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Counselor Demographics, Client Aggression, Counselor Job Satisfaction, and Confidence in Coping in Residential Treatment Programs

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ABSTRACT

COUNSELOR DEMOGRAPHICS, CLIENT AGGRESSION,
COUNSELOR JOB SATISFACTION,
AND CONFIDENCE IN COPING IN RESIDENTIAL TREATMENT PROGRAMS

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Counselors at residential agencies are sometimes assaulted by physically aggressive clients (Flannery & Walker, 2001, 2008). As a possible result of this professional hazard, mental health professionals typically resign from residential counseling positions after approximately 14.6 weeks (Connis, 1979). Although job satisfaction and counselor confidence in coping with client aggression have been widely studied individually in the context of residential settings, researchers have examined these variables together. The overarching purpose of this study was to examine the association between counselor demographic characteristics, agency/environmental characteristics, and crisis intervention training and job satisfaction and confidence in coping with client aggression. Data were collected utilizing two instruments: the Confidence in Coping with Patient Aggression Instrument (CCPAI) and the Work Cognition Inventory (WCI). Results indicate those who reported they had been exposed to verbal aggression reported significantly higher confidence in coping with client aggression. Additionally, those who reported they had received agency training in crisis intervention techniques also reported significantly higher confidence in coping with client aggression and higher job satisfaction.

This dissertation and the research agenda behind it is dedicated to Mark Moore, Terrence Lewis, Glenda Loy, Ryan Moll, Jeff Eagan, Liniya Johnson, Chad Endres, Kyle Yocum, Dan Wilton, and Michael West: Courageous, underappreciated warriors of our profession.

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CHAPTER ONE

INTRODUCTION

In a pilot study on client aggression, Flannery and Walker (2001) found that mental health professionals and residential counselors were most frequently targeted by aggressive clients. Flannery and Walker (2008) reported in a descriptive study 2,152 assaults against staff members at a residential agency during a 15-year period (roughly 2.759 assaults per week). Further, for 1,230 of the incidents (67%) mental health workers were more likely than nurses or residential house counselors to experience physical assault from a client. Mental health professionals typically resign from residential counseling positions after approximately 14.6 weeks (Connis et al., 1979). These statistics demonstrate the importance of investigating residential counselors' experiences with client aggression and its relationship with job satisfaction.

Three factors demonstrate the importance and urgency of research on crisis intervention and physical aggression at residential agencies. First, researchers (Braun, 2010; Flannery & Walker, 2008; Jones & Timbers, 2003; "The therapeutic crisis intervention system," 2010) note that client aggression warrants serious concern for the safety and well-being of counselors and other mental health professionals, particularly at residential agencies. Additionally, the Council of Accreditation for Counseling and Related Educational Programs (CACREP) revised standards attend more to crisis intervention in counseling program curricula (CACREP, 2009). Specifically, understanding the principles of crisis intervention is now a projected learning outcome for students of both mental health and school counseling programs (CACREP, 2009).

Finally, urgency in research relates to the inconclusive nature of previous research (Jonikas, Cook, Rosen, Laris, & Kim, 2004; Nunno, Holden, & Leidy, 2003; "The therapeutic crisis intervention system," 2010) in determining what training elements actually are effective in reducing critical incidents of aggression. A rationale for further study of aggression and crisis intervention training for counselors is also warranted as there is a need to study confidence in coping with client aggression and its possible relationship with job satisfaction at residential agencies.

Although this study did not investigate observable aggressive behavior, crisis intervention programs were studied indirectly in a different way. Confidence in coping with client aggression and job satisfaction had not been studied together even though they had been studied independently at residential agencies. For example, researchers have used confidence in coping with client aggression as a measure of efficacy for training programs (Gately & Stabb, 2005; Nunno, Holden, & Leidy, 2003; Thackrey, 1987), and other researchers have studied job satisfaction in the context of residential agencies (Buckhalt, Marchetti, & Bearden, 1990; Chou, Kröger, & Lee, 2010; Connis et al., 1979). There is minimal literature that addresses demographic variables in relation to job satisfaction and confidence in coping with client aggression at residential agencies.

Research Questions and Hypotheses

The overarching purpose of this study was to better understand how various factors are related to confidence in coping with client aggression and job satisfaction for counselors working

in residential facilities. To evaluate these relationships, the following research questions and hypotheses were considered.

Research Question 1: Is there a relationship between counselor job satisfaction and confidence in coping with client aggression?

Hypothesis 1:

- There will be a significant relationship between job satisfaction and confidence in coping. Specifically, there will be a positive relationship between these two variables.

Research Question 2: How are demographic characteristics (race/ethnicity, gender, age, and months of clinical experience) related to job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 2a:

- There will be a significant main effect between race/ethnicity and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, counselors of color will report significantly lower job satisfaction and confidence in coping with client aggression.

Hypothesis 2b:

- There will be a significant main effect between gender and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, female participants will report significantly lower confidence in coping with client aggression and significantly higher job satisfaction as compared to males.

Hypothesis 2c:

- There will be a significant interaction effect for age and years of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants and those with more years of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2d:

- There will be a significant main effect for age and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2e:

- There will be a significant main effect for months of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants with more years of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

Research Question 3: How are agency/environmental characteristics (staff to client ratio, exposure to physical aggression, and exposure to verbal aggression) related to job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 3a:

- There will be a significant interaction effect for staff to client ratio, exposure to physical aggression and exposure to verbal aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors at agencies with lower ratios who also experience greater exposure to aggression (physical, verbal) will

report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3b:

- There will be a significant main effect between staff/client ratio and job satisfaction and counselor confident in coping with client aggression. Specifically, counselors at agencies with lower ratios will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3c:

- There will be a significant main effect between exposure to physical aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater physical aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3d:

- There will be a significant main effect between exposure to verbal aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater verbal aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Research Question 4: Is there a significant relationship for presence of training (academic and agency) and job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 4a:

- There will be a significant interaction effect for presence of training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic and/or agency settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training. Participants who have received academic training only will report lower job satisfaction and lower confidence in coping with client aggression than those who have also received agency training.

Hypothesis 4b:

- There will be a significant main effect for presence of academic training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

Hypothesis 4c:

- There will be a significant main effect for presence of agency training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training at agencies will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

Definition of Terms

The following terms serve as key variables in this study.

Academic Training

Academic training is defined as coursework related to crisis intervention. Specifically, academic training includes the following categories: no coursework, graduate-level courses geared specifically toward crisis intervention (measured in semester credit hours), and any graduate-level course that incorporated crisis intervention topics yet was not a stand-alone crisis intervention course.

Agency Training

Agency training refers to any crisis intervention training received by the participant that was provided by a residential agency. Specifically, agency training includes the following categories: no training, Therapeutic Crisis Intervention (TCI), Nonviolent Crisis Intervention (NCI), training opportunities unique to the participant's agency, and any other training program the participant received as a part of an agency requirement or procedure. Two major training models, TCI and NCI, are defined as crisis intervention training models that both include components of physical restraint, de-escalation techniques, and debriefing for after a critical incident ("Crisis Prevention Institute," 2009; "The therapeutic crisis intervention system," 2010).

Client Aggression

Client aggression is defined based on 2 of the 4 subcategories identified by Flannery and Walker (2008). Client behaviors that fit the criteria for either physical assault or verbal threats toward counselors will be considered client aggression. Specifically, physical assault, one subcategory of physiological aggression, is defined as "unwanted contact with another person with intent to harm" and include "punching, kicking, slapping, biting, spitting, and throwing

objects" (p. 178). Verbal threats are defined as "statements meant to frighten or threaten" and include "threats against life and property as well as racial slurs and other derogatory comments" (p. 178).

Confidence in Coping with Client Aggression

Flannery and Walker (2008) defined aggression as physical assault, sexual assault, verbal threats, and nonverbal intimidation. For the purposes of this study, *client aggression* refers to aggression that is done *by* clients. Client aggression includes aggressive behavior toward the clinician, another client, or any other person. Counselor confidence in coping with client aggression, as described by Thackrey (1987), is the counselor's confidence in her or his ability to manage and prevent client aggression and her or his ability to cope with or prevent potential anxiety experiencing or witnessing such aggression might cause.

Gender

Gender is defined broadly as the gender-identity self-reported by the participant. Specifically, gender will include the following categories: female, transgender, and male.

Job Satisfaction

Job satisfaction is a person's continued cognitive and emotional well-being derived from one's job (Nimon et al., 2011). More specifically, Nimon et al. (2011) suggested that job satisfaction, as a construct, contains eight factors: autonomy, collaboration, connectedness with colleagues, connectedness with leader, distributive fairness, feedback, growth, and meaningful work.

Race/Ethnicity

Race/ethnicity is defined broadly as the cultural identity self-reported by the participant. Specifically, race/ethnicity will include the following categories: African-American/Black, Native-American/American Indian, Asian / Pacific Islander, White /Caucasian, Latina/Latino, and Multiracial.

Residential Mental Health

Any agency in which clients live on the premises of the agency is considered a residential agency. Residential mental health refers to the treatment of clients in such a context. Typically, a residential counselor's typical responsibilities include teaching skills for independent living, holding clients accountable for their behavior, providing brief mental health treatment daily, responding to critical incidents when they happen, and occasionally, physically restraint to keep the therapeutic milieu safe.

Staff to Client Ratio

Staff to client ratio refers to the proportion of residential mental health professionals in relation to the number of clients on average in a typical shift at a residential setting as reported by participants. A typical shift is defined as the standard full-length shift that the participant's agency regularly assigns to them.

Delimitations

Delimitations are characteristics that limit the scope of inquiry because of intentional decisions made throughout the course of the research process (Creswell, 2009). Certain de limitations may strengthen a study by restricting its focus.

Though a number of authors have gauged the efficacy of crisis intervention training programs (Flannery & Walker, 2008; Jonikas, Cook, Rosen, Laris, & Kim, 2004; Nunno et al., 2003; Thackrey, 1987), this study focused on academic or agency training as a participant characteristic, rather than as a research intervention. Collecting data in this way allowed I to quickly gain information on both variables rather than implementing numerous types of training.

Although this study did not investigate observable aggressive behavior, crisis intervention programs were studied indirectly through the confidence in coping with client aggression. The intention of this delimitation is that it would be difficult to ask counselors to recall specific statistical details of their experiences with aggression as to do so would expect them to rely on memory, which may negatively impact trustworthiness. However, their perceptions are readily available. By measuring confidence in coping with client aggression, it is possible to measure the psychological components of aggression, which are assumed to have a greater impact on aggression than the actual number of critical incidents. Similarly, the scope was limited further in collecting data on exposure to aggression. Data were collected only on physical aggression and verbal threats rather than on all four types of aggression. Nonverbal intimidation is harder to define and may be difficult for participants to recall or interpret. Sexually aggressive behavior relates to a type of aggression that is beyond the scope of the CCPAI.

Additionally, the design was a one-time survey. Though some studies used a longitudinal design in which the effects of training were measured over a number of time increments after implementing the training as a part of research (Grau-Alberola, Gil-Monte, García-Juesas, &

Figueiredo-Ferraz, 2010; Lowe et al., 2007), I collected data only once. Because a training was not implemented as a part of the study itself, collecting data at various time intervals would not have appropriately addressed the developmental aspect that time intervals are intended for investigating.

It was important for this study that confidence in coping with client aggression and job satisfaction be examined only in the context of residential mental health. The results are only generalized to similar residential settings to address the purpose and research questions. This study examined the experiences of counselors and only in the context of physical and psychological assault without examining sexual aggression. Additionally, exposure to aggression may change. The study examined confidence in coping versus actual previous coping methods. Finally, the study did not investigate specific components of each training program, just its presence.

Potential Contributions

Results from this study could contribute to the body of literature in a number of ways. Most notably, confidence in coping with client aggression and job satisfaction have not been studied together even though they have been studied independently at residential agencies. Many researchers have used confidence in coping with client aggression as a measure of efficacy for training programs (Gately & Stabb, 2005; Nunno et al., 2003; Thackrey, 1987), and many other researchers have studied job satisfaction in the context of residential agencies (Buckhalt et al., 1990; Chou et al., 2010; Connis et al., 1979). Results from this study may provide insight into the predictive value of counselor characteristics on job satisfaction and confidence in coping

with client aggression and may allow researchers to better interpret past research in which confidence in coping with client aggression was used as a measure of efficacy for crisis intervention training programs. Ultimately, the intent is to improve counselor retention at residential agencies by better understanding job satisfaction and confidence in coping with client aggression in the context of residential agencies. Results about demographic characteristics as related to job satisfaction and confidence in coping with client aggression may help supervisors at residential agencies understand which employees may need the most support. Finally, understanding which environmental characteristics may help supervisors at residential agencies make decisions about the therapeutic milieu that will be most conducive to residential counselors' job satisfaction and confidence in coping with aggression.

CHAPTER TWO

REVIEW OF THE LITERATURE

To give context to the two primary variables under study, an overview of the literature on client aggression and job satisfaction are provided. With respect to client aggression, this variable and its theoretical framework will be defined first. Crisis intervention training programs, a prominent way that agencies address client aggression, will then be described along with efficacy measures of these programs. Additionally, an overview of frequency of critical incidents as a measure of training program efficacy will be provided. I will also discuss counselors' subjective experiences of client aggression and related categorical variables as well as the relationship of counselor demographics with client aggression. A discussion of the job satisfaction literature will then be provided. Additionally, as burnout is a related variable that is found in the literature, pertinent research focusing on this variable will also be discussed. The chapter will conclude with a discussion of a possible relationship between confidence in coping with client aggression and job satisfaction.

Client Aggression

Client aggression has become a greater focus in mental health professions. Flannery and Walker (2008) reported in a descriptive study 2,152 assaults against staff members at a residential agency during a 15-year period (roughly 2.759 assaults per week). Male and female victims of client assault were in roughly equal numbers (1,068 male and 1,055 female), but males were more likely to be victims of physical assault. Clients diagnosed with schizophrenia were reported to have perpetrated 915 (50%) of physical assault incidents. Further, for 1,230 of

the incidents (67%), mental health workers were more likely than nurses or residential house counselors to experience physical assault from a client. These results make a strong case for the danger inherent in working with aggressive clients, especially for mental health workers. Winstanley and Hales (2008) investigated client assault against staff further to examine which counselor attributes and characteristics were most closely associated with being assaulted by clients. They found no significant differences in the frequency of client assault on staff in age, sex, or experience.

Flannery and Walker (2001, 2008) identified two major categories of aggression from two studies which measured the frequency of aggressive acts at a residential agency and categorized them based on critical incident reports. Physiological aggression, the first category, includes aggressive acts in which the aggressor physically touches another person to bring harm to them. These acts have been a major focus in the literature, presumably because they are more easily and concretely measured than psychologically aggressive acts. Physical assault, one subcategory of physiological aggression, is defined as "unwanted contact with another person with intent to harm" and include "punching, kicking, slapping, biting, spitting, and throwing objects" (p. 178). Sexual assault, the second subcategory, is "unwanted sexual contact" which includes "rape, attempted rape, fondling, forced kissing, and exposing" (p. 178).

With psychological aggression, the second major category, the aggressor does not use physical touch but exerts control over another person using fear. This type of aggression may be an indicator of future physiological aggression for some clients. Psychological aggression is broken down into two subcategories: verbal threats and nonverbal intimidation. Verbal threats

are defined as "statements meant to frighten or threaten" and include "threats against life and property as well as racial slurs and other derogatory comments" (p. 178). Flannery and Walker (2008) defined nonverbal intimidation, the second subcategory, as "actions intended to threaten and/or frighten" (p. 178) and includes threatening gestures, facial expressions, aggressive pacing, and other behaviors intended to invoke fear in another person.

Though these categories do not make distinctions of severity, they provide a basic set of guidelines for identifying and qualifying aggressive behaviors. Presumably because physiological aggression is a greater concern at mental health agencies, the literature on client aggression focuses less on aggressive acts within the psychological categories. Psychological aggression is still important to discuss as it is my assumption that it may have a latent influence on counselor confidence in coping with client aggression.

A Theoretical Framework for Aggression

McAdams and Foster (2002) in a seminal article on aggression and violence presented a framework for understanding aggression. In discussing aggression, McAdams and Foster use Monahan's (1984) definition of violence, which is any threat or actual application of violent behavior that has a potential for physical harm or injury. They perceived that violent or aggressive people view themselves as weak and others as powerful and can engage in proactive aggression, of premeditated use of aggression to maintain a sense of control over others, the self, and the environment. They proposed that proactive aggression is the mark of a violent person. Reactive aggression is a reaction to a real or perceived threat to one's well-being (McAdams & Foster, 2002), which is seen as a more acceptable type of violence because it is precipitated by

an immediate threat. Both reactive and proactive aggression are efforts to maintain control in some way, but proactive aggressors plan for future instances in which maintaining control might be needed (McAdams & Foster, 2002). In this way, the proactive aggression is a way to use fear to communicate to others that the aggressor is in control, whereas acts of reactive aggression are generally done by people who already have some normal sense of being in control but perceive aggression as the best way to immediate self-preservation (McAdams & Foster, 2002).

Whether an act of aggression is reactive or proactive, McAdams and Foster (2002) conceptualized violence as a cycle that involves the following five stages:

1. *Triggering:* In the triggering stage, the person begins to consider choosing aggressive behavior to exert control. Behaviors that indicate that the person is triggered may include nervous pacing, speaking in a harsher tone, and other behaviors atypical to the individual's usual behavior.
2. *Escalation:* The escalation stage is characterized by externalization of internal panic. McAdams and Foster (2002) conceptualized aggressive behavior as an effort to control one's environment done by a person who perceives herself or himself as powerless and not in control. In the escalation stage, the individual begins to feel this loss of control, which may be exacerbated if triggers also continue.
3. *Crisis:* In the crisis stage, the individual begins to attempt to gain power using aggression and compensate for increasing sense of loss of control. This is the stage in which a critical incident occurs.

4. *Recovery:* The recovery stage occurs after aggressive behavior has occurred and is characterized by return of composure and self-control, but opposition may still be evident. In this stage, the individual begins to return to her or his baseline behavior.
5. *Post-crisis depression:* After the recovery stage, the individual may find an interest in making reparations to victims and relieving guilt. Some individuals reach this stage and feel remorse, which is uncomfortable. Making reparations and apologizing assuages these uncomfortable feelings.

Further, they cited three factors as possible predictors of violent behavior: history of violence; substance abuse; and self-control problems. First, McAdams and Foster (2002) viewed aggressive behavior as cyclical, which indicates that those who behave aggressively exhibit such behavior as part of a pattern. Second, substance abuse relates to the assumption that those who exhibit aggressive behavior wish for further control; substance abuse could be an alternative, maladaptive way other than violence that would allow the person to regulate emotions. Therefore, people who have substance abuse diagnoses may be more likely to behave aggressive. Finally, McAdams and Foster conceptualized violence as an aggressive way of being resulting from a feeling of lack of control. Therefore, it is reasonable to argue that difficulties with self-control and self-regulation could lead to aggression.

McAdams and Foster (2002) also noted a number of attributes that should be present in a service setting to most effectively address violence. These attributes include clarity of expectations, minimal restrictiveness that provides a reasonable balance between safety and collaboration to allow some sense of client control over the environment, a sense of physical

safety, and access to physical exits in a facility. Importantly, they also noted that consistent training may be the key to success in managing aggression.

Crisis Intervention Training Programs

CACREP (2009) recently increased accreditation guidelines to include more standards related to crisis intervention, which means increased incentives for counseling programs to include crisis intervention as part of curricula. Further, a number of crisis intervention training programs have been developed at agencies in part to prevent the various forms and stages of aggression. Therapeutic Crisis Intervention and Nonviolent Crisis Intervention are two of such programs mentioned frequently in the literature (Nunno et al., 2003). After these are described, other programs are discussed. Additionally, an overview of the arguments for the elimination of physical restraint from these crisis intervention training programs is also provided.

Therapeutic Crisis Intervention

Numerous authors have investigated the efficacy of Therapeutic Crisis Intervention (TCI; (Nunno et al., 2003; "The therapeutic crisis intervention system," 2010; Titus, 1989). The TCI model teaches practitioners practical strategies for preventing, dealing with, and repairing crises and acts of aggression. The TCI system consists of de-escalation techniques, crisis intervention (including physical restraint), and debriefing. In TCI, the practitioner can be an abuser, a firefighter, or an educator. If a residential counselor uses restraint out of personal anger or as a punishment rather than to maintain a safe environment, then the counselor has taken on the role of abuser, which is avoided as assuming this role causes harm. Counselors may assume the abuser role consciously or unconsciously. When the counselor uses crisis intervention techniques

properly and appropriately, then she or he is a firefighter; she or he observed a problem and solved it. The firefighter role is adequate in maintaining safety, but according to the TCI model, the client has not gained from an interaction with a counselor in the firefighter role. Ideally, the counselor achieves the educator role; the counselor maintains safety as the firefighter would, but she or he views the crisis as a teachable moment. In the educator role, the counselor debriefs after a crisis so that the client can learn from the situation by understanding her or his own behavior better. De-escalation and crisis intervention will usually happen in the abuser role and the firefighter role, but the educator role is the only role that in which the counselor goes above and beyond to debrief after a critical incident ("The therapeutic crisis intervention system," 2010).

Nonviolent Crisis Intervention

Another training program commonly used by mental health agencies is Nonviolent Crisis Intervention (NCI), which has also been assessed by numerous empirical studies (Calabro, Mackey, & Williams, 2002; Jambunathan & Bellaire, 1996; Jonikas et al., 2004; Temple, Zgaljardic, Yancy, & Jaffray, 2007). When evaluating the NCI training program, Calabro, Mackey, and Williams (2002) found significant improvements in knowledge, confidence in coping with client aggression, and behavioral intent to implement techniques learned in training. In the posttest by Jambunathan and Bellaire (1996), participants reported significantly higher averages in the perceptions of the percentage of crises that they were involved in that were resolved. Jonikas et al. (2004) observed physical restraint data at three facilities for a 2.5-year period and found significant decreases in frequency of physical restraint following the

introduction of NCI. Finally, in a pretest-posttest study, Temple et al. (2007) found that participants reported significantly higher confidence in coping with client aggression and a decreased discomfort with client behaviors involving physical and verbal aggression immediately after training.

Positive Behavioural Support

One study investigated the efficacy of Positive Behavioral Support (Lowe et al., 2007), another crisis intervention training program. Most notably, results suggested treatment had at least a temporary effect on perceived confidence. Additionally, results suggested that training had a significant but temporary effects on staff perceptions of the causes of aggressive behavior.

Positive Behavioral Management and Control and Restraint

In a pretest-posttest design, Killick and Allen (2005) compared the efficacy of Positive Behavioral Management with a crisis intervention training program called Control and Restraint. Staff reported an increase in knowledge and confidence in coping with client aggression after the Positive Behavioral Management training and at the one-year follow-up.

Zero Tolerance Programs

Two studies investigated zero tolerance programs (Ching, Daffern, Martin, & Thomas, 2010; Middleby-Clements & Grenyer, 2007). Zero tolerance programs are not training programs but implementation of policy. Specifically, in zero tolerance programs, clients are physically restrained or secluded after any aggressive behavior. However, zero tolerance programs have not been found to be effective, as demonstrated by more rigid staff attitudes toward aggression (2007) and increases in the frequency of seclusion.

Unspecified or Agency-Specific Programs

Most of the authors that have studied crisis intervention or management of aggression investigated unspecified or agency specific programs (Allen & Tynan, 2000; Flannery & Walker, 2008; Gately & Stabb, 2005; Jonikas et al., 2004; Martin & Daffern, 2006; Nau, Dassen, Needham, & Halfens, 2011; Nau, Halfens, Needham, & Dassen, 2010; Needham et al., 2005; Thackrey, 1987). Generally, authors who studied crisis intervention programs have found positive results in reduction of physical restraint and/or confidence in coping with client aggression.

Summary of Crisis Intervention Programs

Generally, posttest results from each of the crisis intervention training programs demonstrated efficacy in both knowledge and confidence in coping with client aggression. However, as few of the studies compared training programs to each other, it is difficult to identify which training program is most effective on any of the measures. Additionally, researchers have not examined how these programs compare or strengthen academic training.

Collectively, many crisis intervention programs rely heavily on physical restraint techniques. Some authors (Braun, 2010; Johnson, 2007; Jones & Timber, 2003) argue that other methods are more therapeutic for the client and clinical context and should be included in training. Braun (2010) conducted a heuristic inquiry on counselor trauma during crisis intervention and noted that staff members at residential agencies discussed two therapeutic concerns related to physical constraint. Specifically, they reported the act of physically restraining clients damages the counselor-client relationship, and clients' knowledge of the

possibility of restraint appears to increase clients' anxiety, which heightens escalation. In addition to therapeutic concerns that physical restraint may cause, Johnson (2007) pointed out that physical restraint can cause health concerns such as respiratory issues when implemented incorrectly. Thus, Johnson recommended the intake process for residential agencies should include a respiratory assessment for each individual client to decide whether or not physical restraint should be indicated in an individual client's treatment plan. Jones and Timbers (2003) noted that there have even been client deaths caused by the improper use of physical restraint. These health concerns are raised in the TCI manual as well; the authors caution practitioners to use physical restraint carefully and minimally ("The therapeutic crisis intervention system," 2010).

Efficacy of Crisis Intervention Training Programs

There is some research available on the efficacy of crisis intervention training programs. This research can be categorized by the following outcome variables: changes in incidence of physical restraint and seclusion; practitioner knowledge acquisition; confidence in coping with client aggression; satisfaction with training model; and proficiency in managing aggression.

Changes in Physical Restraint and Seclusion Practices

Some authors measured the frequency of physical restraint to gauge the efficacy of crisis intervention training programs (Jonikas et al., 2004; Nunno et al., 2003). Jonikas et al. (2004) used a pretest-posttest design, sampling from three settings and reported that "the adolescent unit experienced a 48 percent decrease in the restraint rate one quarter after training occurred and a 98 percent decrease two quarters after the training" (p. 819). Further, in analyzing data from the

general psychiatric unit, Jonikas et al. reported an 85% decrease one quarter after and a 99% decrease two quarters after the training. The clinical research unit yielded a 51% decrease one quarter and a 49% decrease two quarters after the training. Nunno et al. (2003) found that the TCI training was associated with a number of positive outcomes: (a) an increase in participant knowledge and confidence with crisis intervention; (b) consistency in crisis intervention strategies throughout the agency; and (c) decreases in overall critical incidents (particularly in aggressive critical incidents). However, some qualitative data included negative feedback from staff members: staff members reported that the prescribed techniques are not always realistic possibilities (Nunno et al., 2003).

Research on zero tolerance policies has been conducted using changes in seclusion incidents, the practice of not allowing a client out of her or his room at a residential agency to keep other clients safe and to manage the therapeutic milieu. Ching, Daffern, Martin, and Thomas (2010) investigated the frequency and duration of seclusion as a way to gauge the efficacy of a newly implemented zero tolerance policy at a residential agency. Ching et al. found that the number of seclusion incidents were reduced after a zero tolerance policy on client aggression was implemented. However, the methodology implemented in the study by Ching et al. (2010) allowed only for conclusions to be drawn about zero tolerance policies on aggression.

Practitioner Knowledge Acquisition

A number of authors (Allen & Tynan, 2000; Killick & Allen, 2005; Lowe et al., 2007) used knowledge as a measure of efficacy for crisis intervention training methods, although these findings are mixed. Allen and Tynan (2000) concluded in a pretest-posttest study that crisis

intervention training can increase knowledge. Further, Killick and Allen (2005) using multiple baseline data concluded that knowledge can be maintained over a 12-month period. Killick and Allen found similar results across groups, but slightly lower knowledge in the untrained group, which conflicts with results from Allen and Tynan (2000). Additionally, Killick and Allen found a significant increase in knowledge over the time for each assessment point. Results from Lowe et al. (2007) also indicated that crisis intervention training was associated with an increase in knowledge, which were maintained after the year follow-up period.

Practitioner Confidence in Coping with Client Aggression

An additional variable of training method efficacy is confidence in coping with client aggression. This variable has been measured using the Confidence in Coping with Patient Aggression Instrument (CCPAI; Allen & Tynan, 2000; Gately & Stabb, 2005; Lowe et al., 2007; Middleby-Clements & Grenyer, 2007; Nau et al., 2011; Thackrey, 1987) or some modified form (Ching et al., 2010; Killick & Allen, 2005; Martin & Daffern, 2006).

Exposure to training also is associated with confidence in coping with aggression. Allen and Tynan (2000) in a pretest-posttest design collected data from a sample of 109 mental health staff with roughly equal sized groups of those who had been exposed to crisis intervention training and those who had not. Using the CCPAI, Allen and Tynan found that those who had been exposed to the training reported significantly higher confidence in coping with client aggression. Results from other studies using the CCPAI also indicated that crisis intervention training programs are generally associated with increased confidence in coping with client aggression (Lowe et al., 2007; Nau et al., 2010; Thackrey, 1987). Thackrey (1987) found that

participants who were trained in crisis intervention reported higher levels of confidence than did participants who had not been trained. In conceptualizing this body of results together, it is reasonable to hypothesize that crisis intervention training may increase confidence in coping with client aggression and that experience does not necessarily increase confidence in coping with client aggression.

A number of other authors investigated counselor confidence in coping with client aggression using other instruments (McDonnell et al., 2008; Nunno et al., 2003). McDonnell et al. (2008) used the Staff Support and Satisfaction Questionnaire (3SQ) to measure confidence in coping with client aggression and found results that suggested that "staff training can increase staff confidence in managing aggression in people with autism spectrum disorders" (p. 311). Nunno et al. (2003) developed an untitled instrument to measure confidence in coping with client aggression and found that training can increase confidence in coping with client aggression.

There have been mixed findings related to the association between years of clinical experience, age and confidence in coping with aggression. Martin and Daffern (2006) used a modified form of the CCPAI and found no relationship between years of experience and confidence in coping with client aggression. In another study, clinical psychology graduate students who had already had their practicum experience reported higher levels of counselor confidence in coping with client aggression than did graduate students who had not reached the practicum level (Gately & Stabb, 2005). Additionally, time spent in the program had a direct correlation with confidence in coping with client aggression (Gately & Stabb, 2005). Gately and

Stabb (2005) did not suggest a relationship between age and confidence in coping with client aggression.

Martin and Daffern (2006) investigated what factors were most closely related to confidence in coping with client aggression and found that confidence in colleagues and demographics best predicted confidence in coping with client aggression. Specifically, females reported significantly higher confidence in their colleagues than did males.

Practitioner Satisfaction with Training Models

Researchers included satisfaction as a measure of efficacy for crisis intervention training programs (Killick & Allen, 2005; Nunno et al., 2003). *Satisfaction* is used in these studies to refer to trainees' satisfaction with the material being taught in the training program rather than overall job satisfaction. Nunno et al. (2003) collected qualitative data on satisfaction to illuminate what components of TCI were seen as useful by trainees. Trainees reported that the debriefing component was not always possible due to time constraints, but trainees also reported that the proposed thought process for discerning the best response for crises in the moment allows them to be more proactive.

Killick and Allen (2005) collected quantitative data and found that residential mental health professionals reported higher satisfaction with the *Positive Behavioural Support* model than with the *Control and Restrain* model immediately after training and at the 12-month follow-up measurement. Training models that trainees find more satisfying may mean that trainees will be more likely to use the techniques that were taught at the training session, but this relationship remains untested. Gately and Stabb (2005) found a positive correlation between perception of

training received and confidence in coping with client aggression, which may indicate that satisfaction may have some relationship with proficiency, as Nunno et al. (2003) pointed out that confidence in coping with client aggression theoretically leads to more relaxed, rational decision-making in crisis situations. However, little evidence directly suggests that increased satisfaction predicts increased proficiency.

Practitioner Proficiency

Researchers have also attempted to measure participants' proficiency in using strategies and techniques taught in training programs (Middleby-Clements & Grenyer, 2007; Nau et al., 2011; Nau et al., 2010). Using the De-Escalating Behaviour Scale (DABS) developed for their study, Nau et al. (2010) concluded that training has a positive effect on residential counselors' performance in de-escalating aggressive clients. In a factor analysis, Nau et al. (2011) found that the DABS had good predictive value with the CCPAI. Middleby-Clements and Grenyer (2007) developed and used the Skill in Dealing with Aggression Scale (DABS; Grenyer, 2003) and found that both training groups they studied reported an increase in skill.

Limitations of Training Program Efficacy Research

There are a number of limitations that may be considered in designing this study. First, although three studies (Jonikas et al., 2004; Nunno et al., 2003; Temple et al., 2007) claim a potential association between various measures of efficacy and participation in the NCI program, it is questionable whether or not the actual program caused the decrease in cases of physical restraint, or simply that there was increased supervision, as Nunno et al. (2003) noted as a limitation of their own study. In all three studies, researchers attempted to assess the efficacy of

NCI using a pretest-posttest design without a control group, which eliminates the possibility of accurately drawing causal conclusions.

Knowledge was measured by several authors (Allen & Tynan, 2000; Killick & Allen, 2005; Lowe et al., 2007), but no author assessed this variable as the primary measure of efficacy for training methods. Researchers who measured knowledge also measured at least one other variable (Allen & Tynan, 2000; Killick & Allen, 2005; Lowe et al., 2007). Since participants' knowledge increased over time but not across trained and untrained groups, one may consider the explanation trained residential counselors may simply have more experience, which may lead to more knowledge. However, the explanation offered has yet to be tested empirically. Additionally, the small difference in knowledge found by Killick and Allen (2005) may have been a result of type II error, as the significant difference found across trained and untrained groups found by Allen and Tynan (2000) was supported by Lowe et al. (2007).

Although results from three studies claim to suggest relationships and improved efficacy, none of the authors measured proficiency in a way that could create a convincing argument about whether or not a training program is efficacious in terms of improving proficiency. All of the authors used a self-report instrument to measure participants' proficiency. Therefore, what these authors have actually not measured proficiency, but rather, *perceived* proficiency. In conceptualizing this variable as perceived proficiency, then it can be seen that this variable is not much different from confidence in coping with client aggression. For example, Nau et al. (2011) found a positive significant correlation between self-reported "successful use of behavioral management strategies" and confidence in coping with client aggression. The comparison of the

two scales works well as a confirmatory factor analysis for the two scales as measurements for confidence in coping with client aggression, but discussing what is actually measured in each scale as a separate variable is not totally accurate.

Counselor Experiences and Perceptions of Aggression

Several authors have studied residential counselors' experiences and perceptions of challenging behaviors. Braun (2010) used qualitative methodology to investigate experiences of challenging behaviors. Additionally, numerous authors have used quantitative methodology to investigate experiences and perceptions of challenging behavior (Ching et al., 2010; Gately & Stabb, 2005; Lowe et al., 2007; Middleby-Clements & Grenyer, 2007; Temple et al., 2007).

Braun (2010) in a pilot study of two residential counselors investigated counselor trauma during crisis intervention at residential mental health agencies and identified a number of themes regarding residential counselors' experience of critical incidents and attitudes on working in crisis-rich environments. Specifically, Braun (2010) found that residential counselors have varied experiences of critical incidents and two had been physically injured differently during critical incidents. The first participant experienced the incident as anger toward the aggressive client, whereas the second participant experienced the incident as anger toward the situation. Because of the different strategies used by two participants, Braun (2010) concluded that there may be a relationship between how a critical incident is experienced and the strategy used to cope with the traumatic incident itself and working in crisis-rich environments in general. Further, Braun's (2010) study was in the tradition of heuristic inquiry, which meant that I was also the third participant. While Braun (2010) was not physically injured, mild trauma symptoms after

witnessing numerous critical incidents were experienced, including intrusive thoughts and sleep disturbance.

Braun (2010) also investigated participants' attitudes toward working in crisis-rich environments. One participant explained that the shared experience of working at an aggressive unit at a residential agency is what he had imagined it would be like to be in the army or on a football team. Additionally, when approaching aggressive client behavior, two participants were most concerned about their own well-being, and one was more concerned with the client's well-being. Some participants viewed their work positively and others negatively. One possible conclusion that could be drawn from the difference in whether the counselor is more concerned about the self or about the client is that this difference may be related to whether or not they view their work positively or negatively and therefore their overall job satisfaction and possibility of burnout.

In addition to these qualitative pilot data, researchers have investigated quantitative variables with regard to client aggression. Many of these variables have to do with counselor attitudes and perceptions. These variables included the following: attitudes toward seclusion; staff and patient perceptions of the social and therapeutic atmosphere; attitudes toward aggression; and exposure to violence.

Attitudes toward Seclusion

Attitudes toward seclusion refers counselors' perception of when and how seclusion should be implemented. Ching et al. (2010) found no change in attitudes toward seclusion after the implementation of a zero tolerance policy on aggression. A large portion of the sample (96%)

believed that physically striking a staff member and physically striking a client were the most valid reasons to seclude a client (Ching et al., 2010).

Staff and Patient Perceptions of the Social and Therapeutic Atmosphere

Ching et al. (2010) investigated staff and patient perceptions of the social and therapeutic atmosphere. They found no change in staff and patient perceptions of the social and therapeutic atmosphere after the implementation of a zero tolerance policy on aggression. However, Ching et al. found a significant decrease in cohesion or camaraderie between clients after the zero tolerance policy was implemented and no significant increase in clients' perceptions of safety nor in clients' perception of their environment as therapeutic.

Attitudes Toward Aggression

Concerned that a zero tolerance policy might cause too rigid a view of aggression in staff members, Middleby-Clements and Grenyer (2007) used a quasi-experimental design to test this hypothesis. Middleby-Clements and Grenyer created two groups: one group received a training on managing client aggression, and the other received the same training with the zero tolerance component added. The group who did not receive the zero tolerance component significantly decreased in rigidity toward aggression management, whereas the zero tolerance group significantly increased in rigidity (Middleby-Clements & Grenyer, 2007). However, Middleby-Clements and Grenyer operated under the assumption that staff rigidity toward aggression management was detrimental to the therapeutic environment without citing any prior literature that would suggest that is the case. Conceptually, therefore, conclusions cannot be drawn on whether or not this variable is detrimental or therapeutic until this assumption is tested. However,

Middleby-Clements and Grenyer also measured skill and confidence in managing aggression, which will be discussed further.

Middleby-Clements and Grenyer (2007) also measured staff tolerance for aggression. After the treatment, the zero tolerance group had significantly less tolerance for aggression compared to the control group (Middleby-Clements & Grenyer, 2007). A similar conceptual problem exists in Middleby-Clements and Grenyer's measurement of this variable; conclusions cannot be drawn on whether or not this variable is detrimental or therapeutic until this assumption is tested. However, the same group that reported lower tolerance for aggression post-training, also reported lower confidence in coping with client aggression post-training (Middleby-Clements & Grenyer, 2007), which may indicate that there may be a relationship between tolerance for aggression and confidence in coping with client aggression.

Temple et al. (2007) used an instrument called the Rehabilitation Situations Inventory, which contains 30 items and measures the difficulty level of various situations commonly experienced by staff in rehabilitation settings. Participants reported a decreased discomfort with client behaviors involving physical and verbal aggression immediately after the training (Thackrey, 1987).

Finally, in another study, attributions were studied as a categorical variable (Lowe et al., 2007). Attributions refer to beliefs about how physical aggression and other challenging behavior is caused and is categorized in four domains: learned, biomedical, physical environmental, and self-stimulation (Lowe et al., 2007). Lowe et al. found significant changes in attributions as a result of training.

Exposure to Client Violence

Although exposure to client violence is not related to attitudes on aggression, it is included in this sub-section because it is based on counselors' perception of their own experiences. Residential counselors may perceive that they have had a certain amount of exposure to client aggression. Gately and Stabb (2005) explored the relationship between confidence in coping with client aggression and exposure to client violence. However, they measured the counselor's perception of exposure to client violence using a self-report instrument based on the participant's memory. One limitation of that study is that the instrument used relies on the participant's memory to measure the intensity and frequency of aggressive behavior that may have happened years ago (Gately & Stabb, 2005). Therefore, the results related to this variable are difficult to interpret and may not be accurate. Despite this possible conceptual issue, the self-report instrument used by Gately and Stabb (2005) could still prove useful. Future researchers may consider measuring participants' perceived exposure to client violence and comparing those measures to agency records to corroborate how accurate these perceptions actually are.

Job Satisfaction and Burnout

Job satisfaction and burnout are two other variables that have been widely studied in the context of residential settings. Burnout is defined as the summation of a person's emotional exhaustion, depersonalization (i.e., compassion fatigue toward clients), and lack of personal accomplishment within the context of her or his job (Schaufeli, Salanova, González-Romá, & Bakker, 2002). Job satisfaction, as defined by Nimon et al. (2011), is a person's continued

cognitive and emotional well-being derived from one's job. More specifically, Nimon et al. (2011) suggested that job satisfaction, as a construct, contains eight factors: autonomy, collaboration, connectedness with colleagues, connectedness with leader, distributive fairness, feedback, growth, and meaningful work. Autonomy refers to how much permission employees believe they have in using their own judgment to complete their tasks (p. 13). Collaboration refers to how much the employee perceives that cooperation is valued over competition at her or his job site (p. 14). Connectedness with colleagues refers to how much positive interpersonal interaction employees believe they have with their coworkers (p. 15).Connectedness with leader refers to the employee's perception that her or his leader maintains a supportive, non-controlling relationship (p. 15). Distributive fairness refers to the employee's sense that her or his efforts are being fairly rewarded relative to other employees at the organization, e.g. adequate pay and benefits for a reasonably equivalent amount of work (p. 14). Feedback is defined by the amount of accurate information employees believe is available to them in determining the quality of their job performance (p. 13). Growth refers to how much opportunity the employee believe the job has in propelling her or his learning, growth, and career development (p. 14). Finally, meaningful work refers to the employee's sense of her or his job tasks and overall work having importance within the organization and in the external world (p. 13).

Zigarmi et al. (2011) found in a quantitative study using structural equation modeling the following significant relationships: work cognition is positively correlated to work affect, job well-being, and work intentions; work affect is positively correlated to job well-being and work intentions; and job well-being is positively related to work intention.

Employee turnover is a problematic phenomenon at residential care facilities. In a hierarchical linear modeling study, Lakin, Leon, and Miller (2008) found that when residential professionals were asked if they would leave their job for another one of equal pay, 16% said they would leave immediately, and 17 % said they would leave soon. Connis, Braukmann, Kifer, Fixsen, Phillips, and Wolf (1979) collected data from 26 residential agencies and found results that suggested that residential employees generally do not work for the same agency for long periods of time, working for14.6 weeks on average. The high number of client assaults found by Flannery and Walker (2008) and the lived experiences of residential counselors who had experienced trauma discussed by Braun (2010) suggest a work environment that could easily be experienced as hostile.

Predictors of Job Satisfaction and Burnout

To investigate the problem of burnout at residential mental health agencies, a number of researchers have performed correlational studies to understand which factors are most closely associated with burnout or job satisfaction in residential mental health employees (Bersani, 1983; Connis et al., 1979; Eastwood & Ecklund, 2008; Holburn & Forrester, 1984; Ursprung, 1984). A discussion of intrinsic and extrinsic job satisfaction, predictors of burnout at residential agencies, and predictors of job satisfaction at residential agencies are provided. Finally, demographic factors are discussed.

Intrinsic and extrinsic job satisfaction. Job satisfaction at residential agencies is comprised of intrinsic and extrinsic job satisfaction (Holburn & Forrester, 1984). Intrinsic job satisfaction is defined as the reward associated with the actual tasks of the job itself and the sense

of accomplishment one finds in job tasks (Holburn & Forrester, 1984). Holburn and Forrester found that the factors that correlated with intrinsic job satisfaction included organizational standards and degree of contact with clients. However, Connis (1979) also investigated the correlation between degree of contact with clients and job satisfaction and found that the amount of direct client contact was negatively correlated with job satisfaction. Future researchers may consider investigating this discrepancy.

Connis' (1979) estimate was skewed by a few outlier scores from residential mental health staff whose tenure lasted for 74 months, which may suggest that many residential counselors will tend to have either extremely long or extremely short tenures. The possibility of extreme scores in duration of employment at residential agencies in the population may suggest that certain factors predict whether a residential counselor quits early or stays for a long tenure. One possible explanation for the polarity in duration of employment is that people generally begin working in residential settings for reasons other than external rewards (Buckhalt et al., 1990). However, after approximately14.6 weeks, as estimated by Connis (1979), residential counselors may find that the job stress outweighs the job satisfaction. Perhaps those who find greater intrinsic job satisfaction are able to cope with job stress for a longer duration.

Other factors associated with intrinsic satisfaction include the challenge presented by job tasks and having enough time to do tasks the way they should be done (Bersani, 1983). Factors related to intrinsic burnout include excessive workload and a constant demand to make immediate decisions (Bersani, 1983). Perhaps the constant demand to make immediate decisions is inherent in working in crisis-rich environments. For instance, when a critical incident occurs,

if no intervention is implemented, the result could be physical harm. Therefore, it is crucial in these situations for crisis intervention counselors to rapidly decide whether or not to intervene.

Extrinsic job satisfaction is defined by the satisfaction from rewards that are outside of the actual job tasks (Holburn & Forrester, 1984). For example, low salary has been found to be an important factor of job stress at residential agencies, but reward is positively correlated with extrinsic job satisfaction (Buckhalt et al., 1990; Holburn & Forrester, 1984). Other factors associated with extrinsic satisfaction include strong relationships with clients and personal growth (Bersani, 1983) and support outside of work (Eastwood & Ecklund, 2008). Factors related to extrinsic burnout include insufficient privacy and philosophical disagreements with coworkers (Bersani, 1983). Additionally, role conflict and role ambiguity were significantly correlated with emotional exhaustion (Ursprung, 1984).

Demographic variables of burnout and job satisfaction. Numerous authors have investigated the relationship between demographic variables and burnout or job satisfaction (Bersani, 1983; Chou et al., 2010; Hauber & Bruininks, 1986; Lakin et al., 2008). Other authors collected demographic data, but only provided a descriptive analysis of their sample (Connis et al., 1979; Eastwood & Ecklund, 2008). In reviewing the literature, significant results were found in the areas of age, race, training level, and religiosity with regard to job satisfaction or burnout in residential agencies. Age was found to be positively correlated with job satisfaction (Bersani, 1983; Chou et al., 2010). However, Hauber and Bruininks (1986) found this was only true of extrinsic job satisfaction. When race was examined in another study, Native Americans and Latin Americans were found to be the highest in depersonalization and emotional exhaustion

with Native Americans more than three times higher in both categories (Lakin et al., 2008). African Americans were found to be the lowest in their sense of personal accomplishment (Lakin et al., 2008). In another study, number of years of education was found to be positively correlated with job satisfaction (Chou et al., 2010). However, Hauber and Bruininks (1986) found that high job satisfaction was associated with more education but less experience. Finally, though no specific religious groups were examined as possible predictors for burnout or job satisfaction, Bersani (1983) found that religiosity was positively correlated with job satisfaction.

Limitations of Job Satisfaction and Burnout Research

There are a number of limitations of previous research on job satisfaction and burnout. First, few of these studies are current; more research is needed to investigate these factors to account for possible shifts in the profession that may have a different impact in the current zeitgeist. However, the results from such studies are adequate approximations to inform this study.

Second, samples have tended to be restricted in some manner. Lakin et al. (2008), however, sampled participants from only one agency, which means the results cannot be generalized to the entire population. While Connis (1979) sampled participants from 26 agencies, participants came exclusively from group homes in Kansas, which means the results may not be generalizable to the overall population.

Finally, the mentioned studies addressed client turnover at residential agencies (Connis et al., 1979; Flannery & Walker, 2008; Lakin et al., 2008), but they may not be an accurate representation of turnover rates at all residential agencies. Future researchers could conduct a full

descriptive study using rigorous sampling methods to capture an accurate estimate of job satisfaction in the population.

Summary

In this chapter an overview of confidence in coping with client aggression and a discussion of burnout and job satisfaction were provided. Within the overview of confidence in coping with client aggression, categorization of staff assault, crisis intervention training models, and a rationale for the minimization of physical restraint were discussed. Within burnout and job satisfaction, components of both variables were discussed as well as intrinsic and extrinsic factors of each. Finally, demographic variables were also discussed.

Staff support appears to be a synthesis of connectedness with colleagues and connectedness with coworkers, which were factors of job satisfaction measured in the Work Cognition Inventory (WCI; Nimon et al., 2011). As one participant from the qualitative study from Braun (2010) noted, residential mental health professionals may feel more comfortable working in crisis-rich environments when they perceive they are being supported by managers and coworkers. However, McDonnell et al. (2008) studied staff support quantitatively using the Staff Support and Satisfaction Questionnaire (3SQ) and found no increase in staff support over a 10-month training period, which suggests that training does not necessarily increase staff support. That staff support is defined in a manner similar to the two "connectedness" factors within job satisfaction in addition to participants' report of the importance of this component in Braun (2010) may indicate that staff support and job satisfaction are related.

CHAPTER THREE

METHODOLOGY

In this chapter, the purpose statement, research questions, and hypotheses are reviewed. Additionally, a discussion is provided of procedures for sampling participants from the target population, design, and data collection and analysis procedures.

Purpose Statement

The purpose of this study was to better understand the demographic, environmental, and training factors are most closely related to job satisfaction and confidence in coping with client aggression. Demographic factors include race/ethnicity, gender, age, and years of clinical experience. Environmental factors include staff to client ratio, exposure to physical aggression, and exposure to verbal aggression. Training factors include presence of academic training and presence of agency training. The intention of identifying these factors is to help better understand the complexities of these relationships to provide strategies for future training, better quality if care, and lower employee turnover at residential agencies. Future research could be geared toward ascertaining how best to foster or accommodate these factors.

Research Design

In working toward the overall purpose to identify factors that predict which residential counselors will stay at a given residential agency and how they cope with client aggression, a non-experimental survey design was used. Two advantages of a non-experimental survey design are identified. First, the design is parsimonious; no treatments need to be implemented, which expands the eligibility of willing participants (Creswell, 2009). Secondly, since no treatments

need to be implemented, rapid data collection is possible, leaving more time for a robust analysis (Creswell, 2009).

Research Questions and Hypotheses

The overarching purpose of this study was to better understand how various factors are related to confidence in coping with client aggression and job satisfaction for counselors working in residential facilities. To evaluate these relationships, the following research questions and hypotheses were considered.

Research Question 1: Is there a relationship between counselor job satisfaction and confidence in coping with client aggression?

Hypothesis 1:

- There will be a significant relationship between job satisfaction and confidence in coping. Specifically, there will be a positive relationship between these two variables.

Research Question 2: How are demographic characteristics (race/ethnicity, gender, age, and months of clinical experience) related to job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 2a:

- There will be a significant main effect between race/ethnicity and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, counselors of color

will report significantly lower job satisfaction and confidence in coping with client aggression.

Hypothesis 2b:

- There will be a significant main effect between gender and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, female participants will report significantly lower confidence in coping with client aggression and significantly higher job satisfaction as compared to males.

Hypothesis 2c:

- There will be a significant interaction effect for age and years of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants and those with more years of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2d:

- There will be a significant main effect for age and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2e:

- There will be a significant main effect for months of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants with more years of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

Research Question 3: How are agency/environmental characteristics (staff to client ratio, exposure to physical aggression, and exposure to verbal aggression) related to job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 3a:

- There will be a significant interaction effect for staff to client ratio, exposure to physical aggression and exposure to verbal aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors at agencies with lower ratios who also experience greater exposure to aggression (physical, verbal) will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3b:

- There will be a significant main effect between staff/client ratio and job satisfaction and counselor confident in coping with client aggression. Specifically, counselors at agencies with lower ratios will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3c:

- There will be a significant main effect between exposure to physical aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater physical aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3d:

- There will be a significant main effect between exposure to verbal aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater verbal aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Research Question 4: Is there a significant relationship for presence of training (academic and agency) and job satisfaction and counselor confidence in coping with client aggression?

Hypothesis 4a:

- There will be a significant interaction effect for presence of training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic and/or agency settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training. Participants who have received academic training only will report lower job satisfaction and lower confidence in coping with client aggression than those who have also received agency training.

Hypothesis 4b:

- There will be a significant main effect for presence of academic training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

Hypothesis 4c:

- There will be a significant main effect for presence of agency training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training at agencies will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

Participants and Procedures

Participants in this study were mental health professionals at residential agencies. Agencies were identified through the American Association of Children's Residential Centers and through several states' departments of health. I sent an individualized letter of invitation and corresponding survey link by email to the directors of all of over 200 programs (see Appendix B). Directors of all of the programs were asked to distribute the survey link to their staff.

Before data collection began, I obtained Human Subjects approval from the Darden College of Education at Old Dominion University. Upon approval, I obtained informed consent from participants as part of the letter of invitation. Finally, a follow-up email was sent to the directors one week after the initial email to solicit participation.

Data were collected using Survey Monkey. Participation was incentivized; participants were informed that they would each be entered into a raffle to win 1 of 25 $25 gift cards.

Assuming a moderate effect size and Power at .80 at α =.05 (Cohen, 1992), a target sample size of 161 participants was needed to conduct the statistical tests. Thus, assuming a 44.4% response rate, as with the study by Martin and Daffern (2006), the survey package needed

to be completed by at least 363 individuals. Chapter 4 contains further information on participants.

Instrumentation

To address the above research questions, a number of instruments were used. Confidence in coping with client aggression was assessed using the Counselor Confidence in Coping with Patient Aggression (CCPAI; Thackrey, 1987, see Appendix C). Job satisfaction was assessed using the Work Cognition Inventory (WCI; Nimon et al., 2011, see Appendix D). Finally, demographic characteristics, agency/environmental characteristics, and training type was measured with a demographic questionnaire developed specifically for this study (see Appendix E).

Counselor Confidence in Coping with Aggression

Confidence in coping with client aggression was assessed using the CCPAI. A number of authors (Gately & Stabb, 2005; Thackrey, 1987) have used this variable to measure the effectiveness of crisis intervention training programs. Thackrey (1987) developed an instrument for evaluating counselor confidence in coping with client aggression and used it to measure the long-term and short-term outcomes of a crisis intervention training program, comparing results to control group results. The instrument includes 10 questions. However, the CCPAI appears to be the most reliable instrument that has been developed to measure this variable. Thackrey (1987) found a high internal consistency, $\alpha = .92$, when collecting data from a sample containing participants from various roles within the helping professions. Initially, Thackrey (1987) believed this construct was unidimensional, but Martin and Daffern (2006) divided confidence in

coping with client aggression into two constructs: 1) perception of safety, and 2) confidence in treating client aggression. The two factors appear to have a positive relationship with each other (Martin & Daffern, 2006).

Additionally, Martin and Daffern (2006) attempted to improve the CCPAI. To address the possibility that the CCPAI may not be comprehensive enough, Martin and Daffern (2006) modified to include two additional questions that were open-ended. However, in a study by Ching, Daffern, Martin, and Thomas (2010) the modified version of the CCPAI yielded lower reliability than the original version, $\alpha = .73$. Martin and Daffern (2006) used a mixed methods design, which was necessary to analyze results from the modified questionnaire. Therefore, the original version of the CCPAI, with better reliability, will be used. The data collection yielded a high response rate of 55% (69 responded out of 125). With a strong internal consistency, the CCPAI appears to be a reliable instrument and will be used to measure confidence in coping with aggression. However, no validity estimates are available for the CCPAI.

Work Cognition Inventory

The Work Cognition Inventory (WCI; Nimon et al., 2011) contains 40 items and addresses eight factors in job satisfaction. To develop this instrument, Nimon et al. (2011) used a three-step process:

1) The factor structure of the initial 66-item pool was assessed, selecting items that best fit each of the initial factors, confirming reliability. Reliability coefficients of factors ranged from 0.78 to 0.93 (Nimon et al., 2011).

2) A refined set of items was developed based on analysis in step 1, and reliability was confirmed again. Reliability coefficients of factors ranged from 0.855 to 0.951 (Nimon et al., 2011).
3) Finally, step 2 was repeated. Final reliability coefficients of factors ranged from 0.869 to 0.957 (Nimon et al., 2011).

Based on the rigorous development methods and strong results, the WCI and its factors appear to be reliable in measuring constructs within job satisfaction. However, no psychometric information was available on the validity of the WCI.

The factors within job satisfaction measured by the WCI include the following eight factors: autonomy, collaboration, connectedness with colleagues, connectedness with leader, distributive fairness (e.g., fair rewards for adequate work), feedback, growth, and meaningful work.

Demographic Questionnaire

The demographic characteristics that were measured included race/ethnicity, gender, age, and years of experience. Additionally, agency and environmental characteristics that were measured included staff/client ratio, exposure to physical aggression, and exposure to verbal aggression. Type of training received was assessed in terms of academic training, agency training, both or none. Academic training included the education counselors receive on the topic of crisis intervention as a part of her or his educational program. Agency training was defined as the crisis intervention training program given by the agency. Type of training received that included on the demographic sheet that can be found in Appendix D.

Data Analysis

A correlational analysis was performed for the first hypothesis of Research Question 1. For the other research questions, a multiple analysis of variance (MANOVA) was used to analyze data. A conceptual overview of MANOVA was provided. Additionally, the data analysis procedures for MANOVA in the context of this study were provided.

Overview of Analysis

As explained by Field (2009), studies in which the predictability of one categorical predictor variable is assessed with two or more continuous outcome variables. Additionally, the data must meet the assumptions of parametric tests. Importantly, performing a MANOVA in this study would be based on the assumption that job satisfaction and confidence in coping with client aggression are positively or negatively correlated. All three research questions of this study met the criteria for MANOVA.

Results from a MANOVA provide information that could not be provided by simply performing multiple univariate ANOVA tests. MANOVA analyses are capable of providing information on variates, which are combinations of variables. In the context of this study, a MANOVA was used to examine the variate combination of job satisfaction and confidence in coping with client aggression.

Data were analyzed using SPSS. To address the first research question, a four-way MANOVA was used. For the second and third research questions, a three-way and two-way MANOVA were used, respectively. The MANOVA tests provided omnibus results and determined if any significant MANOVAs are found.

Validity Threats

Although I continued to strive for rigor, potential validity threats to this study still existed. Internal validity refers to the researcher's ability to accurately draw trustworthy conclusions from the data as a result of the design (Creswell, 2009). External validity refers to the researcher's ability to generalize results from the sample of participants to the larger population as a result of the design (Creswell, 2009). Internal validity threats are defined as components of the study that effect the researcher's ability to draw trustworthy conclusions about the results (Creswell, 2009). Creswell noted that external validity threats occur when the researcher risks drawing conclusions about a given population when those conclusions should have been drawn about a different population. Below is an overview of internal and external validity threats and how I minimized them.

Internal Validity Threats

When testing the efficacy of crisis intervention training, I ideally would have preferred to measure the effects of crisis intervention training programs on job satisfaction and confidence in coping with client aggression across time. In future research, trend analyses could be used to assess job satisfaction and confidence in coping with client aggression before training, one week after training, and 18 months after training, as Thackrey (1987) did when developing the CCPAI. Therefore, results did not give estimates of the efficacy of crisis intervention training over time. Additionally, only the perceptions of participants were measured rather than observable behavior.

Another internal validity threat is that no psychometric data were available for the instruments used to measure demographic characteristics, agency/environmental characteristics, and type of training received, because the survey was developed specifically for this study. Some information may not have been readily available for participant recall. For instance, staff-client ratio may have been difficult for participants to report on if the number of clients they work with each day varies. Additionally, no psychometric measures of validity are available for the CCPAI or the WCI, and therefore, the results may not be totally accurate reflections of the variables. Internal validity threats are inherent in survey designs. One possible threat is social desirability; participants may have responded to survey questions in a way that they believe others find others find desirability. Another inherent bias to survey research is selection bias; the samples only included those who directors distributed the survey to, those who opted to take it, and those agencies that were sent requests for participation. There may have been some unknown variance associated with those factors that impacted the results. Finally, internal validity threats are inherent in non-experimental designs. Specifically, non-experimental designs are characterized by a lack of control over the independent variables. The disadvantage of this lack of control over independent variables in this study was that no causal conclusions can be drawn from the data.

External Validity Threats

Three threats to external validity were identified, and attempts were made to minimize them. First, since not all residential mental health counselors work in settings where violence is especially common, data may have been implicitly more representative of the experience of those who have been exposed to less violence. Therefore, the results may not have been as

generalizable to those who work in settings where violence is more common. To minimize this threat to generalizability, participants were sampled from agencies who work specifically with aggressive client populations, which will maximize the experience of those who have been exposed to more client aggression. The second threat to external validity is the possibility that respondents may have different attributes than non-respondents, which may have incorrectly represented the population. Accordingly, participation was incentivized as noted earlier to decrease the chances of misrepresentation. Finally, the third external validity threat is inherent in non-experimental design. Causal connections cannot be drawn when the research has no control over independent variables (Creswell, 2009). While this limitation cannot be prevented or minimized with a non-experimental design, I was careful not to use language that implied causality when reporting results.

CHAPTER FOUR

RESULTS

The overarching purpose of this study was to better understand how various factors relate to confidence in coping with client aggression and job satisfaction for counselors working in residential facilities. Four research questions were proposed, and 12 hypotheses were tested. In this chapter, descriptive statistics of the instruments and of the demographic characteristics of the sample are included. Further, findings for respective research questions are provided.

Participants

Most data were collected electronically using *SurveyMonkey.com.* However, 42 participants from a residential agency in Wisconsin completed hard copies of the survey. The director of the agency mailed them to me. The rest of the participants completed the survey electronically. Residential agencies were initially identified from a list posted on the American Association of Children's Residential Centers website, which lists 127 agencies from all 48 of the continental United States. I searched the worldwide web for each agency and found contact information for the directors of each residential program. Directors were each sent a standardized email explaining the study and requesting participation. Those who accepted the request forwarded the email to their residential counselors. Next, I searched the Virginia Department of Behavioral Health and Developmental Services for other residential agencies (458 agencies were listed) and used the same approach that was used when searching American Association of Children's Residential Centers website. A similar procedure was followed for New Jersey,

Connecticut, and New York, which together had hundreds of agencies listed. I also sent email requests to colleagues who were working at residential agencies at the time to forward the survey link to colleagues who fit the criteria. Because of time constraints and low response rates, I also posted a link on CESNET, an online list serve for counselor educators, requesting members of the list-serve forward the survey link to colleagues who fit the criteria. I also posted on Facebook a request, visible to my "friends" list, for friends to forward the survey link to people they knew who fit the criteria.

Overall, 146 participants responded to survey questions. Though no descriptive study could be found in the literature that provided a reliable estimate of the number of direct care workers at residential agencies (as this title is defined in this study), one source estimates that there are 817,000 "personal care aides" employed in group homes and residential settings in the United States (The Scan Foundation, 2011). Therefore, this sample of 146 participants may not accurately represent the overall population.

Out of those 146 participants, 42 worked at a residential agency in Wisconsin. The other 104 were employed at residential agencies in Virginia, New Jersey, Connecticut, New York, and Illinois. Participants may be from other states as well. Considering requests for participants were sent to hundreds of agencies, these 146 participants may seem low. One explanation of this could be the length of the surveys; the WCI alone is 40 items.

Participants provided demographic information, which included gender, age, race/ethnicity, months of experience, exposure to physical and psychological aggression, client characteristics, staff-client ratio, presence of training, and credentials. The limited sample created

difficulty in testing for systematic differences among agencies. Particularly, it is not possible to see the descriptive statistics of each demographic variable by agency to see if agencies were similar demographically. Out of the 144 participants who reported their gender, 38 identified as male (26.4%), 106 as female (73.6%), and 0 as transgender. With respect to age, the mean age for the 142 participants was 34.54 years (*SD*= 11.09, *R*= 19-63 years). Age was positively skewed (.954) and slightly leptokurtic (.120). Of the 144 participants who indicated their race, 11 identified as African-American (7.6%), five as Asian / Pacific Islander (3.5%), 118 as White (81.9%), six as Latina/Latino (4.2%), and four identified as multiracial (2.8%).

Clinical experience at the current residential facility for participants (*n*= 146) was measured in months. The mean months of experience for those reported was 71.69 (*SD*= 81.657, *R*= 0-393 months). The data were positively skewed (1.803) and leptokurtic (2.975) (see Table 1). There were 39 participants (26.7%) who indicated they had a year or less experience. Five participants (5.5%) noted they had one month or less of experience. In the higher range of responses, 36 participants (24%) noted they had 96 months of experience or more. Again, the highest number of months was 393, this score may not be an outlier, as the scores in this highest 24% were spurious but steady across the distribution.

Table 1

Frequency Distribution for Months of Clinical Experience

Months	Frequency	Percent	Cumulative Percent
.00	3	2.1	2.1
1.00	2	1.4	3.4
2.00	1	.7	4.1
3.00	2	1.4	5.5

4.00*	1	.7	6.2
5.00	4	2.7	8.9
6.00	3	2.1	11.0
7.00	4	2.7	13.7
8.00	5	3.4	17.1
9.00	5	3.4	20.5
10.00	1	.7	21.2
12.00	8	5.5	26.7
13.00	1	.7	27.4
14.00	1	.7	28.1
16.00	1	.7	28.8
18.00	4	2.7	31.5
19.00	1	.7	32.2
20.00	1	.7	32.9
22.00	1	.7	33.6
24.00	5	3.4	37.0
25.00	2	1.4	38.4
26.00	2	1.4	39.7
27.00	2	1.4	41.1
31.00	1	.7	41.8
34.00	1	.7	42.5
36.00	4	2.7	45.2
38.00	2	1.4	46.6
42.00	6	4.1	50.7
44.00	1	.7	51.4
45.00	1	.7	52.1
48.00	2	1.4	53.4
49.00	1	.7	54.1
51.00	2	1.4	55.5
53.00	1	.7	56.2
54.00	1	.7	56.8
58.00	2	1.4	58.2
60.00	6	4.1	62.3
61.00	2	1.4	63.7
65.00	1	.7	64.4
69.00	1	.7	65.1

70.00	1	.7	65.8
72.00	3	2.1	67.8
74.00	1	.7	68.5
76.00	2	1.4	69.9
84.00	3	2.1	71.9
86.00	1	.7	72.6
90.00	1	.7	73.3
92.00	1	.7	74.0
96.00	3	2.1	76.0
102.00	1	.7	76.7
108.00	1	.7	77.4
109.00	1	.7	78.1
110.00	2	1.4	79.5
114.00	1	.7	80.1
117.00	1	.7	80.8
120.00	1	.7	81.5
121.00	1	.7	82.2
124.00	1	.7	82.9
126.00	1	.7	83.6
132.00	1	.7	84.2
145.00	1	.7	84.9
147.00	1	.7	85.6
156.00	2	1.4	87.0
161.00	1	.7	87.7
168.00	1	.7	88.4
169.00	1	.7	89.0
180.00	2	1.4	90.4
196.00	1	.7	91.1
212.00	1	.7	91.8
228.00	1	.7	92.5
232.00	1	.7	93.2
240.00	2	1.4	94.5
250.00	1	.7	95.2
274.00	1	.7	95.9
283.00	1	.7	96.6
306.00	1	.7	97.3

323.00	1	.7	97.9
336.00	1	.7	98.6
344.00	1	.7	99.3
393.00	1	.7	100.0

*Roughly the mean Connis et al. (1979) found in their sample of residential counselors.

Participants reported whether they had been exposed to physical aggression or psychological aggression. Out of 144 participants, 87 (60.4%) noted they had been exposed to physical aggression. Additionally, 124 (86.1%) participants indicated they had been exposed to psychological aggression.

Participants also reported the age range and diagnoses of their clients. For age, they were asked to only select the one age range that represents their primary clientele. The disadvantage of this is that there can be a large range of client behaviors and issues within each age rage. People 12 years of age and under are considered children; a six-year-old and a 12-year-old may be at different stages of cognitive development. Adolescents, for the purposes of this study, are between 13 and 21 years of age; a 13-year-old may still be in middle school, while a 21-year-old maybe preparing to graduate from college. The final age group in this study is the adult age group, which is comprised of people 22 years of age and over. People in their mid-twenties may only be beginning to create their identities. At the same time, people in their sixties or seventies fall into this group, and they may have already had a career and retired. With these various developmental milestones in mind, one may be able to imagine the varied issues one might encounter within each age group. Statistically, this may also cause great variance for clinicians' experiences in working with this population. Out of the 143 who responded to this item, 16

participants (11.2%) indicated they work with children (12 years of age and under), 72 participants (50.4%) with adolescents (13-21 years of age), and 55 participants (38.5%) with adults (22 years and over). Participants (n = 142) were also asked to report the diagnoses that describe their clients. This item allowed participants to check multiple boxes to indicate that they served multiple populations. There were 69 participants who noted their clients were diagnosed with a developmental disability, and 78 reported their clients' presenting concerns were defiance and/or physical aggression. There were 66 participants who indicated that their clients presented with sexual abuse/assault issues and 104 participants who noted that their clients' diagnoses included mental illness. Finally, 18 other participants reported their clients' diagnoses as "other / not specified."

With respect to staff to client ratio, participants indicated the number of coworkers they typically work with and the number of clients they serve on an average shift. To create the ratio score, one was added to the value each participant reported for "coworkers" (to include themselves in the value). Next, that value was then divided by the "clients" value noted by each participant. The mean staff to client ratio was 0.985 (SD= 81.657, R= .08- 7.00). As shown in Table 2, the data were positively skewed (2.795) and leptokurtic (9.432).

Table 2

Frequency Distribution for Staff to Client Ratio

Ratio	Frequency	Percent	Cumulative Percent
.08	1	.7	.7
.10	2	1.4	2.1

.12	1	.7	2.9
.14	1	.7	3.6
.17	1	.7	4.3
.18	1	.7	5.0
.19	1	.7	5.7
.20	2	1.4	7.1
.23	1	.7	7.9
.25	5	3.4	11.4
.26	2	1.4	12.9
.27	1	.7	13.6
.28	1	.7	14.3
.30	4	2.7	17.1
.31	1	.7	17.9
.32	1	.7	18.6
.33	7	4.8	23.6
.36	1	.7	24.3
.36	2	1.4	25.7
.37	2	1.4	27.1
.37	1	.7	27.9
.38	4	2.7	30.7
.38	1	.7	31.4
.40	7	4.8	36.4
.43	2	1.4	37.9
.47	2	1.4	39.3
.50	9	6.2	45.7
.53	1	.7	46.4
.55	1	.7	47.1
.58	2	1.4	48.6
.60	5	3.4	52.1
.62	1	.7	52.9
.63	1	.7	53.6
.67	5	3.4	57.1
.69	1	.7	57.9
.70	2	1.4	59.3
.71	1	.7	60.0
.73	1	.7	60.7
.73	1	.7	61.4

.75	3	2.1	63.6
.80	6	4.1	67.9
.83	2	1.4	69.3
.89	1	.7	70.0
.92	1	.7	70.7
1.00	4	2.7	73.6
1.13	1	.7	74.3
1.14	1	.7	75.0
1.17	1	.7	75.7
1.20	2	1.4	77.1
1.22	1	.7	77.9
1.30	1	.7	78.6
1.40	1	.7	79.3
1.50	5	3.4	82.9
1.60	1	.7	83.6
1.67	3	2.1	85.7
1.80	1	.7	86.4
1.83	1	.7	87.1
2.00	2	1.4	88.6
2.20	1	.7	89.3
2.33	1	.7	90.0
2.36	1	.7	90.7
2.50	2	1.4	92.1
2.60	1	.7	92.9
3.00	3	2.1	95.0
3.10	1	.7	95.7
3.57	1	.7	96.4
3.67	1	.7	97.1
4.67	1	.7	97.9
5.50	2	1.4	99.3
7.00	1	.7	100.0

Participants reported that they had either received crisis intervention training from their agency, or received college credit for a course specifically focused on crisis intervention; any

reported training was coded as presence of training. Participants indicated the number of college credit hours they received from a course specifically geared toward crisis intervention. The mean number of credit hours was 4.300 (*SD*= 9.721, *R*= .00- 55.00), and the data were positively skewed (3.180) and leptokurtic (10.130). This great amount of skewness could be accounted for by the outlier value of 55. In sum, the majority of the sample received some type of training in crisis intervention (n = 134), and only 10 participants declared that they had received no training in crisis intervention. A majority (87%) of participants (n = 127) said they had received some crisis intervention training from their agency, and 17 reported that they did not. More than half (n = 78) indicated they had received Nonviolent Crisis Intervention (NCI) training, and more than a third (n = 51) noted they had received a crisis intervention training program that was specific to their agency. More than a quarter of participants (n = 41) reported they had received Therapeutic Crisis Intervention (TCI) training. Finally, a small percentage of participants (n = 15) noted they had received a crisis intervention training program that was not listed on the instrument. Roughly half of the participants (n = 72) noted they had taken a college course that addressed crisis intervention but was not a standalone course in crisis intervention and 69 participants reported they had not.

Descriptive Statistics for Instruments

Participants responded to the Work Cognition Inventory (WCI; Nimon et al., 2011) and the Counselor Confidence in Coping with Patient Aggression Inventory (CCPAI; Thackrey 1987). The WCI measures job satisfaction and contains 40 items, with a scoring range of 1 to 6 (i.e., higher scores indicating greater job satisfaction). For a participant's overall score, a mean

score of all of that participant's responses to the WCI was calculated to represent that participant's overall job satisfaction. The overall mean score was 4.33 (*SD*= .94), with scores ranging from 1.73 to 6.00. The data were slightly platykurtic (-.271) and negatively skewed (-.572).

There were 104 females who completed the WCI with scores ranging from 2.00 to 5.93 and a mean score of 4.335 (*SD* = .933). These data for females were negatively skewed (-.539) and platykurtic (-.415). There were 35 males who completed the WCI with scores ranging from 1.73 to 6.00 and a mean score of 4.331 (*SD* = .967). These data for males were negatively skewed (-.691) and slightly leptokurtic (-.295).

There were 10 people who identified as African-American/Black who completed the WCI with scores ranging from 3.05 to 6.000 and a mean score of 4.500 (*SD* = 1.034). These data were slightly negatively skewed (-.204) and platykurtic (-1.169). There were 5 people who identified as Asian / Pacific Islander who completed the WCI with scores ranging from 3.58 to 5.23 and a mean score of 4.30 (*SD* = .609). These data were slightly negatively skewed (-.189) and leptokurtic (.542). There were 114 people who identified as White/Caucasian who completed the WCI with scores ranging from 1.733 to 5.88 and a mean score of 4.356 (*SD* = .904). These data were negatively skewed (-.620) and platykurtic (-.105). There were 6 people who identified as White/Caucasian who completed the WCI with scores ranging from 2.30 to 4.88 and a mean score of 3.508 (*SD* = 1.232). These data were slightly positively skewed (.046) and platykurtic (-3.146). There were 4 people who identified as Multiracial who completed the WCI with scores ranging from 2.60 to 5.93 and a mean score of 4.143 (*SD* = 1.388). These data

were negatively skewed (-.601) and platykurtic (-.908). Finally, the internal reliability of the WCI was strong for this data set (α = .97).

The CCPAI was used to measure confidence in coping with client aggression and contained 10 items, with a scoring range of 1 to 11 (higher scores indicating higher confidence in coping). For a participant's overall score, a mean score of all of that participant's responses the CCPAI was calculated to represent that participant's overall confidence in coping with client aggression. The overall mean score was 7.81 (*SD*= 2.175), with scores ranging from 1.30 to 10.90. The data were slightly leptokurtic (.315) and negatively skewed (-.869).

There were 106 females who completed the CCPAI with scores ranging from 1.30 to 10.90 and a mean score of 7.467 (*SD* = 2.232). These data were negatively skewed (-.693) and slightly platykurtic (-.031). There were 37 males who completed the CCPAI with scores ranging from 2.90 to 10.90 and a mean score of 8.778 (*SD* = 1.719). These data were negatively skewed (-1.569) and platykurtic (3.003).

There were11 people who identified as African-American/Black who completed the CCPAI with scores ranging from 5.20 to 10.90 and a mean score of 8.546 (*SD* = 1.770). These data were negatively skewed (-.595) and platykurtic (-.301). There were 5 people who identified as Asian / Pacific Islander who completed the CCPAI with scores ranging from 3.00 to 10.00 and a mean score of 8.100 (*SD* = 2.888). These data were negatively skewed (-2.096) and leptokurtic (4.497). There were117 people who identified as White/Caucasian who completed the CCPAI with scores ranging from 1.30 to 10.90 and a mean score of 7.826 (*SD* = 2.144). These data were negatively skewed (-.845) and leptokurtic (.407). There were 6 people who identified as

Latina/Latino who completed the CCPAI with scores ranging from 2.40 to 9.63 and a mean score of 6.004 (SD = 3.013). These data were slightly negatively skewed (-.072) and platykurtic (-2.035). There were 4 people who identified as Multiracial who completed the CCPAI with scores ranging from 5.80 to 9.10 and a mean score of 7.550 (SD = 1.520). These data were negatively skewed (-.228) and platykurtic (-3.329). Finally, the internal reliability of the CCPAI was strong for this data set (α = .954).

Job Satisfaction and Confidence in Coping

Research Question 1 was: Is there a relationship between counselor job satisfaction and confidence in coping with client aggression? For this research question, I tested the following hypothesis:

Hypothesis 1:

- There will be a significant relationship between job satisfaction and confidence in coping. Specifically, there will be a positive relationship between these two variables.

For the above hypothesis, the results indicated a significant positive relationship between confidence in coping with client aggression and job satisfaction, $r = .359, p < .001, \eta^2 = .13$.

Demographic Variables, Job Satisfaction and Confidence in Coping

Research question 2 was: How are demographic characteristics (race/ethnicity, gender, age, and months of clinical experience) related to job satisfaction and counselor confidence in coping with client aggression? For this research question, five hypotheses were tested using a multivariate analysis of variance (MANOVA). These hypotheses were as follows:

Hypothesis 2a:

- There will be a significant main effect between race/ethnicity and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, counselors of color will report significantly lower job satisfaction and confidence in coping with client aggression.

Hypothesis 2b:

- There will be a significant main effect between gender and job satisfaction as well as counselor confidence in coping with client aggression. Specifically, female participants will report significantly lower confidence in coping with client aggression and significantly higher job satisfaction as compared to males.

Hypothesis 2c:

- There will be a significant interaction effect for age and years of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants and those with more years of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2d:

- There will be a significant main effect for age and job satisfaction and counselor confidence in coping with client aggression. Specifically, older participants in residential mental health will report greater coping with client aggression and higher job satisfaction.

Hypothesis 2e:

- There will be a significant main effect for months of clinical experience and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants with more months of experience in residential mental health will report greater coping with client aggression and higher job satisfaction.

For the first hypothesis, the results did not indicate a significant main effect between race/ethnicity and job satisfaction $F_{(1, 138)} = 11.430, p = .077, \eta^2 = .851, P = .456$. The results also did not support the hypothesis of a significant main effect between race/ethnicity and counselor confidence in coping with client aggression, $F_{(1, 138)} = .367, p = .606, \eta^2 = .155, P = .067$. The results with respect to the second hypothesis did not indicate a significant main effect between gender and job satisfaction, $F_{(1, 138)} = 1.088, p = .406, \eta^2 = .352, P = .099$. The results also did not support that there would be a significant main effect between gender and counselor confidence in coping with client aggression, $F_{(1, 138)} = 10.804, p = .081, \eta^2 = .844, P = .439$.

For the third hypothesis for this research question, results did not indicate a significant interaction effect for age and years of clinical experience and job satisfaction ($F_{(1, 138)} = 1.197, p = .485, \eta^2 = .642, P = .106$) or for age and years of clinical experience and counselor confidence in coping with client aggression ($F_{(1, 138)} = 4.810, p = .177, \eta^2 = .878, P = .255$).

For the fourth hypothesis, results did not indicate a significant main effect for age and job satisfaction ($F_{(1, 138)} = .238, p = .971, \eta^2 = .714, P = .061$) or confidence in coping with client aggression ($F_{(1, 138)} = 8.047, p = .116, \eta^2 = .988, P = .371$).

For the fifth hypothesis, results did not indicate a significant main effect for age and job satisfaction ($F_{(1, 138)} = .271, p = .968, \eta^2 = .876, P = .063$) or confidence in coping with client aggression ($F_{(1, 138)} = 7.382, p = .126, \eta^2 = .988, P = .371$).

Although findings did not indicate significant main effects for race/ethnicity, gender, age, and months of clinical experience, effect size estimates for statistical tests for this research question indicate in several cases moderate and high effect sizes. Specifically, there were high effect size estimates for gender, age, and years of experience in relation to counselor confidence in coping with client aggression. For the job satisfaction variable, race/ethnicity demonstrated a high effect. Moderate effect sizes were found for age and years of experience with respect to job satisfaction. These values, coupled with inspection of statistical power, indicate that larger sample sizes could have shown statistical significance.

Agency Characteristics, Job Satisfaction, and Confidence in Coping with Aggression

Research Question 3 was: How are agency/environmental characteristics (staff to client ratio, exposure to physical aggression, and exposure to verbal aggression) related to job satisfaction and counselor confidence in coping with client aggression? For this research question, three hypotheses were tested using a multivariate analysis of variance (MANOVA). These hypotheses were as follows:

Hypothesis 3a:

- There will be a significant main effect between staff/client ratio and job satisfaction and counselor confident in coping with client aggression. Specifically, counselors at agencies

with lower ratios will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3b:

- There will be a significant main effect between exposure to physical aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater physical aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

Hypothesis 3c:

- There will be a significant main effect between exposure to verbal aggression and job satisfaction and counselor confidence in coping with client aggression. Specifically, counselors who experience greater verbal aggression will report significantly lower job satisfaction and counselor confidence in coping with client aggression.

The results did not support the first hypothesis, a significant main effect between staff/client ratio and job satisfaction, $F_{(1, 138)} = 1.064, p = .409, \eta^2 = .520, P = .871$. The results also did not indicate a significant main effect between staff/client ratio and counselor confidence in coping with client aggression, $F_{(1, 138)} = .927, p = .692, \eta^2 = .485, P = .800$. Results indicate a moderate effect size between staff/client ratio and job satisfaction and approach a moderate effect size for counselor confidence in coping with client aggression.

For the second hypothesis, there was not a significant main effect between exposure to physical aggression and job satisfaction, $F_{(1, 138)} = 3.151, p = .081, \eta^2 = .054, P = .415$. The

results also did not show a significant main effect between exposure to physical aggression and counselor confidence in coping with client aggression, $F_{(1, 138)} = .004, p = .949, \eta^2 = .000, P = .050$.

The results did not support the final hypothesis that there would be a significant main effect between exposure to verbal aggression and job satisfaction, $F_{(1, 138)} = .225, p = .637, \eta^2 = .004, P = .075$. However, the results supported the hypothesis that there would be a significant main effect between exposure to verbal aggression and counselor confidence in coping with client aggression, $F_{(1, 138)} = 5.019, p = .029, \eta^2 = .084, P = .595$. However, the effect size estimate for exposure to verbal aggression and counselor confidence in coping with client aggression was negligible; findings should be interpreted with caution.

Training, Job Satisfaction, and Confidence in Coping with Aggression

Research Question 4 was: Is there a significant relationship for presence of training (academic and agency) and job satisfaction and counselor confidence in coping with client aggression? For this research question, three hypotheses were tested using a multivariate analysis of variance (MANOVA). These hypotheses were as follows:

Hypothesis 4a:

- There will be a significant interaction effect for presence of training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic and/or agency settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training. Participants who have received academic training only will report

lower job satisfaction and lower confidence in coping with client aggression than those who have also received agency training.

Hypothesis 4b:

- There will be a significant main effect for presence of academic training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training in academic settings will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

Hypothesis 4c:

- There will be a significant main effect for presence of agency training and job satisfaction and counselor confidence in coping with client aggression. Specifically, participants who report some training at agencies will report significantly higher job satisfaction and confidence in coping with client aggression than those who do not report any type of training.

The results did not support the hypothesis that there would be a significant interaction effect for presence of training and job satisfaction, $F_{(1, 138)} = .997$, $p = .431$, $\eta^2 = .052$, $P = .380$, and counselor confidence in coping with client aggression, $F_{(1, 138)} = .564$, $p = .758$, $\eta^2 = .030$, $P = .218$. The results supported the hypothesis that there would be a significant main effect for presence of academic training and job satisfaction, $F_{(1, 138)} = 2.287$, $p = .009$, $\eta^2 = .227$, $P = .962$. Additionally, this finding indicated a small effect between the two variables. However, the

results did not support the hypothesis that there would be a significant main effect for presence of academic training and counselor confidence in coping with client aggression, $F_{(1, 138)} = 1.094$, $p = .372$, $\eta^2 = .123$, $P = .645$.

The results supported the hypothesis that there would be a significant main effect for presence of agency training and job satisfaction, $F_{(1, 138)} = 3.160$, $p = .046$, $\eta^2 = .055$, $P = .595$, and counselor confidence in coping with client aggression, $F_{(1, 138)} = 12.667$, $p < .001$, $\eta^2 = .189$, $P = .996$. However, effect size estimates related to this hypothesis were negligible and findings should be interpreted with caution.

Summary

Descriptive statistics were provided for job satisfaction, confidence in coping with client aggression, and demographic variables, including individual and agency characteristics. Results for 12 hypotheses, spanning four research questions, were presented. There was a significant relationship between job satisfaction and confidence in coping with client aggression. Additionally, presence of training was found to have a positive relationship with job satisfaction and confidence in coping with client aggression, and exposure to verbal aggression is associated with coping. For a number of the tests, a low power and high effect size were found. Particularly, in testing age, months of experience, gender, and race high effect sizes but low power was found, which may indicate that significance may have been found if a higher sample size were achieved. Finally, since the WCI yielded suspiciously high reliability, a different instrument or a better validated version of the WCI may have provided stronger results for job satisfaction.

CHAPTER FIVE

DISCUSSION

The overarching purpose of this study was to better understand how various factors are related to confidence in coping with client aggression and job satisfaction for counselors working in residential facilities. To evaluate these relationships, 11 hypotheses were tested. Significant results were found for three of those hypotheses, and partial support was found for one of the hypotheses. Specifically, those who reported they had been exposed to verbal aggression reported significantly higher confidence in coping with client aggression. Additionally, those who reported they had received agency training in crisis intervention techniques also reported significantly higher confidence in coping with client aggression and higher job satisfaction

This chapter will provide an interpretation of the results of this study. The context of prior literature will be considered. The possible meanings of the results will be discussed in addition to implications for practice and training. A discussion of the possible impacts of limitations and delimitations on the study will also be addressed. Finally, recommendations for future research are provided.

Job Satisfaction and Confidence in Coping with Client Aggression

In this study, job satisfaction had a positive relationship with confidence in coping with client aggression. Though no causal conclusions can be drawn from this result, it is reasonable to say that those who had higher confidence in coping with client aggression also had higher job satisfaction. Therefore, job satisfaction and confidence in coping with client aggression could be used to predict one another. Although no studies were found in prior literature that specifically

investigated these variables together, perception of safety, a possible factor of job satisfaction, was found to have a positive correlation with confidence in treating aggressive clients (Martin & Daffern, 2006).

Individual Demographics

Males and people of color were underrepresented in the data, which may have affected statistical analyses. Specifically, 106 participants out of 146 (73.6%) were female, and 118 participants (81.9%) were White. A significant main effect was not found between race/ethnicity and job satisfaction, which conflicts with the study by Lakin et al. (2008) who found that Native American and African-American residential counselors experienced lower job satisfaction. Again, this discrepancy may be due to the imbalance of racial/ethnic groups in this study. Similarly, a significant main effect was also not found between race/ethnicity and confidence in coping with client aggression. No studies were found that measured the effects of race/ethnicity with confidence in coping with aggression to compare this result to, which means it is difficult to confidently interpret this result considering the imbalance of racial/ethnic groups in the sample of the current sample.

Gender had no main effect with confidence in coping with aggression or job satisfaction in this study. Similarly, Winstanley and Hales (2008) found no gender difference in frequency of client assault on staff. Although Martin and Daffern (2006) found that females reported significantly higher confidence in their colleagues' competence in managing critical incidents involving aggression. Still, little empirical evidence suggests a significant difference in confidence in coping with client aggression exists between gender groups.

Flannery and Walker (2008) also found that females and males experienced client assault in roughly the same frequency. However, Flannery and Walker found that males experienced physical assault more often. If there is no difference in confidence in coping with client aggression or frequency of client assault between gender groups, it may also be reasonable to suspect that confidence in coping with client aggression and frequency of client assault are related. This study partially supports this notion; exposure to verbal aggression had a main effect on confidence in coping with client aggression. Specifically, those who had been exposed to verbal aggression reported higher confidence in coping with aggression.

In this study, there were no gender differences in job satisfaction. However, the large effect size ($\eta^2 = .851$) suggests that if the sample size were higher, differences may have been discovered. Therefore, these results were practically meaningful; the low power ($\alpha = .456$) suggests that if a higher sample sized had been achieved, a significant difference may have been found. No prior literature was found that addressed the relationship between gender and job satisfaction at residential agencies. Further research could be done to further examine whether or not a difference in job satisfaction exists between gender groups at residential agencies.

Winstanley and Hales (2008) found no significance between years of clinical experience and frequency of client assault. In this study, no interaction effect was found between age and experience with regard to confidence in coping with client aggression. Though it might be reasonable to believe that more experience may increase confidence, the possible effect of age may negate the presumed positive effect of experience. For example, as a clinician's age increases, she or he may be more uncomfortable with the possibility of physical assault, despite a

possible increased comfort with verbal aggression and increased confidence in being able to intervene psychologically. Additionally, as physical restraint is a common practice at many residential facilities, as age increases, a discomfort with physical interventions may increase. This hypothesis is reasonable in the context of Thackrey's (1987) original study using the CCPAI in which age had no effect on confidence in coping with client aggression. Martin and Daffern (2006) found similar results using a modified version of the CCPAI.

This study found no interaction effect between age and months of clinical experience with regard to job satisfaction. In addition, there were no main effects for these two variables with job satisfaction and confidence in coping with client aggression. This may come as a surprise as prior literature suggests there is a positive correlation between age and job satisfaction (Bersani, 1983; Chou et al., 2010). Therefore, it is possible that months of clinical experience has a negative relationship with job satisfaction. Hauber and Bruininks (1986) found age was related only to extrinsic job satisfaction (external rewards such as pay, benefits, etc.); it is reasonable to suspect that increased experience may increase one's demand for compensation. As a residential counselor's experience increases, they may believe she or he have more value than her or his agency pays, and she or he may become increasingly dissatisfied with pay. These hypotheses need to be tested empirically.

Agency Demographics

In this study, the combined effects of staff-to-client ratio and exposure to aggression were not significantly associated with job satisfaction or confidence in coping with client aggression. However, staff-to-client ratio, though no significant main effects were found with regard to job

satisfaction or confidence in coping with client aggression, moderate effect sizes were found (η^2 = .520, and η^2 = .485, respectively), which may indicate that significant main effects may have been found with a higher sample size. This could also be a result of low variability in the sample for staff-to-client ratio. Specifically, most of the data points were close to the mean, which was approximately a one-to-one ratio.

Gately and Stabb (2005) attempted to create a connection between confidence in coping with client aggression and exposure to client violence. Whereas Gately and Stabb used a comprehensive self-report instrument to measure exposure to aggression, I of this study simply asked participants to report whether or not they had been exposed to either physical or verbal aggression from clients. The results of this study suggest that exposure to physical aggression had no main effect on job satisfaction or confidence in coping with aggression. The lack of a main effect on confidence in coping may be explained by the possibility that exposure to physical aggression means more practice in dealing with it while at the same time somewhat weakening confidence through traumatization. Future research could empirically investigate this hypothesis. The lack of a main effect of exposure to physical aggression on job satisfaction could be explained by the way the data were collected. Because participants responded with either "yes" or "no," two groups were created rather than a continuum of varied levels of exposure to physical aggression. As exposure to physical aggression can be seen as an agency characteristic rather than an individual characteristic, participants were essentially categorized as being a part of either (1) an agency where physical aggression is present, or (2) an agency where it is not. Therefore, despite whatever hazards might contribute to any burnout associated with a residential

position at an agency where physical aggression is present, there may also be components of these agencies that contribute highly to job satisfaction to balance these out. For instance, these agencies may serve a population that gives counselors a sense of meaning. Conversely, these agencies may simply pay workers more to give them more incentive to stay with their agency. Although exposure to physical aggression was shown to have little if any impact on job satisfaction and confidence in coping with client aggression, exposure to verbal aggression had a positive main effect with confidence in coping with client aggression. One possible explanation of this result is that those with experience with verbal aggression in a clinical setting have more practice addressing it and de-escalating clients than those who have not been exposed to verbal aggression. In settings where aggression is not common, clinicians may feel anxiety about any level of aggression. Future research could examine more deeply the differences between residential agencies where aggression is common and those where it is not.

Training

The combined effects of academic training and agency training in crisis intervention were not found to impact job satisfaction or confidence in coping with client aggression in this study. With no studies to compare the results of this particular research question to, it may be difficult to corroborate these results. However, the effect sizes were low enough ($\eta^2 = .052$ and $\eta^2 = .030$) and the alpha levels were high enough ($p = .431$ and $p = .758$ respectively) that it is reasonable to say that the result found in this study is probably correct within the bounds of generalizability.

However, the results of this study indicate that the individual main effects had an impact. Particularly, those who had received crisis intervention training at their agency had both higher

job satisfaction and higher confidence in coping with client aggression. Consistent with the results of this study, Calabro, Mackey, and Williams (2002) and Temple et al. (2007) found that NCI training helped increase confidence in coping with client aggression. Other researchers found that agency-specific programs were related to increased confidence in coping (Killick & Allen 2005; Lowe et al., 2007). Generally, authors who studied crisis intervention programs have found positive results in reduction of physical restraint and/or confidence in coping with client aggression (Allen & Tynan, 2000; Flannery & Walker, 2008; Gately & Stabb, 2005; Jonikas et al., 2004; Martin & Daffern, 2006; Nau, Dassen, Needham, & Halfens, 2011; Nau, Halfens, Needham, & Dassen, 2010; Needham et al., 2005; Nunno et al., 2003; Thackrey, 1987). This study indicates that agency crisis intervention training had a positive main effect on job satisfaction. However, no studies were found in the prior literature that can corroborate these results. If residential counselors get the sense that their agency is making an effort to prepare them for critical incidents, they may develop a stronger sense of loyalty to the agency. Future researchers could verify this by using the Work Cognition Inventory (WCI; Nimon et al, 2011) using only the items under the "Connectedness with Leaders" variable.

Further, in this study, those who had taken a college course specifically in crisis intervention had higher job satisfaction, but not confidence in coping with client aggression. Gately and Stabb (2005) found that time spent in a graduate psychology program had a direct correlation with confidence in coping with client aggression, which is contrary to the results of this study. However, in another study, number of years of education was found to be positively correlated with job satisfaction (Chou et al., 2010). These results are consistent with this study.

Specifically, the results of this study indicated that those who had more credit hours dedicated specifically to crisis intervention courses indicated they were higher in job satisfaction. Perhaps a greater understanding of the conceptual framework of crisis helps students find meaning in working crisis-rich environments. Another possible explanation is that those who take courses in crisis intervention are more interested in working in crisis-rich environments and are therefore more likely to have higher job satisfaction. However, these claims have yet to be empirically proven and could be the focus of future research.

Section Summary

Results from this study have been interpreted, and conclusions have been drawn about individual demographics, agency demographics, training, job satisfaction, and confidence in coping with client aggression. Possible explanations for results and inconsistencies with prior literature have also been provided.

Limitations

Homogeneity of the sample may have contributed to a lack of power in two of the statistical tests. Specifically, 106 participants out of 146 (73.6%) were female, and 118 participants (81.9%) were White. In addition to the lack of power this may have caused, this distribution may also not be representative of the overall population of residential mental health counselors. A similar imbalance existed across racial/ethnic groups; 118 participants out of 146 (80.8%) identified as White. Because of this limited variability in the sample, the generalizability is also limited. Specifically, since most participants were White (80.8%) and female (73.6%), the

results may be best generalized to residential counselors who are White females. Further, the low sample size (n = 146) also limits the generalizability.

The self-report nature of the instruments may have influenced results. Specifically, participants may have been influenced to respond to questions in a socially desirable way. For instance, participants could have felt shame about low confidence in coping with client aggression and reported scores that were erroneously high.

Some items on the survey were forced choice items. Particularly, participants were only given the choice to respond with "yes" or "no" to whether they had been exposed to aggression. Additionally, because of the sometimes subtle nature of psychological aggression, when participants were asked if they had been exposed to psychological aggression, they may have erroneously answered "no."

Since the survey was only administered to people who had been currently working at a residential agency, the results also do not capture the experience of those who may have quit due to low job satisfaction. Those who have had a high amount of exposure to client aggression may quit, which would mean that this percentage of the population who might have had low scores in job satisfaction were not included.

Finally, staff-to-client ratio might have been difficult for participants to accurately report, as work environments may change frequently. Staff members may leave, and new staff members may be hired. Similarly, clients may be discharged, and new clients may enter the work environment.

Delimitations

Though a number of authors have gauged the efficacy of crisis intervention training programs (Flannery & Walker, 2008; Jonikas, Cook, Rosen, Laris, & Kim, 2004; Nunno et al., 2003; Thackrey, 1987), this study focused on academic or agency training as a participant characteristic, rather than as a research intervention. Collecting data in this way allowed me to quickly gain information on both variables rather than implementing numerous types of training.

Exposure to aggression were asked to report whether or not they had been exposed to two types of client aggression (i.e., physical and verbal), rather than asking participants to report the specific extent to which they have experienced aggression. The intention of this limitation is that it would be difficult to ask counselors to recall specific statistical details of their experiences with aggression as to do so would expect them to rely on memory, which may negatively impact trustworthiness. However, it was presumably relatively easy for participants to recall and report a "yes" or "no" response to two broad questions on their exposure status.

Further, the scope was limited further in collecting data on exposure to aggression. Data were collected only on physical aggression and verbal threats rather than on all four types of aggression. Nonverbal intimidation is harder to define and may be difficult for participants to recall or interpret. Sexually aggressive behavior relates to a type of aggression that is beyond the scope of the CCPAI.

By measuring confidence in coping with client aggression, it was possible to measure the psychological components of aggression, which are important as my assumption was that these psychological components may have a greater impact on aggression.

Though some studies used a longitudinal design in which the effects of training were measured over a number of time increments after implementing the training as a part of research (Grau-Alberola, Gil-Monte, García-Juesas, & Figueiredo-Ferraz, 2010; Lowe et al., 2007), I collected data only once. Additionally, because a training was not implemented as a part of the study itself, collecting data at various time intervals would not have appropriately addressed the developmental aspect that time intervals are intended for investigating.

It is important for this study that confidence in coping with client aggression and job satisfaction was only examined in the context of residential mental health. The results must only be generalized to residential settings to address the purpose and research questions.

Academic Implications

As job satisfaction and confidence in coping with client aggression were found to be positively correlated, the results have a number of implications. As exposure to verbal aggression was found to have a positive main effect on confidence in coping with client aggression, academic and agency courses on crisis intervention could consider a role-playing activity as a component in the course. Such activities could include situations in which students of the course are exposed to simulated verbal aggression that they could encounter in the field. To avoid possible trauma, students of the course could be briefed and debriefed.

As the presence to academic training was found to increase job satisfaction, counseling programs may consider the importance of offering courses related to crisis intervention as a part of their curriculum. School, mental health, and even college counselors may feel intimidated by the possibility of clients physically assaulting them. Though some courses in CACREP programs

may include content related to crisis intervention, CACREP programs are not required to offer courses intended specifically to foster counselor competence in crisis intervention. Since counseling professionals may act as clinicians in residential agencies, instructors teaching crisis intervention courses may consider including content related specifically to residential agencies.

As it is clear that some amount of crisis intervention training helps increase job satisfaction and counselor confidence in coping with client aggression, counselor educators may consider increasing training opportunities for students. Students may be fearful of physically aggressive clients at first, and counselor educators may find crisis intervention training and important component in coursework and in supervisory relationships. University supervisors may consider familiarizing themselves with educational resources related to physically aggressive clients, or even receiving training themselves that they might pass on to their supervisees.

Additionally, if counselor educators agree that counselors who work in residential agencies are a group worth advocating for, counselor educators trained in crisis intervention may be more inclined to submit proposals and provide training in crisis intervention at state, regional, and national conferences so that other practitioners may increase their job satisfaction and confidence in coping with client aggression. Counselor educators could form partnerships with those who provide crisis intervention training to agencies and help make them more available to untrained practitioners who may not have access to such trainings.

Implications for Agencies

As job satisfaction and confidence in coping with client aggression were found to be positively correlated, the results have a number of implications. As agency training was found to be related to job satisfaction and confidence in coping with client aggression, residential agencies may consider increasing training and making a point to provide training sooner. Though it is unclear which training is the most efficacious (i.e., TCI, NCI, etc.), any agency training appears to be better than no training in terms of job satisfaction and confidence in coping with client aggression, which highlights that agencies who do not provide in-house crisis intervention training should seriously consider doing so.

As the longevity of job satisfaction gained from training is still unclear, supervisors at residential agencies may consider performing periodic check-ins with their staff to ensure staff job satisfaction remains high and burnout factor remain low. Supervisors could administer the WCI or another reliable instrument that measures job satisfaction or burnout and meet individually with those who indicate lower scores. This could help prevent turnover and increase quality of care.

Future Research

In this study, the WCI and the CCPAI both had extremely high reliability (.97 and .954 respectively), which could indicate that some items are redundant. Therefore, future research may involve further validation of these instruments. As no studies could be found in which a researcher conducted an exploratory factor analysis (EFA) for the CCPAI, such a study could be a way to better understand the components of confidence in coping with client aggression. Once the factor structure of the CCPAI is conceptualized, a confirmatory factor analysis (CFA) could

be conducted to investigate the specific weight of each factor. In the development of the WCI, Nimon et al. (2011) conducted an EFA and CFA to validate the instrument. The existing factor structure that Nimon et al. (2011) created could be used in future research after an EFA/CFA is conducted with the CCPAI. Using these two models, future researchers could use structural equation modeling (SEM) to investigate these variables together in a number of ways. Since this study suggested that crisis intervention training improved confidence in coping with client aggression and job satisfaction, an SEM with the CCPAI and the WCI may investigate which specific aspects of confidence in coping with client aggression and job satisfaction are improved by various crisis intervention training programs. Such a study could help those developing crisis intervention training programs identify the strengths and weaknesses of the programs they have developed.

As the relationship between job satisfaction and confidence in coping with client aggression at residential agencies remains unexplored, researchers could perform a simple regression to see if confidence in coping with client aggression is a good predictor for job satisfaction.

Researchers could also use a quasi-experimental approach to compare the major crisis intervention training programs' effects on confidence in coping with client aggression and job satisfaction. Additionally, a trend analysis could be performed to compare the longevity of their effects.

Finally, rich data could be found through a qualitative study about residential agencies. Specifically, a grounded theory study could be conducted to explore the development of

residential counselors' confidence in coping with client aggression and their job satisfaction. People who develop crisis intervention training programs may gain insight on what is needed at each stage, and perhaps develop more advanced courses for those who already have an understanding of the crisis intervention fundamentals. An ethnography could also be done in a residential setting that could focus on environmental factors that foster higher job satisfaction and the factors that increase burnout. This could help agencies gain insight into supervisory issues and help maintain residential counselors' job satisfaction.

Summary

This chapter has provided an interpretation of the results of this study. The context of prior literature was considered. The possible meanings of the results have been discussed in addition to implications for practice and training. A discussion of the possible impacts of limitations and delimitations on the study were also addressed. Finally, the author provided recommendations for future research.

CHAPTER VI

MANUSCRIPT

Residential Program Counselor Demographics, Job Satisfaction, and Confidence in Coping with Client Aggression

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Abstract

Counselors at residential agencies are frequently assaulted by clients (Flannery & Walker, 2001, 2008), which may help explain why many mental health professionals typically resign from these positions after approximately 14.6 weeks (Connis et al., 1979). The overarching purpose of this study was to examine the association between counselor and agency demographics, crisis intervention training, job satisfaction, and confidence in coping with client aggression. Results indicated those who reported they had been exposed to verbal aggression reported significantly higher confidence in coping with client aggression. Additionally, those who reported they had received agency training in crisis intervention techniques also reported significantly higher confidence in coping with client aggression and higher job satisfaction. Implications for practice, training, and future research are provided.

Residential Program Counselor Demographics, Job Satisfaction, and Confidence in Coping with Client Aggression

Two factors demonstrate the importance of research on crisis intervention and physical aggression at residential agencies. First, researchers (Braun, 2010; Flannery & Walker, 2008; Jones & Timbers, 2003) note that client aggression warrants serious concern for the safety and well-being of counselors and other mental health professionals, particularly at residential agencies. Second, previous research (Jonikas, Cook, Rosen, Laris, & Kim, 2004; Nunno, Holden, & Leidy, 2003) is mixed regarding what training elements are effective in reducing critical incidents of aggression. Beyond these two factors, the association between confidence in coping with client aggression and job satisfaction has not been studied even though they have been studied independently at residential agencies. For example, researchers have used confidence in coping with client aggression as a measure of efficacy for training programs (Gately & Stabb, 2005; Nunno, Holden, & Leidy, 2003; Thackrey, 1987), and other researchers have studied job satisfaction in the context of residential agencies (Buckhalt, Marchetti, & Bearden, 1990; Chou, Kröger, & Lee, 2010; Connis et al., 1979). Further, there is also minimal literature that addresses demographic variables in relation to job satisfaction and confidence in coping with client aggression at residential agencies.

Client Aggression and Crisis Intervention Training

Client aggression has become a greater focus in mental health professions. Flannery and Walker (2008) reported in a descriptive study 2,152 assaults against staff members at a residential agency during a 15-year period (roughly 2.759 assaults per week). Male and female victims of client assault were in roughly equal numbers (1,068 male and 1,055 female), but males were more likely to be victims of physical assault. Clients diagnosed with schizophrenia

were reported to have perpetrated 915 (50%) of physical assault incidents. Further, for 1,230 of the incidents (67%), mental health workers were more likely than nurses or residential house counselors to experience physical assault from a client. These results make a strong case for the danger inherent in working with aggressive clients, especially for mental health workers. Winstanley and Hales (2008) investigated client assault against staff further to examine which counselor attributes and characteristics were most closely associated with being assaulted by clients. They found no significant differences in the frequency of client assault on staff for age, gender, or experience.

Crisis intervention training within academic or agency settings is one method for addressing client aggression. The Council for Counseling and Related Education Programs (CACREP, 2009) included more standards related to crisis intervention, requiring increased attention to student learning objectives and outcomes to address crises in future workplaces. Additionally, agencies have developed trainings (e.g., Therapeutic Crisis Intervention, Nonviolence Crisis Intervention) in part to prevent various forms and stages of aggression (Nunno et al., 2003). Available research has investigated the association between agency training and aggression management (i.e., Allen & Tynan, 2000; Flannery & Walker, 2008; Gately & Stabb, 2005; Jonikas et al., 2004; Martin & Daffern, 2006; Nau, Dassen, Needham, & Halfens, 2011; Nau, Halfens, Needham, & Dassen, 2010; Needham et al., 2005; Thackrey, 1987). and found in general positive results in reduction of physical restraint.

Confidence in coping with client aggression has been widely studied as an indicator for crisis intervention training programs of counselor efficacy. Researchers have used the Confidence in Coping with Patient Aggression Instrument (CCPAI; Allen & Tynan, 2000; Gately & Stabb, 2005; Lowe et al., 2007; Middleby-Clements & Grenyer, 2007; Nau et al., 2011;

Thackrey, 1987) or some modified form (Ching, Daffern, Martin, & Thomas, 2010; Killick & Allen, 2005; Martin & Daffern, 2006) to measure this variable. Available research indicates that exposure to agency training is significantly associated with confidence in coping with aggression as compared to those who had not received training (Allen & Tynan, 2000; Lowe et al., 2007; Nau et al., 2010; Thackrey, 1987).

Job satisfaction and burnout have been widely studied in the context of residential settings. Burnout is defined as the summation of a person's emotional exhaustion, depersonalization (i.e., compassion fatigue toward clients), and lack of personal accomplishment within the context of her or his job (Schaufeli, Salanova, González-Romá, & Bakker, 2002). Job satisfaction is a person's continued cognitive and emotional well-being derived from one's job along eight factors: autonomy, collaboration, connectedness with colleagues, connectedness with leader, distributive fairness, feedback, growth, and meaningful work (Nimon et al., 2011). Available research on employee turnover indicates that, when residential professionals were asked if they would leave their job for another one of equal pay, 16% said they would leave immediately and 17 % said they would leave soon (Lakin, Leon, & Miller, 2008). An earlier study (Connis, Braukmann, Kifer, Fixsen, Phillips, & Wolf, 1979) found that residential employees of 26 agencies generally worked for an agency for14.6 weeks on average. Literature indicating a high number of client assaults (Flannery & Walker, 2008) coupled with qualitative data showing residential counselors' experiences with trauma (Braun, 2010) suggest a hostile work environment may be related to level of job satisfaction and turnover.

Thus, previous research provides descriptive data on physical assaults and employee turnover in residential facilities, indicates some associations between training and reduction of physical assaults as well as increased confidence in coping with aggression, and shows some

evidence that negative experiences with client aggression may lead to job dissatisfaction. No research to date has explored the association between job satisfaction and confidence in coping with client aggression as well as the relationship between agency demographics and academic and/or agency training with these two variables. The following research questions were addressed in this study: (1) Is there a relationship between counselor job satisfaction and confidence in coping with client aggression?; (2) How are agency/environmental characteristics (staff to client ratio, exposure to physical aggression, and exposure to verbal aggression) related to job satisfaction and counselor confidence in coping with client aggression?; and (3) Is there a significant relationship for presence of training (academic and agency) and job satisfaction and counselor confidence in coping with client aggression?

Method

Participants and Procedures

After obtaining Human Subjects approval, the primary researcher (first author) obtained informed consent from participants and invited them to complete a survey packet; participants were entered into a raffle to win 1 of 25 $25 gift cards. A priori power analysis indicated a target sample size of 161 participants was needed to conduct the statistical tests. Most data were collected electronically using *SurveyMonkey.com*; however, 42 participants from a residential agency in a Midwestern state completed hard copies of the survey at the request of the director. Residential agencies were initially identified from a list posted on the American Association of Children's Residential Centers website, which lists 127 agencies from the 48 contiguous states. The researcher contacted the directors of each residential program and requested they forward a survey link to their residential counselors. Using a similar process, the researcher then searched, within a Midatlantic state in which the study was based as well as three neighboring northeastern

states, the Department of Behavioral Health and Developmental Services webpage for other residential agencies (750+ agencies were listed). To maximize the response rate, the researcher also sent email requests to colleagues who were working at residential agencies to forward the survey link to colleagues as well as posted the survey link on a counseling listserv and a social media page. Overall, 146 participants responded to survey questions.

Instrumentation

Counselor Confidence in Coping with Patient Aggression (CCPAI). The CCPAI (Thackrey, 1987) is a 10-item questionnaire for evaluating counselor confidence in coping with client aggression. Thackrey found a high internal consistency (α = .92) for a sample of participants from various roles within the helping professions. The CCPAI scores range from 1 to 11 (higher scores indicating higher confidence in coping). The overall mean score for this sample was 7.81 (*SD*= 2.175), with scores ranging from 1.30 to 10.90. The data were slightly leptokurtic (.315) and negatively skewed (-.869). The internal reliability of the CCPAI was strong for this data set (α = .954).

Work Cognition Inventory (WCI). The WCI (Nimon et al., 2011) contains 40 items and addresses eight factors of job satisfaction (i.e., autonomy, collaboration, connectedness with colleagues, connectedness with leader, distributive fairness, feedback, growth, and meaningful work. The WCI yielded a high internal consistency (α = .96). The WCI scores range of 1 to 6 (i.e., higher scores indicating greater job satisfaction). The overall mean score for this sample was 4.33 (*SD*= .94), with scores ranging from 1.73 to 6.00. The data were slightly platykurtic (-.271) and negatively skewed (-.572). The internal reliability of the WCI was strong for this data set (α = .97).

Demographics questionnaire. The primary researcher developed a questionnaire to collect various counselor and agency characteristics as well as training experiences. Counselor demographics assessed included race/ethnicity, gender, age, and months of clinical experience. Agency characteristics included staff to client ratio, and exposure to physical and verbal aggression. Type of training received was assessed in terms of academic and/or agency training, Academic training included the education counselors receive on the topic of crisis intervention as a part of her or his educational program. Agency training was defined as the crisis intervention training program given by the agency. Type of training received was also included on the demographic questionnaire.

Results

Job Satisfaction and Confidence in Coping with Aggression.

Research question 1 explored the relationship between counselor job satisfaction and confidence in coping with client aggression. Participants reported moderate levels of job satisfaction and confidence in coping with aggression. Findings indicated a significant positive relationship between confidence in coping with client aggression and job satisfaction, $r = .359$, $p < .001$, $\eta^2 = .13$.

Agency Characteristics, Job Satisfaction, and Confidence in Coping with Aggression

Research question 2 was as follows: How are agency/environmental characteristics (staff to client ratio, exposure to physical aggression, and exposure to verbal aggression) related to job satisfaction and counselor confidence in coping with client aggression? There was not a significant main effect between staff to client ratio and job satisfaction ($F_{(1, 138)} = 1.064$, $p = .409$, $\eta^2 = .520$, $P = .87$) or counselor confidence in coping with client aggression ($F_{(1, 138)} = .927$, $p = .692$, $\eta^2 = .485$, $P = .80$). Results, however, indicated a moderate effect size between staff to

client ratio and job satisfaction and approach a moderate effect size for counselor confidence in coping with client aggression.

There was not a main effect between exposure to physical aggression and job satisfaction, ($F_{(1, 138)} = 3.151, p = .081, \eta^2 = .054, P = .42$) or counselor confidence in coping with client aggression ($F_{(1, 138)} = .004, p = .949, \eta^2 = .000, P = .05$). There was not a significant main effect between exposure to verbal aggression and job satisfaction ($F_{(1, 138)} = .225, p = .637, \eta^2 = .004, P = .08$). However, the results indicated a significant main effect between exposure to verbal aggression and counselor confidence in coping with client aggression ($F_{(1, 138)} = 5.019, p = .029, \eta^2 = .084, P = .60$). However, the effect size and power estimates for exposure to verbal aggression and counselor confidence in coping with client aggression are weak; findings should be interpreted with caution.

Training, Job Satisfaction, and Confidence in Coping with Aggression

Research question 3 was as follows: Is there a significant relationship for presence of training (academic and agency) and job satisfaction and counselor confidence in coping with client aggression? The results did indicate a significant main effect for presence of academic training and job satisfaction ($F_{(1, 138)} = 2.287, p = .009, \eta^2 = .227, P = .96$), with a small effect. However, the results did not show a significant main effect for presence of academic training and counselor confidence in coping with client aggression ($F_{(1, 138)} = 1.094, p = .372, \eta^2 = .123, P = .65$). Further, the results demonstrated a significant main effect for presence of agency training with job satisfaction ($F_{(1, 138)} = 3.160$, p = .046, $\eta^2 = .055, P = .60$) and counselor confidence in coping with client aggression ($F_{(1, 138)} = 12.667$, $p < .001, \eta^2 = .189, P = .996$). However, effect size estimates related to this hypothesis were negligible and findings should be interpreted with caution.

Discussion

Job satisfaction had a significant positive relationship with confidence in coping with client aggression for the participants, who reported moderate levels for both variables. Although no studies were found in prior literature that specifically investigated these variables together, perception of safety, a possible factor of job satisfaction, was found to have a positive correlation with confidence in treating aggressive clients (Martin & Daffern, 2006).

With respect to agency demographics and job satisfaction and confidence in coping with client aggression, exposure to physical aggression was not significantly related, however, exposure to verbal aggression had a positive main effect with confidence in coping with client aggression. One possible explanation of this latter result is that those with experience with verbal aggression in a clinical setting have more practice addressing it and de-escalating clients than those who have not been exposed to verbal aggression. In settings where aggression is not common, counselors may feel anxiety about any level of aggression. Future research could examine the differences between residential agencies where aggression is common and those where it is not.

For the third research question, there were significant main effects for academic and agency training experiences with job satisfaction and confidence in coping with client aggression. Particularly, those who had received crisis intervention training at their agency had both higher job satisfaction and higher confidence in coping with client aggression. Consistent with the results of the current study, Calabro, Mackey, and Williams (2002) and Temple et al. (2007) found that NCI training helped increase confidence in coping with client aggression. Other researchers found that agency-specific programs were related to increased confidence in coping (Killick & Allen 2005; Lowe et al., 2007). Generally, authors who studied crisis

intervention programs have found positive results in reduction of physical restraint and/or confidence in coping with client aggression (Allen & Tynan, 2000; Flannery & Walker, 2008; Gately & Stabb, 2005; Jonikas et al., 2004; Martin & Daffern, 2006; Nau, Dassen, Needham, & Halfens, 2011; Nau, Halfens, Needham, & Dassen, 2010; Needham et al., 2005; Nunno et al., 2003; Thackrey, 1987).

Further, the current study indicates that agency crisis intervention training had a positive main effect on job satisfaction. However, no studies were found in the prior literature that can corroborate these results. If residential counselors get the sense that their agency is making an effort to prepare them for critical incidents, they may develop a stronger sense of loyalty to the agency. Future researchers could verify this by using the WCI (Nimon et al, 2011), using only the items under the "Connectedness with Leaders" variable.

Further, those who had taken a college course specifically in crisis intervention (i.e., academic training) had higher job satisfaction, but not confidence in coping with client aggression. These findings are mixed, compared with previous research. Gately and Stabb (2005) found that time spent in a graduate psychology program was positively correlated with confidence in coping with client aggression and Chou et al. (2010) found that the number of years of education was significantly positively correlated with job satisfaction. The significant link in this study between academic training and job satisfaction may indicate a greater understanding of the conceptual framework of crisis helps students find meaning in working crisis-rich environments. Another possible explanation is that those who take courses in crisis intervention are more interested in working in crisis-rich environments and are therefore more likely to have higher job satisfaction. However, these claims have yet to be empirically proven and could be the focus of future research.

Limitations

There are several limitations to this study. First, homogeneity of the sample may have contributed to a lack of power in two of the statistical tests. Specifically, 106 participants out of 146 (73.6%) were female, and 118 participants (81.9%) were White. In addition to the lack of power this may have caused, this distribution may also not be representative of the overall population of residential mental health counselors. A similar imbalance existed across racial/ethnic groups; 118 participants out of 146 (80.8%) identified as White. Because of this limited variability in the sample, the generalizability is also limited. Specifically, because most participants were White (80.8%) and female (73.6%), the results may be best generalized to residential counselors who are White females. Further, the low sample size (n = 146) also limits the generalizability.

Second, the self-report nature of the instruments may have influenced results. Specifically, participants may have been influenced to respond to questions in a socially desirable way. For instance, participants could have felt shame about low confidence in coping with client aggression and reported scores that were erroneously high. Third, some items on the survey were forced choice items. Particularly, participants were only given the choice to respond with "yes" or "no" to whether they had been exposed to aggression. Additionally, because of the sometimes subtle nature of psychological aggression, when participants were asked if they had been exposed to psychological aggression, they may have erroneously answered "no."

Fourth, because the survey was only administered to people who had been currently working at a residential agency, the results also do not capture the experience of those who may have quit due to low job satisfaction. Those who have had a high amount of exposure to client

aggression may quit, which would mean that this percentage of the population who might have had low scores in job satisfaction were not included.

Finally, staff to client ratio might have been difficult for participants to accurately report, as work environments may change frequently. Staff members may leave, and new staff members may be hired. Similarly, clients may be discharged, and new clients may enter the work environment.

Implications for Training

As job satisfaction and confidence in coping with client aggression were found to be positively correlated, the results have a number of implications. As exposure to verbal aggression was found to have a positive main effect on confidence in coping with client aggression, academic and agency courses on crisis intervention could consider a role-playing activity as a component in the course. Such activities could include situations in which students of the course are exposed to simulated verbal aggression that they could encounter in the field. To avoid possible trauma, students of the course could be briefed and debriefed.

As the presence to academic training was found to increase job satisfaction, counseling programs may consider the importance of offering courses related to crisis intervention as a part of their curriculum. School, mental health, and even college counselors may feel intimidated by the possibility of clients physically assaulting them. Though some courses in CACREP programs may include content related to crisis intervention, CACREP programs are not required to offer courses intended specifically to foster counselor competence in crisis intervention. Since counseling professionals may act as clinicians in residential agencies, instructors teaching crisis intervention courses may consider including content related specifically to residential agencies.

As it is clear that some amount of crisis intervention training helps increase job satisfaction and counselor confidence in coping with client aggression, counselor educators may consider increasing training opportunities for students. Students may be fearful of physically aggressive clients at first, and counselor educators may find crisis intervention training and important component in coursework and in supervisory relationships. University supervisors may consider familiarizing themselves with educational resources related to physically aggressive clients, or even receiving training themselves that they might pass on to their supervisees.

Additionally, if counselor educators agree that counselors who work in residential agencies are a group worth advocating for, counselor educators trained in crisis intervention may be more inclined to submit proposals and provide training in crisis intervention at state, regional, and national conferences so that other practitioners may increase their job satisfaction and confidence in coping with client aggression. Counselor educators could form partnerships with those who provide crisis intervention training to agencies and help make them more available to untrained practitioners who may not have access to such trainings.

Implications for Agencies

As job satisfaction and confidence in coping with client aggression were found to be positively correlated, the results have a number of implications. As agency training was found to be related to job satisfaction and confidence in coping with client aggression, residential agencies may consider increasing training and making a point to provide training sooner. Though it is unclear which training is the most efficacious (e.g., TCI, NCI), any agency training appears to be better than no training in terms of job satisfaction and confidence in coping with client

aggression, which highlights that agencies who do not provide in-house crisis intervention training should seriously consider doing so.

As the longevity of job satisfaction gained from training is still unclear, supervisors at residential agencies may consider performing periodic check-ins with their staff to ensure staff job satisfaction remains high and burnout factor remain low. Supervisors could administer the WCI or another reliable instrument that measures job satisfaction or burnout and meet individually with those who indicate lower scores. This could help prevent turnover and increase quality of care.

Future Research

In the current study, the WCI and the CCPAI both had extremely high reliability (.97 and .954, respectively), which could indicate that some items are redundant. Therefore, future research may involve further validation of these instruments. As no studies could be found in which a researcher conducted an exploratory factor analysis (EFA) for the CCPAI, such a study could be a way to better understand the components of confidence in coping with client aggression. Once the factor structure of the CCPAI is conceptualized, a confirmatory factor analysis (CFA) could be conducted to investigate the specific weight of each factor. In the development of the WCI, Nimon et al. (2011) conducted an EFA and CFA to validate the instrument. The existing factor structure that Nimon et al. (2011) created could be used in future research after an EFA/CFA is conducted with the CCPAI. Using these two models, future researchers could use structural equation modeling (SEM) to investigate these variables together in a number of ways. Since the current study suggested that crisis intervention training improved confidence in coping with client aggression and job satisfaction, an SEM with the CCPAI and the WCI may investigate which specific aspects of confidence in coping with client aggression

and job satisfaction are improved by various crisis intervention training programs. Such a study could help those developing crisis intervention training programs identify the strengths and weaknesses of the programs they have developed.

Researchers could also use a quasi-experimental approach to compare the major crisis intervention training programs' effects on confidence in coping with client aggression and job satisfaction. Additionally, a trend analysis could be performed to compare the longevity of their effects.

Finally, rich data could be found through a qualitative study about residential agencies. Specifically, a grounded theory study could be conducted to explore the development of residential counselors' confidence in coping with client aggression and their job satisfaction. People who develop crisis intervention training programs may gain insight on what is needed at each stage, and perhaps develop more advanced courses for those who already have an understanding of the crisis intervention fundamentals. An ethnography could also be done in a residential setting that could focus on environmental factors that foster higher job satisfaction and the factors that increase burnout. This could help agencies gain insight into supervisory issues and help maintain residential counselors' job satisfaction.

Appendix A: Informed Consent and Participant Email

Dear [Participant Name],

I am Erik Braun, a doctoral candidate in Counselor Education at Old Dominion University. I am conducting my doctoral dissertation research under the guidance of Dr. Danica G. Hays, Ph.D. I am interested in learning about job satisfaction and confidence in coping with client aggression in the context of residential mental health agencies. The study has been reviewed and approved by the Old Dominion University Human Subjects Review Committee in the Darden College of Education.

I would like to take this opportunity to invite you to participate in this study. Participation is voluntary and anonymous; it will not impact your relationship with your agency or your training center. If you agree to participate in this study, you will complete a series of questions that include demographic information, the Confidence in Coping with Patient Aggression Instrument (CCPAI), and the Work Cognition Inventory. Completing the survey will take approximately 30 minutes to complete. Please note that you may refuse to answer any questions that you do not wish to answer. You can also discontinue participation at any time by closing your web browser.

The information you provide by completing the online survey is completely anonymous. To ensure anonymity: 1) no identifying information will be collected through the on-line survey and, 2) participant email address will be maintained in a separate, secure file. The survey data will be stored on a password-protected computer. Only the primary researchers (Braun and Hays) will have access to the data. Please note that aggregated research findings may be presented at professional conferences or published in scholarly journals.

This study poses minimal risk to the participants in that you may experience some mild discomfort when reflecting on your experience as you complete the survey. If you feel that you need to seek consultation regarding your participation in this study, please seek a mentor or a trusted advisor. There are no direct benefits to you for participating in the study.

To thank you for your participation, you will be offered the opportunity to participate in a random drawing to win 1 of 15 $25 gift certificates to amazon.com by entering your email address at the completion of the survey. The webpage that solicits your email address will remain separate from the survey so as to not connect your contact information with your survey responses. Following data collection, 15 individuals will be randomly selected and the gift certificates will be sent electronically. The file containing participant email addresses will then be deleted.

If you have any questions regarding this study or what is expected of your voluntary participation, please feel free to contact me at ebraun@odu.edu or (309) 339-4596 or my dissertation chair, Danica G. Hays, Ph.D. at dhays@odu.edu or (757) 683-6692. If you have any questions about your rights to participate in this research, or if you feel that you have been placed at risk, you may contact the Office of Research, Institutional Review Board, Old Dominion University, 4111 Monarch Way, Suite 203, Norfolk, Virginia, 23529. Thank you in advance for participating in this study.

By clicking the "NEXT" button below, you agree that you have read and understood the explanation provided and voluntarily agree to participate in this study.

Sincerely,

Erik Braun, MA, NCC

Doctoral Candidate

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Danica G. Hays, PhD

Associate Professor

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Appendix B: Email to Residential Directors

Dear [Director],

I am Erik Braun, a doctoral candidate in Counselor Education at Old Dominion University. I am conducting my doctoral dissertation research under the guidance of Dr. Danica G. Hays, Ph.D. I am interested in learning about job satisfaction and confidence in coping with client aggression in the context of residential mental health agencies. The study has been reviewed and approved by the Old Dominion University Human Subjects Review Committee in the Darden College of Education.

I would like to take this opportunity to invite mental health professionals at your agency to participate in this study. I am requesting that you forward the below message to residential mental health professionals at your agency, which includes a link to an informed consent document and an online survey. Participants will be entered into a raffle to win 1 of 15 $25 gift cards.

Please feel free to review the attached message to get a better sense of what will be asked of potential participants. If you have any questions regarding this study or what is expected of your voluntary participation, please feel free to contact me at ebraun@odu.edu or (309) 339-4596 or my dissertation chair, Danica G. Hays, Ph.D. at dhays@odu.edu or (757) 683-6692. If you have any questions about your rights to participate in this research, or if you feel that you have been placed at risk, you may contact the Office of Research, Institutional Review Board, Old Dominion University, 4111 Monarch Way, Suite 203, Norfolk, Virginia, 23529. Thank you in advance for participating in this study.

Sincerely,

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Appendix C: Confidence in Coping With Patient Aggression Instrument

Please mark the number that best reflects your feelings, thoughts, and attitudes of each question.

1) How comfortable are you in working with an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very uncomfortable very comfortable

2) How good is your present level of training for handling psychological aggression?

1 2 3 4 5 6 7 8 9 10 11

very poor very good

3) How able are you to intervene physically with an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very unable very able

4) How self-assured do you feel in the presence of an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

not very self-assured very self-assured

5) How able are you to intervene psychologically with an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very unable very able

6) How good is your present level of training for handling physical aggression?

1 2 3 4 5 6 7 8 9 10 11

very poor very good

7) How safe do you feel around an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very unsafe very safe

8) How effective are the techniques that you know for dealing with aggression?

1 2 3 4 5 6 7 8 9 10 11

very uncomfortable very comfortable

9) How able are you to meet the needs of an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very unable very able

10) How able are you to protect yourself physically from an aggressive patient?

1 2 3 4 5 6 7 8 9 10 11

very unable very able

Appendix D: Work Cognition Inventory (WCI)

Using a 6-point scale, please indicate the extent to which you agree or disagree with each statement.

Autonomy (AU)

1. I have the ability to choose how tasks are performed.

1 2 3 4 5 6

strongly disagree strongly agree

2. I have the information I need to make decisions about my work.

1 2 3 4 5 6

strongly disagree strongly agree

3. I have the authority I need to make decisions about my work.

1 2 3 4 5 6

strongly disagree strongly agree

4. I am trusted to do my job without interference.

1 2 3 4 5 6

strongly disagree strongly agree

5. I know the boundaries of my own decision-making authority.

1 2 3 4 5 6

strongly disagree strongly agree

Collaboration (CO)

1. People share professional ideas with me.

1 2 3 4 5 6

strongly disagree strongly agree

2. People I work with are team players.

1 2 3 4 5 6

strongly disagree strongly agree

3. Most people who work with me are positive and collaborative.

1 2 3 4 5 6

strongly disagree strongly agree

4. People support me on projects and tasks.

1 2 3 4 5 6

strongly disagree strongly agree

5. Leaders support their people on projects and tasks.

1 2 3 4 5 6

strongly disagree strongly agree

Connectedness with colleagues (CC)

1. My colleagues share personal information with me.

1 2 3 4 5 6

strongly disagree strongly agree

2. My colleagues make an effort to build rapport with me.

1 2 3 4 5 6

strongly disagree strongly agree

3. My colleagues take an interest in me personally.

1 2 3 4 5 6

strongly disagree strongly agree

4. My colleagues take an interest in me professionally.

1 2 3 4 5 6

strongly disagree strongly agree

5. I trust my colleagues to act in my best interest.

1 2 3 4 5 6

strongly disagree strongly agree

Connectedness with leader (CL)

1. My boss shares personal information with me.

1 2 3 4 5 6

strongly disagree strongly agree

2. My boss makes an effort to build rapport with me.

1 2 3 4 5 6

strongly disagree strongly agree

3. My boss takes an interest in me personally.

1 2 3 4 5 6

strongly disagree strongly agree

4. My boss takes an interest in me professionally.

1 2 3 4 5 6

strongly disagree strongly agree

5. I trust my boss to act in my best interest.

1 2 3 4 5 6

strongly disagree strongly agree

Distributive fairness (FA)

1. This organization makes an effort to fairly and appropriately balance my workload.

1 2 3 4 5 6

strongly disagree strongly agree

2. This organization makes an effort to fairly and appropriately distribute resources to me.

1 2 3 4 5 6

strongly disagree strongly agree

3. The benefits this organization offers me are fair.

1 2 3 4 5 6

strongly disagree strongly agree

4. Decisions, policies, and procedures are fairly and consistently applied to all.

1 2 3 4 5 6

strongly disagree strongly agree

5. This organization compensates me fairly based on performance and industry averages.

1 2 3 4 5 6

strongly disagree strongly agree

Feedback (FB)

1. I receive enough feedback on my job performance to know how well I am doing.

1 2 3 4 5 6

strongly disagree strongly agree

2. I am recognized for improvements in my performance.

1 2 3 4 5 6

strongly disagree strongly agree

3. The feedback I get compares my work to a clear standard of performance.

1 2 3 4 5 6

strongly disagree strongly agree

4. I am recognized for contributing good ideas at work.

1 2 3 4 5 6

strongly disagree strongly agree

5. I am recognized for a job well done.

1 2 3 4 5 6

strongly disagree strongly agree

Growth (GR)

1. This organization finds ways to support my future career planning.

1 2 3 4 5 6

strongly disagree strongly agree

2. I have opportunities to grow and improve in my current job.

1 2 3 4 5 6

strongly disagree strongly agree

3. This organization offers me options for discussing my future development, needs, and interests.

1 2 3 4 5 6

strongly disagree strongly agree

4. I have opportunities to develop new skills to do my present job.

1 2 3 4 5 6

strongly disagree strongly agree

5. I can chart my future career path in my company.

1 2 3 4 5 6

strongly disagree strongly agree

Meaningful work (MW)

1. I believe I am working on projects that matter.

1 2 3 4 5 6

strongly disagree strongly agree

2. I understand how my work serves the organization's purpose.

1 2 3 4 5 6

strongly disagree strongly agree

3. This organization's purpose is meaningful to me because it is not just about making money.

1 2 3 4 5 6

strongly disagree strongly agree

4. I think the organization does meaningful work.

1 2 3 4 5 6

strongly disagree strongly agree

5. I think my work creates positive results.

1 2 3 4 5 6

strongly disagree strongly agree

Appendix E: Demographic Questionnaire

1. Gender (check one)
    a. Male___
    b. Female ___
    c. Transgender _____
2. Age: _____
3. Race (check the one you most identify with)
    a. African-American/Black___
    b. Native-American/American Indian ___
    c. Asian / Pacific Islander ___
    d. White / Caucasian ___
    e. Latina/Latino ___
    f. Multiracial ___
4. How long have you worked in residential settings (current and past jobs included) _____ years _____ months
5. Exposure to aggression
    a. Has a client ever physically assaulted you? Y__ N__ (i.e., has a client ever used physical force with the intent to harm you, including punching, kicking, slapping, biting or other forms of physically aggressive behavior?)
    b. Has a client ever verbally threatened you? Y__ N__ (i.e., threats against your life or property, racial slurs, and other derogatory comments meant to frighten)
6. Which best describes the age group of clients you work with (check one)?
    a. Children __
    b. Adolescents __
    c. Adults __
7. Which best describes the diagnoses / presenting problems of the clients you work with? (check all that apply)
    a. Developmentally disabled __
    b. Defiant / physically aggressive __
    c. Sexual abuse/assault issues __
    d. Mental illness __
    e. Substance abuse __
8. How many clients do you serve directly on average per shift? _____
9. How many coworkers do you typically work with directly on an average shift? _____
10. How many semester credit hours (if any) have you earned in a college-level course geared specifically toward crisis intervention? _____
11. Have you taken a college-level course that incorporated crisis intervention topics yet was not a stand-alone crisis intervention course?
    a. Yes

b. No

12. Have you received any crisis intervention training at your agency?
    a. Yes
    b. No
13. Types of agency training received:
    a. None
    b. Nonviolent Crisis Intervention (NCI)
    c. Therapeutic Crisis Intervention (TCI)
    d. Training program specific to your agency
    e. Other, please specify_____
14. Credentials : Please check all credentials you currently hold:
    a. NCC__
    b. LPC__
    c. Master's degree__
    d. PhD__
    e. EdD __
    f. LCSW__
    g. CCMHC__
    h. MAC __
    i. NCSC__
    j. Other__
    k. If "Other," please specify other professional credentials held:_____

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