argued that the nature of the job and its occupational culture construct the worker's identity and influence his perceptions of himself and his work environment. Policing identity operates at a collective level to "normalize" some emotional responses and "pathologize" others that are contrary to the police organizational culture (Dick, 2000). On the other hand, healthcare providers tend to downplay violence from the patients in order to preserve their identity as caregivers, which will allow them to maintain a caring relationship (Åkerström, 2002). Workplace aggression has been trivialized in the healthcare sector to the point that is has been integrated in its culture (Åkerström, 2002; Menzel et al., 2004; Rippon, 2000).

7.1.5.3 Trivialization and perceived organizational strategies

Few studies have investigated the impact of organizational strategies on trivialization of workplace aggression. "Zero tolerance" policies in the nursing environment, for example, were designed to reinforce the perception of workplace aggression as unacceptable and liable to some sort of sanction (Whittington, 2002). However, results from such initiatives are mitigated. Overall, in a trivialization context, acceptance of workplace aggression has been

depicted as a result of professional socialization (Brown et al., 1999; Dick 2000) that management has to struggle against.

7.1.5.4 Trivialization and gender

Gender has been associated with differences in perceptions of and coping with stressful events. Johnson et al. (2007) argued that gender can directly affect men and women's behaviours and perceptions by ascribing different roles, responsibilities, and activities to individuals based on their gender. For example, masculinity is often associated with toughness in our society. As a result, masculine individuals may be less likely to seek help for health concerns as they prefer to "tough it out". This emphasizes the need to differentiate the effects of trivialization according to gender since support provided to workers should be adapted to the needs and coping strategies of individuals.

7.1.6 Aims of the study

In light of this scientific evidence, knowledge about the effects of trivialization of workplace aggression on the psychological consequences of victims of such events is very scarce. Thus, studies are needed to better understand the impact of trivialization of workplace aggression on psychological wellbeing in order to help workers better cope with this phenomenon. Therefore, the first objective of the present study was to assess the effect of trivialization of workplace aggression on the psychological consequences of victims of workplace aggression in a path analysis model. More specifically, direct effects of normalization and tabooing were tested. Since reviewed studies suggested that perceptions might also intervene or contribute to the effects of other factors linked to psychological

consequences following a SVA victimization, the intervening effects of normalization and tabooing were also explored. A second aim of this study was to assess gender differences in the predictors of psychological consequences for workers who were victims of violence. Thus, this study, conducted among healthcare providers and law enforcers, focused on the gender-differentiated effects of individual and organizational factors on psychological consequences following a violent victimization in the workplace. Derived from the literature, a conceptual model was created (Figure 6) and five hypotheses were formulated:

(1) Female workers are more likely than male workers to develop psychological consequences after experiencing an SVA in their workplace;

(2) The more workers are exposed to workplace aggression in the workplace; the more likely it is that they will develop psychological consequences after experiencing an SVA in their workplace;

(3) The more workers perceive that their organization provides strategies to help them cope with workplace aggression, the less likely they are to develop psychological consequences after experiencing an SVA in their workplace;

(4) Healthcare providers are more likely than law enforcers to develop psychological consequences after experiencing an SVA in their workplace;

(5) The more workers trivialize workplace aggression, the more likely they are to develop psychological consequences after experiencing an SVA in their workplace.

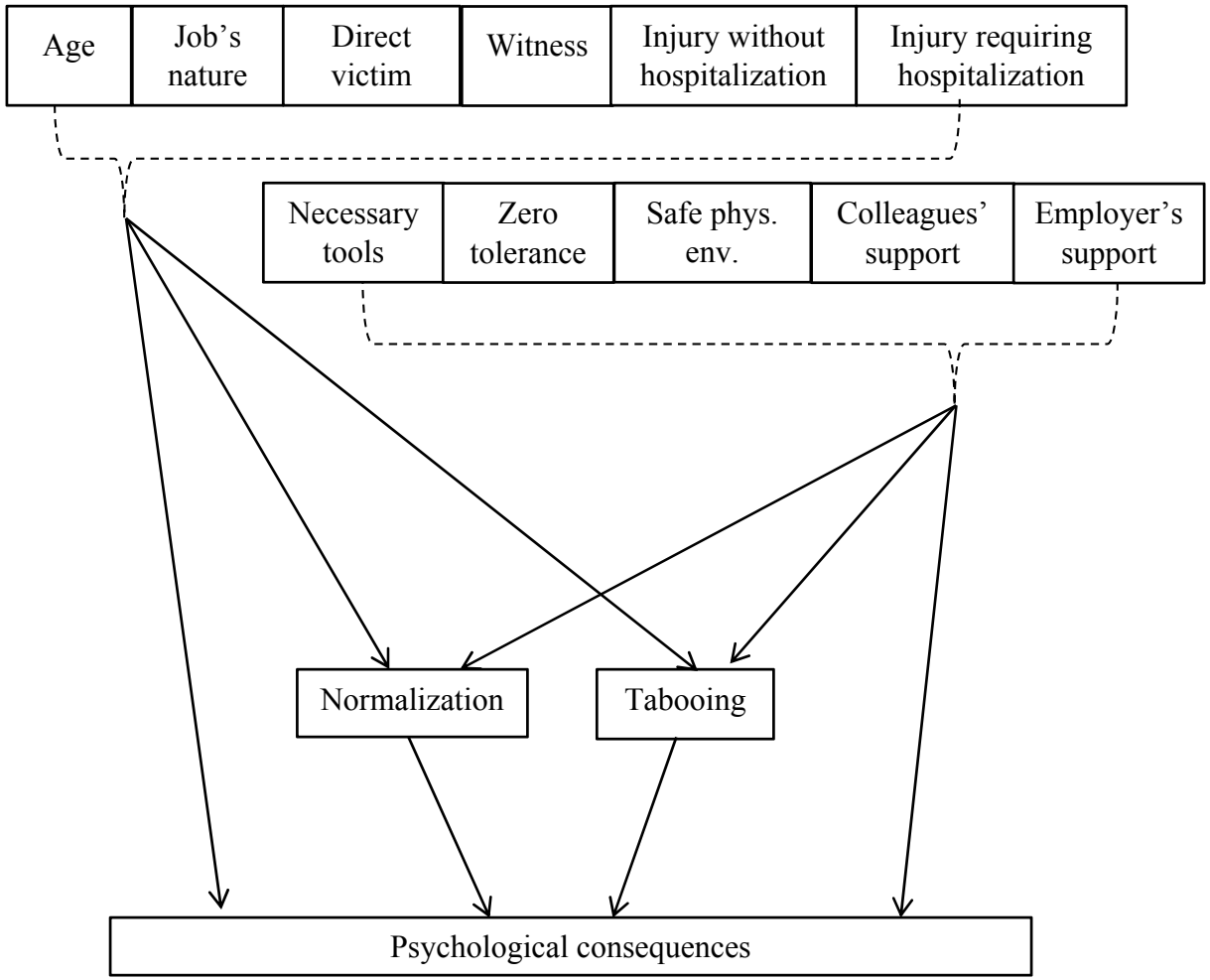


Figure 6 – Conceptual model for the impact of individual and perceived organizational characteristics on the psychological consequences of victims of SVA in the workplace.

7.2 Method

7.2.1 Participants

The current convenience sample is extracted from a study carried out in the province of Quebec, Canada. A total of 2,889 workers from seven categories of employment responded to the survey: law officials, healthcare professionals, nursing staff, managers, administrative workers, skilled and service industry workers, and public transportation workers. For the purpose of the present study, we only selected law officials, healthcare professionals and nursing staff who had been victims or witnesses of at least one SVA in the workplace in the past 12 months. As a result, we obtained a sample of 376 workers of which 54.3% were women and 70.5% were healthcare providers. Security agents (29.7%), park rangers (14.4%) and police officers (55.9%) constitute the law enforcers group. Orderlies (12.5%), nurses (61.9%) and healthcare professionals (25.6%) represent the healthcare providers group. Based on the most disturbing SVA experienced in this assessed period, respondents were asked to report their PTSD symptoms linked to this victimization.

7.2.2 Sampling procedure

The study was conducted among French-speaking workers who were recruited by three organizations linked to the Agency for Health and Safety at Work, which is dedicated to promoting health and safety in different work sectors. Between January 2011 and October 2012, workers were reached by email or on-site to complete a survey online or on paper. Advertisement and questionnaires were distributed by the Agency for Health and Safety at Work. All the workers were informed of the purpose of the study through the websites as well as the anonymous nature of their answers. A majority of the participants completed the survey

online (74.2%), vs. on paper (25.8%). All questionnaires were answered anonymously and on a voluntary basis. This study was approved by the Ethics committee of the Institut universitaire en santé mentale de Montréal (Montreal Mental Health University Institute).

7.2.3 Measures

A survey was developed by the VISAGE (Violence in the workplace according to sex and gender) research team for the current study. The questions were related to episodes of workplace aggression that the respondents might have had either as a victim or as a witness during the past 12 months and their repercussions. The survey also studied workers' perceptions with regard to workplace aggression, social support received at work to cope with this reality and psychological consequences engendered by their victimization.

7.2.3.1 Exposure

A distinction was made between two types of exposure to violent acts: being a *direct victim* or being a *witness*. Furthermore, exposure had to be work-related; it had to occur either in the workplace or during an activity directly related to the job. Respondents were asked to report on a scale from "0 to 10 and more" how many times they have been a direct victim of or a witness to 7 different types of SVAs: assaults, death threats, robbery with violence, armed robbery, sexual contact, sexual aggression and homicide. These categories were not mutually exclusive; respondents may have been victim and witness. Respondents also had the opportunity to report other types of violent acts in an "other" category. Some declared having been a direct victim of or witness to verbal abuse, threats, intimidation, harassment and vandalism.

Two variables were then created in order to measure the level of exposure to violence. First, *frequency of direct victim* sums up direct victimization events of each type of violent act including the "other" category experienced in the 12 past months in the workplace. Second, *frequency of violent act witnessed* sums up the number of times a worker has been a witness of each type of violent act during the 12-month reference period.

A third variable was included as part of the exposure dimension. *Injury* referred to physical consequences following the SVA experienced. Respondents had three options: (1) no injury, (2) injury that required medical examination but no hospitalization and (3) injury that led to hospitalization.

7.2.3.2 Perceived organizational characteristics

Five different items from the questionnaire explored workers' perceptions toward organizational characteristics concerning violence in the workplace. On a 4 point Likert-scale ranging from "not at all (0)" to "completely (3)", respondents had to declare the extent to which the following features were "present" in their work environment: (1) "to what extent do you have the necessary tools to cope with violence (training, procedure, guidelines, etc.) in your workplace", (2) "to what extent do you have a "zero tolerance" policy in regards to violence in your workplace", (3) "to what extent do you have safe physical environments (cameras, bulletproof glass, etc.) in your workplace", (4) "to what extent do you benefit from colleagues' support in your workplace, and (5) "to what extent do you benefit from employer's support in your workplace".

7.2.3.3 Trivialization of violence

Three items from the survey were selected to create two aspects of trivialization: normalization and tabooing. First, respondents were asked if they believed that "severe violence is normal in (their) workplace, it is part of the job." On a 4-point Likert-scale, workers could answer "not at all, slightly, highly or completely". Based on the distribution of this item and on conceptual grounds, we dichotomized it to measure *normalization* (0=no, 1=yes) of violence in the workplace; "not at all" was coded "no" while all other responses were coded "yes". Second, respondents were asked on the same 4-point Likert-scale if they thought (1) "(they) would be judged by their colleagues if they complained about severe violence in (their) workplace" and (2) "(they) would be judged by their employer if they complained about severe violence in (their) workplace". These two items were computed, generating a scale with high reliability ($\alpha = .81$). Since the distribution was skewed and based on our definition of *tabooing*, we dichotomized this variable (0=no, 1=yes) in order to measure *tabooing* workplace aggression.

7.2.3.4 Psychological consequences

Participants were asked if they experienced any psychological consequences following the SVA that affected them the most in the past 12 months. A scale of post-traumatic stress reactions was created based on the DSM-IV-TR Post-traumatic stress disorder symptoms. Respondents had to report the presence (yes/no) of ten symptoms: flashbacks, nightmares related to the event, avoiding elements that arouse recollection of the event, guilt, irritability, loss of interest in pleasurable or important activities, sleep problems, hypervigilance, concentration problems or other psychological symptoms such as sleep problems. The total number of experienced symptoms was then calculated. The scale was

found to have high internal consistency (Cronbach's alpha =.88). The *psychological consequences* variable used in this study represents the sum of these 10 categories. This item, ranging from 0 to 10, was positively skewed.

7.2.4 Analyses

Two sociodemographic characteristics were controlled for in the present study. First, participants had to indicate whether they were a man or a woman. Second, they had to indicate their age; five categories were made for this variable. Another individual factor was considered and referred to the nature of the job done by the worker. As mentioned, the grouping of different occupations led to the creation of a third individual factor that attests the nature of the jobs: healthcare providers and law enforcers.

Preliminary analysis to assess the link between normalization and tabooing was tested with Spearman rho correlation analyzes. Gender associations with psychological consequences were also assessed with this analysis. According to Bobko (2001), Spearman rho should be privileged over Pearson when correlations between self-reported ordinal scales are assessed because they are more conservative and help compensate for the possible inflation due to self-report. A general path analysis model was then used to answer the first objective and to test the formulated hypotheses in a multivariate model. This technique allowed for the verification of direct and indirect effects. Indeed, using structural equation modeling is appropriate for observing indirect effects between X → Y through an intervening variable (M) (Mathieu & Taylor, 2006). Consequently, it made it possible to consider how individual and organizational factors were associated with the endogenous variable as well as to test the intervening effects of normalization and tabooing. Intervening effects with multiple

intervening variables were tested using bootstrapping (with $n = 5\,000$) procedures as instructed by Preacher and Hayes (2008). Level of significance used was $p \leq .05$. *MPlus 7.3* was used to compute the analyses of this study.

Another advantage of using path analysis to test our hypotheses was that it enabled the assessment of between-group differences using the covariance SEM approach (Qureshi & Compeau, 2009). It was possible to compare if the predictors were similarly or differently associated with the endogenous variable when moderated by gender. Thus, gender was not introduced in the path analysis models since it acted as a moderator to assess differences between groups.

To meet the assumptions of the linear model and in order to minimize errors engendered by outliers, victimization variables were transformed into Z scores. For physical consequences, *no injury* was used as the reference category.

7.3 Results

Table IX depicts the correlation matrix of the different measures. Of the 376 workers, 54.3% thought that violence was normal in their work environment while 57.8% believed that their colleagues or employer would judge them if they complained about violence in their workplace. Regarding the link between normalization and tabooing, the correlation was not significant ($p = .08$). Participants reported an average of 2.87 types of psychological consequences after their exposure to SVA. Contrary to what was predicted, gender is not associated with psychological consequences, thus already infirming *hypothesis 1*.

Table IX

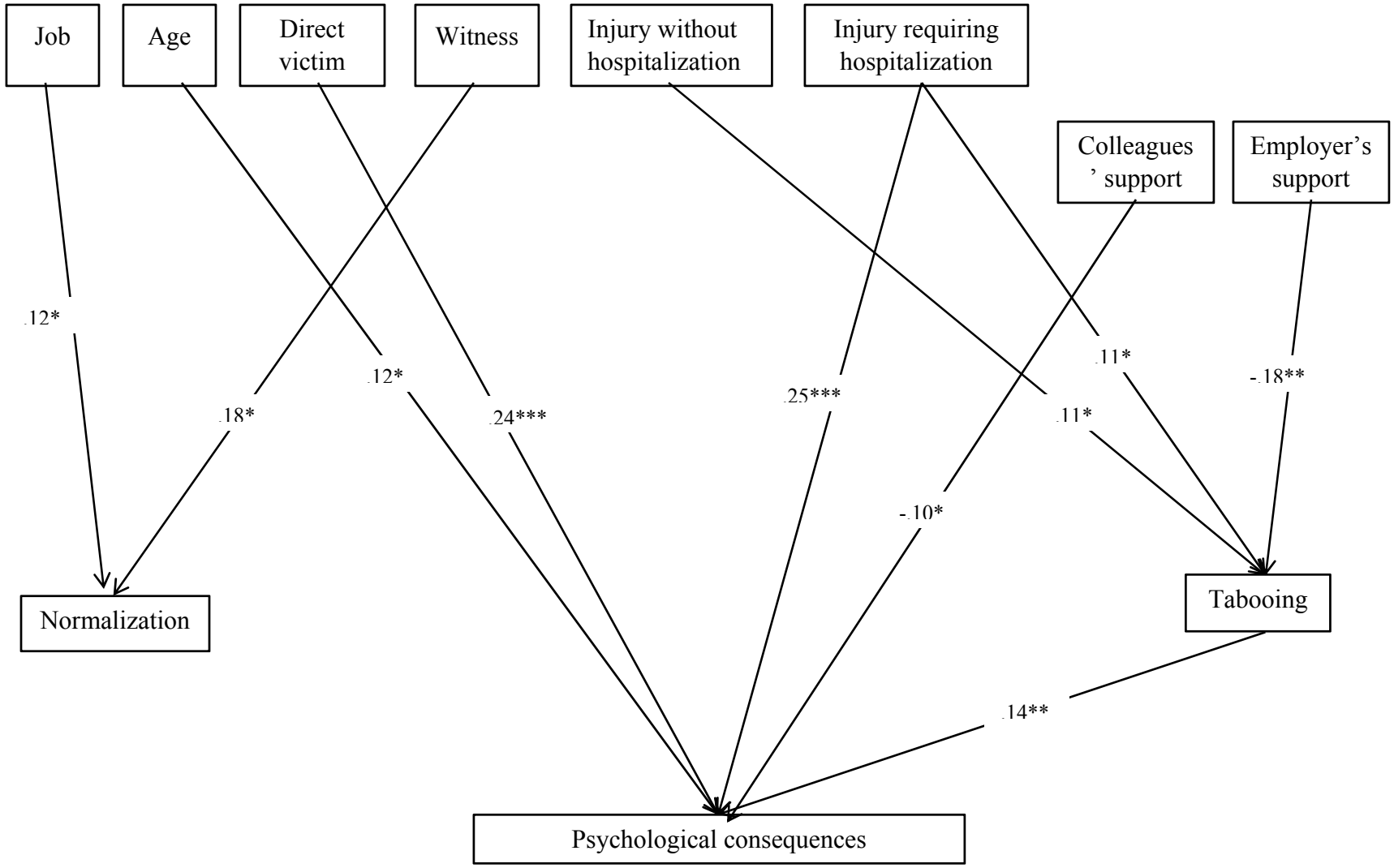
Descriptive Statistics and Correlations Among Variables

Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Gender[1]	1.54	0.50	-														
2. Age[2]	3.00	1.14	-.05	-													
3. Nature of the job[3]	1.30	0.46	-.37	-.24	-												
4. Direct victim.[4]	12.23	11.50	-.15	-.22	.19	-											
5. Witnessing[4]	18.30	15.48	-.12	-.14	.26	.71	-										
6. Injury without[5]	0.17	0.37	.08	-.04	.04	.15	.12	-									
7. Injury with[6]	0.14	0.34	.02	.01	.03	.09	.11	-.18	-								
8. Necessary tools[7]	1.56	0.85	-.08	-.02	.11	-.04	.11	-.04	-.02	-							
9. Zero tolerance[7]	1.51	0.91	.05	-.02	-.04	-.22	-.13	-.10	-.11	.41	-						
10. Safe physic. env.[7]	1.30	0.95	-.08	-.07	.11	-.06	.06	-.06	-.05	.31	.28	-					
11. Colleagues' sup.[7]	1.90	0.82	-.08	-.10	-.02	-.04	-.00	-.01	-.07	.34	.25	.11	-				
12. Employer's sup.[7]	1.31	0.88	-.01	-.05	-.03	-.23	-.15	-.07	-.11	.49	.45	.27	.48	-			
13. Normalization[6]	0.54	0.50	-.08	-.13	.19	.09	.19	.01	-.01	.11	.01	.13	.02	-.01	-		
14. Tabooing[8]	0.58	0.50	-.02	.02	.06	.12	.09	.12	.13	-.26	-.28	-.12	-.24	-.34	.09	-	
15. Psy. Cons.[4]	2.87	2.75	.08	.12	-.02	.25	.12	.01	.31	-.22	-.22	-.21	-.24	-.31	-.09	.27	-

Note. N=376. [1]1= men, 2=women; [2] 1=15 to 25, 2=26 to 35, 3=36 to 45, 4=46 to 55, 5=56 to +; [3]1=caregiver, 2= law enforcer; [4] Zscore were used in correlations; [5] Injury without hospitalization (0=no, 1=yes; dummy = no injury); [6]Injury with hospitalization (0=no, 1=yes; dummy = no injury);[7] 0=not at all, 3=completely;[8] 0=no, 1=yes; $r = .11–.14$, $p < .05$; $r = .15–.18$, $p < .01$; $r > .19$, $p < .001$.

7.3.1 Objective 1: Assessing the direct and indirect effects of individual and organizational factors on psychological consequences

The general path model is shown in Figure 7. R^2 for psychological consequences was 0.27. The general model was just-identified, thus goodness-of-fit measures are not presented. As mentioned by Pearl (2003), just-identified models are appropriate for testing hypothesized directional relations between variables. Consequently, it was possible to test hypothesis 2 to 5.



Note. **p* < .05, ***p* < .01, *** *p* < .001

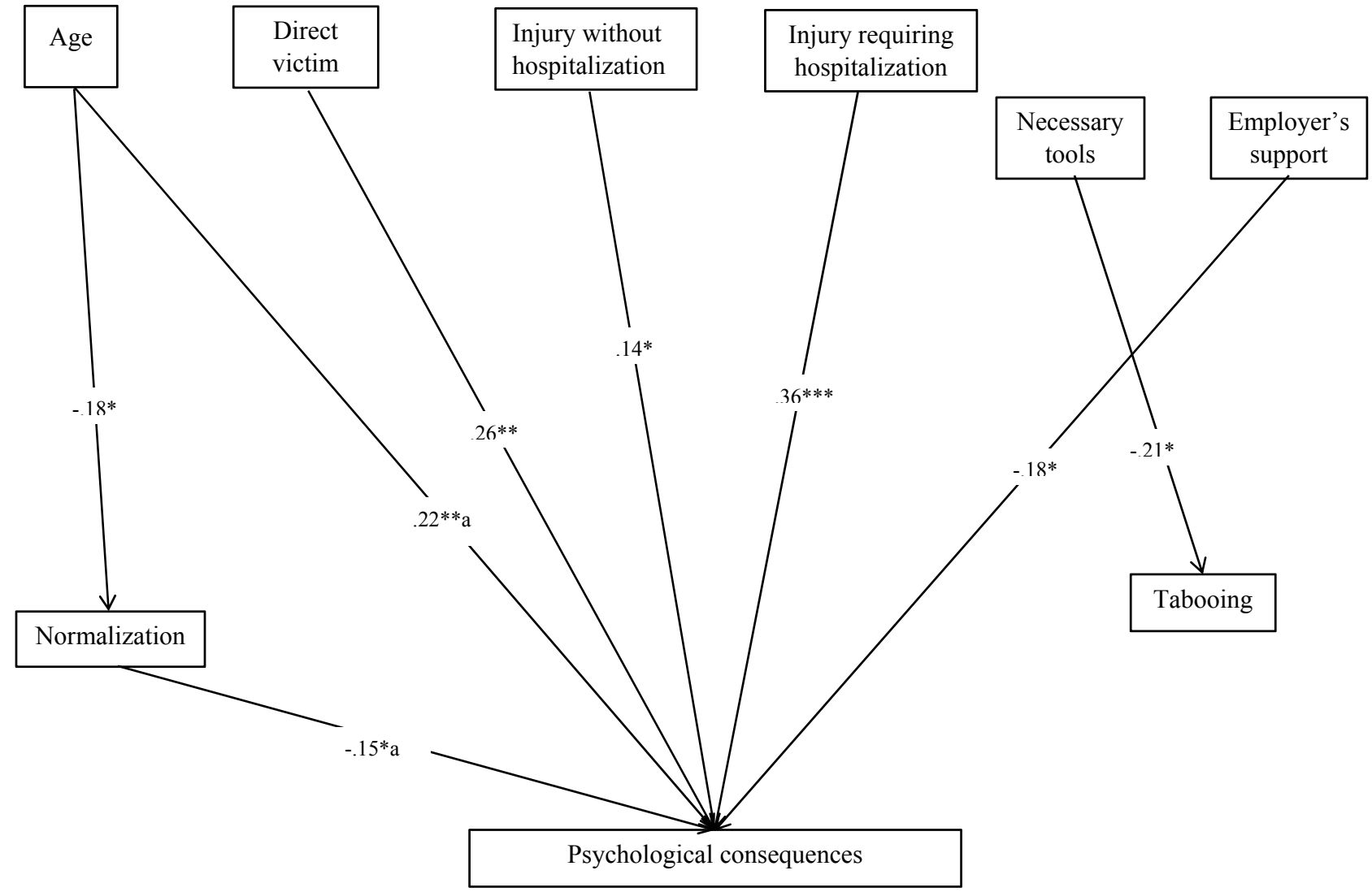
Figure 7 – Path diagram for psychological consequences.

If this model accurately reflected reality, only four individual factors had direct effects on psychological consequences. In a descending order of strength of relations and statistical weights, they were injury requiring hospitalization, prior direct victimization, tabooing and age. Even though prior direct victimization was associated with the endogenous variable, *hypothesis 2* was partially confirmed since witnessing aggression was not statistically related to psychological consequences. Colleagues' support was negatively associated with the endogenous variable, but other perceived organizational strategies were not. *Hypothesis 3 was then partially confirmed*. Contrary to what was predicted, the nature of the job was not related to psychological consequences, thus refuting *hypotheses 4*. *Hypothesis 5* was partially confirmed since tabooing was slightly predictive of the outcome variable, but not normalization.

In order to fully address the first objective, tests of indirect effects with multiple intervening variables revealed that normalization and tabooing had no indirect effect in the general model. Even though path diagram suggested indirect effects for injury variables and support from the employer through tabooing, these indirect paths were not statistically significant. These relations must then be seen as two independent sets of relationships. Therefore, trivialization only influenced psychological consequences through a direct and slightly positive effect of tabooing.

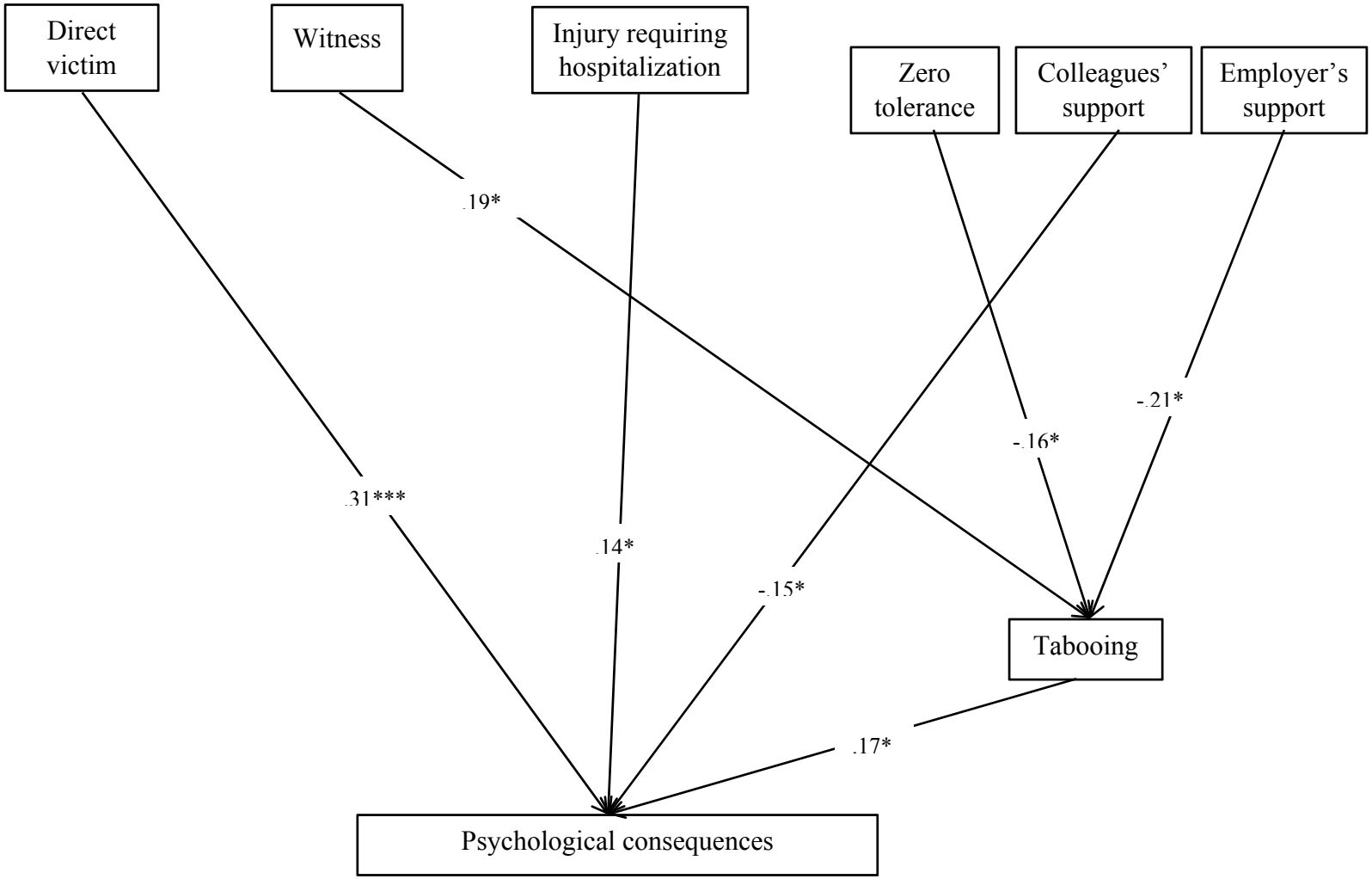
7.3.2 Objective 2: Gender-differentiated effects of individual and organizational factors on psychological consequences

Figures 8 and 9 illustrate the multi-group analysis and show the path diagrams for male participants and female participants respectively. Both models were just-identified, thus goodness-of-fit measures are not presented.. As mentioned by Pearl (2003), just-identified models are appropriate for testing hypothesized directional relations between variables.



Note. **p* < .05, ***p* < .01, *** *p* < .001, a = statistically different than female respondents

Figure 8 - Path diagram for male participants' psychological consequences.



Note. **p* < .05, ***p* < .01, *** *p* < .001

Figure 9 - Path diagram for female participants' psychological consequences.

7.3.2.1 Male participant model

R^2 with all variables for the male model was equal to 0.36. If this accurately reflected reality, five individual factors and one organizational factor had direct effects on psychological consequences. In descending order of strength of relations and statistical weights, they were injury requiring hospitalization, prior direct victimization, age, support from the employer, normalization and injury without hospitalization. Tests of indirect effects with multiple intervening variables revealed that normalization had no indirect effect in this model.

In sum, the negative direct effect of normalization on psychological consequences differed from the general model, in which normalization had no effect. Moreover, the absence of a significant association between the endogenous variable and tabooing in the male model also contrasted with the general model. Injury without hospitalization also had a direct effect, which was not the case in the general model. Finally, support from the employer was directly, but only slightly, related to the endogenous variables which again was not the case in the general model.

7.3.2.2 Female participant model

R^2 with all variables for this female model was equal to 0.29. Three individual factors and one organizational factor had direct effects on psychological consequences. In descending order of strength of relations and statistical weights, they were prior direct victimization, tabooing, support from colleagues and injury requiring hospitalization. Once again, tests of indirect effects with multiple intervening variables revealed that tabooing had no indirect effect in this model.

In sum, the positive direct effect of tabooing contrasted with the male model. Unlike the general and male model, age had no effect. Still, and similarly to previous models, the overall strengths of these relations were weak to moderate.

7.3.2.3 Male-female differences

In order to assess whether the differences found in the gender-specific models were significant or spurious, the covariance SEM approach was used (Qureshi & Compeau, 2009). Of all the differences between male and female participants, only two predictors significantly differed: age and normalization. For both, they were only significant in the male model, making them specific for this gender. Other variables, even if significant in both or in one of the models and having great differences in estimates, were not significantly different. For these predictors, the general model that encompasses both male and female participants is appropriate since no difference were found between genders. In other words, gender only moderated the effect of age and normalization.

7.4 Discussion

Using a victimization survey regarding the perceptions of 376 workers employed as healthcare providers and law enforcers, the main objective of the present study was to evaluate the effects of trivialization of violence in a path analysis modeling of psychological consequences following workplace aggression. When individual and organizational factors were controlled for, tabooing had a positive effect on psychological consequences for victims of a SVA. Being older, prior direct victimization and injury requiring hospitalization also

increased psychological consequences following SVA victimization. Gender was not associated with psychological consequences. However, when models where specified based on gender, some predictors differed for male and female respondents. Normalization decreased psychological consequences only for male participants, contrasting with the general model. Age was also a positive predictor for men, not for women.

7.4.1 The effects of individual and perceived organizational factors on psychological consequences

Contrary to the first hypothesis, analysis did not support the assumption that females were more likely than males to develop psychological consequences after being a victim of a SVA in the workplace. This contrasts previous literature that found that women were more likely than men to meet criteria for PTSD and reported greater severity of PTSD after experiencing a traumatic event (DeCarlo & Gruenfeld, 1989; Findorff et al., 2005; Tolin & Foa, 2006; Van Voorhis et al., 1991; Wells et al., 2006; Wright & Saylor, 1991). However, this result complements studies within law enforcement and healthcare settings that reported no gender differences in PTSD symptomatology after workplace aggression (Armstrong & Griffin, 2004; Fitzpatrick & Wilson, 1999; Lilly et al., 2009; Santos et al., 2009).

The second hypothesis, which assumed a positive association between exposure to workplace aggression and psychological consequences, was partially confirmed since witnessing aggression was not related to psychological consequences. Nevertheless, prior direct victimization was. This finding is consistent with the literature that has positively associated exposure to workplace aggression in healthcare and law enforcement settings to psychological consequences, especially PTSD (Brown et al., 1999; Lam, 2002).

The third hypothesis was refuted in the general model. Of all the perceived organizational factors that are known in the literature to dampen the effects of SVA victimization in the workplace, only colleagues' support had an effect on psychological consequences. Thus, organizations that promote social support may counter the consequences of workplace aggression.

The present study was unable to confirm the fourth hypothesis. More specifically, healthcare providers were not more likely than law enforcers to develop psychological consequences after experiencing an SVA. In sum, the nature of the job does not protect from or exacerbate PTSD symptoms following victimization in the workplace. Thus, the findings expand on Åkerström (2002) and Dick (2000). Even though nurses' and police officers' work culture influence the meanings given to workplace aggression, the insular nature of both types of occupations does not play a role in the prevention of psychological consequences following workplace aggression. Moreover, even though police officers are expected to manage aggressive behaviours in society, this characteristic of the job does not protect these workers from PTSD symptoms more than nurses who are less expected to deal with violent manifestations. However, future studies should investigate the moderating role of the nature of the job on trivialization and test for differences in predictors of psychological consequences.

Based on the bi-dimensional definition of trivialization of violence used in this study, the fifth hypothesis was partly confirmed. Only tabooing workplace aggression had an effect on psychological consequences in the general model, thus for male and female participants. Still, gender-specific path analysis revealed specific results according to gender, Expanding on these findings, individual and organizational predictors of normalization and tabooing were found in the general model. Witnessing workplace aggression increased normalization while

nature of the job was also associated with this outcome; law enforcers were more likely than caregivers to normalize workplace aggression. This may suggest that acceptance of aggression as a characteristic inherent to the job may even be more prevalent in the law enforcement setting (Åkerström, 2002; Brown et al., 1999; Dick 2000). On the other hand, being injured following SVA victimization reinforced the perception of taboo around workplace aggression while support from the employer countered this perception. Some organizational strategies may therefore prevent psychological distress by mitigating the perceived taboo.

7.4.2 Gender differences

Gender differentiated analyses revealed distinctions between male and female workers especially in terms of the effects of normalization of workplace aggression. Gendered perceptions of workplace aggression thus play a significant role in psychological consequences. For male participants, trivialization meant normalizing workplace aggression in addition to tabooing. Furthermore, normalization was found to reduce psychological consequences thus making it an adequate coping strategy for male participants. For female participants, trivializing referred only to tabooing. For both genders, tabooing may inhibit coping strategies such as support seeking and increase their psychological consequences to workplace aggression. These gender-differentiated findings are consistent with studies on stress and gender, which suggests significant differences in the perceptions and coping skills of male and female workers (Barnett et al., 1987; Brown & Campbell, 1990; He et al., 2002). According to Matud (2004), men tend to use more instrumental coping while women are more likely to use emotion-focused coping strategies such as emotional-discharge. Moreover, this reflects the socialization hypothesis that suggests that men are socialized to use more active

and instrumental strategies while women are socialized to use passive and emotion-focused strategies such as relying on social support (Ptacek, Smith, & Zanas, 1992). Thus, using learned and reinforced coping strategies may protect from psychological consequences. On the other hand, inhibiting them may contribute to the development of psychological distress.

The results for between-group differences also provide evidence that predictors may contribute differently to trivialization of violence. In the male participant model, age had a negative effect on normalization, which means that the older the male workers were, the less they tended to normalize. Consequently, the less likely men were to use normalization as a coping strategy, the more vulnerable they were to SVA victimization in the workplace.

7.4.3 Policy and clinical implications

The findings of this study suggest that gender and perceptions regarding workplace aggression play a significant role in psychological consequences for workers exposed to SVA, which leads to multiple policy and clinical implications. First, it implies that men may benefit from the normalization of workplace aggression. For men, accepting that violence is part of the job may prevent a number of psychological consequences related to exposure to workplace aggression as it reinforces socially learned coping strategies. Thus, training and supervision may be adapted for men in order to help them frame violence in the boundaries of their work. Like Åkerström (2002) concluded about nurses, as long as men define their experiences according to the boundaries of their profession, they can maintain the psychological state that allows them to do their job. On the other hand, our results suggest that an organization seeking to help their employees to cope with workplace violence may need to reduce the taboo around workplace aggression since it hinders the use of adequate coping strategies such as support-

seeking. Our findings highlight the benefits of support from the employer on this aspect. Even though this study may not conclude that other organizational strategies seem to counter the taboo of violence in the workplace, organizations should keep on disseminating policies that aim to counter workplace aggression as well as strengthening support from the employer since the introduction of policies such as zero tolerance is relatively new in the assessed work environments and may take some time to influence how workers define workplace aggression (Whittington, 2002). The findings also bolster the role of support from colleagues in reducing psychological consequences following SVA victimization. "Peer-support" interventions in which workers are encouraged to talk about their traumatic experience with trained colleagues who are sympathetic and supportive could thus represent an adequate organizational strategy to counter workplace aggression consequences (Stephens, Long, & Miller, 1997).

7.4.4 Study limitations and directions for future research

Since this survey was based on a convenience sample, the findings are not generalizable to the healthcare provider and law enforcement populations. Furthermore, data may have been collected only from people who were willing to discuss or complain about workplace aggression. It is also possible that the distribution of the questionnaire by a member of a joint association for health and safety at work in their work environment and the nature of the survey may have influenced the reported prevalence. This may explain the low prevalence of respondents who think that violence is "part of the job"; workers who wanted to complete the questionnaire were the ones who wanted to denounce violence in the workplace, not the ones who accept it as a reality of their work. There is also a potential limitation stemming from the fact that healthcare providers and law enforcers self-reported their experience of

workplace aggression. In order to minimize recall bias, the questionnaire only focused on victimization that occurred during the past year. As mentioned by Nachreiner et al. (2007), this method has successfully been used in previous studies. Finally, findings may not be generalized to other types of occupations. However, we suspect that our sample may share similarities with female-dominant work (education, for example) and male-dominant work (construction trades, for example). This hypothesis should be tested.

Still, more research is needed in order to assess the consequences of trivialization of workplace aggression on psychological consequences. In this vein, further research should rely on random sampling while controlling for other important individual characteristics, such as personal history of abuse and years of experience. These studies should also use valid instruments to assess PTSD according to the DSM-5 criteria, such as the PCL-5, and other psychological distress manifestations. Moreover, the findings of the current study demonstrate the importance of simultaneously assessing individual and organizational factors. Thus, future research should include other variables related to the individual and to the organization and test the interactions between these variables. Nevertheless, the current study demonstrated that workers and their organizations should encourage employees to freely discuss workplace aggression since it may contribute to wellbeing at work, especially for women.

Chapter 8 - Conclusion

8.1 When the clothes make the man: the stress-mitigating effect of the professional role

The main aim of the present thesis was to assess how professional identity helps caregivers and law enforcers cope with the adversity inherent to their work. Through the four objectives, it was demonstrated that professional identity, which encompasses individual and organizational factors, influences how caregivers and law enforcers deal with stressors specific to their work. The stressors assessed in this study were exposure to workplace aggression, exposure to traumatic material and accountability stress. Explicitly and implicitly, professional identity was found to have a stress-mitigating effect that protects the mental health of workers. However, it was also found that professional identity might partially account for the psychological consequences of work-related stress when it inhibits coping strategies such as support-seeking. Overall, gender differences were also found concerning the perceptions of these stressors and the consequences engendered by these stressors on the mental health of workers. Findings related to the four objectives are summarized in the next section and then discussed in a global perspective articulated through the criminologist profession.

8.1.1 Objective 1

The first objective of this thesis was to propose a theoretical framework that encompasses workplace aggression, exposure to traumatic material and felt accountability as well as compassion satisfaction and fatigue as measures of the mental health of workers operating in public services. This objective was addressed in the article *Rethinking*

Compassion Fatigue Through the Lens of Professional Identity. By integrating notions from identity theory to Figley's (1995) compassion fatigue model, it was possible to add a subjective perspective in the understanding of the development of compassion fatigue. Contrasting with the deterministic approach of C.R. Figley (1995), it was argued that workers have a certain control over how they experience work-related stress since they may interpret these stressors positively or negatively. However, it was also stipulated that this interpretation is not completely relative; it is highly influenced by social structures such as occupational culture, codes and regulations guiding the provision of services, organizational policies and professional orders.

The consideration of this social structural influence on professional identity also made possible the integration of a fourth variable in Figley's (1995) model: accountability stress. Since compassion fatigue is specific to work-related situations (Adams et al., 2006), it is argued that this type of stress can affect workers as much as other traumatic stress present in Figley's (1995) model.

By relying on professional identity theories, it was possible to discuss the impact of role conflicts on compassion fatigue for caregivers working in authoritarian settings. Caring and controlling at the same time may lead to intrapersonal or interpersonal conflicts that create additional stress which in turn, amplify compassion fatigue (Boyd & Pasley, 1989). Moreover, research has shown that accountability to different instances often creates clashes, requiring prioritization and thus, may result in role conflict (Hall et al., 2006).

Finally, it was proposed that the self, which is comprised of multiple identities, modulates the impact of compassion state on mental health in a bidirectional relation.

Therefore, individuals and organizations may adopt and promote strategies that soothe or exacerbate the effects of compassion fatigue on mental health.

8.1.2 Objective 2

The second objective was to empirically test some of the hypotheses proposed in the first article. This objective was addressed in the article *Towards an integrated and adapted model of compassion fatigue: a quantitative examination of the Professional Quality of Life model of child protection workers.* More precisely, this article empirically tested an adapted version of the *Professional Quality of Life* model (Stamm, 2009) for child protection work. As hypothesized in the first objective, high exposure to workplace aggression and high felt accountability were associated with heightened levels of compassion fatigue in a representative sample of child protection workers. Adherence to professional identity, masculinity and confidence in coping with client aggression were revealed to be protective factors, partially suppressing the impact of work-related stressors. Sex differences were not significant in this study but gender role (e.g. masculinity in this case) had direct effects on both CS and CF and contributed to an indirect effect, demonstrating the added value of considering gender in the understanding of compassion fatigue. Indeed, masculine attitudes were found to suppress a part of the positive effect of exposure to workplace aggression on compassion fatigue.

8.1.3 Objective 3

The third objective was to test the notion of professional identity in two other professions: healthcare workers and law enforcers. The aim was thus to investigate how

individual and organizational factors – which refer to professional identity - influence perceptions/meanings given to workplace aggression, and more precisely, trivialization of workplace aggression. This objective was answered in the article *Predictors of trivialization of violence among workers of two at-risk sectors*. Using a convenience sample of 1141 caregivers and law enforcers, evidence was found that professional identity influences how workers perceive workplace aggression. The results also revealed gender differences in these perceptions. As such, male participants were more likely than female participants to think that workplace violence was normal, that it was "part of the job". Law enforcers were more likely than caregivers to refrain from complaining about violence because they feared being stigmatized as incompetent, since the expected professional identity of being "cool" in the face of violence was not displayed. This last result was especially significant for female law enforcers, whose odds of tabooing violence were twice as high, suggesting that women working as law enforcers can be affected by an added level of stigmatization: being a woman in "man's" job (Breakwell, 1986; Johnson, Greaves, & Repta, 2007). Organizational factors (violence prevention training, support from colleagues and supervisors, 'zero tolerance' management policy and safe physical environment) were all significant negative predictors of tabooing violence. In sum, this article demonstrated how professional identity may be the nexus between individual, organizational and cultural factors that help understand the perception of work-related stressors.

8.1.4 Objective 4

Still rooted in the concept of professional identity, the fourth objective was to assess how meanings given to workplace aggression can affect mental health at work. Expanding

upon the third objective, the fourth was then to assess the gender-differentiated impact of trivialization of workplace aggression on psychological consequences of caregivers and law enforcers who have experienced a severe violent act. This objective was addressed in the article *The Effects of Trivialization of Workplace Aggression on its Victims: Is Gender an Issue?* Using a subsample from the same convenience sample than that of the third objective, tabooing violence was found to increase psychological consequences following a severe violent act and this, in a multivariate model accounting for individual and organizational factors. When models where specified based on gender, predictors differed for male and female respondents, especially for the trivialization variables. Normalization decreased psychological consequences only for male participants. Tabooing increased psychological consequences for both. Not explicitly emphasized in the article, these findings once again provide evidence of the influence of professional identity in mental health at work. Individual (e.g. gender, past victimization) and organizational (e.g. policies, support) factors as well as occupational culture – which refer again to professional identity – shape how one interprets work-related stressors or how one may cope with them. In this case, it has been shown that the interaction between professional and gender identities may result in different outcomes and coping strategies. In sum, men may benefit from normalization of workplace aggression while all could benefit from breaking the taboo around workplace aggression.

8.2 Contributions

This thesis may contribute to the advancement of scientific knowledge on different topics. Theoretical and methodological contributions are first discussed. Then, potential policy

and clinical advancements are summarized. Finally, accomplished and upcoming knowledge transfer is presented.

8.2.1 Theoretical contributions

With the two articles on compassion fatigue and the review of the different concepts associated with it, this thesis offered a clearer definition of compassion fatigue and its principal features. By combining a constructivist approach (professional identity) to a concept that has been studied from a more deterministic approach (Alderson, 2004), it was possible to include a subjective perspective in the understanding of compassion fatigue. Since the identification of external causes does not explain the psychological impact of stressors on its own, this thesis expands on Thoits's (1999) work, which relied upon self and identity concepts in the study on mental health. In fact, the present thesis introduced the notion of professional identity in the understanding of compassion fatigue among child protection workers, which simultaneously includes a subjective and an objective perspective. Thus, merging two theories embedded in different epistemological positions was fruitful and allowed for an enhancement of the compassion fatigue concept.

Furthermore, the introduction of professional identity allowed for the consideration of felt accountability, which was not present in the Figley's (1995) model. As initially demonstrated by Ferris, Mitchell, Canavan, Frink, and Hopper (1995) and then by many others (Hall et al., 2006; W. Hochwarter, Kacmar, & Ferris, 2003; W. A. Hochwarter, Perrewé, Hall, & Ferris, 2005; Ito & Brotheridge, 2007; Siegel-Jacobs & Yates, 1996), felt accountability may represent a stressor because of its potentially anxiety-provoking effects. This thesis then

included this stressor in Figley's (1995) compassion fatigue model in order to illustrate its effect on child protection workers.

Not only the findings of this thesis propose a new theoretical framework to understand compassion fatigue, but it also support the empirical validity of Stamm's *Professional Quality of Life model* in a multivariate model. When accounting for all stressors, findings revealed that felt accountability was impacting compassion fatigue, thus enhancing current knowledge. Not only did they confirm that felt accountability was indeed a work-related stressor as proposed by Ferris et al. (1995), but they specified that it can result in compassion fatigue for child protection workers. Thus, negative outcomes of felt accountability may be experienced as PTSD-like symptoms and burnout-like symptoms, which specify the strain reactions described by Ferris et al. (1995).

Multivariate analysis, however, demonstrated that vicarious trauma may not be associated to compassion fatigue when other stressors are controlled, contrasting with Charles R Figley (1995) and Stamm (2009) original propositions. Indeed, integrating all stressors and mediating variables in one model to consider compassion fatigue and satisfaction jeopardized the assumed impact of vicarious trauma on the mental health of caregivers. This thesis then answered Kadambi and Ennis (2004) argument that the conceptualization of vicarious trauma and its impact on the development of trauma in caregivers should be considered in light of the contributions of the subjective interpretation and condition of the caregiver. In fact, this thesis evaluated how professional identity influences perceptions of work-related stressors and how these perceptions impact on the mental health of workers.

Intervening variables were also found in the *Professional Quality of Life model* Stamm (2009), thus specifying how each stressor really affects compassion fatigue and satisfaction.

As such, this thesis was consistent and reinforced studies that demonstrated that a strong professional identity contributes to psychosocial adjustment, wellbeing, and life satisfaction while decreasing levels of depression and anxiety (Christiansen, 1999; Kroger, 2006; McKeague, Skorikov, & Serikawa, 2002; Skorikov, 2008; Vondracek, 1995). Furthermore, it nuanced findings of Schauben and Frazier (1995) and van Minnen and Keijsers (2000) on the association between coping strategies and compassion fatigue. Indeed, positive appraisal was found to be positively associated with compassion satisfaction instead of being negatively linked to compassion fatigue. In addition, contrary to Badger, Royse, and Craig (2008) and Figley (2002), avoidance was found to be a positive predictor of compassion fatigue, not a negative one. Moreover, it confirmed the positive effect of self-confidence in managing workplace aggression. This result endorsed the dissemination of violence minimization and de-escalation training programs, which have been shown to increase self-confidence (Allen & Tynan, 2000; Collins, 1994; Farrell & Cubit, 2005).

Trivialization workplace aggression and its impact were revealed and bolster the consideration of subjective appraisal of stressors to understand their impact on mental health. Consistent with Âkerström (2002) and Thoits (1999), this thesis empirically and quantitatively demonstrated that differing perceptions of a given situation may account for the impact of stress related to the aggression. Regarding trivialization of workplace aggression, this thesis also proposed a bidimensional definition of trivialization of workplace aggression (i.e. normalizing and tabooing), which was inexistent in the literature.

By relying on professional identity explicitly and implicitly throughout the four articles, this thesis also demonstrated the importance of simultaneously assessing individual and organizational factors. As demonstrated by Geoffrion & Ouellet (2013), it is imperative to

consider individual and organizational factors when studying workplace aggression since both influence how one copes with this stressor. Moreover, it shows the relevance of gender-differentiated analysis. As such, this thesis is part of an emerging stream which incorporates the concept of sex and gender in the scientific study of various phenomena (Johnson et al., 2007).

8.2.2 Methodological contributions

By using a theoretical framework rooted in symbolic interactionism, which traditionally relies upon qualitative methods, this thesis demonstrated that quantitative methods may be used to evaluate how meanings given to situations influence mental health. In this vein, this study was conceptualized according to Blumer (1969)'s conditions for using quantitative methods in an symbolic interactionist framework. Indeed, by relying upon self-report and maximizing the use of validated measurement instruments, this thesis (a) treated individuals, and not the variables, as agents of action (e.g. variables were used to represent how participants think, interpret and act), (b) extrapolated that social causation lies not in variables or statistical models, but rather in the interpretative process that lead individuals to define the situations they live and act accordingly and (c) reduced the conceptual distance between the measurement scales and measured phenomena. In the same vein, it has methodologically contributed to the sociology of occupation which, similarly to symbolic interactionism, relied traditionally on ethnographies.

The second article provided evidence of internal, discriminant, discriminative and exportability validity (Haynes, 2001) of our translated version of the *Perception of Prevalence of Aggression Scale, Felt Accountability, Confidence in coping with patient's aggression* and

the *Professional Identity Scale*. The POPAS-FRC (French Canadian), the FA-FRC (French Canadian), the CONF-FRC (French Canadian) and the PIS (French Canadian) appear to be valid and reliable instruments to assess their respective construct.

8.2.3 Policy and clinical implications

Based on all the findings demonstrating the influence of professional identity on mental health at work, this thesis lead to multiple policy and clinical implications that were reported in each article. Overall, this thesis suggested that individuals may have control over the meaning given to work-related stressors and may therefore be able to preserve their mental health. Moreover, it showed that organizational strategies may also influence these meanings. Thus, restructuring meanings given to stressful work situations in the boundaries of the profession may help caregivers and law enforcers to cope. As such, Klerx-van Mierlo and Bogaerts (2011) stated that health care workers who use cognitive coping are less vulnerable to client aggression than those who use behavioral coping. Cognitive coping may thus be related to reconsideration of meanings given to stressful situations in ways that protect mental health (Åkerström, 2002) or that enable identity negotiations to preserve the self (Thoits, 1999). Coping styles might also be related to involvement in aggressive encounters. Indeed, studies have shown that individuals who use behavioral/emotion-focused coping styles are more likely to be involved in an aggressive situation than individuals who use cognitive/problem-focused coping styles (Winstanley & Whittington, 2002).

Another implication that emanates from this thesis is that sex and gender matters when developing policy and strategies that aim to care for the mental health of workers. Indeed, sex differences were found in the perception of workplace aggression and in consequences

following violent victimization in caregiving and law enforcement settings. Normalization of workplace aggressions was found to help men cope with this stressor while tabooing increased the traumatic symptoms for female victims of workplace aggression. Thus, it has been suggested that training and supervision should be adapted for men in order to help them interpret violence in the boundaries of their work. On the other hand, it was suggested that organizations keep on disseminating policies that aim to counter workplace aggression since these policies diminish the taboo around workplace aggression and therefore, may help employees to reach out for support.

In child protection settings, gender role was found to help workers cope with their exposure to work-related stress. Indeed, masculine attitudes were found to protect workers from the impact of exposure to workplace aggression. It has then been argued that, during hiring procedures, management may screen for individuals who are able to deal with risk-taking, defend their decisions and are self-confident; individuals showing masculine traits. Also, management can accompany others who correspond to those traits to a lesser extent with risk-management and decision-making through clinical supervision or by providing standardized clinical tools.

Since the impact of accountability has been demonstrated, this finding now urges managers to support their workers in coping with this stressor. During the different procedures and knowledge transfer conferences at the CJM, the author realized that even though accountability was experienced as a stressor for child protection workers, few workers could really explain to what extent they were accountable. Even though they knew of the existence of sanctions, they were clueless about the severity of their application and about the available

resources to counter them. Managers should therefore start by defining the boundaries of accountability and describing sanctions and resorts to diminish the effects of this stressor.

Overall, the findings of this thesis should urge organizations to develop training programs and sensitization workshops adapted to sex and gender differences and promote professional identity. Moreover, clinical supervision or monitoring of personnel should be adapted to these differences, should promote "good" professional identity while emphasizing cognitive coping strategies such as positive appraisal and problem-solving. Management could conduct promotional campaigns to enhance a sense of belonging to the profession.

8.2.4 Knowledge transfer and application

This thesis was conducted within an applied research perspective. Indeed, the common objective was to improve practices within the field in a perspective of enhancing the mental health of workers who are regularly exposed to aggression and are held accountable. Four major partners were involved in the realization of this research and in the dissemination of the results: the *Association paritaire pour la santé et la sécurité du travail du secteur affaires sociales* (ASSTSAS), the *Association paritaire pour la santé et la sécurité du travail, secteur «affaires municipales»* (APSAM), the *Institut universitaire en santé mentale de Montréal* (IUSMM) and finally, the Centre Jeunesse de la Montérégie (CJM). Collaboration with these partners lead to different knowledge transfer and applications that are detailed in the following section.

8.2.4.1 A web tool to sensitize workers

First, the findings regarding trivialization of workplace aggression have guided the creation of an interactive web tool that aims to sensitize workers on workplace aggression and its consequences (www.violenceautravail.ca). Developed by the VISAGE (Violence in the workplace according to sex and gender) research team in collaboration with the previously named partners, this technological tool (e.g. e-learning) responds to a need in the healthcare and law enforcement sectors. The two main objectives of the tool are (1) to sensitize workers to the psychological consequences of workplace aggression and (2) to incite them to seek help from colleagues and the employer when they experience such situations. Specifically, sensitization helps workers psychologically prepare for a possible victimization and promotes the adoption of safe behaviors during an incident. As for the help-seeking objective, it aims to break the isolation that some victims of workplace aggression are experiencing. More precisely, the target audience of this objective was women since the present thesis revealed that they are more affected by the taboo surrounding workplace aggression. By speaking of their victimization or officially declaring it, victims will find support for their needs and contribute to improving the care of victims of workplace violence. Therefore, they will decrease the risk of being "victimized", and a culture change is possible.

The web tool was launched in August 2014. According to the partners that have disseminated the instrument in their organizations, the web tool has responded to a mental health need by breaking the silence around workplace aggression. At the IUSMM, managers have become aware of their role in supporting victims of violence, which allowed for a more appropriate and adapted response to the different needs of their male and female caregivers. Following the launch of the web tool and its promotion at the CJM, the direction of human

resources was able to testify about the positive impact of this tool on its members. In this vein, the CJM has sought the author of the thesis to develop a sensitizing workshop.

8.2.4.2 A sensitizing workshop

Based on the findings of this thesis, the workshop aims to raise awareness and educate child protection workers on the gender-differentiated effects of their work on their mental health. The content is based on validated theoretical models and evidence based practices in order to promote coping strategies and attitudes that foster good mental health. With lectures using an interactive format, the participant is asked to identify attitudes and strategies for positive mental health. It also introduces participants to self-evaluation in order to assess the impact of potentially traumatic events and then, to seek the appropriate coping strategy. At the end of the workshop, participants are able to identify personal coping strategies that protect them from the inherent effects of their work as child protection workers. In sum, this workshop, adapted to the child protection profession, aims to sensitize workers to the psychological impact of their work while stimulating the tendency to self-evaluate mental health.

To date, the author of this thesis has presented the workshop to more than 700 child protection workers and managers of the CJM. This institution has then initiated procedures to perpetuate the workshop to new employees by including it in their curriculum. Thus, the author will have to form a group of trainers that will present the workshop on their own.

8.2.4.3 The ProQol in clinical supervision

Still based on this, the CJM asked the author to incorporate an assessment tool in their supervision practices in order for managers to detect compassion fatigue and support their workers. To do so, the *Professional Quality of Life Scale* (Stamm, 2010) was implanted and instructed to clinical supervisors. This scale, based on empirical studies and evidence-based practices, offers assessment of compassion fatigue and satisfaction. After the interpretation of scores on each scale, the *Professional Quality of Life Scale Manual* proposes evidence-based interventions that managers can deploy to help their workers enhance compassion satisfaction while decreasing compassion fatigue. Thus, it provides decision-making guidelines adapted to the compassion "state" of the worker.

8.3 Intervening in a criminological setting: simultaneously caring and controlling

Since this study focuses primarily on the worker and on the effects of his or her work on mental health, this thesis may be related to issues of criminological interventions when professionals have to simultaneously care and control. Indeed, some constraints of the criminological intervention in this setting can significantly affect the individual. Thus, findings from the present thesis may well be applicable to the criminological profession. So, what about the professional role of criminologists hinders or protects their mental health?

8.3.1 Exposure to workplace violence

A certain type of clientele served by criminologists has difficulties in their interpersonal relationships. As can be expected, this clientele's troubled feelings and distorted

cognitions towards power and authority, that may have arisen in earlier stages of development, will be exacerbated by the authoritarian context of the criminological intervention (Rothman & Papell, 1990). Furthermore, the mandatory context of the intervention also labels the client as deviant, which reinforces deficient or damaged self-perceptions. Typically, clients are not aware of the choices or alternatives that could be present in their lives; instead, they are more likely respond with anger and blame others, especially authority and society, for their trouble (Rothman & Papell, 1990). These attitudes and factors therefore increase the odds of exposure to Type II violence in the context of the criminological intervention. Thus, workplace aggression and violence in general may be considered as part of the curriculum and therefore, trivialized. As demonstrated, this trivialization, which is influenced by professional identity, may protect or amplify the impact of workplace aggression on the criminologist.

8.3.2 Exposure to traumatic material

In addition, criminological interventions in authoritarian settings lead to high exposure to traumatic material. Indeed, clients narrate their histories of trauma on multiple occasions. As argued by Saakvitne and Pearlman (1996), doing work that others avoid and helping people that are not valued in our society, such as sexual delinquents, contribute to the appearance of compassion fatigue. When interviewing them, criminologists are then exposed to stories of cruelties committed on others or experienced by delinquents. Thus, they are exposed to traumatic material.

8.3.3 Accountability

Furthermore accountability stress is a reality for criminological interventions in authoritarian settings. Acting under certain legal powers and abiding to codes and regulations, these criminologists are accountable for their professional acts. This may impact the mental health of the worker above and beyond the effects of exposure to workplace aggression. Derived from the findings on accountability stress, it may also be hypothesized that the authority of the criminologist, which is closely linked to his accountability, may also heighten failures and successes because the reputation of the criminologist is as much as stake as the people receiving services. The organizations employing criminologists are ones where the public eye is attentive and prone to criticize the interventions that are made in this context of authority. Therefore, most organizations respond by implanting follow-up procedures in order to demonstrate the effectiveness of their work and therefore reach optimal external legitimacy. This particular context significantly increases accountability stressors among intervening criminologists.

8.3.4 Role conflict

Importantly, a particularity of the professional identity of criminologists is the presence of role conflict: in intervention, these professionals must aid the marginalized in authoritarian settings. As argued in the theoretical statement articulated around child protection work, the criminologist has to deal with the dualism of his role which is providing help as well as controlling. This apparent role conflict can affect the criminologist as well as the helping relationship by increasing the hostility of the client, as exposed by role theory (Katz & Kahn, 1978). This position of authority and felt accountability may exaggerate the place that the intervening criminologist takes in the lives of others thus misinterpreting the expected roles

and attitudes of the caregiver. This may then result in the criminologist trespassing the boundary of his work. Adopting such a professional identity, some criminologists may react with self-rejection (e.g. compassion fatigue), while others may react by forcing things too far (resulting in violence by or against the authority). Thus, role conflict represents another stressor that impacts the mental health of the criminologist. The professional identity of the criminologist has to be consistent with the mandate of the work while proportionally responding to occupational expectations and to the clientele's needs. Moreover, it has to promote a flexible position between caring and controlling in order to be effective (Rothman & Papell, 1990).

8.4 Strengths and limitations of the thesis

This research has several noteworthy strengths. First, two different samples of caregiving and law enforcing professions totaling 1451 workers were incorporated. All of these workers had to cope with workplace aggression and accountability in their daily routine. Such a strategy maximizes the external generalizability of the research (Scandura & Williams, 2000). It is important to recall that the child protection worker sample was representative. Further, this mixture of different samples allowed to attend to Ganster and Schaubroeck's (1991, p. 240) contention that, "In general, studies that have examined particular occupations in depth have not produced data that contribute new insights about the more general process of job stress." Thus, it was beneficial to employ samples that possessed contextual diversity. Occupations included in the child protection study were educators and human relation agents. In the studies on trivialization, caregivers ranged from orderlies to professionals and, among law enforcers, from security agents to police officers.

The context of the thesis also represents a strength. Participants of the different studies were able to respond anonymously in the setting of their choosing (Boruch, 1971). Given the potentially charged nature of the research measures, this procedure may have enhanced the accuracy of responses. This procedure also reduced the potential influence of social desirability bias (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). The ability to consider the influence of control variables (e.g., age, gender, nature of the job, work environment) while assessing individual and organizational factors simultaneously is a strong point of this study as well.

The use of a social psychological theoretical framework to study a psychological problem was fertile. Indeed, this introduced a phenomenological perspective in the understanding of mental health at work. Thus, the theoretical propositions and empirical findings may be fruitful for other professions. Even though the articles focused on particular professions, the suggested model and findings may be adapted to other occupations with similar issues, such as penitentiary work. Moreover, the emphasis on sex and gender differences may also inform female-dominant occupations (education, for example) and male-dominant occupations (construction trades, for example).

Like all studies, this thesis has limitations. Despite the incorporation of multiple samples, the thesis relied only on self-report data. This introduces the possibility of measurement bias. The effects of method bias should result in consistent structural links among study variables. However, recent research has suggested that the net effect of such bias is typically minor (Meade, Watson, & Kroustalis, 2007). In addition, incorporation of multisource methods does not necessarily remove the potential for bias effects in the results (Avolio, Yammarino, & Bass, 1991). Since survey instruments were used to collect all of the

data, immediate concerns can be raised regarding common method variance. However, common method variance would be a legitimate concern if spuriously high relationships between independent and dependent variables were evident in this thesis (James, Gent, Hater, & Coray, 1979). An examination of the correlation matrix fails to suggest such a generally inflating mechanism (*rho*=.55 for PIS and CS in the examination in chapter 4 represents the highest correlation). Although it is impossible to completely rule out common method variance effects, they do not appear to be overly influential in the current thesis.

Two articles were based on a convenience sample. This may have introduced another bias since data may have been collected only from people who were willing to discuss or complain about workplace aggression. It is also possible that the distribution of the questionnaire by a member of a joint association for health and safety at work and the nature of the survey may have influenced the reported prevalence.

Finally, the cross-sectional nature of the data appears as a limit since constructs of the present study are dynamic and fluctuate through time. Thus, longitudinal research would have increased the generalizability of study results and conclusions while monitoring the effect of time on mental health at work.

8.5 Questions raised and directions for future research

While the findings of this thesis have clinical and policy outcomes, they also raise questions that could be fruitful for scientific advancement. Indeed, the impact of role conflicts on mental health at work has only been mentioned in the theoretical paper. It should be further investigated in empirical studies. Future studies should also assess the extent to which the context of authority contributes to workplace aggression. The bidirectional link between

compassion "state" and the self has only been hypothesized. Thus, studies should be undertaken to assess how identity repositioning could prevent compassion fatigue from leading to psychological distress.

Even though this thesis assessed individual and contextual factors in a multivariate model, a missing aspect could also provide useful knowledge on mental health at work: the biological influence. For example, many studies have demonstrated associations between trauma-related psychiatric disorders, such as PTSD and major depressive disorder, and hypothalamic—pituitary—adrenal (HPA)-axis dysregulation (De Kloet et al., 2006; Shea, Walsh, Macmillan, & Steiner, 2005). Bureaucratic constraints and institutional contingencies should also be included in multivariate models since they may affect mental health at work.

Research on the helping relationship in authoritarian settings have also highlighted the importance of considering macrosystem factors (e.g., ideologies, policies), the immediate environment of the helping relationship (e.g., physical setting, guardians) as well as the individual characteristics of the caregiver and care recipient (Orsi, Lafortune, & Brochu, 2010). In this thesis, professional identity captured macrosystem factors and individual characteristics of the caregiver. Future research should then consider the immediate environment of the helping relationship as well as the characteristics of the care recipient since these factors could influence the occurrence of aggression. For example, working in inpatient settings could increase exposure to workplace aggression, there augmenting psychological distress, since inpatient workers spend more time with the clientele than outpatient workers. Time spent with the clientele has been associated with higher exposure to violence in institutional settings (Gadon, Johnstone, & Cooke, 2006). Accountability should also be further assessed as it relates to mental health at work. Qualitative inquiry may be a good

approach to gather more information on what represents accountability for caregivers and law enforcers, how it affects them and how they cope with it.

Nonetheless, future research should utilize a prospective and longitudinal research design. In doing so, it would be possible to measure how identity repositioning can be an adequate coping strategy in the face of work-related stressors. Further, such a design could assess the fluctuation of mental health at work through time and then, capture the effects of variables that would not have been otherwise accessible in cross-sectional data. Future research should also incorporate a variety of methods (including qualitative analysis) and data (official vs. self-report) to further validate the relationships found in this study.

All in all, this thesis has inspired the author to pursue research on mental health at work and workplace aggression. In the five years to come, the author will further investigate the relations between the mental health of child protection workers and the services they provide. This research will assess how the quality of child protection systemic interventions affects the "maltreatment trajectory" or "delinquent trajectory" of youths placed in readaptation centers. The same research will also allow for the examination of the environmental features of the readaptation unit that contribute to or dampen aggression. In parallel, a final objective will be to evaluate the potential impact of PTSD treatment for youths in terms of their level of aggression, restraint and isolation on the unit. The outcomes of such a research program will not only help to prevent the victimization of child protection workers, but it will also benefit the youths while increasing treatment success. In sum, it will contribute to the clinical mandate of Youth Centers.

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