Client Violence toward Iranian Social Workers:

A National Study

Mojgan Padyab

Department of Social Work
Umeå University, Sweden

Copyright © Mojgan Padyab
ISSN: 0283-300-68
ISBN: 978-91-7459-346-4
Printed by: Print & Media
Umeå, Sweden 2011

Dedicated to all Iranian social workers (*Madadkar*) who truly hold the meaning of Sa'adi's poem:

Human beings are like parts of a body,
created from the same essence.
When one part is hurt and in pain,
the others cannot remain in peace and be quiet.

CONTENTS

ABSTRACT	i
ORIGINAL PAPERS	ii
INTRODUCTION	1
The mediating role of coping in the violence-health link	1
Rationale of the study	3
AIMS AND OBJECTIVES	5
THEORETICAL PERSPECTIVE	6
Violence	6
Cognitive theory of stress and coping	6
Mental health	8
Burnout	8
DEVELOPMENT OF THE SOCIAL WORK PROFESSION IN IRAN	10
Social work organization in Iran	12
Centres for Socially Injured People (CSIP)	12
MATERIALS AND METHODS	14
Setting	14
Sample and data collection procedure	14
Instruments	15
RESULTS	19
DISCUSSION	24
Methodological considerations	26
CONCLUDING REMARKS AND RECOMMENDATIONS	28
ACKNOWLEDGEMENTS	30
REFERENCES	34

ABSTRACT

Introduction Client violence toward social workers has become recognized as a common problem, and major concern has been raised with regard to its impacts on the workers' practice, and physical and psychological health. More than half a century has passed since the social work profession was established in Iran, and yet client violence and the associated health-related consequences remain unexplored. This thesis aims to address this gap in knowledge.

Methods A national survey was conducted involving 390 social workers from the Centres for Socially Injured People (CSIP), affiliated to the Social Affairs Department of the State Welfare Organization, Iran. The survey included self-administered questionnaires, namely, the Workplace Violence in the Health Sector questionnaire, the General Health Questionnaire-28 (GHQ-28), the Ways of Coping questionnaire**,** the Burnout Measure, and the Rosenberg Self-esteem Scale.

Results A high proportion of CSIP social workers (67%) have experienced violence. Psychological violence was about three times more common than physical violence. A high tendency of not reporting psychological violence to managers/supervisors was found. Psychological violence was associated with poorer mental health. Social workers with experience of psychological violence were found to be more worried about occurrences of violent events. Worrying about violence was significantly correlated with poorer mental health. Active coping had a direct effect on health, suggesting a poorer health status with more frequent use of active coping. Burnout was experienced by 10.9% of social workers, and 17.4% were found to be at risk of developing burnout symptoms. Low self-esteem and experience of violence were associated with burnout.

Conclusion The results suggest the importance of not neglecting cases of client violence and of putting the health and safety of social workers on top of the agenda. A victimized social worker with limited resources at work needs to note that coping skills may reduce the impact of stressors, not only by changing the stressors themselves, but also by changing how the social worker responds to them.

Keywords: Social worker, Client violence, Mental health, Coping, Burnout, Iran

ORIGINAL PAPERS

The thesis is based on the following papers:

I. Padyab, M., Chelak, H. M., Nygren, L., and Ghazinour, M. (2011). Client violence and mental health status among Iranian social workers: A national survey. *British Journal of Social Work*. (Published).

II. Padyab, M., Ghazinour, M., and Richter, J. (2011). Factor Structure of the Farsi version of the Ways of Coping Questionnaire. *Journal of Applied Social Psychology*. (Accepted).

III. Padyab, M., Ghazinour, M., and Richter, J. (2011). Coping and mental health in Iranian social workers – the impact of client's violence. (Submitted).

IV. Padyab, M., Richter, J., Nygren, L., and Ghazinour, M. (2011). Burnout among social workers in Iran: relations to individual characteristics and client violence. (Submitted).

The original papers are reprinted here with permission from the respective publishers.

INTRODUCTION

Why is violence a critical issue for social work practice?

> *A young social worker, who worked for Child Protective Services in Michigan, went to a client's home to explain how a mother, whose house had been deemed unfit, could get her children back. Two days later, the social worker's body was found beaten and strangled. Two sisters were charged in her murder and police believe that the sisters became incensed when the social worker refused to say who had made the child protection complaint against them because reports of child abuse and neglect are confidential.*
> (Lisa's Law, 1998 in Newhill, 2003, p. 1)

This image of violence in social work is extreme in the sense that it describes a fatal situation. Fatal or not, violence in social work is not limited to Michigan or the United States, but occurs in all countries in the globe. Sadly, evidence shows that incidents involving violent and aggressive clients are serious concerns in social work (e.g., Newhill, 2003; Pollack, 2010; Macdonald & Sirotich, 2005). Social work is among the professions with a high incidence of occupation-related violence, because social work often contains elements of control and intervention in the private sphere of life.

Research on social work practice confirms that the nature of working with clients' problems and illnesses (substance abuse, mentally ill individuals, removing an abused/neglected child from parent's home, divorce mediation, etc.) is a source of tension and stress (Jayaratne & Chess, 1984; Evans et al., 2006; Ringstad, 2009; Koritsas, Coles & Boyle, 2010). This is particularly evident when social workers deal with tense situations that demand immediate attention. Social workers often have to deal with belligerent, agitated, uncooperative, and violent clients (Newhill, 2003; Spencer & Munch, 2003). Client violence can have a significant impact on social workers in a number of ways. It may result in both physical outcomes such as bodily injuries and psychological outcomes such as feelings about their profession, and in emotional outcomes such as anxiety disorder and fear (Newhill, 2003).

The mediating role of coping in the violence-health link

Feelings of shock, dismay, and disbelief often occur as immediate emotional reactions followed by feelings of fear; anxiety and anger represent stages that social workers may experience after a violent incident. The extent of the impact and the severity of outcomes cannot be predicted based on the event per se, but on other

factors as well; the personality of the victim, previous exposure to traumatic events, and coping behaviours have been found to be predictive (Joseph, William & Yule, 1995; Newhill, 2003). The importance of coping as a factor in psychological and somatic health outcomes is well documented (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986; Aldwin, 1994; Dempsey, 2002). In addition, a body of literature has focused on the role of coping in relationships between workplace violence and psychological well-being in diverse contexts in terms of types of violence, coping behaviours, and occupations (Lee & Brotheridge, 2006; Neuman & Baron, 1998).

The choice and the effectiveness of coping behaviours are very much influenced by the context in which the violence occurs. For example, Folkman (1984) found that under conditions where individuals are helpless and unable to actively influence their environment, emotion-focused coping could be effective. The following example projects the importance of context on the choice of coping:

Imagine yourself a social worker on your way home from work. In the neighbourhood of your workplace, you recognize one of your clients, a 16-year-old girl whom you had disciplined for assaultive behaviour in the shelter for run-away girls. She comes at you brandishing a knife. You feel endangered, alone, and without protection. You scream for help, but no one responds. Satisfied with having terrorized you, she takes off. You go back to your office, badly shaken emotionally, trembling and tearful. Now imagine two possible scenarios. First scenario: you have a good capacity to use support, and you have a good support system. Your supervisor hears you and immediately responds to your distress and asks you to relate what happened. Second scenario: you are isolated and are left to cope all on your own. You cannot calm down.

This example presents the importance of context. According to Lazarus (1993), what a person does to cope depends on the context in which the stressful event occurs, and this will change over time because what is attended to and the threats themselves also change.

Rationale of the study

The most extensive body of literature on client violence toward social workers exists from countries of the developed West. Given the continuing interest in doing something about violence, there has been no shortage of ideas about how to approach the problem in those parts of the globe. Prevention recommendations such as "person-centred"[1] or "situation-centred"[2] are well defined and practiced in the Western world (Jayaratne, Croxton & Mattison, 2004). Such working models in the West are not always suitable for developing countries, and there is a potential to fail as a result of differences in both personal (e.g., cultural conformity) and environmental factors, such as work environmental factors (weekly working hours), daily stressors, or perceived social support. Considering these differences, one essential question is raised at this point: What strategies in preventing violence should be most effective in the Iranian context? If prevention fails and yet social workers face violence, what are the applicable care strategies for victimized social workers? There is a need for national data so that effective interventions can be introduced to decrease the vulnerability of this working group.

Recalling the declaration by the World Health Organization Assembly (World Health Assembly, 1996; Krug, Dahlberg, Mercy, Zwi & Lozano, 2002a; Krug, Dahlberg, Mercy & Zwi, 2002b) of violence as a major and growing public health problem across the world, there has been considerable effort to urge Member States to assess the problem of violence in their respective territories. As violence is considered a global health threat, more national studies especially in developing countries – including Iran – are considered important. The results of such studies can help provide an overview of client violence toward social workers and the risks inherent in social work practice, an overview that is less biased with Western values. The current dissertation is in line with the public health sector's concern about violence and its serious consequences for individuals, both in the short term and the long term.

The following represents an example of aggression and violence that illustrates a real-life context of the experiences of many Iranian social workers[3]:

> *I was working as a child-protection social worker. I was alerted to the probability that I would be assaulted during a home visit to a family in which the children were living with their addicted mother who has been sentenced*

[1] Deals with worker training.

[2] Deals with organizational factors.

[3] This is quoted from a social worker who was willing to share it with the project investigator.

> *to prison many times. Plans were made for another social worker to accompany me on the visit. After I told the mother that we should remove children from her and take them to protective custody, she began yelling, stood up, and picked up a steak knife and tried to stab me. My colleague was able to intervene and got the knife away from her. I was terrified.*

A major concern is raised regarding the exposure of social workers to violent clients, and perhaps the time is ripe for the international community in the social work profession, with the assistance and inputs of experts and researchers throughout the world, to develop rules, conventions, and agreements to address the issue of dealing with violent clients (Pollack, 2010).

AIMS AND OBJECTIVES

The growing recognition of client violence towards social workers and its effects on them as human beings as well as on their practice has not been paralleled by a growth in the literature about this phenomenon in Iran. This thesis aims to address this issue in an attempt to improve the evidence base for suggesting future contextualized interventions in the Iranian setting. Specifically, the objectives of this work are to:

- Assess the one-year prevalence of client-based (client/client's family, relative or companion) violence in terms of physical and psychological violence and how social workers responded to violent incidents (Paper I);
- Determine the extent to which exposures to client violence are associated with general health status and well-being (Paper I);
- Propose an empirically evaluated model of consequences of client violence among social workers and the role of coping (Papers II & III);
- Seek information on burnout levels and the relations of burnout to individual characteristics and client violence (Paper IV).

THEORETICAL PERSPECTIVE

In this section, I explain the 'Cognitive Theory of Stress and Coping' and the kinds of explanations that can be derived grounding the research in this theoretical approach. In addition, discussions on the impacts of violence on social workers' mental health and burnout need to take account of a clear definition of violent behaviour, mental health, and burnout.

No deductive model (a priori development of theory to be tested through data collection) was used in this research. Rather, I used theory to explain the core findings of the thesis. Each of these definitions and theoretical approaches favours its own particular perspective on the kinds of explanations that can be derived from the research process.

Violence

Research on violence and agreements on strategies to deal with violence at the workplace become problematic in the absence of a clear and consistent definition to be utilized by workers, managers, and researchers in this field (National Institute for Social Work, 1999; Brockmann, 2002). To tackle the problem of inconsistent definitions of violence against social care staff, the UK Government's National Task Force on Violence Against Social Care Staff (Department of Health, 2000) recommended the use of the European Commission DG-V (3) inclusive definition:

"Incidents where persons are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being or health".

The term 'violence' is used throughout this thesis to denote not only physical violence but also different types of abusive behaviours, such as verbal abuse or threat. This is because threats of violence are as important as, if not more important than, some types of actual physical violence in producing negative effects on the social worker.

Cognitive theory of stress and coping

The cognitively oriented theory of stress and coping was developed by Lazarus and his colleagues over a number of years (e.g., Coyne & Lazarus, 1980; Lazarus, 1966, 1981; Lazarus & Folkman 1984a, 1984b; Folkman, 1984).

The theory identifies two processes, *cognitive appraisal* and *coping*, as mediators of stressful person-environment relations and their immediate and long-

term outcomes. The cognitive theory of stress and coping is *relational* and *process oriented*.

The *relational* characteristic is considered in the definition of stress as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering his or her well-being. This relational definition distinguishes this theory from those approaches in which stress is defined as a stimulus (stressor), such as an exam or a noxious medical procedure, or as a response, such as psychological arousal or subjective distress. In the definition of stress offered here, stress is not a property of the person or the environment, nor is it a stimulus or a response (Folkman, 1984).

The *process oriented* aspect of the theory has two meanings in relation to the cognitive theory of stress: first, that the person and the environment are in a dynamic relationship that is constantly changing, and, second, that this relationship is bidirectional, with the person and the environment each acting on the other (Folkman, 1984).

Cognitive appraisal is a process through which the person evaluates whether a particular encounter with the environment is relevant to his or her well-being, and if so, in what ways (Folkman et al., 1986). In other words, the significance or meaning of an event is determined by cognitive appraisal processes. There are two major forms of appraisals, *primary appraisal* and *secondary appraisal*.

In *primary appraisal* the person evaluates whether he or she has anything at stake in the encounter. Through primary appraisal a person judges whether an encounter is irrelevant, benign-positive, or stressful (Lazarus & Folkman, 1984b). An appraisal that an encounter is irrelevant is a judgment that it has no significance for well-being, and a benign-positive appraisal indicates that an encounter does not tax or exceed the person's resources and signals only positive consequences. Stressful appraisals are characterized by harm/loss, threat, or challenge. In harm/loss, some damage to the person has already been sustained. Threat refers to harms or losses that have not yet taken place but are anticipated. Even when a harm/loss has occurred, it is always fused with threat because every loss is accompanied with negative implications for the future (Lazarus & Folkman, 1984b). Challenge refers to an opportunity for growth, mastery, or gain.

In *secondary appraisal*, the person evaluates if anything can be done to overcome or prevent harm or improve the prospects for benefit. Secondary appraisal addresses the question, What can I do? It becomes crucial when there is a primary appraisal of harm/ loss, threat, or challenge.

Coping refers to the person's constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources. With reference to Folkman and colleagues (1986), there are three key features of the coping definition:
First, it is process oriented, meaning that it focuses on what the person actually thinks and does in a specific stressful encounter, and how this changes as the encounter unfolds. The process of coping contrasts with trait approaches, which are concerned with what the person usually does.
Second, coping is contextual, that is, influenced by the person's appraisal of the actual demands in the encounter and resources for managing them. The emphasis on context means that particular person and situation variables together shape coping efforts.
Third, coping is defined independently of its outcome. That is, coping refers to efforts to manage (master, reduce, tolerate) demands, regardless of the success of those efforts.

Mental health

In the official web site of the World Health Organization (WHO) mental health is defined as

> *a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*

Furthermore, mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in WHO's definition of health: "a state of complete physical, mental and social well-being, and not merely the absence of disease" (World Health Organization, 2011).

This definition of mental health projects an individual's capacity to deal with daily life stress in a creative and productive manner leading to the individual's growth. Regarding this issue, WHO (Department of Mental health and Substance Abuse, 2011) states:

> *Positive mental health is linked to a range of development outcomes and is fundamental to coping with adversity. On the other hand, poor mental health impedes an individual's capacity to realize their potential, work productively, and make a contribution to their community.*

Burnout

As a metaphor for the draining of energy, burnout refers to the smothering of a fire or the extinguishing of a candle. It implies that a fire is burning, but the fire cannot

continue burning brightly unless there are sufficient resources to keep it replenished (Schaufeli, Leiter & Maslach, 2009). In most early writings, there was no standard definition of burnout; it was defined by merely summing up its symptoms. Since it is quite impossible to include all symptoms of burnout into one definition, different definitions gradually emerged. The two most common definitions of burnout are "burnout as a multidimensional syndrome" given by Maslach and Jackson (1986) and "burnout as exhaustion" given by Pines and Aronson (1988).

According to Maslach and Jackson (1986), burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind.

Pines and Aronson (1988) define burnout as "a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding" (p. 9). Pines and Aronson's definition is slightly broader as it includes physical symptoms, and their view of burnout is not restricted to the human services.

However, Pines (2003) explains that the two definitions are not mutually exclusive and that burnout is experienced as a state of physical, emotional, and mental exhaustion (Pines & Aronson, 1988) that manifests itself in a lowered sense of accomplishment and depersonalization of service recipients (Maslach & Jackson, 1981).

This dissertation aims to explore the relationship between client violence and mental health, including burnout, and to assess the mediating effect of coping in the violence-mental health relationship. While there is a conviction that the ways people cope with stress affect their psychological and physical well-being, the interplay between client violence, coping, and mental health has not been supported by a single comprehensive theory. Nonetheless, the 'Cognitive Theory of Stress and Coping' is the dominating theoretical framework. The two processes (appraisal and coping) of this theory have been successfully responsive to explain the underlying mechanism in stressful events in relation to health outcomes studied in previous research (e.g., Folkman et al., 1986; Coyne, Aldwin & Lazarus, 1981). While poorer mental health is expected to be related to client violence in the current study, I sought to answer how coping plays the mediating role by elaborating the research findings using the aforementioned theory.

DEVELOPMENT OF THE SOCIAL WORK PROFESSION IN IRAN

In this section, I will present how the social work profession and the practical ways of solving social problems developed in Iran. Details about dates and the historical part of the development of social work are given in the first original paper (Padyab, Chelak, Nygren & Ghazinour, 2011). This section will open a perspective of Iranian society and its relation to social problems. Iran is no exception to human miseries, and as it is in other nations it has always been a challenge for people to deal with those difficulties. The present investigation and the following text represent just a small part of the social work research in Iran.

The initiation of welfare activities, benevolence and helping the needy in ancient Iran was based on charitable individuals/organizations with religious backgrounds. A review of religious documents shows the special attention directed towards caring for people suffering from disease, the needy, orphans, and the elderly.

In the late 1800s, the initial idea of building orphanages was conceptualized and developed up until 1915, when the first governmental orphanage was built. In the 1950s, Iran was basically feudal, and nearly 70% of the people lived in rural areas. Living standards were very low, and girls could be married as soon as possible, since unmarried girls were considered a burden on the family. The results from the first official census showed that 41% of women aged 15 to 19 were married. Iran's population explosion was underway (Farman Farmaian, 2007). Besides, land reform uprooted rural communities, and many illiterate, unskilled peasants fled to big cities in search of work and a better life but what they often found, however, was misery from hunger and poverty. Due to industrialization, urbanization, and population growth and its related consequences (such as unemployment, more need for health, education, and welfare), Iranian society faced new-found challenges, and traditional and religious activities were no longer responsive. While in my country help came to the needy only through alms, there was felt an absence of programs to tackle population growth and programs that would help people become stronger, improve their standards of living, and give them self-reliance. Gradually, the range of social services expanded to the ratification of governmental supportive rules in favour of pensions, disabilities, and sufferers from natural disasters and other losses (Chelak, 2009). The radical socioeconomic changes of society in the 1950s reinforced the development of the social welfare system in Iran, including the social work profession. In 1958, the education of social workers started as Sattareh Farman Farmaian established the social work profession in Iran with the Tehran School of Social Work (Saleh, 2008; Farman Farmaian & Munker, 1992). Since there was no word for social worker in the Farsi vocabulary (the official language of Iran), the word Madadkar (one who helps) was coined. Farman

Farmaian writes in her memoir, *Daughter of Persia: A woman's journey from her father's harem through the Islamic Revolution*, that

> *For the first time I saw how social workers developed ways to address the problems that made people needy: well-regulated orphanages, licensed homes for the aged, the disabled, and the mentally ill. There were thousands of family service agencies, hospital clinics and training programs in which social workers not only assisted human beings in emergencies but tried to give them ways of dealing themselves with broken families, sickness, physical disability, mental illness, old age, unemployment and other problems – always with the goal of helping them to rely not on benefactors and protectors, but on themselves.* (Farman Farmaian & Munker, 1992, p. 232)

In 1959, social workers established community welfare centres that provided a range of services, from family planning and literacy campaigns to social, cultural, and educational activities. Since 1959, the number of community welfare centres began to increase, reaching up to 612 welfare centres across the country in 1976 (Chelak, 2009). The goal of such centres is to deliver care and support to the needy and fulfil society's social needs. As a result of this increasing trend, a higher demand on social workers' job skills and knowledge emerged. To control and organize social and welfare affairs in the country, the Ministry of Welfare and Social Security was established in 1974.

A general social political instability started in Iran in 1979 and resulted in a Revolution, after which the Islamic Republic of Iran was established. The new political and religious government paid less attention to the social work profession as a scientific field. This may be attributed to the Iranian Islamic culture that values intrinsically the support and care for the needy and people in socially vulnerable situations. In the early 1980s, after the Cultural Revolution was initiated in all universities in Iran, a discussion took place among social work practitioners, the social work scientific community, and politicians as to whether social work education should exist or not. The discussion led to the core belief that the social work profession is not an unneeded subject, and by then the first social welfare policy and education was prepared within the new political system. The social work profession was defined based on its historical development as "a profession which is based on the social workers' professional skills and aims to help people in crisis and also reach a higher level of social independence and social network" (Ghandi, 2001 in Chelak, 2009, p. 40). A second definition is influenced by the American social work scientist Perlman (1957), who defined social work as "activities and assistance offered by welfare organizations to clients who face problems at work and social interactions in order to enhance their capacity to cope more effectively"

(Chelak, 2009, p. 41). These definitions and concepts are taught in universities and are expected to be known by field social workers.

Social work organization in Iran

In 1981, bringing all welfare, rehabilitation and family protection centres together, the State Welfare Organization was established, consisting of four departments (i.e., Prevention, Rehabilitation, Social Participation, and Social Affairs). All departments have several subsections that are responsible for implementing social welfare policies and programs in society. The Department of Prevention concentrates on the design, implementation and supervision of preventive programs such as pre-marriage skill training, mother-child care, distributing educational packages on high risk sexual behaviours, screening programs for congenital hypothyroidism, and prevention of drug abuse and HIV.

The Department of Rehabilitation works with issues such as care of the disabled and the elderly as well as mentally ill people. The Department of Social Participation deals with community-based activities by volunteers and local participants who are interested in providing services to people in crisis situations. The department plays a crucial role in developing, implementing and evaluating the guidelines and regulations of those activities. The duty of the Social Affairs Department is to help service users who are not capable of managing their affairs and performing effectively in the society due to the lack of economic, social or cultural resources. The implementation of this policy is done by four centres for (i) socially injured people, (ii) children and adolescents' affairs, (iii) foster parents and families, and (iv) women and family.

Based on the State Welfare Organization official web site (2010), all four departments are responsible for presenting programs and policies to the subsections as well as monitoring the effectiveness of implementation of policies at lower levels in the hierarchy. The present study is focused on the Centre for Socially Injured People (CSIP) which is affiliated to the Social Affairs Department of the State Welfare Organization. Since the main issue in the current study is client violence towards social workers, this centre was suggested by the head of the CSIP because its task (dealing with vulnerable clients and crisis situations) increases the potential of this centre to face a higher rate of client-violence incidents compared to centres in other departments.

Centres for Socially Injured People (CSIP)

The main goal of the CSIP is to help those who have developed anti-social norm behaviours (which often lead to police/court involvement) and who have lost their

potential to be effective in the family and society. Clients referred to these centres usually expect social workers to make the police disappear or the criminal charges go away. These centres have approximately 500 staff members with different educational backgrounds, such as psychology, social work, educational sciences, and child health care. In Iranian society, these centres play an important role in the social work practice. The CSIP aims to act quickly to help clients to not develop a criminal register which may cause catastrophic consequences for them. One concrete plan for this kind of intervention is called the "social emergency" programme. In this programme, social workers are present in stations located in several crossroads and main streets in all cities of Iran. The interventions are facilitated in special constructed minibuses with special built-in space for counselling and conflict intervention. In critical conditions, a close collaboration between police officers and social workers in the social emergency programme was initiated in which the social workers have the legal right to intervene instead of police. Social workers in these centres mainly deal with issues such as child abuse, homeless people, people with mental health issues, people who have drug problems, domestic violence, women who are exposed to rape or sexual assault, street children, labour children, couples in divorce crisis, elderly abuse, suicide, and runaway children. Additionally, the centre works currently with clients of all ages. For example 'street children' are a serious problem in Iranian society. Ahmadkhaniha, Shariat, Torkaman-nejad and Moghadam (2007) showed that street children are prone to a variety of psychosocial problems such as depression, suicidal tendencies, and sexual abuse. For these children, the role of field social workers includes providing free education and food and familiarizing them with their rights and social values.

Social workers in these centres are very likely to face service users who have a variety of unmet social needs that require immediate attention. The role of social workers is often to empower the service users through discussions about their entitlements and provide them with useful information about what is available to them and refer them to the appropriate services where they can meet their needs.

Family crisis intervention centres, the social emergency telephone line (123), the mobile social service team, and local social service centres are examples of activities run by the CSIP which often involve inevitable challenges, risks and tension.

MATERIALS AND METHODS

Setting

Three of the four papers in this thesis (I, III, IV) are based on a comprehensive cross-sectional study that was conducted in all 30 provinces of Iran, including 57 cities, between 1 July and 15 September 2009. There are CSIPs affiliated to the Social Affairs Department of the State Welfare Organization in cities of all provinces. All centres participated in the survey, and all social workers who were present at work during the study period were included. The participants had different educational backgrounds and were all engaged in social work activities. In Iran, all staff members of the centres are referred to as social workers.

The study covered in paper II was conducted on a representative sample of the Iranian general population. Details of the sample are given in the following section.

Sample and data collection procedure

Two independent data collection procedures were carried out in this thesis. Figure 1 outlines the design in selecting participants.

Studies I, III, and IV are based mainly on the sample of social workers in CSIPs. One trained project coordinator from the CSIP in Tehran assisted with the distribution of study questionnaires, the instruction of respondents, and the supervision of completion of the questionnaires. Questionnaires were posted from the CSIP in Tehran to affiliated centres in the cities of Iran. Participants were informed about the purpose of the study and were encouraged to contact the project coordinator in the CSIP in Tehran in case of questions. Completed questionnaires were mailed back to Tehran from each centre. Of the 500 social workers who were approached, 78% (n=390) accepted the invitation and participated in the study. All completed questionnaires were anonymous and confidential. Participants were informed that participation in the research project was voluntary and that they were free to refuse their participation at any time during the investigation.

Of the 390 social workers who participated, 235 had experiences of client violence and had answered Ways of Coping questions regarding those experiences. This sub-group of social workers was then eligible for inclusion in study III.

Study II is based on a sample of 739 native Farsi-speaking subjects from Tehran, Iran. A non-probability sampling technique was applied, based on the last population census (Iran statistical yearbook 2006, Statistical centre of Iran). The

sample is representative of the Iranian urban population according to age and gender distribution. The investigation started in one household in each of the different geographical areas of Tehran and continued with the next household that agreed to participate. The pre-requisite of prior oral consent and the option for individuals to refuse to participate without any consequences ensured that participation was voluntary. The participants were instructed on how to complete the questionnaire and the purpose and character of the study was explained.

Instruments

The survey included an introductory letter stating the purpose of the research project, a consent form, and a self-administered questionnaire that was used to collect information on socio-demographic characteristics, experiences of violence at work, general mental health status, ways of coping, burnout, and self-esteem of the participants.

Workplace violence was assessed using the "Workplace Violence in the Health Sector" questionnaire (ILO/ ICN/ WHO/PSI, 2003). In the questionnaire, violence is defined as either psychological or physical. Psychological violence is defined as intentional use of power, including threat of physical force against another person that can result in harm to physical, mental, spiritual, moral, or social development. Psychological violence includes verbal abuse, bullying/mobbing, harassment, and threat. Physical violence is defined as using physical force against another person, including beating, kicking, slapping, pushing, shooting, stabbing, biting and pinching.

This questionnaire was developed in 2003 through a joint program by the World Health Organization (WHO), the International Labour Organization (ILO), the International Council of Nurses (ICN), and the Public Services International (PSI) to reduce the incidence of violence in the health sector and to minimize the negative impacts on the victims (ILO/ ICN/ WHO/PSI, 2003). The questionnaire was originally in English and was translated into Farsi, the official language of Iran. To check for face validity[4], the Farsi version of the questionnaire was distributed to 25 staff members of the State Welfare Organization in Tehran, and appropriate modifications were made based on the results of the pilot study.

Given a written list of different types of violence defined by WHO and definitions of physical and psychological violence, respondents were asked to select

[4] Validity: the extent to which the scale measures the underlying concept of interest.
Face validity: at face value, does the scale appear to measure what it is intended to measure; is it unambiguous and appropriate? (Bowling, 2001).

the response (Yes/No) and write the type of violence closest to their experiences in the last 12 months in their work environment. The instrument includes *worry*[5] *about future violent events at work* by a single item "How worried are you about violence in your current workplace", on a five-point Likert scale ranging from 1 (*Not worried at all*) to 5 (*Very worried*).

Another question of interest in the WHO questionnaire is, "How did you respond to the incident". Answers to this question gave us information about the reporting of violent incidents to managers/supervisors. Respondents who did not report an incident of client violence were asked to indicate their reasons for not doing so based on the following possible responses: (a) it was not important, (b) afraid of negative consequences, (c) felt ashamed, (d) felt guilty, (e) useless, (f) did not know whom to report to, (g) others.

General mental health was assessed by the General Health Questionnaire-28 (GHQ-28), in which respondents were to compare their psychological state in the last month relative to their normal conditions. This screening instrument was developed to detect minor psychological disturbances in a community sample and non-psychiatric clinical settings (Goldberg & Williams, 1988; Goldberg et al., 1997). The GHQ-28 was validated for previous studies in Iran by Noorbala, Mohammad, and Begheri-yazdi (1999), and was used to evaluate the general mental health by four scales of physical symptoms, anxiety and sleep disorders, social dysfunction, and depression. The findings are based on the original scoring used by Goldberg with response category scores of 'not at all' and 'no more than usual' as 0 and 'rather more than usual' and 'much more than usual' as 1, indicating that the higher the score the poorer the individual's mental health. The best cut-off point to detect possible cases of mental disorder in Iranian samples was found to be 6 (Noorbala et al*.,* 1999).

Coping was assessed by means of the revised version of the Ways of Coping questionnaire (Folkman & Lazarus, 1985) consisting of 66 items relating to cognitions and behaviours people use to manage internal or external demands in specific stressful encounters, to be answered on a four-point Likert scale (0=does not apply and/or not used; 1=used somewhat; 2=used quite a bit; 3=used a great deal). The scores for each coping scale were calculated following the manual of the WOC questionnaire (Folkman & Lazarus, 1988).

[5] Worry is defined as the chain of thoughts and images, negatively affect-laden and relatively uncontrollable (Borkovec, Robinson, Puzinsky & DePree, 1983).

Burnout was measured by the 21-item Burnout Measure (Pines, Aronson & Kafry, 1981). The 21 items correspond to the three components of the burnout definition: physical exhaustion (e.g., 'being tired' and 'feeling weak'), emotional exhaustion (e.g., 'feeling burned out' and 'feeling depressed'), and mental exhaustion (e.g., 'being unhappy' and 'feeling rejected'). Four of the 21 items are positive (e.g., feeling happy, optimistic). The response to all items is on a seven-point frequency scale ranging from 1 (*never*) to 7 (*always*), and higher scores reflect more severe symptoms of burnout. The composite burnout score is the mean of responses to the 21 items, with the positive items reversed. Burnout scores are classified into three groups: no burnout (≤2.9), at risk of developing burnout (3-3.9), experienced burnout (4 and higher). The Farsi version of the Burnout Measure was developed in several steps following established guidelines (Sartorius & Kuyken, 1994). This procedure included translation, back translation, pilot testing, and determining the semantic equivalence of the translation.

Self-esteem was measured using the Rosenberg Self-esteem Scale. Self-esteem refers to an individual's self-appraisal of competence and personal worth (Schaufeli & Enzmann, 1998). The Rosenberg Self-esteem Scale contains 10 items, half of which are positively worded (e.g., I feel that I have a number of good qualities), the other half being negatively stated and reverse scored (e.g., I feel I do not have much to be proud of). The self-esteem scale is scored using a four-point response format resulting in a scale range of 10-40, with higher scores representing higher self-esteem. The internal consistency of the scale, the stability of the scores, and the concurrent[6] and construct validity[7] of the instrument are supported by empirical findings in an Iranian sample (Shapurian, Hojat & Nayerahmadi, 1987).

[6] Concurrent validity: correlations with an existing measure of the same construct (Bowling, 2001).

[7] Construct validity: the extent to which a construct measures the theoretical construct it is designed to measure (Bowling, 2001).

	Sample	Instruments	Analysis
Study I	390 social workers from CSIP	- Workplace Violence in the Health Sector - General Health Questionnaire (GHQ-28)	- Chi-square test - t tests for independent samples - Mann-Whitney U test - Multivariate analysis of variance - Spearman correlation coefficient
Study II	739 native Farsi-speaking subjects from Tehran, Iran	- Ways of Coping Questionnaire (WOC)	- Cohen's effect size measure for chi-square tests - Confirmatory factor analysis - Parallel analysis - Exploratory factor analysis - Reliability[8] analysis
Study III	235 social workers who experienced violence at work and responded to WOC items regarding violent encounters	- Workplace Violence in the Health Sector - General Health Questionnaire (GHQ-28) - Ways of Coping Questionnaire (WOC)	- Multivariate analysis of variance - Confirmatory factor analysis - Structural equation modeling
Study IV	390 social workers from CSIP	- Burnout Measure - Rosenberg Self-esteem Scale - Workplace Violence in the Health Sector - General Health Questionnaire (GHQ-28)	- Reliability analysis - t-tests for independent samples - Pearson correlation coefficient - Analysis of covariance - Parallel analysis - Exploratory factor analysis

[8] Reliability is a measure of the internal consistency of the construct indicators, depicting the degree to which they indicate the common latent construct (Hair, Anderson, Tatham & Black, 1998).

RESULTS

The detailed findings from each study are presented in the original publications appended at the end of this thesis. The following provides an overview of the main findings from each study. Table 1 gives the characteristics of the study participants.

Table 1: Characteristics of 390 social workers at CSIP, Social Affairs Department of the State Welfare Organization, Iran

		Mean (SD)	%
Gender			
Male			16
Female			84
Age (years)		32(6.3)	
<25			8.6
25-29			32.4
30-35			33.6
36-39			14.4
≥40			11.0
Satisfaction with income			
No			56
Yes			44
Marital status			
Single			33.6
Married			66.4
Working in Shifts			
Day			78
Night			22
Experience of violence in the last 12 months			
None			32.3
Physical only			3.0
Psychological only			44.7
Physical and Psychological			20.0
Self-esteem	(Range: 18-40)	33(4.7)	
Burnout Measure (BM)	(Range: 1.0-5.8)	2.6(1.0)	
No burnout			71.7
Risk of developing burnout			17.4
Experienced burnout			10.9

What is the one-year prevalence of client violence against social workers and how did they respond to violent incidents?

The results from study I show that 67% of Iranian social workers who work in CSIP had experienced client violence of some kind (psychological, physical or both) over the previous year, with considerably higher magnitude of psychological violence than physical violence (Figure 2).

Among the social workers who experienced psychological violence, 66% did not inform their manager/supervisor while 60% of social workers who experienced physical violence indicated that they had reported the violent incident.

Is exposure to client violence associated with general health status and well-being?

No statistical difference was found for GHQ scores between social workers who were exposed to physical violence at work and those who were not (study I). Psychological violence, on the other hand, was associated with psychological symptoms with regard to physical symptoms, anxiety and sleep disorder, social dysfunction and GHQ total score.

Is exposure to violence associated with social workers' worry of recurring violence and is worry disposition correlated with health outcomes?

The results reveal that social workers who had been victimized by violence (either physical or psychological) from clients were more worried about occurrences of violent incidents in their workplace. In addition, worrying about violent events was significantly correlated with poorer health status (study I).

What are the coping responses to client violence?

To answer this question, a valid and reliable tool to study coping was needed. This led to the design of study II, in which the psychometric properties of the WOC are assessed.

The results from the second study show that the WOC is applicable to the Iranian population considering some changes compared with the original 8-factor solution proposed by Folkman et al. (1986). Six items (7, 19, 28, 35, 63, 66) had loadings less than 0.3 on their factors and were dropped; ten items (16, 40, 46, 61, 3, 10, 44, 32, 25, 9) had higher residuals than the acceptable level (0.8), and four items (29, 33, 53, 64) were deleted for conceptual and semantic reasons rather than empirical reasons. Better fit-indices were obtained for the final 7-factor solution on the remaining 46 items of the WOC. Fit indices for the adjusted WOC were all accepted: (Root Mean Square Error of Approximation (RMSEA) =0.051, 90% Confidence Interval: 0.0488 to 0.0532; Comparative Fit Index (CFI) =0.935;

Incremental Fit Index (IFI) =0.935, Goodness of Fit Index (GFI) =0.909, Adjusted Goodness of Fit Index (AGFI) =0.899). The seven scales (factors) developed in this study as well as their descriptions (Folkman & Lazarus, 1988) are given below:

- *Planful problem solving* describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem.
- *Escape avoidance* describes wishful thinking and behavioural efforts to escape or avoid the problem. Items on this scale contrast with those on the Distancing scale, which suggest detachment.
- *Distancing* describes cognitive efforts to detach oneself and to minimize the significance of the situation.
- *Seeking social support* describes efforts to seek informational support, tangible support, and emotional support.
- *Confrontive coping* describes aggressive efforts to alter the situation and suggests some degree of hostility and risk taking.
- *Positive reappraisal* describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension.
- *Self-control* describes efforts to regulate one's feeling and actions.

In study III, the coping responses to client violence were investigated. The results show planful problem solving to be the most frequent coping behaviour, followed by seeking social support, positive reappraisal, self-control, distancing, escape avoidance, and confrontive coping.

Can we propose an empirically evaluated model of consequences of client violence and the role of coping?

Study III analyses a model consisting of three constructs, namely, health, active coping[9] and passive coping[10] and their relationships to answer the proposed question. The following indicators of constructs are used in this model: health is assessed by anxiety/sleep disorders and depression; active coping is assessed by confrontive coping, seeking social support, and planful problem solving; and

[9] Active coping, sometimes called problem-focused, refers to the management of the problem that is causing the distress.

[10] Passive coping, sometimes called emotion-focused, refers to regulation of emotions or distress.

passive coping is assessed by distancing, self-control, escape avoidance, and positive reappraisal. The findings show that active coping has a direct effect on health (β=1.32, P<0.001). No significant association was found between active coping and passive coping. Following model modification indices for improvement of the model, an error correlation between confrontive coping and distancing was suggested (β=0.22, P<0.001). Although chi-square goodness of fit is very sensitive to sample size[11], the model achieved a non-significant chi-square (χ^2=36.35, df=25, p-value=0.066), indicating a fairly acceptable model fit. The GFI and CFI values were 0.950 and 0.988, respectively, and the RMSEA was 0.045 (90% confidence interval: 0.0 to 0.075).

Do social workers at CSIP experience burnout?

Paper IV explores the magnitude of burnout and provides information on whether individual characteristics and the experience of client violence are related to higher susceptibility of burnout or not.

The results reveal that 10.9% of social workers experience burnout and 17.4% are at risk of developing signs of burnout, i.e., physical, mental or emotional exhaustion. We examined whether social workers' burnout scores differed depending on their gender, age, satisfaction with their income, marital status, experience of violence and self-esteem. No association was found in levels of burnout with regard to marital status, gender, and age. The mean burnout score of those who were dissatisfied with their income was significantly higher than that of social workers who were satisfied (2.7±0.9 vs. 2.4±0.9, p<0.01, respectively). Social workers who experienced violence of any kind were found to have higher burnout scores compared with those without experience of violence (2.7±1.0 vs. 2.3±0.9, p<0.001, respectively). The Burnout Measure score was significantly and negatively correlated with self-esteem (r= -0.61, p<0.001). Analysis of covariance results with burnout score as dependent variable, satisfaction with income and experience of violence as fixed factors, and self-esteem as covariate showed significant main effects of self-esteem (p<0.001) and experience of violence (p=0.004).

[11] In models with large samples, trivial differences between sample and estimated population covariance matrices are often significant (indicated by a significant χ^2), solely because of sample size.

Table 2: Overview of specific findings

Study I Client violence and mental health status among Iranian social workers: A national survey	Sixty-seven percent of Iranian social workers had experienced violence. Psychological violence was about three times more common than physical violence. There was a high tendency (66%) of not reporting the psychological violent incidents, but 60% of social workers had reported the physical violence to their managers/supervisors. Client violence was not associated with personal risk factors. Psychological violence was associated with poorer general mental health. Social workers with experience of psychological violence were found to be more worried about occurrences of violent events. Worrying about violence was significantly correlated with poorer general mental health.
Study II Factor structure of the Farsi version of the Ways of Coping Questionnaire (WOC)	The original 8-factor solution yielded poor fit to the Iranian data. The optimal number of factors to be extracted proved to be seven. After deletion of items (low loading factor/high residuals/conceptual and semantic rather than empirical reasons) and modification attempts, the Farsi version of the WOC was found to have good reliability and model fit.
Study III Coping and mental health in Iranian social workers – the impact of client's violence	In client violence incidents against social workers, active coping was the most frequent coping behaviour used by CSIP social workers. Active coping had a direct effect on health, suggesting a poorer health status with more frequent use of active coping.
Study IV Burnout among social workers in Iran: relations to individual characteristics and client violence	Among CSIP social workers, 10.9% had experienced burnout and 17.4% are at risk of developing burnout. Social workers scored higher in burnout if they were dissatisfied with their income, had experienced violence, or had lower self-esteem. However, holding constant differences in experience of violence and self-esteem, differences in burnout did not associate with satisfaction with income.

DISCUSSION

Client violence and its risks inherent in the practice of social work have become a major concern for the international social work community. Increasing research on this phenomenon has shed some light on the issue. The most extensive body of literature exists in the countries of the developed West while research is sparse in the Iranian context. The main goal of this dissertation was to look into the magnitude of this issue and determine whether exposure to client violence is associated with health outcomes. In exploring this association, the most primary question raised is, How do social workers cope with this situation and what role does coping play? Therefore, the second major area that the thesis gives insights into is the coping mechanism and understanding its role in the violence-health relationship.

While there are difficulties in defining violence (Waddington, Badger & Bull, 2005), a common response and perhaps even a prevailing one is to adopt what Renold and Barter (2003) describe as an 'inclusive' definition. This definition, which was used in this dissertation, was also the one employed by ILO/ICN/WHO/PSI (2003). There is a widespread agreement, if not a consensus, in favour of the inclusive definition of violence. The inclusive definition of violence acknowledges a diverse range of actions and events to be interpreted as 'violence' by victims. However, there are some difficulties and dilemmas associated with such an inclusive definition. Waddington and colleagues (2005) argue that this definition is too broad, that almost any situation that a person finds disagreeable can be described as a form of 'violence'. They argue that such a broad definition of violence could confuse connotation and leave the analyst referring to very different events and experiences whilst using the same conceptual framework. Again, this approach was chosen in this dissertation, and it has merit in the sense that it draws attention to the harm suffered by workers and appreciates the subjective meaning of their experiences.

The participants of this national research were social workers from CSIPs, which makes the thesis unique as these centres are considered the most prominent example of outreach and mobile emergency intervention centres.

The findings that warrant particular attention are as follows:

- The high prevalence (67%) of violence, with remarkably higher magnitude of psychological violence than physical violence;
- The higher level of physical symptoms, anxiety and sleep disorders, social dysfunction, and GHQ total score for social workers with experiences of psychological violence;

- Presentation of a reliable and culturally adapted instrument to assess coping in the Iranian population;
- The more frequent use of active coping than passive coping in client violence incidents against social workers;
- The concomitant poorer health status and more frequent use of active coping;
- Results showing 17.4% of social workers at risk of developing burnout and 10.9% experiencing burnout, with a higher magnitude found among social workers with low self-esteem as well as among those who had experienced violence (of any type).

Higher levels of physical symptoms, anxiety and sleep disorders, social dysfunction, and GHQ total score were found for social workers with experience of psychological violence. This may be due to the high prevalence and repetitive occurrence of psychological violence. This issue can also be discussed in terms of reduced well-being as a consequence of violence. Tengland (2007) argues that reduced well-being can occur as a result of a mismatch between 'cognitive content' and 'feeling', i.e., when the feeling is not what one would expect given the beliefs and attitude of the person. When social workers are the target of offensive and damaging remarks from clients, the social workers accept the situation as part of the job and somehow believe that they should not bother. However, this is not what they substantially feel, and the internal conflict between beliefs and the real feeling constitutes decreased well-being and ill health. These social workers were disappointed to report the incident to managers/supervisors, and believed "it was not important" or "it was useless to report". Notably, their reasons did not concern issues like stigma or fear of retribution, but the absence of action from their superiors. The demands of social work in an environment in which the social worker is the constant target of derogatory remarks ('worthless' or 'useless') from vicious clients may desensitize social workers and lead them to habituate the situation as occupational hazards.

Poor health can make social workers more vulnerable to work stress and job burnout, which consequently leads to underperformance and job performance inability (Ashtari, Farhady & Khodaee**,** 2009).

The most frequent coping behaviour in violent encounters by CSIP social workers was active coping, and it was related to poorer health. According to the cognitive theory of stress and coping, the risk of maladaptive outcomes are greater when the appraisal of control does not match reality, as, for example, when an uncontrollable event is appraised as controllable and the person is likely to engage in problem-focused coping, which may finally result in disappointment, emotional burden, and poor well-being. The appraisal of being able to control the situation

contradicts the limited resources of the CSIPs. Unfortunately, the efforts of social workers go for naught, which could be a possible explanation for why their general mental health status was poorer.

In addition to the violence-health relationship and the role of coping identified so far, the burnout level and its contributing factors should also be discussed among this working group. Since neither a clinically valid nor a statistically valid criterion for burnout exists (Schaufeli & Enzmann, 1998), I hesitate to report how many social workers are actually 'burned out'. The relative occurrence of burnout is presented instead. No demographic and individual differences were found to be related to higher susceptibility to burnout, which is in line with Maslach's statement that no key individual predictors have emerged with regard to burnout (Maslach, 1998).

Social workers with experience of violence as well as those with lower self-esteem were found to have higher burnout scores. Poor self-esteem as a personality trait may predispose individuals to burnout, but it can also result from environmental factors or even burnout (Schaufeli & Enzmann, 1998; Tharenou, 1979). The negative correlation between self-esteem and burnout is consistent with other studies (for example, Golembiewski & Kim, 1989; Rosse, Boss, Johnson & Crown, 1991; Maslach, Schaufeli & Leiter, 2001). However, it tells us little about whether self-esteem is an antecedent or a consequence of burnout.

The evidence presented on the psychometric properties of the WOC and the Burnout Measure in this dissertation supports their considerable potential for use in future research among social workers. The factorial structure of the Burnout Measure was consistent with Enzmann and colleagues (1998), and the high correlation of factors justifies the calculation of one single burnout score.

It is important to emphasize that this work contributed to existing research literature on client violence towards CSIP social workers and its impacts on their general mental health, including burnout level for this profession. It represents the first comprehensive investigation to address these issues in Iran.

Methodological considerations

- This thesis is based on self-reported questionnaires. The assessment of coping will always have to face the issue of self-report versus observational techniques. Furthermore, the primary limitation often cited by critics is the heavy reliance on one's self-report on health conditions. Self-reported health instruments are useful tools to screen and monitor the health conditions of a population, but they are rather subjected to reflect one's general perception of health than well-defined and clinically approved health outcomes.

- I failed to assess the frequency of occurrence of client violence. However, based on what I learned during data collection and the experiences shared by some social workers, psychological violence happens often and repetitively.
- The cross-sectional design of the study does not allow inference of causality.
- Due to the lack of registry data and identification number for the complete study population, the possibility of comparing the data of respondents and non-respondents was rejected. Nonetheless, of the 500 social workers who were approached, 78% (number of respondents=390) participated in the study.
- The necessity of conducting a qualitative study on CSIP social workers' views and reflections on client violence, possibly on causes of such events and preventive strategies are acknowledged in this thesis.

CONCLUDING REMARKS AND RECOMMENDATIONS

This dissertation has attempted to bridge the knowledge gap concerning client violence against Iranian social workers in CSIPs. Providing knowledge on this issue should help greatly in the effort to introduce effective interventions to reduce social workers' vulnerability. Crucially, effective intervention is attainable only if it is tailored to the specific needs, social environment, and resources of *this* working group. Social workers working in CSIPs, as well as policy makers, can benefit from a better understanding of client violence incidents and the association of such incidents with health-related outcomes, and the role of coping in such events. Two avenues of prevention are suggested (Jayarante et al., 2004; Pollack, 2010) to be applied in the workplace with intention of reducing such incidence: 'situation-centred approaches' that deal with organizational factors (e.g., assessing the antecedents that lead to the violence, reviewing how staff dealt with the incident, etc.) and 'person-centred approaches' that deal with worker training. However, training alone, without the proper institutional support system, cannot protect social workers. Considering the findings of this thesis, I make the following recommendations:

- CSIP authorities should establish programs addressing issues of client violence and the institutionalization of periodic mandatory reporting procedures. Debriefing social workers involved in such incidents helps to identify the antecedents that lead to the violence and eventually minimize the probability of a similar incident in the future.
- Supervisors/managers must consistently take the worker's concern seriously and take responsibility for creating a climate that encourages open discussion. A sense of belonging to the organization and empathic help for a victim of violence lessen the negative impacts of violence, reduce the feeling of self-blame, and enhance self-esteem.
- The development of preventive coping skills is crucial, considering that client violence is a common occupational hazard/stressor in today's world of social work practice. Such skills should aim to reduce/prevent the impact of stressors, not by changing the stressors themselves, but by changing how the individual responds to them. Victimized social workers need to assess how their personal ideals to cope with violent clients interact with work conditions and available resources.
- It is worthwhile to disclose the issues of violent clients in the early social work education at university. Social work programs should include contents that

deal with evaluating the potential situations for client violence and vulnerable occasions. Giving students the opportunity to acquaint themselves with this issue and reflect upon it can increase their capability to deal with such events in their future practice.

I hope this work will provide evidence for Iranian social work authorities to raise their awareness and take serious actions to provide accustomed solutions to minimize client violence in social work practice and improve the health and safety of social workers in their workplace.

ACKNOWLEDGEMENTS

This dissertation is the output of my interest, dedication, and persistence. My interest in research began to grow in the early years of my undergraduate education at the Department of Statistics, Shahid Beheshti University in Tehran. Having started my professional career as a statistical consultant in medical research, I am glad that my statistical knowledge can be applied in other fields of research. The PhD project gave me the opportunity to work in the field of social sciences, which was quite demanding and challenging in the beginning. If this work can contribute to greater understanding among social workers and affiliated authorities about client violence and add something to their awareness of the challenges and risks inherent in social work practice, I will feel that I have succeeded in doing something tangible. Many people have helped and encouraged me throughout the process that naming anybody risks leaving somebody out. Therefore, I begin with an all-encompassing THANK YOU to all of you whom I have had the pleasure of working with, sharing ideas with and learning from along this journey. I express my sincere gratitude to all committed respondents, and to the administrators and heads of the Centres for Socially Injured People who contributed to this work.

To Mehdi Ghazinour, my mentor and supervisor. You noticed potential in me and made my dream come true. Your guidance and thought-provoking interactions are very much appreciated. You have taught me so much and your expertise and good humour have made the PhD process an absolute joy.

To Lennart Nygren. You have been an endless source of encouragement and guidance since I first joined the department of social work in Umeå. It has been an honour and a privilege to be supported by such an esteemed teacher and warm-hearted individual.

To Jörg Richter. A thousand thanks for your wise criticisms and your constructive thoughts. Your generosity in sharing your knowledge with me has been a priceless gift.

To Hassan Mousavi Chelak. A special thanks to you for taking all the hassle out of the data collection procedure. Thank you for opening the door to the fascinating world of social work and for teaching me the true meaning of *Madadkar*. God bless you.

I am grateful to all my friends and colleagues in the Department of Social Work at Umeå University for taking their time to make me feel so welcome.

This work was made easier by the constant source of support that I can rely on from my brothers. Thank you, Ali, for all the technical help and for always being there when I need you.

A heartfelt thank you to Pehr for being there during the ups and downs, for your generous support and believing in me.

Most of all, I am beyond thankful to my parents who have been the most wonderful, inspiring, and important part of my life. Your tireless love, patience, and support inspire me to do everything in life to the best of my ability. I am and will eternally be grateful and indebted to you.

Figure 1: Outline of selection design of participants

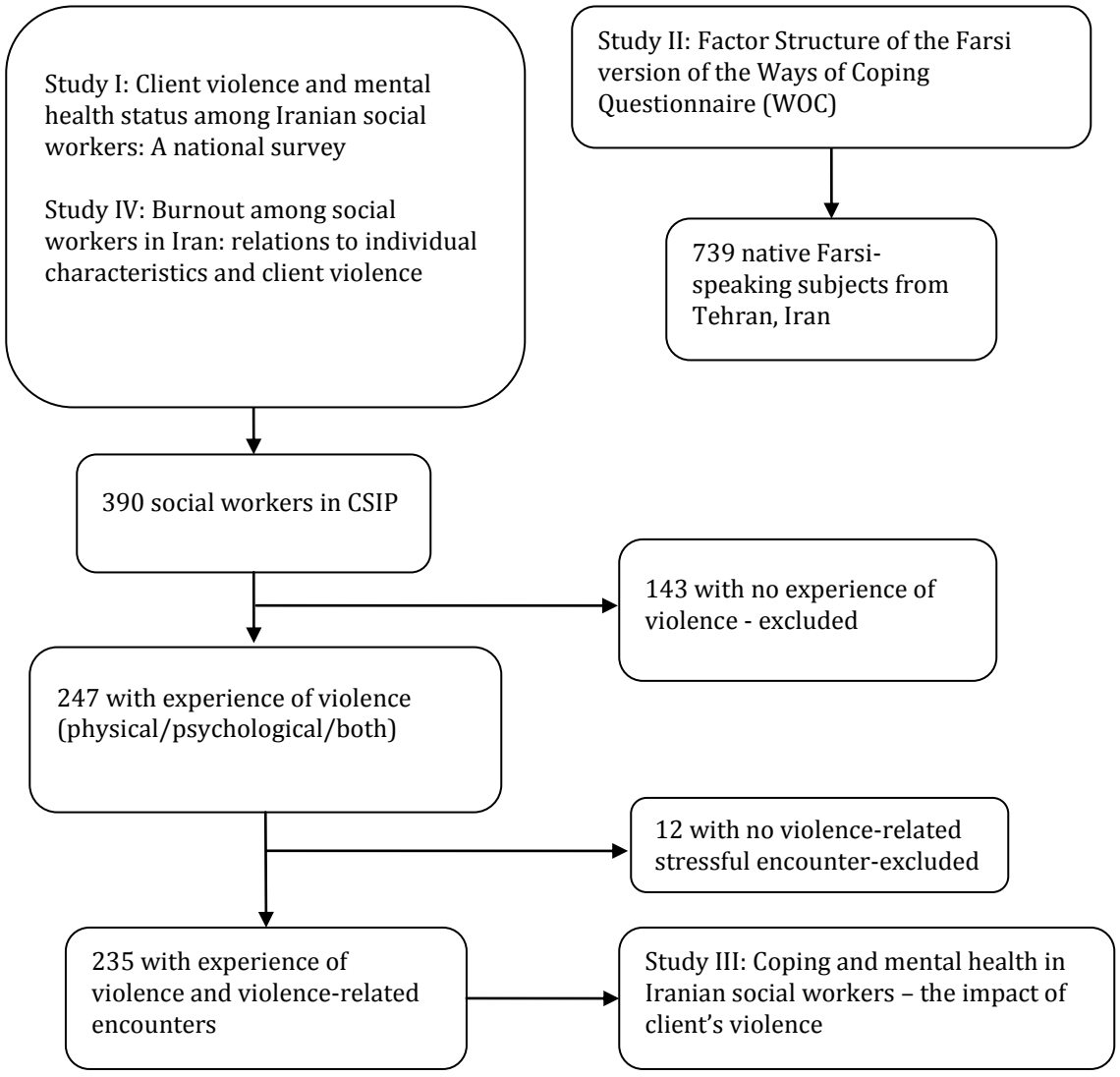
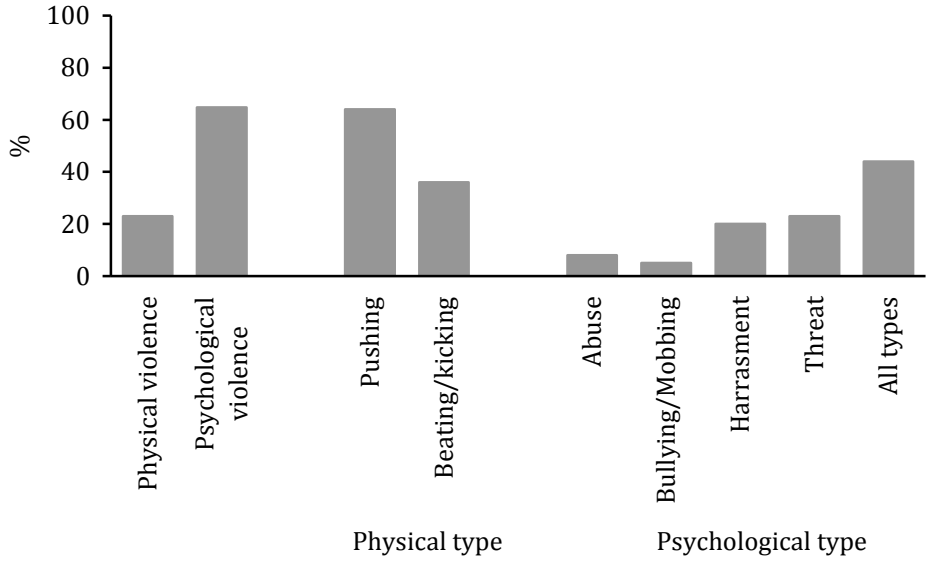


Figure 2: Frequency (%) of physical and psychological violence, by violence type among 390 CSIP social workers



REFERENCES

Ahmadkhaniha, H. R., Shariat, S. V., Torkaman-nejad, S and Moghadam, M. M. (2007).The frequency of sexual abuse and depression in a sample of street children of one of the deprived districts of Tehran. *Journal of Child Sexual Abuse*. 16(4), 23-35.

Aldwin, C. M. (1994). *Stress, Coping, and Development: An Integrative Perspective*. New York: Guilford Press.

Ashtari, Z., Farhady, Y., and Khodaee, M. R. (2009). Relationship between job burnout and work performance in a sample of Iranian mental health staff. *African Journal of Psychiatry*. 12(1), 71-74.

Borkovec, T. D., Robinson, E., Puzinsky, T., and DePree, J. A. (1983). Preliminary exploration of worry: some characteristics and processes. *Behavior Research and Therapy*. 21, 9-16.

Bowling, A. (2001). *Measuring Disease: A Review of Disease- Specific Quality of Life Measurement Scales*. Maidenhead: Open University Press.

Brockmann, M. (2002). New Perspectives on Violence in Social Care. *Journal of Social Work*. 2(1), 29-44.

Chelak, H. M. (2009). *Social Work (1): Case work.* Tehran: Samt Publication (in Farsi).

Coyne, J. C., and Lazarus, R. S. (1980). Cognitive style, stress perception, and coping. In I. L. Kutash, and L. B. Schlesinger (Eds.), *Handbook on stress and anxiety: Contemporary knowledge, theory, and treatment* (pp. 144-158). San Francisco: Jossey-Bass.

Coyne, J. C., Aldwin, C., and Lazarus, R. S. (1981). Depression and coping in stressful episodes. *Journal of Abnormal Psychology*, 90, 439-447.

Dempsey, M. (2002). Negative coping as mediator in the relation between violence and outcomes: Inner-city African American youth. *American Journal of Orthopsychiatry*. 72 (1), 102-109.

Department of Health (2000). *A Safer Place: Report of the Task Force and National Action Plan on Violence Against Social Care Staff.* London: Department of Health.

Department of Mental health and Substance Abuse (2011). *WHO MIND - Mental Health in Development*. Geneva, Switzerland: World Health Organization. Available online at http://www.who.int/mental_health/policy/en/ (Accessed 9 November 2011).

Enzmann, D., Schaufeli, W. B., Janssen, P., and Rozeman, A. (1998). Dimensionality and validity of the Bumout Measure. *Journal of Occupational and Organizational Psychology*. 71, 331-351.

Evans, S., Huxley, P., Gately, C., Webber, M., Mears, A., Pajak, S., Medina, J., Kendall, T., and Katona, C. (2006). Mental health, burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*. 188(1), 75-80.

Farman Farmaian, S. (2007). Broadening Muslim tradition: Bringing family planning to Iran. In L. J. Suttenfield, P. E. Collins, and D. E. Pellegrom (Eds.), *Courageous pioneers: Celebrating 50 years of Pathfinder International and 80 years of pioneering work in family planning and reproductive health around the world* (pp. 27-31), Watertown, MA: Pathfinder International.

Farman Farmaian, S., and Munker, D. (1992). *Daughter of Persia: A woman's journey from her father's harem through the Islamic Revolution*. New York: Crown.

Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology*. 46, 839-852.

Folkman, S., and Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*. 48, 150–170.

Folkman, S., and Lazarus, R. S. (1988). *Ways of Coping Questionnaire.* Palo Alto, CA: Consulting Psychologists Press.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., and Gruen, R. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology*. 50, 992-1003.

Ghandi, M. (2001). Social work. In H. M. Chelak (Ed), *Social Work (1): Case Work*.Tehran: Samt Publication (in Farsi).

Goldberg, D. P., and Williams, P. (1988). *The User's Guide to the General Health Questionnaire*. Windsor: NFER—Nelson.

Goldberg, D. P., Gater, R., Saratorious, N., Ustun, T. B., Piccinelli, M., Gureje, O., et al. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine*. 27, 191-197.

Golembiewski, R. T., and Kim, B. S. (1989). Self-esteem and phases of burnout. *Organizational Development Journal*. 7(1), 51-58.

Hair, J. F., Anderson, R. E., Tatham, R. L., and Black, W. C. (1998). *Multivariate Data Analysis.* Upper Saddle River, NJ: Prentice-Hall.

ILO/ICN/WHO/PSI (2003). *Workplace Violence in the Health Sector, Country Case Study-Questionnaire*. Geneva.

Jayaratne, S., and Chess, W. A. (1984). Job satisfaction, burnout, and turnover: A national study. *Social Work*. 29(5), 448-453.

Jayaratne, S., Croxton, T., and Mattison, D. (2004). A National Survey of Violence in the Practice of Social Work. *Families in Society*. 85(4), 445-453.

Joseph, S., Williams, R., and Yule, W., (1995). Psychosocial perspectives on post-traumatic stress. *Clinical Psychology Review*. 15, 515-544.

Koritsas, S., Coles, J., and Boyle, M. (2010). Workplace Violence towards Social Workers: The Australian Experience. *British Journal of Social Work*. 40(1), 257-271.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., and Lozano, R. (2002a). *World Report on Violence and Health.* Geneva, Switzerland, World Health Organization. Available online at http://www.who.int/violence_injury_prevention/violence/world_report/en/ (Accessed 15 October 2011)

Krug, E. G., Dahlberg, L. L., Mercy, J. A., and Zwi, A. B. (2002b). The world report on violence and health. *Lancet*. 360(9339), 1083-1088.

Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Lazarus, R. S. (1981).The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman, and P. Maxim (Eds.), *Models for clinical psychopathology* (pp. 177-214), New York: Spectrum.

Lazarus, R. S. (1993). Coping theory and research: past, present, and future. *Psychosomatic Medicine*. 55(3), 234-247.

Lazarus, R. S., and Folkman, S. (1984a). Coping and adaptation. In W. D. Gentry (Ed.), *The handbook of behavioral medicine* (pp. 282-325). New York: Guilford.

Lazarus, R. S., and Folkman, S. (1984b). *Stress, appraisal, and coping*. New York: Springer.

Lee, R., and Brotheridge, C. (2006). When prey turns predatory: Workplace bullying as a predictor of counteraggression/bullying, coping, and well-being. *European Journal of Work and Organizational Psychology*. 15(3), 352-377.

Macdonald, G., and Sirotich, F. (2005). Violence in the social work workplace: The Canadian experience. *International Social Work*. 48(6), 772-781.

Maslach, C. (1998). A multidimensional theory of burnout. In C. L. Cooper (Ed), *Theories of Organizational Stress* (pp. 68-85), Oxford, UK: Oxford University Press.

Maslach, C., and Jackson, S. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*. 2, 99-113.

Maslach, C., and Jackson, S. (1986). *Maslach burnout inventory manual*. Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., Schaufeli, W. B., and Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology.* 52, 397-422.

National Institute for Social Work (1999). *Violence Against Social Care Workers: Briefing Paper No. 26*. London: NISW.

Neuman, J. H., and Baron, R. A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management*. 24(3), 391-419.

Newhill, C. E. (2003). *Client violence in social work practice: Prevention, Intervention, and Research*. New York: Guilford Publication.

Noorbala, A. A., Mohammad, K., and Bagheri Yazdi, S. A. (1999). Validation of GHQ-28 in Iran. *Hakim*. 5, 101-110.

Padyab, M., Chelak, H. M., Nygren, L., Ghazinour, M. (2011). Client violence and mental health status among Iranian social workers: A national survey. *British Journal of Social Work*. First published online, doi:10.1093/bjsw/bcr053

Perlman, H. (1957). *Social casework: A problem solving process*. Chicago, IL: University of Chicago Press.

Pines, A. M. (2003). Occupational burnout: A cross-cultural Israeli Jewish-Arab perspective and its implications for career counseling. *Career Development International*. 8, 97-106.

Pines, A. M., and Aronson, E. (1988). *Career burnout: Causes and cures*. New York: Free Press.

Pines, A. M., Aronson, E., and Kafry, D. (1981). *Burnout: From tedium to personal growth*. New York: Free Press.

Pollack, D. (2010). Social work and violent clients: An international perspective. *International Social Work*. 53 (2), 277-282.

Renold, E., and Barter, C. (2003). 'Hi, I'm Ramon and I run this place': challenging the normalisation of peer violence in children's homes. In E. Stanko (Ed.), *The Meaning of Violence*, London: Routledge.

Ringstad, R. (2009). CPS: Client Violence and Client Victims. *Child Welfare*. 88(3), 127-144.

Rosse, J. G., Boss, R. W., Johnson, A. E., and Crown, D. F. (1991). Conceptualizing the role of self-esteem in the burnout process. *Group and Organization Studies*. 16 (4), 428-451.

Saleh, M. F. (2008). Sattareh Farman Farmaian: Iranian Social Work Pioneer. *Affilia Journal of Women and Social Work*. 23, 397-402.

Sartorius, N., and Kuyken, W. (1994). Translation of health status instruments. In J. Orley and W. Kuyken (Eds.), *Quality of life assessment: International Perspectives*. Heidelberg: Springer-Verlag.

Shapurian, R., Hojat, M., and Nayerahmadi, H. (1987). Psychometric characteristics and dimensionality of a Persian version of Rosenberg Self-esteem Scale. *Perceptual and Motor Skills*. 65, 27-34.

Schaufeli, W., and Enzmann, D. (1998). *The burnout companion to study and practice: A critical analysis*. London: Taylor & Francis.

Schaufeli, W. B., Leiter, M. P., and Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*. 14, 204-220.

Spencer, P., and Munch, S. (2003). Client violence toward social workers: The role of management in community mental health programs. *Social Work*. 48(4), 532-544.

State Welfare Organization (2010). About Organization. Available online at www.behzisti.ir (Accessed 15 October 2011).

Tengland, P. A. (2007). A two-dimensional theory on health. *Theoretical Medicine and Bioethics*. 28, 257-284.

Tharenou, P. (1979). Employee self-esteem: A review of the literature. *Journal of Vocational Behavior.* 15, 316-346.

Waddington, P. A. J., Badger, D., and Bull, R. (2005). Appraising the inclusive definition of workplace violence. *British Journal of Criminology*. 45, 141-164.

World Health Organization (2011). *Mental Health*. Available online at http://www.who.int/topics/mental_health/en/ (Accessed 15 October 2011)

World Health Assembly (1996). *Prevention of violence: Public health priority (WHA 49, 25)*. Geneva, Switzerland: World Health Organization.