

## **Workplace Violence**

### **APNA 2008 Position Statement**

#### *Executive Summary*

The American Psychiatric Nurses Association (APNA), the largest professional organization for psychiatric nurses, recognizes that violence in the workplace is a pressing occupational concern for all registered nurses and for psychiatric nurses in particular. To examine the scope of the problem and to identify solutions, the APNA chartered a Task Force on Workplace Violence in May 2007. Content experts conducted a comprehensive review of the literature focusing on the following practice areas: inpatient psychiatric settings, outpatient settings, emergency departments, nonpsychiatric areas such as home care, and academic environments. Workplace violence was broadly defined, including physical, sexual, and verbal threats and abuse from peers (i.e., horizontal violence) as well as consumers. Based on the findings, the task force developed recommendations for environmental safety, education, and research, both globally and specific to each setting.

The task force examined a wide range of issues including the high rates of nonfatal assaults on nurses, the underreporting of violent incidents, the physical and emotional health consequences of violence, the associated costs relative to recruitment and retention of qualified staff, and the state of the science in management and prevention.

It is abundantly clear that violence at work from consumers, colleagues, and workplace intruders is a significant occupational health hazard for nurses in all settings. The evidence base is rapidly improving and reports relative to the efficacy of various risk management, regulatory, and legal interventions are identifying important protective measures. Nevertheless, barriers to effectively addressing the problem of workplace violence persist and include inconsistent legal and regulatory protections, widely varying prevention programs lacking an evidence base, the belief that violence is “part of the work,” and the absence of standardized operational definitions precluding benchmarking and monitoring.

The task force respectfully submits the following recommendations relative to workplace violence in all settings. Specific recommendations linked to discreet practice areas are addressed in each of the position papers developed by the task force.

### ***Recommendations***

- *Professional nursing organizations* must advocate for (a) safe work environments, (b) education about risk management and prevention, (c) research support, as well as (d) stricter laws and mandatory regulations enforcing safe work practices.
- *Health organizations* must establish and maintain a comprehensive program for the prevention, reporting, and management of all types of workplace violence.
- *Nurse managers* need to create and maintain supportive work environments where respectful communication is the norm, organizational policies are followed, and incident reporting is efficient and blame-free.
- *Individual nurses* should intervene when they witness aggression among their colleagues, recognize factors that may predispose patients to becoming violent, and report all incidents of violence.
- *Nursing educators* must include workplace violence prevention and conflict management in the curriculum and prepare professional nurses in the prevention, assessment, and management of aggression in patients, visitors, and colleagues.
- *Investigators* should study proactive prevention and intervention strategies, efficacy of training modalities, and efficacy of specific policies and leadership styles to identify best practices for prevention of workplace violence.
- *Researchers and clinicians* must develop consistent and operationally defined definitions of what constitutes acts of violence in health care settings.

APNA supports a sustained commitment to fostering a safe and healthy workplace. APNA recognizes that the ultimate responsibility for maintaining the safety of staff and other individuals in treatment and learning environments rests with the nursing and administrative leadership of each setting. The association and its members must advocate for continued work on the prevention and reduction of workplace violence as well as for ongoing research to support

evidence-based practice in this area. APNA is committed to working with nursing colleagues, clients and families, physicians and other health care providers, and advocacy groups to minimize workplace violence.

## Introduction

Violence in the workplace is a pressing concern for nurses in all settings and for psychiatric nurses in particular. In a large survey in 2007, the American Psychiatric Nurses Association (APNA) found that safety is one of the top issues of concern for registered nurses (RNs) working in mental health settings. Nurses serve as front-line care providers who practice in a wide variety of settings caring for individuals facing all types of trauma, suffering, and life-altering events.

In May 2007, the APNA Board of Directors commissioned a Task Force on Workplace Violence to examine the scope of the problem and to make recommendations for improving workplace safety. The task force steering committee was composed of a multinational group, representing a variety of practice settings. Focus areas for the task force included violence on inpatient settings (including private, forensic, and state funded), outpatient psychiatric settings, and other settings, specifically emergency departments (EDs) and home care. The emerging concern regarding horizontal violence, and the high-profile campus shootings compelled the task force to include aggression from coworkers and violence in schools and universities in the review. A volunteer panel of content experts conducted a comprehensive review of the literature in each of these areas of nursing by searching nursing, medical, and occupational health journals from 1970 to 2008. The APNA task force performed a review of the literature using the key words of *psychiatric*, *nursing*, and *violence* in the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, and Academic Search Premier. While some international literature was reviewed, most was from North America.

The task force made recommendations specific to each area and assisted in the development of the final report. The findings of the task force are included in three position papers on workplace violence: (a) inpatient and outpatient psychiatric settings, (b) other health care settings, and (c) schools. This document, the first position paper, reports on workplace violence in both inpatient and outpatient psychiatric settings.

Initially, *workplace violence* was broadly defined as any physical assault, threatening behavior, or verbal abuse occurring in the work setting (Antai-Otong, 2001) or outside the workplace but related to work (Occupational Safety and Health Administration [OSHA], 2002, p. 1). The review, however, revealed a wide range of definitions and measurement strategies that are discussed in the context of the paper.

### ***Workplace Violence: Scope of the Problem***

Violence is a pervasive problem in our world community. Violent scenes depicted on television, video games, and in music and cinema are commonplace. Rage reactions and emotional breakdowns have been glamorized by substance-impaired celebrities. The extremes of domestic violence, road rage, gun violence, and mass murder in schools and other public places fill the evening news. Guns are easily accessible and assault rifles are designed for efficient mass slaughter. Today's youth are intrigued by and desensitized to extreme violence. The darkly humorous euphemism, "going postal" is a sad testament to the way senseless acts of violence are minimized and inculcated into the American landscape.

Smoyak and Blair (1992) wrote about violence and abuse. They noted that at that time society was bombarded by violence and called for nonreactionary psychiatric treatment of patients moving toward progressive, understanding, and therapeutic care to reduce violence in clinical areas (Smoyak, S.A.. & Blair, D. T. 1992).

The International Council of Nurses (ICN) in 2006 reported that occupational violence is a major worldwide public health problem (Farrell, Bobrowski, & Bobrowski, 2006). According to a 2002 U.S. Department of Labor report, an estimated nearly 2 million acts of nonfatal work-related violence occur annually (Findorff, McGovern, Wall, & Gerberich, 2005). Work-related violence is the third leading cause of occupational injury fatality in the United States and the second leading cause of death for women at work (Findorff, McGovern, Wall, & Gerberich, 2005).

A 10-year study of rape occurring in the workplace in Washington State found that 11% of the rape victims were health care workers in hospitals or other nursing care facilities (Alexander,

Franklin, & Wolf, 1994). Hatch-Maillette and colleagues (2007) found that 63% of their sample—84% of whom were female nurses—reported a past incident of sexual threat, and 84% reported a past incident of physical or sexual assault.

Violence is one of the most vexing and risky hazards facing nurses in the psychiatric health care environment. There are clinical, ethical, legal, and political dimensions to this occupational hazard that can serve as formidable barriers to prevention and harm reduction. Inurnment due to chronic and protracted exposure to violent individuals, underreporting, few effective external regulations, and the belief that violence is “just part of the job” are just a few of the roadblocks to effective violence prevention (Love & Elliott, 2002).

In recent years, the health and safety consequences of horizontal violence (i.e., verbal, physical, and sexual abuse from coworkers) have received wide attention. A work environment with hostile interactions negatively impacts staff health and well being; furthermore, it has been associated with reduced quality of care and recruitment and retention problems. In 1982 Poster and Ryan studied assaults in psychiatric nursing, and in 1992 Lanza described nurses as victims of assault. It has only been since the early 1990s that violence has been considered a public and occupational health hazard (Lipscomb & Love, 1992).

The literature from 1970 to 1990 yielded articles which primarily described the characteristics of units where violence occurred and described the staff response to assault. Most of the inpatient violence research describes trends and patterns across populations and the effectiveness of various risk assessment technologies. There is a pressing need for research describing successful violence prevention interventions.

In recent years, the National Institute for Occupational Safety and Health (NIOSH) and the U.S. Department of Labor’s Occupational Safety and Health Administration (OSHA) have accelerated their efforts to study workplace violence and provide resources for employers. At the state level, only California, Washington, Florida, Illinois, New Jersey, Tennessee, and Nevada have passed laws requiring special violence prevention protections in health care workplaces. More recently, many organizations have adopted “zero tolerance” policies related to workplace violence. The

effectiveness of the various zero tolerance programs remain unclear, although they continue to grow in popularity. Beginning January 1, 2009, the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission) will require accredited health care organizations to have a formal process for managing behavior seen as unacceptable, such as a code of conduct and policies that support zero tolerance for violence and bullying. APNA recommends research in outcomes and means to these outcomes.

Without the provision of support, education, and training programs that address prevention and intervention techniques, policies alone cannot effectively reduce the incidence of workplace violence. Rew and Ferns (2005) note that government initiatives have been beneficial in highlighting managers' responsibility to ensure the well being of their staff. They emphasize the importance of reporting and monitoring systems, but maintain that more emphasis is needed in recognition of the trigger factors to patient/client behavior, and its appropriate management.

In the past few years, nursing organizations, including the International Council of Nurses (ICN), the American Academy of Nursing (AAN), the American Nurses Association (ANA), and labor groups representing health care workers have advocated for improved protective regulations and research support to study effective risk management programs (McPhaul & Lipscomb, 2004). The Center for American Nurses has issued a statement on workplace violence as well as a position statement (February 2008) addressing bullying and other forms of horizontal violence in the workplace.

On July 9, 2008, the Joint Commission issued an alert regarding rude and disruptive behavior in health care settings. The Joint Commission states that

intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on more professional environments. Safety and quality of patient care is requires teamwork, communication, and a collaborative work environment. To ensure quality and to promote a culture of safety, health care organizations must address the problem of behavior that threaten the performance of the health care team. (Joint Commission, 2008)

Suggested actions include better systems to detect and deter unprofessional behavior, more civil responses to patients and families who witness bad acts, and overall training in basic business etiquette, including phone skills and people skills for all employees. Clearly, there is increased professional and organizational attention on workplace violence.

### ***Incidence and Prevalence***

According to the Bureau of Justice Statistics, workplace assaults injure 1.7 million workers each year (U.S. Department of Justice, 2001). In terms of injury rates from workplace violence, health care and social service industries are second only to the field of law enforcement (OSHA, 2003). Nearly 500,000 nurses become victims of violence in their workplace each year, according to the U.S. Department of Justice. Nurses are three times more likely to be the victims of violence than any other professional group (Keely, 2002). Three registered nurses in hospitals and five psychiatric nurses and home health aides died as a result of assaults and violent acts in the workplace in 2004 (U.S. Department of Labor, Bureau of Labor Statistics, 2005).

In *Nursing Management's* 2008 Workplace Violence Survey, 1,377 of 1,400 respondents claimed that employee safety in health care is woefully inadequate (Hader, 2008). Nearly 74% of respondents experienced some form of violence in the work setting. This survey took place across the United States and in 17 other countries, including Afghanistan, Taiwan, and Saudi Arabia. Women made up 92.8% of the respondents, a gender distribution consistent with the nursing population as a whole. Most respondents worked in a hospital setting, followed by outpatient facilities, community health, academia, and rehabilitation. Of the types of violence encountered, 51% to 75% were bullying, intimidation, and harassment. Nearly 26% of respondents reported physical violence. Weapons were involved in 5.6% to 7.5% of the incidents. Perpetrators of violence against respondents included patients (53.2%), colleagues (51.9%), physicians (49%), visitors (47%), and other health care workers (37.7%).

Manderino and Berkey (1997) estimated that 90% of nurses experience verbal abuse on an annual basis. The Joint Commission surveyed nurses and found that more than 50% reported being subjected to verbal abuse (as cited in American Association of Critical Care Nurses, 2005,



p. 16). Of the 303 nurses surveyed, 53% reported having been bullied at work (Vessey, Demarco, Gaffney, & Budin, in press).

It has been estimated that as few as one in five violent events are reported in psychiatric settings (Mayhew, 2000). Typically, violent acts that result in injury to patients or staff are reported, whereas acts of physical violence that do not result in injury or nonphysical types of violence are not reported. Findorff, McGovern, and Sinclair (2005) found that 43% of physical violence and 61% of nonphysical violence went unreported. Several factors may explain the low incidence of reporting in this study. Thirty-two percent of assaulted employees and 8% of those experiencing nonphysical violence reported that they considered violence to be part of the job, whereas others felt they were “telling on” a coworker or worried how reporting the incident would affect their working relationships.

In another study, Findorff, McGovern, Wall, et al. (2005) examined the individual and employment characteristics associated with reporting workplace violence and the relationship between the incidence of reporting and the characteristics of the violent event. Of those who experienced physical violence at work, 57% reported the events to their employer, compared to 40% who reported nonphysical violence. Frequency of assault and severity of symptoms were associated with the tendency to report. Women experienced more adverse symptoms and reported violence more frequently than men. Eighty-six percent of the reports of violence in this study were reported verbally rather than in writing.

There have been a number of reasons cited for the underreporting phenomenon:

- peer pressure not to report (Lanza, 1988)
- ambiguity in defining violence (Lanza, 1988)
- excusing the behavior of “ill” patients (Mayhew, 2000)
- perception that violence is part of the job (Lanza & Carifio, 1991; Mahoney, 1991; Poster & Ryan, 1994)
- organizational culture (Farrell & Cubit, 2005; Mayhew, 2000), including onus on the victim to be proactive and make the complaint (Jackson & Mannix, 2002) and the employer’s belief that it would be too costly to institute protective measures for the staff

- stigma of victimization, including embarrassment (Mayhew, 2000) and shame, isolation, and fear of judgment
- fear of job loss (Poster, 1996)
- fear of blame of provoking the assault or being negligent (Lanza, 1992; Lanza & Carifio, 1991)
- victim's self-blame (McCoy & Smith, 2001)
- time-consuming, ineffective, or gender-biased reporting mechanisms (Mahoney, 1991)
- no benefit, either personal or organizational, of reporting (Lanza, 1985; Mahoney, 1991; Poster & Ryan, 1989; Rose, 1997)
- unhelpful experience with prior reporting

### *Types of Violence and Definitions*

The Occupational Safety and Health Administration (OSHA) under the U.S. Department of Labor defines workplace violence as “any physical assault, threatening behavior, or verbal abuse occurring in the work setting.” A workplace may be any location either permanent or temporary where an employee performs any work-related duty (OSHA, 2004). “Workplace violence ranges from offensive or threatening language to homicide. National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty” (NIOSH, 2006). And the World Health Organization (WHO) defines workplace violence as "incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (WHO, n.d.).

Workplace violence can be divided into four main types: physical, sexual, verbal, (Copeland, 2007, p. 2) and horizontal violence. Subtypes and definitions include:

Physical:

- *assault*—“attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives” (NIOSH, 2006). Other definitions are: (a) “a violent physical ... attack,” or “a threat or attempt to inflict offensive physical

contact or bodily harm on a person (as by lifting a fist in a threatening manner) that puts the person in immediate danger of or in apprehension of such harm or contact” (Merriam-Webster, 2006);

(b) “unwanted physical contact by a patient whether or not there is intent to harm. The contact may or may not result in injury. Physical assaults involve the use of force and include punching, kicking, slapping, biting, spitting, and thrown objects that hit another person” (National Database of Nursing Quality Indicators [NDNQI], 2005, p.1)

- *battery*—“the act of battering or beating,” or “an offensive touching or use of force on a person without the person's consent” (Merriam-Webster, 2006); “assaults intended for the purpose of inflicting severe or aggravated bodily injury, usually accompanied by a weapon or by means likely to produce death or great bodily harm” (U.S. Department of Justice, as cited in Brumbaugh-Smith, Gross, Wollman, & Yoder, 2008, p. 366)
- *physical harassment*—“to create an unpleasant or hostile situation ... especially by uninvited and unwelcome ... physical conduct” (Merriam-Webster, 2006)
- *homicide*—“killing of one person by another” (Copeland, 2007, p. 23)
- *mugging*—“aggravated assaults, usually conducted by surprise and with intent to rob” (NIOSH, 2006)

Sexual:

- *rape*—sexual intercourse with a person “forcibly and against her will including attempt or assaults to rape” (U.S. Department of Justice, as cited in Brumbaugh-Smith et al., 2008, p. 366)
- *fondling*-- consisting of words, conduct, or action of a sexual nature, directed at a specific person, that annoys, alarms, or causes substantial emotional distress to that person” (Garner, as cited in Copeland, 2007, p. 23)

Verbal:

- *threat*—Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats (NIOSH, 2006); explicit or implied expression to

inflict pain, injury, or harm to another (Privitera, Weisman, Cerulli, Tu, & Groman, 2005)

- *verbal abuse*— Yelling, swearing, intimidating, demeaning, public scolding, and/or sexually harassing, using words (Carroll, 2003)

Horizontal violence, which can be verbal or nonverbal:

- *hostility*—“deep-seated ... ill will” or “conflict, opposition, or resistance in thought or principle” (Merriam-Webster, 2006)
- *verbal harassment*—“to annoy persistently” or “to create an unpleasant or hostile situation ... especially by uninvited and unwelcome verbal ... conduct” (Merriam-Webster, 2006)
- *bullying*—when a person “intentionally exerts power or intimidation in a manner that leads [the victim] to feel that there may be a threat to his or her personal well-being” (ICN, as cited in Kolanko et al., 2006, p. 38) in a pattern occurring over time (Einarson, 1999); “repetitive aggressive behavior from a person of higher position or power with the deliberate intent to cause psychological or physical harm” (Vessey, DeMarco, Gaffney, & Budin, in press); frequent objectionable behavior imposed upon an employee by another person (MacIntosh, 2006)

Nonverbal aggression (i.e., disparaging looks and noises, offensive gestures, ignoring another, and physically standing over another with the intention of intimidating) are all forms of bullying and workplace abuse (Murray, 2007, 2008). Vessey, Demarco, Gaffney, and Budin (in press) define bullying as “repetitive aggressive behavior from a person of higher position or power with the intention to cause psychological or physical harm” (Center for American Nurses, LEAD Summit, 2008).

Five categories of workplace bullying described by Rayner and Hoel (1997) are: (a) threat to personal status, such as belittling opinion, public professional humiliation, and accusation of lack of effort; (b) threat to personal standing, such as gossiping, name calling, insults, and teasing; (c) isolation, such as preventing access to work opportunities, physical or social isolation, and withholding of information; (d) overwork, such as undue pressure to produce work, impossible

deadlines, and unnecessary disruptions; and (e) destabilization, such as failure to give credit when due, meaningless tasks, removal of responsibility, shifting of goals, repeated reminders of error, and setting up to fail (Rayner & Hoel, 1997, p. 183).

Workplace violence can also include manipulation of the working environment, that is, withholding needed information, setting unreasonable deadlines, excluding from critical meetings, changing work schedules unfairly, failing to give credit, and retarding opportunities for advancement, promotion or higher pay. To meet the definition of workplace violence or abuse these offenses must occur repeatedly and over time (Murray, 2007, 2008).

### ***Risk Factors for Horizontal Violence***

The literature reveals numerous factors that contribute to horizontal violence in the workplace:

- greater amount of time spent at work (Harvey & Keashly, 2003) or high workload (Quine, 1999)
- female senior manager in a male-dominated organization, with low job control and lack of participation in decision-making processes (Quine, 1999)
- shift rounds as a high occurrence time for bullying (in a neonatal intensive care unit) (Patole, 2002)
- lack of nursing staff cohesion and positive leadership, associated with aggression (Rew & Ferns, 2005)
- victim's low self-esteem (Harvey & Keashly, 2003; Randle, 2003;) and lack of assertiveness (McCabe & Timmins, 2006)

### ***Consequences of Horizontal Violence***

Exposure to bullying, and verbal and physical abuse from superiors and coworkers drains nurses of their enthusiasm for the profession and undermines job satisfaction and employee morale (Thomas, 2003). Insider-initiated aggression also appears to lower employees' commitment to their organization, although aggression by a member of the public does not (LeBlanc & Kelloway, 2002).

Costs to organizations include low worker morale, absenteeism, sick leave, property damage, early retirement, high turnover, grievances and litigation, increased accidents, decreased performance and productivity, security costs, worker's compensation, reduced trust of management, and loss of public prestige (Gilioli, Campanini, Fichera, Punzi, Cassitto, 2006; Jackson & Mannix, 2002; McKenna, Smith, Poole, & Cloverdale, 2003; NIOSH, 2002; Speedy, 2006). The direct effect of horizontal violence on productivity has yet to be determined. Hoel, Rayner, and Cooper (1999) noted that persons subjected to bullying might be more eager to demonstrate their ability and commitment because of feelings of low self-esteem.

Horizontal violence affects recruitment. In a study by Curtiss, Bowen, and Reid (2007), about 90% (77) of the 86 nursing students reporting or witnessing horizontal violence responded that their experiences would affect their employment choices.

Study findings are mixed about the emotional and psychological impact of horizontal violence on nurses. Several studies found that horizontal violence contributes to lower levels of job satisfaction, higher levels of job-induced stress, and increased likelihood of clinical anxiety and depression (Longo & Sherman, 2007; Quine, 1999; Taylor & Barling, 2004). Farrell (1999) found horizontal violence to be more disturbing to nurses than other distressing work issues, such as workload or emotional needs of patients, whereas Hillhouse and Adler (1997) reported that nurses did not identify conflict with other nurses as stressful.

Bullying has harmful effects on health. Quine (1999) examined workplace bullying among 396 nurses with a questionnaire that included questions about emotional and somatic illness. Nurses who experienced being bullied perceived that it affected their health both physically and mentally. They reported an increase in drinking and smoking behaviors and a decreased ability to sleep. Targets of bullying behaviors did report various response strategies including ignoring the behavior, talking to friends, issuing a formal complaint, and directly confronting the perpetrator.

Workplace violence can also include manipulation of the working environment, that is, withholding needed information, setting unreasonable deadlines, excluding from critical

meetings, changing work schedules unfairly, failing to give credit, and retarding opportunities for advancement, promotion or higher pay. According to Murray (2007, 2008), to meet the definition of workplace violence or abuse these offenses must occur repeatedly and over time.

Effective policies regarding workplace violence, grievance procedures, and counseling are methods to reduce workplace violence (Howard, 2001). Every health care organization should have a comprehensive plan for workplace violence, including horizontal violence. The administration and managers should:

1. Establish a steering committee to define workplace violence and establish a plan of action.
2. Survey staff attitudes about intimidation and lateral violence.
3. Create a code of conduct and have existing and new staff sign the code, at their hire and annually.
4. Hold frank discussions about workplace violence using objective moderators.
5. Establish a standard, assertive communication process (Griffin, 2004).
6. Create a conflict resolution process stated in a professionalism policy and include a chain of command for resolution.
7. Encourage one-on-one conflict resolution and provide a mechanism for confidential reporting.
8. Enforce a zero tolerance policy (full punishment for an infraction) (Hader, 2008; Joint Commission, 2008).
9. Provide ongoing education to reinforce the organization's commitment to ensuring a caring and respectful environment.
10. Lead by example and reward outstanding role models (Schaffner, Stanley, & Hough, 2006).

A concern with the use of the term *zero tolerance* is the possibility that violent acts will be reported less often if the policy states "zero tolerance," which implies certain consequences from the employer. With the Joint Commission now using the term of "zero tolerance" in the sentinel alert effective January 2009 regarding disruptive behavior, it is apparent the term is increasing in

use and zero tolerance for violence and bullying is becoming the normative practice in the workplace.

In an attempt to reduce horizontal violence, Griffin (2004), in a controlled study without randomization, taught “cognitive rehearsal” to newly graduated nurses. These nurses received education on horizontal violence, role modeling, and rehearsal in an interactive session and then received cue cards with a script and professional behaviors to act out for each of 10 identified types of horizontal violence (see Appendix). At the end of the training, participants reported using their skills when experiencing horizontal violence and reported that the training prevented further acts of horizontal violence. The retention of newly registered nurses during this first year was 91%, when the national average has been described between 40% and 60% (Griffin, 2004).

### ***Stalking***

An act that can cross all types of violence is stalking. Stalking is “a crime involving threatening and potentially dangerous acts of pursuit of an individual over time” having three elements: “a pattern of unwanted behavioral intrusion,” an implicit or explicit threat,” and “fear as a result of these behavioral intrusions” (Maxey, 2003, p. 30).

### ***Typology of Workplace Violence***

NIOSH subscribes to a typology of workplace violence that the Injury Prevention Research Center (IPRC) at the University of Iowa (2001) developed. Table 1 lists this typology (NIOSH, 2006, p. 6). NIOSH states that definitions of workplace violence are as yet not consistent among government agencies, employers, workers, and other interested parties. One of its agenda items for partnerships with research institutions is to develop consistent definitions of workplace violence (NIOSH, 2006).



<b>Table 1. Typology of workplace violence</b>	
<b>Type</b>	<b>Description</b>
I: Criminal intent	The perpetrator has no legitimate relationship to the business or its employee, and is usually committing a crime in conjunction with the violence. These crimes can include robbery, shoplifting, trespassing, and terrorism. The vast majority of workplace homicides (85%) fall into this category.
II: Customer/client	The perpetrator has a legitimate relationship with the business and becomes violent while being served by the business. This category includes customers, clients, patients, students, inmates, and any other group for which the business provides services. It is believed that a large portion of customer/client incidents occur in the health care industry, in settings such as nursing homes or psychiatric facilities; the victims are often patient caregivers. Police officers, prison staff, flight attendants, and teachers are some other examples of workers who may be exposed to this kind of workplace violence, which accounts for approximately 3% of all workplace homicides.
III: Worker-on-worker	The perpetrator is an employee or past employee of the business who attacks or threatens another employee(s) or past employee(s) in the workplace. Worker-on-worker fatalities account for approximately 7% of all workplace homicides.
IV: Personal relationship	The perpetrator usually does not have a relationship with the business but has a personal relationship with the intended victim. This category includes victims of domestic violence assaulted or threatened while at work, and accounts for about 5% of all workplace homicides.
<i>Note:</i> From NIOSH, 2006.	

Crimes of violence—Type I in the NIOSH typology—include rape, gender sexual assault, robbery, and assault (Bureau of Justice Statistics, 2008).

Type II violence in the health care setting often victimizes patient caregivers, including nurses.

Type III, worker-on-worker violence, may occur *vertically*—when workers in authority positions perpetrate violence over those in lower positions, when staff members in lesser positions are violent toward those in higher positions, or when a vertical workplace event is reflected. A study by Sofield and Salmond (2003) found primarily physicians, then patients, and lastly

patients' families were responsible for the most verbal abuse of nurses. The Institute for Safe Medication Practices published a survey in 2004 on reporting of intimidation and found that almost 50% of 2,095 respondents, including nurses, pharmacists, and other health care providers, recalled that a physician verbally abused them when they wanted to clarify orders (Center for American Nurses, 2008). Quine (1999), however, found the most common perpetrator of bullying to be senior managers.

Another form of type III violence is between workers holding the same or similar positions, termed *horizontal violence* or *lateral violence*. The most frequent manifestations of horizontal aggression are not acts of overt aggression but less dramatic psychologically aggressive acts, such as spreading rumors about and giving dirty looks to colleagues (Baron, Neuman, & Geddes, 1999). Also common are nonverbal innuendos, verbal affronts, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences (Duffy, 1995; Farrell, 1997, 1999; McCall, 1996). Acts of horizontal violence also can include belittling or criticizing a colleague in front of others, blocking a chance for promotion, and isolating or freezing a colleague out of group activities (Longo & Sherman, 2007). Studies have shown that a high prevalence of nurses (Griffin, 2004; Stanley, Martin, Michel, Welton, & Nemeth, 2007; Vessey, DeMarco, Gafney, & Budin, in press) and nursing students (Longo, 2007) witness or experience horizontal violence in practice settings. However, one survey reported that, despite this high prevalence, 75% of nurse respondents perceive that their coworkers often treat them with courtesy and respect (Stanley et al., 2007).

Domestic violence occurring in the workplace is considered type IV aggression. According to the U.S. Department of Labor (1996), homicide is the leading cause of death for women on the job, and for 17% of these women, their killer is an intimate partner. Although personality conflicts between employees, employers, and customers account for most workplace violence incidents, family and marital problems define 15% of incidents (Stouffer & Varnes, 1998). The National Safe Workplace Institute's national survey conducted in the mid-1990s found that 94% of corporations' security directors ranked domestic violence as a high security problem for their

companies (Marmer-Solomon, 1995). Worksite harassment correlates positively with actual physical domestic violence (McFarlane et al., 2000).

Some university centers have been working to identify occupational violence and develop related definitions. For example, the Peace Studies Institute at Manchester College in Indiana has done extensive research on ways to measure violence in the United States. The institute developed the National Index of Violence and Harm (NIVAH), used to identify trends in interpersonal, intrapersonal, institutional, and structural violence (Brumbaugh-Smith et al., 2008).

In the National Index of Violence and Harm (NIVAH), Brumbaugh-Smith and colleagues further conceptualize violence into personal and societal, including two categories in each. *Personal violence* can be either (a) interpersonal, which is “harm between people,” or (b) intrapersonal, “harm done to oneself” (Brumbaugh-Smith et al., 2008, p. 354). They group *societal violence* into (a) institutional violence, “violence that occurs by the action of societal institutions ... by individuals whose actions are governed by the roles that they are playing in an institutional context” (Brumbaugh-Smith et al., 2008, p. 354), and (b) structural violence defined as “harm done by the overall structuring of society” (Brumbaugh-Smith et al., 2008, p. 354). Institutional violence is further grouped into government, corporate, and family. Using this framework, it appears that workplace violence is mainly interpersonal and institutional.

### ***Consequences of Violence***

Nurses who have been assaulted experience both physical and emotional consequences including traumatic injuries and even death. The majority of physical injuries due to patient violence tend to be minor, although career-ending incidents involving permanent disability are not uncommon (Hunter & Carmel, 1992). Caldwell (1992) found that approximately half of the assaulted staff experienced minor injuries. Nijman and Palmstierna (2005) found that only 1% to 5% of the reported aggressive incidents resulted in injury requiring medical attention.

The impact of an assault is often underestimated because physical injury is the most common measure used to assess impact. However, individuals have strong emotional and psychological reactions to assaults and threats of assault regardless of whether or not injury was sustained.

The emotional consequences of workplace violence include anxiety, depression, insomnia, stress-related disorders, and loss of self-confidence (Gilioli et al., 2006). In one study approximately 78% of health care employees experienced at least one adverse symptom in response to work-related violence, while 20% of those physically assaulted and 25% of victims of nonphysical violence experienced five or more troublesome symptoms (Findorff, McGovern, & Sinclair, 2005).

Burnout and exhaustion are associated with verbal abuse (Grandey, Kern, & Frone, 2007; Thomas, 2003). Bullying is associated with fear, demoralization, hypertension, panic attacks, lower morale at work, and negative relationships at work (Hutchinson, Wilkes, Vickers, & Jackson, 2008). Sexualized violence sometimes can evoke strong psychological reactions from staff (Sandburg, McNiel, & Binder, 2002).

The frequency of post-traumatic stress disorder (PTSD) following workplace violence mirrors that of other traumatic life events. Caldwell (1992) found that of staff members who reported experiencing an assault, 61% of the clinical staff and 28% of the nonclinical staff reported symptoms of PTSD. Ten percent of clinical staff and 7% of nonclinical staff met the diagnostic criteria for PTSD.

It is noteworthy that Caldwell (1992) found that most of the assaulted employees in the study did not take advantage of employer-provided resources such as occupational health services or the Employee Assistance Program (EAP).

Anxiety and stress about personal safety exacerbates other inherent work stressors (Erickson & Williams-Smith, 2000). O'Connell, Young, Brooks, Hutchings, and Lofthouse (2000) found a direct link between workplace aggression and increases in nurses' sick leave, drug and alcohol use, burnout, and staff turnover. Violence and an adverse psychosocial work environment are

related to poor health and a low commitment to nursing (Lawoko, Joaquim, Soares, & Nolan, 2004). In different care situations, violent episodes of both a physical and a verbal nature were found to increase intent to leave nursing (Sofield & Salmond, 2003).

It is noteworthy that studies addressing the effects of violence on patient victims and patient witnesses are rare.

### ***Financial Costs***

The National Institute for Occupational Safety and Health (NIOSH, 2002) found that employees lost a total of 160 days due to patient violence. Lanza (1983) surveyed 40 nursing staff in a Veterans Affairs (VA) psychiatric hospital and found that 45% reported losing time from work due to patient assault. Lanza and Milner (1989) reported the annual cost from inpatient violence to be approximately \$38,000. Two of eight staff members incurring medical expenses and 78 days from work cost more than \$6,200. Hunter and Carmel (1992) found that patient assaults in 1 year cost \$766,290.

At a presentation at the Center for American Nurses 2008 LEAD Summit, Colonel John S. Murray, President of the Federal Nurses Association, conservatively estimates the cost of violence in the workplace at \$4.3 million annually or approximately \$250,000 per incident, excluding hidden expenses from the emotional pain of victims, witnesses, and families suffering with anxiety, depression, and feelings of isolation (Murray, 2008).

The costs associated with workplace violence have major implications for the health of the workforce and the organization. Rew and Ferns (2005) include the following:

- increased staff turnover, recruitment, and retention costs
- increased staff absence from work
- reduced efficiency and performance at work
- reduced staff morale
- reduced staff numbers, especially the loss of experienced staff, leading to increased pressure on remaining staff

- higher incidence of patient complaints
- higher risk of increased frustration by patients and staff
- higher risk of violent incidents
- falling reputation for the organization

Clearly, health care organizations and other employers have not only a social responsibility but also an enormous financial incentive to prevent workplace violence.

### **Inpatient Violence in Psychiatric Settings**

On September 3, 2006, Wayne Fenton, psychiatrist, researcher, National Institute of Mental Health scholar, editor of the *Schizophrenia Bulletin*, and decades-long advocate for people with schizophrenia was shot and killed by one of his patients (*Washington Post*, 9/4/06). Rare and high-profile incidents like this serve as chilling reminders of the service provider's vulnerability in psychiatric care. Stalking, sexual assault, and threats are also concerns (Love & Elliott, 2002; Sandberg, McNeil, & Binder, 2002).

Inpatient psychiatric settings include freestanding mental health facilities, private and public inpatient units affiliated with medical hospitals, county units, state hospitals, and forensic units in prisons, jails, or hospitals. Care of the most severe developmentally disabled individuals may occur in an inpatient state facility. The populations of these various inpatient settings range from patients with anxiety, depression, psychosis, eating disorders, dementia with psychosis, or behavioral difficulties to crisis-prone, more agitated, and usually repetitively admitted persons. Dangerousness as a patient trait is often seen in acute care environments and state hospitals. Patients who are court admitted for crimes are most often seen in state hospital forensic units. In acute inpatient settings, services include treatment of acute psychiatric symptoms, detoxification, and crisis stabilization.

“Dangerousness” is the standard for both civil and penal involuntary commitment in the United States and most Western countries. Violent behavior toward self or others is typically the precipitant for involuntary admission to an inpatient unit (Doyle & Dolan, 2002). Thus, people

remanded to acute care settings have been found to be dangerous just before their admission. Highly dangerous and mentally ill people are brought to inpatient settings because it is not safe for them to live in the community or in less secure settings.

### ***Historical Perspective***

Psychiatric violence is a long-standing, complex and multifaceted phenomenon -- the final common pathway of a variety of factors having to do with the immediate environment and the individual's internal world. For centuries, and in relative professional isolation, inpatient psychiatric nursing staff have cared for people prone to violent and self injurious behavioral emergencies--often resorting to coercive, rudimentary, and primitive measures to maintain safety.

The early inpatient violence research (1970s – 1980s) tends to characterize the violent inpatient as a unitary phenomenon--where patients were either “violent” or “not violent.” We now know that the violent inpatient is a heterogeneous group of people with a variety of precursors and motivations. As far back as 1989, Poster and Ryan studied the prevalence of assault in psychiatric nursing, and in 1992 Lanza initiated a scholarly program of research delineating psychiatric violence and its consequences.

### ***Epidemiology***

Nurses working in some psychiatric inpatient settings are exposed to violence on a daily basis due to the nature of the populations served, the public protection functions of inpatient settings, the culture and demands of the institutional environment, the reduced number of RNs to lesser-trained mental health workers, and the limitations of the treatment services provided. This last is especially true of state hospitals and, in some localities, in public and private hospital psychiatric units.

Staff surveys show that 75% to 100% of nursing staff on acute psychiatric units have been assaulted during their careers (Caldwell, 1992; Hatch-Maillette et al., 2007). Poster (1996)

reported that 75% of psychiatric nursing staff experienced an assault at least once during their career. Caldwell (1992) found that 62% of psychiatric clinical staff and 28% of nonclinical staff reported that patients assaulted them at least once. And from the same study, 28% of clinical staff and 12% of nonclinical staff reported an assault within the last 6 months. Poster and Ryan (1989) found that 94% of Canadian psychiatric nurses reported having been assaulted at least once in their careers and 54% reported having been assaulted more than 10 times.

For psychiatrists, the risk of violence when treating mentally ill patients is more than four times greater than the risks facing other physicians. An article from *The Times* of London (Ahuja, 2006) reported that the rate of nonfatal, job-related violent crime among general medical physicians is 16.2 per 1,000. For psychiatrists and mental health professionals, the rate is 68.2 per 1,000.

Bjorkly (1999) found that 15% to 30% of hospitalized psychiatric patients were involved in physical assaults during their hospitalization. In a study by Hatch-Maillette and colleagues in a state psychiatric facility, it appeared that a high degree of patient contact placed the staff at the greatest personal risk of an incident of workplace violence (Hatch-Maillette et al., 2007). Gale, Pellett, Coverdale, and Paton Simpson (2002) examined risk factors for violent events reported to managers in psychiatric units in New Zealand. Results of the survey indicated the following: (a) Inpatient care poses a higher risk to staff for all violent events than does community care; (b) geriatric psychiatry has a higher risk of assault, attack, and sexual harassment than other forms of care; and (c) child and adolescent psychiatric units, alcohol and substance abuse units, and other specialty units were no more violent than other units.

The literature consistently reports that a small number of individuals are responsible for most of the assaults in institutional settings (Convit, Isay, Otis, & Volavka, 1990). Bjorkly (1999) found that four patients were associated with 77% of the violence in a Norwegian secure unit. Using data from a large inpatient forensic hospital, Love and Hunter (1996) found that the habitually violent patients were younger, had a length of stay in excess of 3 years, and averaged 20 more assaults than the average inpatient. Focusing resources to prevent violence in this group has the potential to substantially reduce overall levels of institutional aggression.



## *Forensic Settings and State Hospitals*

People are in forensic settings because they have come to the attention of both the mental health and criminal justice systems. Forensic inpatients generally receive treatment in prison psychiatric facilities or state hospitals. The forensic populations in the United States are burgeoning. Prisons and jails are overcrowded with people who have serious psychiatric problems, trauma histories, and addictions.

In the forensic mental health nursing literature, the tensions between criminal elements and psychiatric phenomena have given rise to the widely debated “custody and care” dilemma (Scales, Phillips, & Crysler, 1989). The tension created between the police power of the state (i.e., custody and security) can sometimes seem at odds with the clinical mandate to provide care and treatment and to meet the requirements of external medically oriented regulatory bodies (Love & Morrison, 2003).

State mental health hospitals and psychiatric units serve people who experience difficult-to-manage psychotic disorders and severely limiting personality disorders. People in state hospitals require long-term treatment, either for their own protection or the protection of others. Most state hospital inpatients are involuntarily committed. It is not unusual for civil commitment (state hospital) populations to contain a large proportion of people who have criminal offenses in their background.

As public sector institutions, state hospitals are “the end of the line” for many severely impaired and habitually violent people. State hospitals house an accumulation of dangerous people who have failed many treatment trials in various settings. Public sector patients tend to either not respond or only partially respond to psychotropic medications. This accumulation of severely impaired people can lead to cultures of hopelessness, coercion, and violence.

Many states have enacted “sexual violent predator” legislation, which has led to a large number of the most dangerous sex offenders being civilly committed to psychiatric hospitals after they have served their prison terms (Sreenivasan, Weinberger, & Garrick, 2003). The sexually

violent population tends to be difficult for mental health staff to manage, especially since legal issues may be involved in their care. As the number of highly dangerous, hospitalized sex offenders increases, the frequency of sexual stalking and verbal abuse increases.

### ***Targets of Inpatient Aggression***

Targets of inpatient violence can include staff, visitors, and fellow patients. In a large forensic state hospital in the United States, Love (1995) found that patient-to-patient aggression was more common than patient-to-staff aggression. In a review of British psychiatric hospitals, nursing staff were the most frequent targets of assault (Trenoweth, 2003), as was the case in a study of London hospitals (Gournay, Ward, Thornicroft, & Wright, 1998).

Due to long exposure and numerous security functions, psychiatric nurses are assaulted more frequently than other members of the interdisciplinary team (Hatch-Maillette et al., 2007). Among U.S. nursing staff, injury rates resulting from inpatient violence are twice as high as injuries from all causes in the traditionally high-risk industries of mining, lumber, and heavy construction (Lipscomb & Love, 1992). Love and Hunter (1996) found that, in a 1-year period, in five different public sector hospitals, 14% of registered nurses and 25% of nursing aides experienced an OSHA-reportable injury due to patient violence. In these five settings, staff members were injured most often when physically containing an individual during a crisis. Injuries from direct assaults were less frequent. These alarmingly high numbers are twice as high as the occupational health industry standard (Lipscomb & Love 1992).

Some reports suggest that assaults occur less frequently to female staff members than to male staff. Hunter and Carmel (1993) noted that male staff were overrepresented in their 1-year sample of staff injuries in a forensic hospital. In a recent report men and women were equally at risk of violence in inpatient settings, and typically the perpetrator was the same gender as the victim (Flannery, Marks, Laudani, & Walker, 2007). Among 328 mental health professionals from a state psychiatric facility with forensic, inpatient, and community-based patients, female staff reported more verbal and physical assaults and more frequent sexual threats compared with male staff (Hatch-Maillette et al., 2007).

## ***Risk Management and Prediction of Violence***

Nursing staff and other mental health professionals are expected to be able to identify imminent dangerousness and predict the potential for future violence. In the early 1980s, researchers undertook the challenge of measuring the accuracy of clinician's dangerousness predictions. These early studies, dubbed the "first generation" of violence prediction technology, relied on clinical judgments and repeatedly found that clinical impressions were inaccurate to the extent that they tended to be wrong more often than they were right (Monahan, 1981, 1984). The limitations of this first-generation technology led to the identification of important distinctions among various violent inpatients across a variety of settings.

The "second generation" of prediction research employed actuarial methods to measure the relative contributions of specific perpetrator-based variables categorized as either "static" (i.e., fixed and historical factors) or "dynamic" (changeable). Static factors include items such as gender, history of violence, childhood experiences, and behaviors. Dynamic factors include items such as symptoms, age, setting, and degree and type of substance impairment. This actuarial approach to risk assessment vastly improved the accuracy of violence prediction. Static historical factors alone are consistently found to be more accurate than dynamic factors. A history of violence remains the single most important predictor of violence in inpatient settings, particularly a history of institutional violence (Love & Elliot, 2002).

Psychiatric nurses play an important role in the identification of risk factors for violence and in the implementation of interventions that promote and maintain safety. Much of the prediction research has been directed at community placement predictions. Only recently have prediction efforts focused on prediction of violence in institutions (Johnson, 2004). Interactions typical on inpatient units, such as limit setting, denying a request, gaining compliance, involuntarily medicating someone, and de-escalation are associated with violent incidents and emphasize the importance of mental status assessment skills, therapeutic communication competency, unit environments, and nurse-patient alliance.

Trenoweth (2003) found that nurses tend to rely extensively on their personal knowledge of their patients when assessing for dangerousness. The study indicated that nurses perceive the development of nurse-patient relationships and working in a supportive team as protective factors against risk. Protective factors specific to the patient relationship included knowing the patient, understanding the patient's frame of reference, recognizing the impact the mental health problem has on the patient, being aware of the patient's history of violence, observing the situation, and identifying behavior chains leading to aggression. When faced with a potentially violent situation, the nurses were able to draw on specific knowledge of the patient to effectively intervene. The study demonstrated that nurses believe the level of risk in a potentially violent scenario does not stem solely from factors within the patient but also reflects external factors, such as the skills of staff, the ability to work effectively in a team, the presence of others who could escalate aggressive behavior, and the availability of weapons.

Several instruments have been tested relative to efficacy for inpatient violence prediction. Bowers, Nijman, and Palmstierna (2007) compared the Attempted and Actual Assaults Scale (Attacks) with Modified Overt Aggression Scale (MOAS)—instruments designed to record the nature and severity of inpatient assaults. The Attacks scale is completed after a violent incident has taken place, and captures details of inpatient violent events. The MOAS measures verbal aggression, property damage, and violence toward self and others. To compare the instruments, the researchers had staff subjects view videotapes of inpatient assaults and then rate the severity of the assault using both instruments. In their study, the Attacks scale was considered superior to the MOAS.

Another tool, the Dynamic Appraisal of Situational Aggression (DASA), was developed and tested by Ogloff and Daffern (2006). The DASA is a 16-item scale drawn from research and other scales including the Broset Violence Checklist and the Historical, Clinical, Risk Management-20 (HCR-20). DASA items include; irritability, impulsivity, unwillingness to follow directions, sensitivity to perceived provocation, easily angered when requests denied, negative attitude, and verbal threats, with irritability as the strongest predicting factor. The DASA scale predicted inpatient violence more accurately

than nurses' clinical judgments alone. Tools such as the items mentioned above can provide greater accuracy in identifying the risk of violence in psychiatric settings and can potentially augment clinical prevention efforts.

Flannery, Marks, et al. (2007) examined the impact of assaults over a 15-year period and produced several cost-effective risk management strategies. From an organizational perspective, risk management strategies should include the development of a quality management database to assess patient and staff victim characteristics, provide clear definitions of assaults to increase reporting, develop and uphold workplace violence policies, create restraint-free environments that incorporate trauma, informed care, post-crisis counseling for victims, and improve law enforcement liaison links within the community. Staff development strategies should include training in behavioral warning signs of impending loss of control; conflict resolution skills; coping skills; nonviolent self-defense, restraint and seclusion procedures; alternatives to restraint and seclusion; psychological trauma; and de-escalation skills.

In another study, staff from 111 different psychiatric units were queried about the preventive and safety measures in their settings. In 45% of the units, personal alarms were provided, 41% had panic buttons installed, 27% had security alarms, 2.7% had metal detectors, 30% had de-escalation teams in place, and 44% had security staff on site (Gale et al., 2002).

Weapons screening is a preventive measure. In a 5-year retrospective study of weapon use in a large forensic hospital, Love and Hunter (1996) found that the most common weapons used by patients in assaults were objects readily available in the environment (e.g., chairs, food trays, trash cans, tables, pens and pencils, and silverware).

“Manufactured weapons” (e.g., shanks, blackjacks and garrotes) were rarely used in attacks, but were confiscated from patients who were carrying the handmade items for self protection or self harm. In this study, staff and patients were targeted equally in weapon incidents. The authors endorsed weapon-screening practices and careful adaptations of the hospital environment to reduce the number of items that patients could use as weapons.

### *Patient factors*

The violence research that focuses on the patient tends to attribute aggression to biologically based emotional regulation, especially the serotonergic system (Blair & Charney, 2003). Link, Stueve, and Phelan (1998) studied the effects of various delusional systems (“threat-control override”). Bjorkly (1999) focused on the role of emotional distress as a mediator between the individual’s thoughts and violent behavior. Command hallucinations calling for the patient to hit another, although relatively rare, have been associated with an increased risk of violence, particularly when the individual’s emotional mediators are unable to override the command voices.

The literature suggests that internal events—the evidence of symptoms such as delusions and hallucinations—are risk factors for assaults in newly admitted patients. External events—primarily a conflict with staff or another patient—were more commonly perceived as precipitants by patients (Crownier, Peric, Stepic, & Lee, 2005). Interpersonal factors, such as abrasive words, property struggles, disagreements, and invasion of personal space were more commonly offered as reasons for assaults than internal factors (Crownier et al., 2005). When queried about the provocations of violent incidents, patients often report coercive behavior on the part of staff as the key provocation (Morrison, 1992, 1993).

Other researchers conducted a study to establish whether there are temporal and causal relationships between psychotic symptoms and assaults (Nolan et al., 2003). The authors found that 20% of the assaults were directly related to the presence of positive psychotic symptoms. Patients with psychosis-motivated aggression reported delusions and hallucinations with threatening content more frequently than command hallucinations.

A study conducted by Bowers, Allan, Simpson, Nijman, and Warren (2007) found a relationship between adverse incidents and psychiatric admissions, particularly of male patients. The results indicate the following:

- Verbal aggression was significantly associated with an increase in admission of psychotic individuals, physical aggression, and property damage.

- Property damage was significantly associated with male admissions, physical and verbal aggression, deliberate self-harm, and an increase in substance abuse admissions 2 weeks prior to the damage.
- Self-harm behaviors were significantly correlated with increases in physical aggression, reduced staffing, and increased number of discharges.
- Absconding from psychiatric units was significantly associated with increases in admissions of psychotic individuals in the previous week, physical and verbal aggression, a decrease in minority group admissions from the previous week, and fewer observation hours.
- Most adverse incidents occurred during the early stages of admission.
- When inpatients committed acts of physical violence in this study, they were more likely to be male than female.

In a geriatric population, Wystanski (2000) conducted a study to evaluate the relationship between psychosocial stimulation and changes in medications, with the emergence of assaultive behavior and the course of behavior, in a 24-hour period. Assaultive behavior occurred during 222 of 1,396 observations. Patients with organic brain disorders displayed more assaultive behaviors than those with nonorganic conditions. The study also found that with no modifying factors, such as changes in medications or psychosocial stimulation, the proportion of patients who became assaultive in the first 24 hours of admission was higher in the organic group than the nonorganic group. In the presence of modifying factors, a 20% decrease in aggression occurred in patients in the organic group, and the group with nonorganic conditions experienced a 9% decrease in aggression (Wystanski, 2000). This study confirmed that patients with organic conditions display more aggression and that the use of psychotropic medications is effective in the management of aggression in the inpatient geriatric population. Impulsivity, which is a common symptom of organic brain disorders, may be a factor in this group.

Crowner and associates (2005) conducted a study that focused on episodes of assaults between chronically ill patients in a long-term psychiatric care facility. The study grouped behavioral cues into three categories: threatening behaviors (yelling, arguing, physical contact), intrusive behaviors (following, touching, kissing, or placing a body part within 6 inches of someone), and

mixed cues (approach or initiation, competition, immediate threat, and the use of a karate or boxing stance). Results indicate 60% of assaults were preceded by at least one threatening or intrusive behavior; however, the earliest cues of assault were noted just 2 minutes before the assault (Crownier et al., 2005).

### ***Personality and Violence***

While acute symptoms such as delusions and hallucinations have been implicated in various violence prediction schematics, the importance of enduring personality traits is also an important clinical consideration. Features such as lifelong difficulties in regulating emotions, impulse control problems, narcissistic and entitlement cognitive style, and a tendency toward paranoia and a hostile attributional bias are all factors relevant to violence management in hospital settings. The cluster B personality disorders, most notably antisocial personality disorder and borderline personality disorder, include violent behavior in their diagnostic criteria and have been associated with inpatient violence and habitual violence.

*Psychopathy* is a damaging personality syndrome that includes emotional, interpersonal, and behavioral characteristics such as a callous disregard for others, shallow emotion, egocentricity, lack of empathy, pathologic lying, proneness to boredom, thrill seeking, and a propensity to highly impulsive and irresponsible behavior and criminal versatility (Hare, 1991, 2003). It has been noted that while only about 1% of the general population has the psychopathic syndrome, these people are associated with a markedly disproportionate frequency of violent crime, white collar crime, and other forms of social distress (Forth, Kosson, & Hare, 2003). Compared to the general population, people with psychopathy are vastly overrepresented in the forensic population (Hare, 2003). The gold standard in measurement of psychopathy is the Psychopathy Checklist Revised (PCL-R). A high score on the PCL-R is a highly robust predictor of future violence. It has been estimated that between 15% and 20% of forensic patients score high on the PCL-R. Among sex offenders, especially rapists, the percentage of high scorers has been reported to be between 35% and 50%. The presence of psychopathy has important implications for assessing risk of dangerousness and for risk management in helping relationships (Love & Hunter, 1996).



### *Staff factors*

Patient characteristics alone cannot completely explain the violence that occurs in psychiatric units; certain staff member characteristics, attitudes, or communication styles may result in staff being the target of violence (Ray & Subich, 1998). Mackay, Paterson, and Cassells (2005) conducted a qualitative study of mental health nurses to examine the process of observation of violent patients, nursing skills used during the observation, and benefits and drawbacks for the observed patients. The process of close observation of acutely disturbed psychiatric patients was more than “just watching”; it was described as both caring and interactive. Six effective nursing roles included intervening, maintaining safety of the patients and others, preventing de-escalation and managing aggression and violence, assessment, communication, and therapy. Nurses skilled in these roles, along with years of experience, were thought to have an impact on the success of interventions in practice.

The immediate environment can either raise or lower an individual’s level of dangerousness, and nursing staff behaviors function as antecedents and consequences to aggression (Love & Hunter, 1996). Whittington and Wykes (1994) found that 86% of assaults on staff occurred immediately after the nurse intervened with a patient frustration or requested a patient do some activity.

The recent mental health consumer movement has made it clear that service providers tend to overuse coercive measures. The terms *psychiatric survivor* and *sanctuary harm* appear in the lay and scientific literature (Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005). The degree to which a patient feels coerced (and therefore powerless or cornered) depends largely on the manner in which staff communicates with the individual, according to Monahan and colleagues (1995). In his classic study of asylums, Goffman (1961) noted that a basic split exists between staff and patient realities—two world views that essentially run parallel, rarely intersecting. His observations apply to contemporary institutions. Opinions vary widely between consumers and providers when asked about the same violent incident. Typically, patients perceive staff behavior to be more coercive than the staff members think it is. In a review of the literature on consumer perceptions, Abderhalden, Hahn, Bonner, and Galeazzi (2005, p. 74) concluded that “among all research samples, users consider staff behaviors as a

central cause of violence describing it as ‘provocative and disrespectful.’” Power struggles between staff and patients commonly take place in secure settings. Power struggles, if not handled delicately and diplomatically, can activate a violent incident.

Researchers now understand that violence in psychiatric hospitals is highly contextually based. The experiences of both parties—staff and patients—can be useful to deepen the staff’s understanding of violence across many inpatient settings. Units with high predictability, order, and organization have fewer violent incidents than units that are haphazard, disorganized, and unpredictable (Katz & Kirkland, 1990).

The 2007 APNA Position Paper on Seclusion and Restraint discusses prevention of aggression by (a) maintaining a presence on the unit and noticing early changes in the patient and the milieu (Delaney & Johnson, 2006; Johnson & Delaney, 2007); (b) assessing the patient and intervening early with less restrictive measures such as verbal and nonverbal communication, reduced stimulation, active listening, diversionary techniques, limit setting, and as-needed medication (Canatsey & Roper, 1997; Johnson & Delaney, 2007; Johnson & Hauser, 2001; Lehane & Rees, 1996; Maier, 1996; Martin, 1995; Morales & Duphorne, 1995; Richard, Trujillo, Schmeizer, Phillips, & Davis, 1996); and (c) changing aspects of the unit to promote a culture of structure, calmness, negotiation, and collaboration rather than control (Cahill, Stuart, Laraia, & Arana, 1991; Delaney 1994; Harris & Morrison, 1995; Johnson & Morrison, 1993; Whittington & Patterson, 1996).

### *Staffing*

Relative to violence prevention, the role of staffing is consistently cited as a critical factor. To date, the relationship between staffing and skill mix is poorly understood. Bowers and colleagues (2007) found a significant relationship between lack of staff availability (and/or lack of adequate staffing levels) and the incidence of violence.

In many psychiatric settings, the least-trained staff members (e.g., ancillary staff, aides, mental health technicians, behavior specialists, etc.) spend the most time with the patients. The training

requirements for ancillary mental health workers vary widely from state to state (Quinn & Love, 1993). Many of these care providers are unlicensed and have limited on-the-job training. Many studies from medical nursing settings demonstrate that the proportion of registered nurses to other nursing personnel is directly related to quality indicators. That is, the higher the nurse-to-ancillary staff ratios, the better the care. In her study of five inpatient settings, DeLacy (2005) found a negative correlation between the proportion of nurses to other nursing personnel and the number of hours and events of seclusion or restraint.

### ***Staff Education***

To date, there are no national standards for staff training in the prevention and management of inpatient violence. Given the scope and significance of inpatient violence, it is both curious and troubling that staff training programs vary widely in content and process and tend to lack a consistently scholarly and empirical base. Training in the management of assaultive behavior varies from setting to setting and can be as short as one hour and as long as ten days.

There are no standards or evidence compelling enough to draw conclusions about which patient containment tactics are safest. Historically, psychiatric workplace safety programs have been “home grown” programs designed by local staff involving physical tactics for containment, restraint and seclusion, and basic physical self-defense techniques. Farrell and Cubit (2005) evaluated the content of 28 violence prevention and management training programs. They found that the use of restraints, pharmacologic management of aggression, and seclusion were common features. Most programs did not address the psychological and organizational costs associated with aggression in the workplace. Although the authors concluded that the programs they reviewed did tend to cover basic content necessary to educate staff, Farrell and Cubit recommend further research to determine the effectiveness of these training programs.

Many violence prevention training programs focus on de-escalation skills for staff, and they teach that observable autonomic arousal (e.g., loud voice, muscle tension, pacing, pupillary dilation) is a precursor to inpatients’ violent incidents. Violence accompanied by a cycle of escalation is linked to emotional arousal. The patient is visibly upset and getting worse by the

moment. Staff members learn to stay calm, lower their voices, and avoid crowding or unreasonable demands. They make every effort to assist the individual in crisis by offering reassurance, negotiating, and arranging choices to allow the individual to “save face.”

Signs of emotional arousal do not precede all violent events, however. Certain kinds of events, by certain patients, may appear “unprovoked” or are carried out in an unemotional, cold, instrumental manner. The belief that some violent events are unprovoked is a fallacy. Behaviorally speaking, all human behavior has provocations and antecedents. Rather than being unprovoked, it is more accurate to say that provocations were hidden or unobserved. Thoughts and emotions can be provocations or antecedents to violent behavior. Predatory or instrumental violence (violence toward some end) tends to be associated with severe personality disorders, particularly antisocial and psychopathic traits. Training programs tend to miss this less frequent but potentially more dangerous subtype of violence. Being able to identify an individual’s psychopathic traits is a competency for all psychiatric nurses as they assess individuals who are at high risk of violence.

While most training programs emphasize de-escalation skills, it should be noted that de-escalation is a relatively late intervention. De-escalation implies that the crisis is already beginning. Efforts to establish rapport and to “know the patient” are early interventions. Inpatient staff should be trained to establish rapport with patients immediately so that, when a crisis begins, staff will be more influential and effective in preventing an emergency. Although people in psychiatric settings vary widely in their need and tolerance for alliance building, nursing staff should, whenever possible, engage with the people they serve and convey trust, empathy, consistency, and fairness.

Love and Morrison (2003) noted in their white paper on workplace violence that staff training programs in hospitals should include how to remain safe in a hostage situation. Although hostage-taking situations in health care are rare, they can be lethal. Hospitals should have an emergency hostage-response plan in place and maintain a close alliance with local police.

### *Prosecution for Assault*

Prosecution for criminal acts committed in a psychiatric hospital pose inherently complicated ethical, practical, clinical, and occupational health consequences (Coyne, 2001). Victims of an assault (patient or staff) have the right to report the incident to police. Staff have the obligation to report instances of dependent adult abuse, even if a fellow staff person or patient committed the abuse. The factors influencing the decision of whether to take action against an individual for an assault include the severity of the assault, the mental state of the patient, the context in which the assault occurred, and opinions about the therapeutic value (or lack thereof).

For many reasons, individuals in psychiatric settings often are not charged for their violent behavior. For example, district attorneys may be reluctant to prosecute assault cases for people who are already receiving treatment because of a criminal offense or people who are being restored to competency for a crime. Prosecution may affect the staff victim's recovery from an assault. If, on the one hand, the hospital is unwilling to submit the case for prosecution, this can lead to righteous indignation and anger. If a case is submitted and accepted, the staff victim or victims most likely will be involved in protracted legal proceedings and may have to face the assailant in court. This process can reactivate trauma responses.

When faced with a patient's criminal behavior, mental health agencies may resort to other forms of action such as discharge from the facility and transfer to a more secure, restricted care environment or other changes in the treatment regimen (Coyne, 2001).

Mental health agencies may not pursue prosecution for other reasons, such as negative publicity, concerns that the provision of service will be scrutinized, assurance of patient confidentiality, or the belief that staff provoked the attack. On the other hand, ignoring criminal behavior in the hospital undermines hospital security and creates the impression that antisocial behavior is acceptable. Many antisocial individuals go through life believing rules are for other people. If the hospital does not prosecute certain individuals for criminal behavior, the hospital wittingly reinforces this cognitive distortion. Inpatient psychiatric settings should not be "felony-free-

zones” that tolerate any and all forms of criminal behavior. Hospitals should have clear policies regarding who may prosecute whom for what and under what circumstances, as well as the process for making decisions on a case-by-case basis. Hospital bioethics committees may be involved. When violent instances go unreported to the police the instances never become part of the public record. Prosecution ensures that the aggressive act becomes an accessible part of the public record.

### ***Post Violence Staff Needs***

It is generally accepted that education and social support should be available for staff after they experience inpatient violence. The trauma and victimology literature provides a theoretical basis when studying the post-assault needs of nurses. For the past two decades, a large body of theoretical, clinical, and empirical literature has focused on the psychobiological effects of trauma. Various trauma survivor studies have empirically validated the following key points:

1. Most victims of violence benefit from talking about a violent incident.
2. The social environment of assaulted staff members can affect their recovery for better or worse.
3. The victim’s proximity to the assailant after the incident has implications for recovery.
4. The victimized staff member has to go about establishing a sense of personal safety and predictability in the workplace.

A Swedish study recommended group discussion for victims of patient violence (Arnetz & Arnetz, 2000). In Taiwan, Lu, Wang, and Liu (2007) sought to determine how occupational experience, in-service education, and social support can lessen the psychiatric nurse’s response to assault by a patient. The most common physical reaction was soreness in the area where the nurse was hit. Fear of the assaultive patient was the initial emotion, which was followed by feelings of anger. Other common reactions included the need to talk about the event, discomfort in caring for assaultive patients, suppression of the unpleasant feeling, desire to keep the incident a secret, and desire to retaliate. The greater the number of years of experience as a psychiatric nurse, the fewer the number of physical reactions reported. The more responses a nurse experienced in regard to the assault, the longer the time they required to return to work. Nurses

who received more social support after the assault had less severe emotional and social reactions (Lu, Wang, & Liu, 2007).

Lanza, Demaio, and Benedict (2005) implemented an extensive educational program for nurses who have experienced assault. The program consisted of twelve 1-hour sessions, each focusing on a specific content area. Sessions covered introduction and sharing of the assault experience, statistics and victim response, analysis of the assault experience (two sessions), relationship with patients, coworker relationships, relationship with family, placement of blame, role conflict, interventions, coping strategies, and personal plan development. The group was limited to 10 members. Results of the study indicate that participants had positive experiences with the program, rating the success of educational objectives as 4.9 or higher on a 5.0 scale. The program increased participant knowledge about the various aspects of assault (e.g., how the family of the victim as well as the victim reacts) and gave participants a supportive network, which helped them recognize that there were other individuals who have experienced similar emotions after such events (Lanza, Demaio & Benedict, 2005).

Unguided education may not be enough after a workplace assault. A study conducted in the United Kingdom (Nhiwatiwa, 2003) found a high risk of repeated assaults at medium-secure psychiatric facilities. Nhiwatiwa suggested this made staff more vulnerable to denial, which could slow recovery time. The author evaluated an educational booklet aimed at reducing the effects of trauma and improving coping measures after violence. The nurses who were assaulted in four medium-secure hospitals in England and Wales and who received the booklet showed greater distress scores 3 months later than those who did not get the booklet. Nhiwatiwa found that the booklet alone, without directions, did not help the nurses to cope with the stress of the assault. The author suggested additional study and different use of the booklet.

Critical Incident Stress Debriefing (CISD) is an intervention designed to support healthy coping and to reduce the immediate and long-term reactions of trauma victims, witnesses, and responders. It focuses on prevention and early intervention and may reduce the risk of chronic, disabling emotional and physical consequences (Antai-Otong, 2001). The components of CISD include immediate emotional support, education about normal stress reactions, symptom

reduction, and referrals for further intervention (Antai-Otong, 2001). In recent years many articles have claimed that CISD does not prevent PTSD. Some published reports have suggested that debriefing can actually make participants worse, by exposing them to graphic details from other participants. The studies from which these conclusions were drawn had no control over the quality and methods of the debriefing processes and were drawn from victims of car accidents, natural disasters, and violence in the community. Based on the available information, it is advised that (a) in extremely graphic incidents, first responders and eyewitnesses be debriefed separately from staff members who were not present at the traumatic incident; and (b) providers should refrain from claiming that CISD prevents PTSD, until the research findings become conclusive.

Practical recommendations derived from a study by Privitera and colleagues (2005) include the following: (a) multidisciplinary personal safety training to enhance team-building, improve communication, and help prevent violent events and (b) establishment of post-event protocols to assist staff victims and administrators in navigating complex issues occurring after a violent event (Privitera et al., 2005).

### ***Administrative Policies***

Hospital administration, staff, and even nurses have tended to view violence as part of the job. Expecting that patients will be violent renders everyone—staff, patients, and administrators—inured, or less concerned, when violent incidents occur and result in an institutional tolerance for violence (Blair, 1991). Whenever a violent event occurs, the administration should view it as a system failure and should evaluate it as such. If a patient assaults a staff member, the patient owns the violent behavior. Staff should not be blamed for the behavior of an individual patient or group of patients.

It should be made clear, however, that staff members are accountable for their competence in the workplace; that is, they are competent to perform therapeutically and safely in the work environment. In some situations, the manner in which the staff interacts with the individual may be provocative and tends to escalate the problem rather than defuse it. Administration must not



tolerate staff behaviors that are nontherapeutic; these behaviors demonstrate incompetence, and processes are necessary to correct these individual's competence.

### ***Legislation***

Some states have added nurses to their list of protected job classifications. So-called "hit a nurse, go to prison" legislation makes it a felony to assault a nurse. It is now a felony to assault a nurse in Alabama, Arizona, Illinois, Massachusetts, Nevada, and New Mexico. In other states it is a felony to assault a police officer, an emergency medical technician (EMT), an animal regulations officer, and a little league umpire, but not a physician or nurse. At the time of this writing, New York nurses are lobbying for the same type of legislation (Press and Sun-Bulletin, April 8, 2008). Consumer groups, however, have lobbied to prevent this type of legislation from passing, for fear of "criminalizing the mentally ill."

### **Outpatient Psychiatric Settings**

Mental health regulatory agencies and public policies over the past several decades have emphasized the use of community-based treatment settings rather than inpatient settings for patients with psychiatric needs. The major national movement to deinstitutionalize mental health services about 25 years ago has led to a vast growth of outpatient mental health services. Despite the push to deinstitutionalize mental health services, very little research exists in regard to violence in outpatient psychiatric settings. Part of the reason may be that researchers tend to focus on physical violence, rather than nonphysical violence.

Violence in outpatient care settings such as psychiatric clinics and partial hospitalization programs have been steadily increasing. Ambulatory patients often are in crisis, have recently left the hospital or prison with a history of violence, or have a substance abuse problem, which also increases the risk of physical violence.

## ***Targets***

Often security is not present in outpatient clinics, so mental health staff is vulnerable. Repeatedly violent patients in outpatient psychiatric units are more likely to assault staff than fellow patients (Blow et al., 1999).

One study of outpatient service settings found that employees identified clients, frequently mentally impaired clients, as the perpetrators in physical aggression and violence, whereas other employees were frequently the perpetrators of nonphysical violence (Findorff, McGovern, & Sinclair, 2005). In another study, medical and nursing colleagues were the second most common perpetrators of workplace aggression after patients/clients or their visitors (Farrell, Bobrowski, & Bobrowski, 2006).

When patients are the victims, females are found to be at greater risk of suffering assault than male patients (Flannery, Fisher, & Walker, 2000).

## ***Risk Factors***

Otto (2008) classified violence risk factors in outpatient settings as static or dynamic. *Static* risk factors are those that either cannot be changed, such as age and gender, or those that are not particularly amenable to change, such as psychopathic personality structures (Otto, 2008). *Dynamic* risk factors are those that are amenable to change, such as substance use/abuse or psychotic symptoms. There are two types of dynamic risk factors: acute and stable. The *acute* dynamic risk factors refer to client conditions, such as alcohol intoxication, that can change rapidly and tend to pose imminent risk. *Stable* dynamic risk factors refer to client conditions, such as alcoholism, that do not pose imminent risk but are amenable to change over time.

Static risk factors that Otto (2008) identified include the following:

- history of violence (significantly increased risk if the violence began before age 12 years)
- victim of and/or witness to domestic violence

- low IQ score or neurological impairment
- antisocial personality disorders and traits

Dynamic risk factors include (Otto, 2008):

- substance abuse
- poor medication compliance
- psychotic symptoms that induce perceptions of threat or perceptions that external forces are controlling one's actions
- stressors such as environmental, health, financial, or interpersonal
- command hallucinations, especially if the internal voice was familiar
- current symptoms and/or history of anger, impulsivity, irritability, and poor judgment related to underlying mental illness or disorder

### *Client Factors*

Rew and Ferns (2005) examined the current literature and identified the following patient/client factors that may trigger aggression or violence:

- fear and anxiety
- past experiences of personal and/or workplace violence
- lack of self-confidence and self-esteem
- personal problems
- misunderstandings or lack of communication
- troublesome journey to the hospital or clinic
- pain, disease, or conditions that affect an individual's mood and behavior
- use of drugs or alcohol
- perceived loss of control or autonomy over a situation
- a feeling of depersonalization

Flannery, Fisher, Walker, Kolodziej, and Spillane (2000) examined assaultive behavior directed toward staff of community-based residential facilities. Their long-term results are consistent with

other research findings, which indicate that in assaultive patients with a diagnosis of schizophrenia, gender does not play a role in the number of assaults. However, unlike some recent findings of younger age and a high frequency of personality disorder among assaultive patients, the assaultive patients in this study were on average older, and most did not have a personality disorder diagnosis.

A diagnosis of schizophrenia was present in 47% of repeat assaulters in a study by Blow and associates (1999) of multiple assaults in VA medical centers and freestanding outpatient clinics.

### ***Staff Factors***

In the study by Blow and colleagues (1999) of multiple assaults on staff and other patients, nursing staff members were the typical targets of attack. This study found that most assaults occurred during the day shift (7 a.m. to 3 p.m.), a finding that the authors stated is in agreement with earlier studies, including those in non-VA settings (Blow et al., 1999).

Flannery, Fisher, and Walker (2000) examined patient assaults toward other patients and staff in community residences during the first 12 months after hospitalization for a group of patients who had not been violent as inpatients. They found lack of experience by staff to be a risk factor for assault.

### ***Consequences of Workplace Violence***

The consequences to staff of workplace violence in the outpatient setting are similar to those in the inpatient setting. For example, in a study of the prevalence of workplace aggression among 6,326 nurses in Tasmania, Australia, the consequences of workplace violence influenced the nurses' level of distress, their desire to stay in nursing, productivity, ability to meet patient needs, and potential to make errors (Farrell, Bobrowski, & Bobrowski, 2006). Despite the negative effects that violence had on the nurses, they were reluctant to make official reports.

## **Interventions**

### ***Risk Assessment and Screening***

To determine the risk of violence, psychiatric clinicians should utilize a screening tool (Rew & Ferns, 2005). Screening and risk assessment tools used in combination with traditional clinical assessment techniques can help clinicians form clinical impressions regarding violence risk.

Otto (2008) discussed the use in the outpatient setting of the HCR-20, an evaluation guide that covers 20 assessment areas relevant to identifying a client's potential for violence. The first section of this tool focuses on the client's history of violence, examining factors such as age of first violent incident, relationship instability, employment problems, substance use, major mental illness, early maladjustment, psychopathology, personality disorders, and prior supervision failure. The second section identifies clinical factors such as lack of insight, negative attitudes, active symptoms of mental illness, impulsivity, and unresponsiveness to treatment. The third section focuses on risk management items, such as feasibility of violent plans, exposure to weapons or substance use, lack of personal support, noncompliance, and stress. The HCR-20 can be reliably scored and has some predictive power compared with other violence risk assessment instruments (Otto, 2008).

## **Recommendations for Inpatient and Outpatient Settings**

### ***Clinical Practice, Education, and Research***

Based on the review of current literature, there are a variety of implications for clinical practice, staff education, and further research in both inpatient and outpatient settings.

#### ***Clinical Practice***

- Develop healthy, nurse-client relationships.
- Use structured assessment tools in combination with traditional assessment techniques to identify risk. Recognize factors that may predispose patients to becoming violent, including

- history of violence, particularly recent
  - head injuries, cerebrovascular accidents, cerebral pathology, organic brain dysfunction, or clinical brain injury
  - hypoxia
  - endocrine disorders: hypoglycemia or hyperglycemia
  - seizures: frontal, temporal, or limbic epilepsy
  - psychotic disorders, especially paranoid schizophrenia; hallucinations; depression, especially with history of suicidal tendencies; anxiety; or personality disorders (antisocial or borderline)
  - history of post-traumatic stress disorder
  - side effects of prescribed medication
  - intoxication or drug overdose, or drug or alcohol withdrawal
  - dementia or senility
  - disorders of childhood and adolescence: conduct disorders, hyperactivity, autism, or learning disability
- Implement preventive measures based on training and education programs.
  - Reduce and/or eliminate positive psychotic symptoms or other symptoms, including confusion and disorganization.
  - Reduce impulsivity through therapeutic methods in conjunction with medication if indicated.
  - Examine incidents of violence in the workplace to identify the underlying causes and the impact of the event on individuals who are involved.
  - Establish protocols to assist staff victims and administrators in navigating complex issues occurring after a violent event.
  - Encourage group discussions for victims of violence.
  - Design intervention strategies to address specific types of violence (physical and nonphysical).
  - Stress the importance of reporting physical and nonphysical incidents of violence in workplace settings.
  - Develop policies and procedures for safety in the event of a weapon threat, such as lockdown procedures, and practice them.

- Be informed and aware of one’s legal rights related to workplace violence.
- Take seriously and follow up on all threats, even verbal threats.
- When transferring to an inpatient facility have each patient checked thoroughly by security or other staff for any contraband items prior to transfer.
- Have a security guard at outpatient facilities
- Perform lockdown practice sessions on a regular basis.
- Familiarize staff with takedown procedures and practice them regularly (even though they are rarely used).
- Have a system in place for reporting all threats by phone and take immediate measures involving local police if a patient has made a threat and is en route to a clinic.

***Clinical practice specific to outpatient practice settings***

The following recommendations are based on experience in an outpatient clinic. Research and evidence-based practices are needed in this area:

- Complete a mental status examination and a risk assessment for each patient and document it. The following risk assessment questions are recommended:
  - Do you have firearms at home?
  - Is there a prior history of violence?
- Patients at high risk for violence should be seen within a 1- to 2-week timeframe after discharge from the inpatient setting; discuss these patients weekly in an interdisciplinary staff meeting.
- At interdisciplinary meetings with the high-risk patient present, discuss the ongoing behaviors that have been inappropriate (verbal escalation in the clinic, use of profanity, etc.). Give the patient a copy in writing of what behaviors are inappropriate, the expected behaviors, and the consequences the patient can expect if the behavior continues, such as the termination of services to the patient.
- Ensure that all staff members know the behavioral expectations of clients and are aware of any behavioral contract.
- Maintain relationships with local police and use “welfare checks” on high-risk clients.
- Encourage clients to sign releases of information to facilitate communication regarding the client and improve continuity of care.

- Teach clients that when there is a risk of harm to others, the Health Insurance Portability and Accountability Act (HIPAA) privacy laws do not apply and staff has a duty to report a realistic threat.
- All threats should be taken seriously with follow-up with patients, making the patient accountable for such threats.
- Call police when necessary to an outpatient facility (when possible, have them come in a back entrance to minimize alarm for other patients).
- A list of patients recently discharged and/or at a high risk for violence and/or with a previous history of violence should be kept. Some computerized systems can even flag these patients; if they are later evaluated as lower risks the “high-risk” status can be changed through a call to the “gatekeeper.”
- Recommend alarm systems in all outpatient office areas, which are wired to a main desk or to security.
- Recommend use of regular rounds by security and walkie-talkie connections to security in outpatient clinics when available.
- Recommend use of visual screening/monitoring devices when available to monitor parking lots, entrances and exits, and remote parts of the facility.
- Recommend use of visual monitoring systems for areas in and around the clinic when possible.
- Recommend outpatient facilities have all exits and entrances (except the main entrance) monitored with access only via a fob (electronic system of entry) for staff.

### ***Staff education***

- Define workplace violence and the types, causes, and consequences of violence.
- Discuss work-related violence prevention and management policies and procedures, including reporting work-related harassment and assault.
- Recognize the early signs of escalation, identify patient and staff factors that increase risk, and learn structured assessment processes in order to prevent violent episodes.
- Conduct personal safety training, such as how to operate safety alarms or other safety devices.



- Address nonphysical and physical techniques that decrease the potential for injury for all individuals (staff and patients), such as conflict management, de-escalation techniques, and effective communication skills.
- Train in crisis debriefing, coping skills, alternatives to restraint and seclusion, and trauma informed care approaches.
- Explain legal and ethical concepts related to workplace violence.

### ***Research***

- Develop consensus-based definitions so that research findings can be compared and replicated.
- Determine the effect of relationships on reducing the incidence of violence in inpatient settings.
- Review legal issues and responsibilities of addressing violence in clinical practice.
- Evaluate outcomes related to staff training (recognizing early signs of escalation and the effectiveness of techniques used in de-escalation).
- Assess outcomes of the use of structured assessment tools in combination with traditional assessment techniques to identify risk
- Identify which techniques help contain the violent individual with the greatest degree of safety.
- Examine staff characteristics and environmental factors that increase the risk of aggression and violence.
- Explore the effect of nurse-patient relationships on reducing the incidence of violence.
- Develop a uniform standard instrument or instruments for measuring aggression and violence that will identify the type and mode (direct or indirect) of aggression and the severity of the impact (physical, psychological, and/or emotional).
- Test the effectiveness of proactive strategies such as establishment of work environments that are not conducive to violent behavior.
- Include longer follow-up periods in studies.

## ***Horizontal (Lateral) Violence***

### ***Clinical practice***

- Help create a work environment that facilitates and supports collegiality and effective communication and interpersonal skills.
- Develop clear organizational guidelines regarding the responsibility of all leaders and employees to be accountable for workplace behavior and implement measures for reporting, documenting, and addressing bullying.
- Inform all staff about the existence of such guidelines during orientation and annual review, and via EAP programs.
- Intervene when witnessing victimization and bullying of colleagues.
- Change a culture of horizontal violence by:
  - observing for verbal and nonverbal cues of horizontal violence in the behavior of your staff;
  - raising the issue at staff meetings and allowing staff members to tell their stories of horizontal violence;
  - being responsive when staff members bring concerns of horizontal violence to your attention;
  - engaging in self-awareness activities and reflective practice to ensure that your leadership style does not support horizontal violence.

### ***Staff education***

- Educate newly graduated nurses on horizontal violence, and provide cognitive rehearsal techniques (role modeling and rehearsal in an interactive session using cue cards with a script and professional behaviors for each of the identified types of horizontal violence).
- Coach nurses to develop their conflict management and conflict resolution skills.
- Provide ongoing education to reinforce the organization's commitment to ensuring a caring and respectful environment.

### ***Nursing education***

- Teach students that horizontal violence is not acceptable.

- Educate about horizontal violence, including how to identify it and appropriately confront it. Include cognitive rehearsal techniques.
- Mentor students, building their self-esteem and self worth.
- Equip students with assertiveness tools and with conflict resolution and healthy communication techniques.

### ***Research***

- Determine whether zero tolerance policies or sanctions against aggressive behavior are effective in preventing aggression.
- Evaluate the effectiveness of organizational training programs aimed at preventing aggressive behaviors.
- Assess whether emotional or other support from organizational insiders (e.g., peers, supervisors) and outsiders (e.g., family members, friends) lessens the negative effects of workplace aggression on victims.
- Examine which leadership styles promote assertiveness and lessen bullying.
- Identify which strategies most effectively reduce horizontal violence in the workplace.

### ***Organizational Recommendations***

#### ***Professional nursing organizations***

- Continue to advocate for a safe work environment for all nurses.
- Continue to recommend research and education in this area.
- Acknowledge horizontal violence, including bullying, as a very real problem in the workplaces of nurses.
- Increase awareness of this issue among nurses, nurse researchers, employers, and the general public.
- In all publications use the standard definitions for workplace aggression and violence, as outlined in this document.
- Lobby for legislation that would increase assault of a health care worker to felony status.
- Request that OSHA guidelines become mandatory for health care workplaces.

### ***Employers of nurses***

- Establish and maintain a comprehensive program for prevention and management of all types of workplace violence.
- Analyze workplace security and perform risk assessments of the physical environment.
- Improve screening of potential employees.
- Select staff preceptors who will support workplace violence policy and who will intervene if they observe other staff demonstrating any horizontally violent behaviors.
- Make ongoing formal education about workplace violence compulsory.
- Reward outstanding role models.
- Track all assaults no matter who was the victim or where or when in the organization they occurred, and use performance improvement strategies as indicated.
- Ensure anonymity in reporting through the use of occupational health or human resources.
- Modify administrative practices to ensure the following:
  - time-out areas and quiet places
  - adequate staffing
  - specialist security staff
  - covert distress messages and coded responses
- Provide environmental security features such as
  - personal alarms and panic-button alarms
  - bulletproof glass
  - adequate lighting
  - metal detectors
  - two-way communication systems
  - closed-circuit television
  - controlled access to, and security monitoring of entrances, exits, and high-risk areas of the facility.

## Appendix

### Cue Cards for Responses

**Nonverbal Innuendo** (raising eyebrows, etc.)

I sense (I see from your facial expression) that there may be something you wanted to say to me. It's okay to speak directly to me.

**Verbal Affront** (snide remarks, lack of openness)

The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation?

**Undermining Activities** (unavailable, turning away)

When something happens that is "different" or "contrary" to what I understood, it leaves me with questions. Help me to understand how this situation may have happened.

**Withholding Information** (practice or patient)

It is my understanding that there was (is) more information available regarding the situation, and I believe if I had known that (more), it would (will) affect how I learn.

**Sabotage** (deliberately setting up negative situation)

There is more to this situation than meets the eye. Could you and I meet in private and explore what happened.

**Infighting** (bickering with peers)

Always avoid unprofessional discussions in nonprivate places. This is not the time or the place. Please stop (physically walk away or move to a neutral spot).

**Scapegoating** (attributing all that goes wrong to one individual)

I don't think that's the right connection.

**Backstabbing** (complaining to others about someone instead of talking to him/her)

I don't feel right talking about him/her/the situation when I wasn't there or don't know the facts. Have you spoken to him/her?

**Failure to respect privacy**

It bothers me to talk about this without his/her permission. I only overheard that. It shouldn't be repeated

**Broken Confidences**

Wasn't that said in confidence? That sounds like information that should remain confidential. He/she asked me to keep that confidential

Adapted from Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing*, 35(6), 1-7.

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