

"Taking Back" the Workplace

Workplace Violence: A Hidden Risk in Women's Work

À cause d'inégalités sociales et structurelles, d'attitudes sexistes, ou de leur position sur les lieux de travail, les femmes sont souvent victimes de violence au travail. Cette violence comprend des abus de pouvoir, des menaces, du harcèlement sexuel, sexiste ou raciste, aussi bien que des assauts physiques. Les études publiées soulignent le cas des infirmières, des enseignantes et des travailleuses sociales, mais le tableau n'est pas complet. Les femmes qui travaillent auprès du public dans des fonctions cléricales d'aide détiennent un pouvoir apparent envers leurs clients, mais aucun contrôle réel. Lorsqu'elles interagissent avec des personnes qui, comme les bénéficiaires de l'aide sociale, ne contrôlent pas eux non plus leur situation, ces travailleuses peuvent devenir la cible de colères déplacées. On attribuera parfois ces épisodes de violence aux comportements des travailleuses, alors que les causes structurelles de ces abus demeureront cachées. On a développé, en Angleterre, une approche utile pour un processus de résolution de problèmes. Les sources potentielles de violence sont détectées à partir d'un examen des facteurs associés aux assauts, à la situation des travailleurs, à leurs interactions, à l'environnement de travail et à la tâche à accomplir, selon une approche non culpabilisante. Ce processus aboutit à une meilleure reconnaissance des problèmes inhérents à l'organisation du travail, aux procédures pour rapporter les événements, à la formation et au soutien du personnel. Des recherches ultérieures devraient porter sur l'évaluation de ces processus de résolution de problèmes, et sur un élargissement des recherches sur la violence. Cela, afin d'inclure ces secteurs peu étudiés, en incorporant les connaissances acquises grâce aux recherches sur la violence contre les femmes dans d'autres contextes.

Because of social and structural inequities, sexist attitudes and the position of women in the workplace, women are often the victims of workplace violence. Forms of violence include: abuse, threats or assaults,

including severe verbal abuse and persistent sexual and racial harassment. Published reports focus on nurses, teachers and social workers, but there are missing voices. Many of those dealing with the public in clerical and support positions have perceived power over others, but no real control. When they deal with people, such as welfare recipients, who also lack control over their situations, workers may become objects of displaced rage. The workers' behaviour may be blamed for violence at work while the structural reasons for on-the-job abuse remain hidden. The British offer a useful framework for a problem-solving process. Potential sources of violence are identified by examining in a non-blaming way factors associated with assailants, workers, the interaction between them, the work environment and the outcome. Responses developed from this process include recognizing problems in work organization, reporting, training and support procedures. Further research should focus on assessing problem-solving measures, widening the scope of research to include the missing voices and incorporating insights from research on violence against women in other contexts.

INTRODUCTION

Violence at work is a serious public health hazard — perhaps one of the most serious in jobs where workers deal with people. It has been minimized, like "family violence," or tolerated as "part of the job." Women, as the caregivers and the front-line service and clerical workers in our society — the people who deal with people — are most at risk for this oft-ignored occupational hazard.

That is the overall picture, pieced together from work done by a few researchers and some unions, and from anecdotal evidence collected from a variety of workers in Canada, the United Kingdom and the United States.¹ In this article I will define and examine some of the evidence about workplace violence, focusing on how it affects women. After describing an analytical approach to the issue, I will discuss a variety of possible solutions and conclude with some recommendations about work to be done.

DEFINING VIOLENCE

Violence is about power and control. It is a process that involves using force or deliberately trying to intimidate someone; the abuser may feel frustration or powerlessness or be fighting loss of control.² It is a social problem with structural sources, not a medical or psychiatric issue (Morrison, 1987-1988).

This description will sound familiar to those interested in violence against women and to those concerned with workplace violence. Unfortunately, there is little crossover between the two topics (one exception is Roberts, 1991). The Montreal massacre was not commonly described as an attack against women at work (although those killed or injured were Polytechnic employees or future workers) and workplaces are described as "safe" places for battered women (Kahn, 1991). The recent Canadian report on violence against women continues this separation, limiting workplace violence almost exclusively to a discussion of sexual harassment and ignoring the wide spectrum of other literature, and other definitions, available (Canadian Panel on Violence Against Women, 1993).

This gulf in understanding may partially explain the inconsistent definition of workplace violence.³ Some authors use the words without defining their meaning; others use different terms and/or limitations (Kushnir Pekrul, 1992; Lipscombe and Love, 1992; Mahoney, 1991; Schniedon, 1992).⁴ Some limit their focus to physical assault, or assault resulting in injury,⁵ ignoring many of the subtler aspects of violence at work, particularly as they affect women. Others say verbal abuse, including harassment, provides a much more accurate picture of the extent of aggressive behaviour, is a good indicator of the potential for physical assault and improves understanding of the impact of aggression (Lanza and Campbell, 1991). A proposed United Nations Declaration⁶ recognizes non-physical abuse or assaults when defining violence against women, and interview-based studies of workplace assaults almost always show that physical injury is just the tip of the iceberg (Poyner, 1989).

In this discussion of workplace violence, I have used the definition developed by the Canadian Union of Public Employees (CUPE), which places the violence in the context of a process that includes actions, causes, effects and responses:

Violence is any incident in which an employee is abused, threatened or assaulted during the course of her/his employment. This includes the application of force, threats with and without weapons, severe verbal abuse and persistent sexual and racial harassment (Pizzino, 1994).

IDENTIFYING THE PROBLEM

Murder is Definitely Violence

Homicide is the leading cause of occupational death for American women (41 percent of American women killed on the job from 1980-1985 were murdered) and the third most common cause of death for all American

workers between 1980 and 1989 (National Institute for Occupational Safety and Health [NIOSH], 1993).

Workplace homicide is so serious a problem that the National Institute for Occupational Safety and Health issued an alert about the topic in September, 1993 (NIOSH, 1993). Its background study showed the risk for women to be highest amongst stock handlers and baggers (eg. in liquor or grocery stores), police and detectives and hotel clerks (Castillo and Jenkins, 1994). The authors postulated that working alone, working in the late evening or early morning hours and exchange of money were key high risk factors. Others agree that robbery is often the original motive in the U.S.; a California study found the highest workplace homicide rates for women in retail and personal services work, where handling money was a key factor (Kraus, 1987).

Gender is rarely considered in studies of murder on the job. A 1992 American review found only six articles and no systematic review of female workplace homicides (Levin, Hewitt and Misner, 1992). Retail trade and service industries are cited most often as being at highest risk. (Food and dairy stores, eating/drinking establishments and gasoline service stations were the most dangerous.) Jobs with the highest risk included sales personnel, service employees (eg. waitresses and grocery baggers), managers and clerical workers. Gunshot wounds were the primary cause of death, although older women were more often stabbed to death. One study examined cases reported to a surveillance system between 1980 and 1985 (Bell, 1991). The highest rates were among working women 65 years of age or older and blacks (killed at 1.8 times the rate of whites). The most frequent time for attacks was between 4 and 5 p.m., but 30 percent were killed between 6 p.m. and midnight and 69 percent between 3 p.m. and 7 a.m.

There may be up to 24 workplace homicides a year in Canada and Quebec, according to the only published study of workplace homicide here (Liss and Craig, 1990). After examining the 84 work-related homicides in Ontario between 1975 and 1985, Liss and Craig confirmed many American findings. The ratio of work-related homicides to all homicides is of the same order of magnitude as in American studies, with a few exceptions. The 11 women killed in the 10 years were 25 percent of all women killed on the job in Ontario. The major job categories posing risk for women were sales and managers/professionals.

Workplace Violence in General

Occupational sectors with the highest risk of workplace homicide usually also have the highest risk of non-fatal injuries from occupational violence

(Hales et al., 1989). However, there is little material about workplace violence in general, except a few American studies of occupational violent crime (OVC) injuries from attack, rape and/or the psychological effects produced by a criminal act. In one study, 21 of 59 injuries were from rape or attempted rape; this study found that retail food industry workers were at highest risk (Thomas, 1992). When Hales et al. (1989) examined Ohio workers' compensation claims from 1983 to 1985, they found rapes were most common amongst grocery store workers (especially those in convenience stores) and real estate employees, but overall OVC rates by gender could not be determined.

The only general report of less physically violent forms of workplace abuse is Stockdale and Phillips' (1989) survey of 800 women and 200 men in England. Those most vulnerable to physical attack were carers, retail outlet workers and professionals who often worked outside the office.

For the most part, though, recent studies and reports about workplace violence have concentrated on experiences in three sectors: health care, education and social work.

Violence in Health care

It would be difficult to find an experienced, practising nurse in Canada today who at some time in his or her career has not been struck, pushed, insulted, threatened, kicked or had something thrown at him or her by a patient. Yet, the extent of the abuse and its ramifications is one of nursing's better kept secrets (McCaskell, 1990).

Assault is an occupational hazard in hospitals⁷ and a psychological stressor for health care personnel (Leppänen and Olkinuora, 1987; Sullivan, 1993; Browner, 1987). Reports of patient assault date back to 1889 (Lanza, Kayne, Hicks and Milner, 1991) but only recently has there been a plethora of published stories and studies about nurses' experiences.⁸ The British Health and Safety Executive (HSE) reported in 1986 that, amongst health authority workers, nursing staff and ambulance crews were most at risk of assault (HSE, 1986). In the early 1980s, UK and American studies began to concentrate on mental health facilities⁹ and, more recently, hospital emergency rooms.¹⁰ Those studies included some investigations of long-term care facilities and pediatric units (Bollinger and Edwards, 1989).

In Canada, where 95 percent of nurses are female (Statistics Canada, 1993a), nurses have studied their own work. When the British Columbia

Nurses' Union (BCNU) commissioned a study in 1991, 72 percent of the 505 respondents had been abused or threatened within the previous five years and 22 percent had been injured; 8.2 percent had experienced more than 100 separate incidents. Verbal abuse was almost universal and 83 percent had been grabbed, 79 percent hit, 68.5 percent threatened with physical violence, 62.5 percent kicked and 51 percent had faced "mental harassment" (BCNU, 1991a).

B.C. nurses had 651 successful violence-related workers' compensation claims from 1986 to 1990 — a figure which comprises 11 percent of all their accepted time loss claims in those years (Gawthrop, 1991; BCNU, 1991b). Between 1985 and 1989, nurses, nurses' aides and orderlies were paid for 7633 "days lost" due to violence on the job (a doubling of their rates in that time), compared to 936 for law enforcement officers, who are usually viewed as being at high risk of attack (BCNU, 1992). Next door in Alberta, the picture is similar: Its compensation board accepted 130 claims in 1992 from nurses for acts of violence resulting in injuries, compared to 56 from police officers (Brasen, 1993).

Verbal abuse was most common in a Saskatchewan survey (Kushnir Pekrul, 1992), affecting 81 percent of the 720 registered nurses working in clinical patient settings. Fifty-four percent had experienced physical abuse in the previous 12 months; patients were usually responsible.

In Manitoba, more than half of the province's 10,000 registered nurses answered their union's 1987 questionnaire (Manitoba Association of Registered Nurses, 1989). In acute care facilities, 31 to 44 percent of respondents had been subjected to verbal abuse. That figure rose to 59 percent in extended/personal care work and was more varied in community agencies. Physical abuse was much less common in community agencies but rose dramatically in acute care and extended/personal care.

The situation is no better in Ontario, where several studies have been done (Roberts, 1991; Lechky, 1994a; *The ONA News*, November 1992). In a 1991 survey of 800 Ontario nurses, 59 percent reported having experienced physical assault during their careers, 35 percent in the previous 12 months and 10 percent in the previous month (Nurse Assault Project Team et al., 1992). Ninety-two percent experienced harsh or insulting language on the job. Patients were responsible for most physical assaults, while harsh and insulting language came most often from patients, patients' families and physicians. Male nurses reported an average of 3.3 assaults in the previous year, compared to 2.1 for female nurses.

After these results were published, the Ontario Nurses Association asked the Ontario government to examine non-supervisory nurses' compensation claims for violence-related injuries. Only accepted claims were

used for the 1987 to 1989 study period, and it was found that male rates were 13.9 per 1000 while female rates were 1.4 per 1000 (Liss, 1993). This was 54 and six times higher, respectively, than rates for men and women in the entire Ontario labour force. Most nurses were "struck by" people. The Ontario study could not determine if nurses filed claims about verbal harassment as well, or if the Board accepts those claim types.

Health care workers are often subjected to sexual harassment and assault.¹¹ The findings range from one in six Ontario nurses being sexually assaulted at work (Phillips and Schneider, 1993), to 26 percent in the BCNU survey (1991) who had to deal with sexual advances, to 39 percent of the Saskatchewan respondents reporting sexual harassment (Kushnir Pekar, 1992). Patients and physicians are usually the culprits. In a violence survey at an Ontario hospital, nurses wrote "reams" about sexual harassment by doctors, even though they were not asked about it (Lechky, 1994a). Seventy-seven percent of female Ontario doctors responding to a survey reported having experienced sexual harassment by a patient at least once in their career (Phillips and Schneider, 1993).

Violence in Social Work

Books have been written about violence in social work (see Owens and Ashcroft, 1985; Brown et al., 1986). Schultz (1987) says social workers are seen as system critics, making them vulnerable at times of stress, not just because of who they are or what they do but because of what they represent. He found types of physical violence, verbal threats and property damage varied, depending on where the respondents worked. For example, 25 percent of social workers in correctional settings reported knife attacks. Verbal threats were common in all work settings but most pronounced in correctional institutions.

There are few published reports from Canada, where 72 percent of social workers are women (Statistics Canada, 1993a). When the Alberta Union of Public Employees (AUPE) surveyed 1,111 social service and institutional workers in 1985, 30 percent had been physically assaulted, 42 percent physically threatened and 61 percent verbally threatened (AUPE, 1986). In late 1993, a union representative said that, in the Alberta Department of Family and Social Services, there were 59 "security-related incidents" in the second quarter of 1993, compared to 51 in the first three months of the year (COHSN, October 4, 1993).

CUPE analyzed the responses of its Ontario social service workers (70 percent of whom are female) to the union's national survey and found that 65.2 percent of surveyed workers had been subjected to at least one

aggressive act at work in the previous two years (CUPE, 1993). Forty-eight percent of workers reporting acts of aggression said that they had been subjected to more than three such incidents in the previous two years. Verbal abuse, including death threats, was most common, but workers were also struck, scratched, hit, kicked and grabbed.

Like nursing staff (see Lechky, 1994b), social workers often must return to work with the individual who assaulted them. Unless action is taken against assailants, where warranted, this may appear to condone their actions. This no-win situation becomes an additional stressor for workers (Wigmore, 1995).

Violence in Education

Education is the third major sector where violence has been recognized as an occupational hazard. The issue is important in England, where the government has issued an education sector guideline (Health and Safety Commission, 1990).

In Canada, 70 percent of teachers and related workers are female (Statistics Canada, 1993a). In 1990, the Manitoba Teachers' Society (MTS) looked at violent events during the previous 15 months amongst members who taught kindergarten to grade 12 (MTS, 1990). Seven percent of respondents had been physically assaulted and almost 40 percent had been abused in some way. A 1993 update showed increased rates of violence (MTS, 1993). The current discussion in Ontario about "zero tolerance policies" to deal with school violence reflects either an increasing concern about the topic and/or an increased incidence. One reason it's on the agenda is work done by the Ontario Teachers' Federation (Robb, 1993a).

Violence Against Other Workers

There's one striking feature in all the above-mentioned reports. Except for some union work, studies and reports deal almost exclusively with professionals, ignoring the experiences of those who work with them in support positions, those shown to be at risk in the OVC studies and others who work with "the public." Women do many of these jobs (in 1989, women comprised 46 percent of Canadian sales workers [Shea, 1990]; and in 1991, 88 percent of bank tellers and cashiers were women [Statistics Canada, 1993a]).

There is a socially accepted incongruity between the position of, and respect accorded to, "professionals" at work and violence.¹² But the story

is different for those lower in the hierarchy, who have less control, prestige and voice, especially if they are women (CUPE, 1990). Their stories, like those of nurses, until recently have been heard only at union workshops or (especially for the non-unionized) informal settings. This is partly a result of the sometimes overt, sometimes subtle, condition of their employment: Violence is a part of the job (Wigmore, 1995).

For example, a recent review of violence in health care focuses on nurses and physicians (Jones, 1985). The people they work with are rarely mentioned (eg. nurses' aides, orderlies) or are totally ignored (eg. dietary, cleaning, clerical and reception staff).¹³ Liss (1993) agrees that other health care workers are at risk for workplace abuse but says nurses appear to be the victims in the majority of incidents. To support this statement, he cites three studies of American psychiatric hospitals. The experience in those hospitals may be atypical, however, and may not be relevant for hospitals in Canadian settings in particular.

We know that other health care workers face violence on the job:

- BC nurses' aides and orderlies file more than twice as many accepted compensation claims as do nurses for violence-related "injuries" (Britt, 1992). Acts of violence or force accounted for nurses' aides and orderlies' second highest category of wage loss claims in 1989 (Gawthrop, 1991). These claims numbered slightly more than all accepted provincial hearing loss claims and half all successful BC mining sector claims (Statistics Canada, 1991);
- 64 percent of 328 Nova Scotia CUPE members working in 19 homes for the elderly were verbally abused and one-third suffered work-related stress (CUPE, 1990), and the 399 accepted violence-related compensation claims in 1992 were more than 10 percent of provincial health care "accidents" (Pizzino, 1994);
- a Finnish study of health care personnel's psychological stressors refers to a study showing cleaners and social workers were attacked at the same rate (Stymme, 1981);
- the only published English-language study of nursing home nursing aides (according to Statistics Canada [1993a], 83 percent of Canadian "nursing attendants" are women) calls for attention to reducing abuse of these workers, saying the only similar study (about student nurses) also found high assault rates (Lusk, 1992); and
- several authors (Lavoie et al., 1990; Jones, 1985; Convey, 1986; Rix and Seymour, 1988) report that nursing assistants are assaulted more than staff nurses, although in some American public and psychiatric institutions, nurses were more likely to be injured than aides, orderlies and all other staff combined (Rosenthal et al., 1992).

Some of the "missing voices" have work similar to the wide spectrum of service and public sector jobs held by CUPE members. Therefore, a recent survey of the union's members and locals offers some insight into the experiences of these "missing voices" (Pizzino, 1994). Some 1421 individuals (at least 72 percent female) responded to the survey. Sixty-one percent had been subjected to an aggressive act in the past two years and 55 percent of this group reported at least three attacks. Verbal abuse was most common (69 percent), followed by being struck with an object, hit, grabbed, scratched, kicked and slapped. Death threats comprised 20 percent of the verbal abuse; 60 percent was comprised of threats of injury.

Without a collective voice, non-unionized women's experiences are difficult to hear and must be pieced together from disparate studies. For example, in addition to the OVC studies, there is a British document about violence in bank work (HSE, 1993). The presence of these and other "missing voices" shows we have an incomplete picture of workplace violence and increases the odds that jobs at risk are ignored when activities are designed to prevent violence or deal with it when it occurs.

RISK FACTORS

A Framework for Identifying Risk

Something else is missing in most North American work about violence on the job — a comprehensive framework to analyze and address problems (Messing, 1991).¹⁴ It is important to look beyond the horror stories and limited descriptions of "occupation" or job title to more exact descriptions of activities — or "exposure" profiles — especially when investigating women's occupational health issues (Messing, 1991).

Fortunately, a useful framework for doing so is available in British government-sponsored materials about workplace violence.¹⁵ Like others who have studied the problem of workplace violence,¹⁶ the Health and Safety Executive (HSE) in Britain says working with "the public" is the key risk factor¹⁷ but that it is misleading to try to compare the size or seriousness of the risk in different sectors when developing solutions (Poyner and Warne, 1986). One HSE study showed that "... rather than simply reporting on the problems of violence in a variety of organizations, it would be more valuable to identify those aspects of the problem which were common across a wide range of organizations" (Poyner and Warne, 1988). The starting point for doing this in Britain is a five-element analytical framework (Table 1), developed by bipartite committees established by the HSE and based on a key public health principle: Attempt

to find solutions whether or not the cause of the problem is known (Poyner and Warne, 1988).

Table 1 Factors in Developing an Exposure Profile — The British Elements (Poyner and Warne, 1988)

Assailant: personality; temporary conditions (eg. drugs, alcohol, illness, personal stress); presence of negative/uncertain expectations; age and maturity (particularly immaturity in children); people with dogs
Employee: appearance (eg. physical build, uniforms); health (stress, other illness, overwork); age and experience; gender; personality and temperament; attitudes; expectations
Interaction: must involve direct contact (not necessarily physical contact, as in nursing, but contact that occurs when someone believes that the worker, or the system the worker represents, is being unfair or unreasonable)
Work environment: the total context of the job (ie. details of work and features of the organizational culture and physical environment: relationships between workers and co-workers and managers; working alone; job location (local service means people are more likely aware of local issues and tensions); handling cash; waiting (eg. bus queue, waiting areas); time of day (eg. after school hours, minor assaults on bus crews by children rise to a peak); territory (where people involved feel most comfortable/threatened); privacy
Outcome: physical injury; attempted injury; threats with a weapon; verbal abuse; angry behaviour

In the following sections I will use these elements to briefly analyze some of the available literature, particularly findings specifically mentioning women or women's work. A selection of other materials is referenced only.

The Assailant

Attitudes such as homophobia, sexism and racism affect how we deal with other people. Most workplace assailants are men (Newhill, 1992). For example, male patients do not treat female doctors primarily as physicians. According to a 1993 study, "the vulnerability in their sex seems in many cases to override their power as doctors" (Phillips and Schneider, 1993). Women in less powerful positions may be at least as vulnerable. Other important factors are covered in studies about health care (Lipscomb and Love, 1992; Keep and Glibert, 1992; Lavoie et al., 1990; Rix, 1987) and social work (Stockdale and Phillips, 1989; Newhill, 1992).

The Employee

Employee gender is a logical risk factor, but the link between violence and gender seems to depend on the kind of interaction involved in the work. Men are physically assaulted more frequently in some settings (eg. in psychiatric units, as orderlies) (Rosenthal et al., 1992). However, the British exposure profile and studies of violence elsewhere indicate that, in general, women are more likely to be assaulted at work than men. The attitudes that lead to attacks on women in the street or in their homes don't stay there. The "public" carries these attitudes into the places women work — welfare and municipal offices, hospitals and elder care facilities, retail stores, banks and libraries. Undervalued work by those in subordinate and powerless positions only reinforces sexist attitudes (Rebeck and Kaufman, 1991).

Health care researchers have found links amongst position in an administrative hierarchy (Lanza et al., 1991; Rix and Seymour, 1988), lack of, or inadequate, training (Rosenthal et al., 1992) and expectations of dire consequences (Dubin, 1989). It is understandable that women fear violence in our society — a majority of Canadian women have been sexually assaulted at least once (Statistics Canada, 1993b).

Problematic Interactions

The British HSE's list of problematic interactions includes: giving a service; caring; education; money transactions; delivery/collection; controlling; and inspecting (Poyner and Warne, 1988). Health care studies link violence to routine health care contacts such as feeding, bathing, restraining and the administration of medication (Lanza et al., 1991; Keep and Glibert, 1992; Lipscombe and Love, 1992). Few studies have looked at interactions in sufficient detail (for example, how much time is spent in each of the above activities?) to have a complete picture of these risk factors in specific settings.

The Work Environment

General work environment factors contributing to an increased risk for a cross-section of British workers (most of them women) included: cutbacks; lack of security; poor office layout; workplace policies (for example, working alone); aggressive and sexist behaviour being the norm at work; and toleration of threatening behaviour as "part of the job" (Stockdale and Phillips, 1989). CUPE members report similar problems

(CUPE, 1987); their additions to the list include management attitudes, such as lack of support and dismissal of staff concerns, and prevalence of the attitude that violence is "part of the job."

"Inadequate staff levels" is at, or near, the top of many lists that examine the causes of increasing workplace abuse rates (CUPE, 1991b; Robb, 1993b, c; Hobbs, 1991). Health care work environment factors that increase risk include: working at certain times of day (Lipscomb and Love, 1992); long waiting times (Hobbs, 1991); staff shortages; department overcrowding; availability of drugs and hostages; and using the emergency department for psychiatric and medical clearance of patients with alcohol and drug abuse.¹⁸ It should be noted that emergency department "victimization" is different from abuse of workers in long-term care, chronic care or psychiatric settings (Mahoney, 1991). Nurses working in the former area are more likely to be abused during night and evening hours while in-patient nurses are more likely to be victimized during high-activity times. Verbal abuse and threats or intimidation were higher during 12-hour shifts in all departments.

"Working alone" was the most commonly cited factor in the reported incidents of sexual harassment of female Ontario doctors (Phillips and Schneider, 1993). Combined with fear of the outcome of sexist attitudes, it is often a top concern for women workers (Pizzino, 1994).

The Outcome

The effects of workplace violence — from death to physical injuries to psychological trauma — may appear either immediately or some time after an assault, and may last for months.¹⁹ As is common with the after-effects of domestic violence, coping mechanisms often include denial (Lanza, 1983; Flannery et al., 1991). Nurses tend to minimise their emotional reactions to assault, which may then affect work performance, interactions with co-workers and/or family and job satisfaction (Lanza, 1983). This is likely not unique to nurses.

CONTROL, POWER AND VIOLENCE

Some of the links between power, control and workplace violence include:

- people who behave in a violent way may be in settings or situations where they have little or no control over their own lives (eg. chronic care units) and/or are facing people they perceive have power (eg. nurses, unemployment office clerks) (Morrison, 1992);

- after an attack, assaulted workers may initially feel loss of a sense of control. This is more difficult for women to deal with, perhaps because most attacks on them seem to be "unprovoked" (Engel and Marsh, 1986);
- women admitting to feelings of vulnerability support stereotypes about women's incompetence. Therefore such feelings may be suppressed by female caregivers, who believe they should convey strength (Chinn, 1986);
- workers do not control the organization of their workplace, and the employers who do have control often refuse to acknowledge valid concerns and/or make changes to reduce/prevent violence.

Women at risk of workplace attack are often caregivers and/or front-line workers dealing with the "public," and are often subordinate to (usually) male bosses. Hierarchical organization and sexism is reinforced when patients are moved after a supervisor or (usually male) doctor is assaulted, while (often female) personal care workers reporting abuse are not believed, are blamed for the incidents or are ignored (CUPE, 1991b; Lechky, 1994b).

Roberts says institutional failure to respond to violence against nurses reflects the power dynamic within the male-dominated health care system (Roberts, 1991). The nurse's role is that of nurturer and subordinate caretaker (linked to her role as woman), and she is overseen by mostly-male physicians and administrators. Caretaking partly involves maintaining order — including the balance of power — so that things run smoothly. Assaults upset this order and force nurses to try to deal with the conflicting roles of victim and caregiver, and with their self-image; in the process, they may blame themselves (as do battered women) — self-blame goes with the assigned role.

Women in other subordinate roles in health care settings and in other workplaces may be in a similar position. "Perceived control" is a common state for those who work with the public, where front-line workers and others often seem to be able to determine what people can and cannot do, when and how. But these workers really have little control over the situation; they have not designed their work environment and have little or no say in the policies, priority-setting and budgets that frame the limits of their work. The real rule-makers are hidden from the public, and sometimes from the workers, literally and figuratively. At the same time, the workers interact with people who may be unhappy or disturbed for many reasons and who see the (mostly women) workers doing their job as part of "the system." In short, two sets of people are trying to deal with

situations over which they have little control. This powerlessness, which is common, is not conducive to problem-solving (Mahoney, 1991).

RESPONSES TO THE PROBLEM

Violence is ... a complex but analyzable process, the understanding of which calls not so much for the assigning of labels as for an approach that is rational, systematic, structured according to phases, topological, research-based, and inter-disciplinary. And this understanding should be only an aid to society's efforts to deal with the problem (Agudelo, 1992).

General

Violence at work is not necessarily a random or accidental event (Hales et al., 1989) and is often associated with an organization's main purpose (Poyner and Warne, 1988). Therefore, preventive or control measures are an integral part of managing and work organization.

The best general approach is the public health one used for other occupational health and safety hazards: identify the problem and solve it, with a preventive focus that involves those affected in the process. The British approach does this: It requires the identification of risky jobs/ work situations (using the five elements), a decision about what action to take and monitoring of the decision's effects (Poyner and Warne, 1988). This problem-solving strategy is not victim-blaming, tries to avoid creating new hazards and is most effective when it is specific to the situation (Poyner, 1989).

Common Responses to Avoid

The following are common responses to workplace violence and must be avoided.

Underreporting

My own encounters with nurses discussing issues of violence, both physical and psychological, have convinced me that violence is an issue of mammoth proportions for nurses. However, just as family violence is privatized, violence in the personal and work lives of nurses is silenced and denied (Chinn, 1991).

Many workplace attacks go unreported unless they produce relatively serious physical injuries, especially when women and/or the less powerful are involved. This reinforces the status quo (Roberts, 1991) and undermines attempts to understand and deal with workplace violence, especially for less-obvious forms of assault.

Most estimates of underreporting come from the health care sector. Sixty-three percent of nursing staff completing a questionnaire after a physical attack also completed an incident form about the assault (Convey, 1986). Liss (1993) estimated the number of assaults that could or should be compensated in Ontario is between 2000 and 5290 every year — 20 to 50 times current levels. Citing her own and others' work, Lanza (1991) says underreporting ranges from three to 300 percent.

Lanza's explanations of underreporting in a health care setting, which may apply elsewhere, include: the definition of assault varies and many victims believe it should be reported only if it is "sufficiently severe"; there are various opinions about the patient's degree of intent to harm; staff is inured to assault ("assaults are so common here"); staff characteristics make reporting difficult (eg. peer pressure to not report, and different kinds of reporting based on gender of the person assaulted); there is fear of blame and/or excessive paper work involved in reporting assaults and not enough time to do so (Lanza, 1991).

Other reasons for underreporting include: the victim is a woman (Corea, 1985); bad experience(s), or knowledge of others having a bad experience, reporting an assault; concern about consequences for the assailant (eg. N.S. workers fear violent residents will be given Haldol, which sedates them but changes them into "zombies" [CUPE, 1991b]); financial worries, especially if workers' compensation claims are contested or not allowed²⁰; and minimization of the gravity of attacks (eg. attacks are called "incidents" or severity is downplayed if no physical injury occurs) (Roberts, 1991; Rosenthal et al., 1992; Engel and Marsh, 1986).

It's My/Your Fault

An obvious parallel between abuse of women elsewhere and in their workplaces is victim-blaming. Even those who know better blame themselves (Atkinson, 1993). Lanza and Carifio (1991) showed women were blamed more often than men in situations involving verbal threats and in severe "assault." She suggests traditional coping methods are used in severe assault (ie. more stressful events), including "violence is a man's domain," "men protect women," and, if things go wrong, "women are to blame."

Blame takes several forms. Roberts (1991) points to the potential for blaming victims when forms ask: "What could you have done to prevent this incident?" Almost half the nurses in one survey believed they could predict violence; the difficulty with this mistaken understanding is that, if you fail, you are more likely to feel responsibility or guilt (Ryan and Poster, 1991). Prediction is linked to fear; it is a myth that fear leads to assaults, at least amongst nurses. Blaming the victim (ie. saying she was afraid) contributes to the positive effects of violence for the patient (Morrison, 1987-88).

Another form of blame is rarely acknowledged (Morrison, 1987-88) but becomes apparent after reading most articles about how to respond to workplace violence. Behavioural solutions (eg. de-escalation), in particular, assume women always can respond appropriately to potentially violent situations and ignores the presence of many other workplace hazards and their effects. It is victim-blaming to expect even the best-prepared woman to respond perfectly each time she is in a situation that may lead to workplace abuse, especially if she is in an understaffed, over-worked, powerless position.

Good Ideas Badly Executed

Steps employers adopt too easily (eg. security devices or personal defence courses) often raise questions and don't really solve problems (Poyner, 1989). Plexiglass shields and "better" guns may give a false sense of security, feed a "siege" mentality and make things worse. Other inappropriate responses include incomplete or ineffective application of basically good ideas.

Guidelines, programmes and policies are useful but must be up-to-date and easily available to staff (Leiber, 1992). In one study (Johnson, 1988), social workers' guidelines tended to reframe old problems as solutions and did not provide a framework to analyze assaults or attempt any comprehensive risk assessment (workers tend to blame themselves rather than situational factors). There were no provisions for evaluation or collating and analyzing reported incidents. There was also far too much concern for a bureaucratic approach (Poyner, 1988). This may be reflected in the language used in guidelines: Some British health care workers talked about guidelines written in a language that bore no resemblance to their practical work situations (Poyner, 1988).

Many recommended responses to potential violence are behavioral (eg. de-escalation, better training, security devices) or make the worker responsible for taking all kinds of precautions (Stevenson, 1991). Nurses

are told their "skilled response" will have the most direct effect among the many forces influencing the likelihood of violence in an emergency department (Bjorn, 1991). This ignores organizational and other factors, pretends nurses have more control than they really do and may lead to victim-blaming after an assault.

Training is often seen as *the* solution, especially after an attack (Poyner, 1988). It may be inadequate, however. In one study (Health and Safety Commission, 1986), only 16 percent of the 12 percent of British health care workers who received training in the prevention of workplace violence found it useful. Work practices taught in training may require changes once workers return to their jobs. "But what happens is staff get back to the workplace and they only have 10 minutes to do a whole list of chores. It just negates all of it [the training workshop]" (Pilon, 1987).

Responses to Encourage

The following responses to workplace violence encourage understanding of the issue and change.

Define Violence Inclusively

The definition of violence used in a workplace is key. Inclusive definitions recognize non-physical violence such as verbal abuse, sexual and racial harassment and the possibilities of institutional sources linked to work organization. They recognize that violence is a process, not an isolated incident (Agudelo, 1992).

Design and Implement Comprehensive Workplace Programmes

Comprehensive programmes start from an inclusive definition of violence and a policy incorporating management's commitment to prevent violence on the job. They have specific procedures about work environment requirements, security measures, how to deal with potentially violent events and attacks, training, restraint procedures, post-incident support (including debriefing and counselling for witnesses and those attacked), other follow-up, evaluation, making changes, etc.²¹

Too often, programmes are presented as having all the correct answers from the start, with no need for evaluation and changes (Poyner, 1989). The truth is that evaluation and follow-up procedures are part of effective comprehensive programmes. Such programmes work best with complete worker involvement and when there is evident enforcement of the programme and its policy (CUPE, 1991a).

Report Attacks

Incident or report forms provide a standard way to document assaults; they also make it easier to analyze events, if they provide the right kind of information and are used in a tracking system. When one hospital used incident reports to flag patient charts (and institute certain measures when patients were checked in), violent incidents decreased by 92 percent in one year (Drummond et al., 1989). There is some discussion about the information that forms should include, the effectiveness of the forms and their uses in a preventive context (Eisenberg and Tierney, 1985; Turnbull, 1993; Gentry and Ostapiuk, 1989). In general, it is important to avoid formats that give set answers (eg. for "contributing factors") which may be irrelevant to certain situations and that have no space to fill in the "Other (specify)" category. HSE documents provide several examples. CUPE (1994) has a useful one-page version with copies for various parties, including the joint health and safety committee.

Provide Support

Medical help, counselling and other support are often considered essential for women who are assaulted at home or on the street but have been ignored in many workplaces where workers face abuse (Engel and Marsh, 1986; Leiba, 1992). For example, although social workers in particular know the value of individual counselling or group work for clients, in a 1987 study no agency had "trauma leave" and few offered counselling or related services to their employees (Schultz, 1987).

Much of the nursing, social work and union writing about workplace violence emphasizes the need for post-assault counselling and health care. Responses to assault vary and some are consistent with post-traumatic stress syndrome — in those cases, longer-term help may be needed (Whittington and Wykes, 1992). Support should include medical care, legal advice, information about rights and benefits such as filing charges, workers' compensation, counselling and peer support programmes.²² Victim-blaming almost vanished in one workplace where an assaulted staff support programme was in place (Flannery, 1992).

Provide Training

Training is *part* of a comprehensive approach to workplace violence. In one study, the overall staff injury rate decreased when a "critical mass" of health care workers used techniques in which they were trained; individual compliance with training was linked to a lower violence-associated

injury rate (Carmel and Hunter, 1990). Individuals also become more competent and confident about dealing with a range of situations (Rosenthal et al., 1992; Paterson et al., 1990). Training must include more than information, be integrated and well-balanced and be rigorously evaluated (Poyner and Warne, 1988; Paterson et al., 1990). Regular updating and refresher courses are needed. "Train-the-trainer" approaches are often useful (Health and Safety Commission, 1990).

Important training programme ingredients include: identifying causes of violence and aggression and the magnitude of the problem; learning how to evaluate/anticipate/recognize potential problems; analyzing personal and interactional skills; dealing with specific situations (eg. emergencies, "sundowning"); studying the use of restraints and medication (when, how, who); integrating all aspects of the programme; demonstrating methods of debriefing, support and follow-up after an incident; and clarifying the rights of workers and patients/clients/residents.

Recognize the Importance of Work Design/Organization

... although there is a need for some training of staff to cope with difficult customers, and there will be many ways in which security devices can help protect staff, the most satisfactory solution to problems of violence is through the *redesign of the work itself and the way in which staff have to deal with the public* [emphasis added] (Poyner, 1989).

The British materials show the possibility and importance of getting to the root of one of the major factors behind an assault — the work environment (Poyner and Warne, 1988; Hobbs, 1991; Poyner, 1988). One aspect of the work environment that affects the potential for violence is the physical design, which can be analyzed according to the following elements: privacy; colours; lighting; noise level; layout (eg. isolation, dead ends); amount of available space; presence of materials to reduce boredom and frustration; presence or absence of potential missiles and other weapons; presence of shatterproof glass/plastic (where needed); and the reduction of separation between workers and patients/clients/residents (within limits). CUPE documents also have useful recommendations.

How work is done can also change. Work organization topics to address include: control issues for workers and patients/clients/residents, especially work pace and time required to interact with people; and demand issues related to staffing levels and staff — patient/client

ratios, working alone, hours of work, etc. For example, Alzheimer patients tend to become more excited, confused and aggressive as the sun sets. This "sundowning syndrome" often coincides with shift changes. A gradual changeover or calming activities would benefit both potential assailants and all workers, rather than new leaving staff to cope (Lewis, 1993).

Cover the Legal Angles

Legal measures — regulation, enforcement, collective agreements — are resisted in many jurisdictions and workplaces. For example, health care regulations about worker health and safety, which included requirements for dealing with violence, have been held up for years in Ontario despite a 1987 bipartite committee agreement. The much-mutilated draft 1993 version left out the sections about violence, for "financial" reasons among others (Ontario Ministry of Labour, 1993).

But some jurisdictions *are* taking action. British Columbia's recent regulation defines violence in such a way as to include threatening statements or behaviour, requires a risk assessment and development of policy and procedures, sets out rules for responding to incidents and requires workers be given training and information (WCB, 1992). Saskatchewan added a vague section about "violent situations" to its legislation in 1993, requiring employers in prescribed workplaces to develop and implement a "policy statement" to deal with potentially-violent situations (Occupational Health and Safety Act, 1993).

The only available American government documents are the Cal/OSHA (1993) health care guidelines and a two-page guideline for public sector health care facilities issued by the New Jersey Department of Labor (1991). (The New Jersey guidelines include a requirement that "safe staffing levels" be maintained.) The California Emergency Nurses Association has written and is pressing for legislation to deal with violence in emergency departments (Keep and Glibert, 1992).

In Europe, aside from the HSE, Sweden recently changed its laws to update a violence regulation originally implemented in 1983. The ordinance includes background and suggested measures, questions, etc. It requires many of the programme components listed earlier and states that workplaces must be "positioned, designed and equipped in such a way as to avert, as far as possible" the risk or threats of violence. It also requires that "cash-in-transit" operations be organized and conducted in a manner that protects workers (Swedish National Board of Occupational Safety and Health, 1993).

Unions recommend that workers demand enforcement of guidelines and regulations/laws by employers and government agencies. Suggested

strategies include using the right to refuse (especially if expected to work alone) and filing grievances and workers' compensation claims for all attacks, whether physical or psychological. They also have prepared and won contract language to establish joint health and safety violence sub-committees and anti-violence programmes.²³

Enforcement is possible. The British Columbia WCB gave Vancouver's University Hospital 28 days to ensure a safe level of staffing on its psychiatric ward and to ensure that the workers knew of the changes being made (COHSN, 1992). This occurred after a nurse (who had complained for months and had been attacked) and a nursing aide each used their right to refuse because they would be alone at several points during their 12-hour shifts.

Assailants can be charged. There are precedents for charging psychiatric clients (Ryan and Poster, 1991). A B.C. nurse successfully pressed an assault charge against a patient in a psychiatric unit (Dramer, 1993). The Sudbury and District Children's Aid Society provides up to \$250 for an assaulted employee to get outside legal advice and may provide more later (Children's Aid Society of the District of Sudbury and Manitoulin, 1993). A 1990 Calgary General Hospital draft policy allowed staff to charge patients who abuse them (*Calgary Herald*, 1990). An American nurse successfully charged a doctor with assault and battery when he struck her on the forearm and told her to "turn on the [goddam] suction" (Creighton, 1988).

RESEARCH ISSUES

We need a common definition of violence that includes verbal abuse, harassment and institutional violence for use in research, legislation, workplace policies and reports. Then we could start to integrate and share information, knowledge and studies of the violence against women and workplace violence. We also need to integrate workplace violence into the musings and discussion of other occupational hazards and ill-health. The issue may offer unique opportunities to make workplace changes and address some important stressors.

We also need to hear from those "missing voices." The HSE's five elements are a useful method to develop exposure profiles, especially in female job ghettos. In doing so, we have to pay attention to several questions: How is gender entwined in the risk factors for workplace violence? Do women work in poorly-designed work areas? How does gender affect the responses of assaulted women and their co-workers, supervisor(s), non-work friends and family? What barriers do women face in dealing with all aspects of abuse at work, including causes, blame,

reporting of incidents and addressing of problems? How can we deal with all of these questions in a problem-solving, inclusive way?

Research work should examine solutions and processes for dealing with the issue. It should critically examine "solutions" requiring behaviour changes and compare them with those that affect workplace design and organization. We need information about problem-solving processes that avoid developing a siege mentality and fostering fear, and give workers a way to integrate their experience and knowledge with that gained elsewhere.

CONCLUSION

Women are often the victims of workplace violence because of social/structural inequities/attitudes and because of the work they do. As a society, we must recognize and condemn violence wherever it occurs — behind the closed doors of a private home, on the streets of our cities and towns and in our workplaces. Workplace violence is all the more offensive because it is a public and occupational health hazard that can be prevented and/or controlled.

Women have fought for years, with some success, to bring violence against women out of the closet at home and to "take back the night" on our streets. Now we are talking about the need to "take back" our workplaces, for our individual and collective health and safety.

NOTES

1. This literature review is limited to English-language materials, although work has also been done in other countries. For example, in 1993, Danish academic Eva Hultengren wrote up a participatory research project in: *Bag om volden. Forsknings- og udvuklingsprojekt*, (Nordjyllands Amt, Socialforvaltningen, Amtsgården, Neils Bohrsvej 30, 9220 Aalborg Ost., Denmark).

2. Agudelo, F., "Violence and Health: Preliminary Elements for Thought and Action", *International Journal of Health Sciences* 22 (1992), pp. 365-76. Agudelo defines violence as "an event that has a motive, that is materialized in different forms, that produces immediate alterations and delayed consequences, and that is oriented toward the attainment of certain goals. Its causes, forms, and consequences can vary, interact and change."

3. The most common terms are abuse, assault and violence. Assault tends to be used to describe physical violence, while abuse is often associated with verbal violence. Some authors use the terms as substitutes for one another. Others talk of aggression. A study about emergency room nurses uses "victimisation" to describe a variety of violent acts and incidents.

4. For a unique definition of assault (unauthorised touching incidents), see: Reid, W.,

M. Bollinger and J.G. Edwards, "Serious Assaults by Inpatients," *Psychosomatics* 30 (1989), pp. 54-6.

5. This is particularly true of those Americans studying "occupational violent crime."

6. United Nations, "Declaration on the Elimination of Violence Against Women," in *Changing the Landscape: Ending Violence — Achieving Equality*, cited in *Canadian Panel on Violence Against Women*, (Ottawa: Supply and Services Canada, 1993), p. 6.

7. Gestal, J.J., "Occupational Hazards in Hospitals: Accidents, Radiation, Exposure to Noxious Chemicals, Drug Addiction and Psychic Problems, and Assault," *British Journal of Industrial Medicine* 44 (1987), pp. 510-20. However, the focus is on physicians dealing with patients who are mentally ill; a malpractice suit is also considered an assault.

8. Based on the number of documents found after searching health, sociology, education and psychological databases and other sources of information for this and related reviews.

9. Morrison, E.F., "The Assaulted Nurse: Strategies for Healing," *Perspectives in Psychiatric Care* 25, 3/4 (1987/88), pp. 120-6; Lipscomb, J., and C. Love, "Violence Towards Health Care Workers," *American Association of Occupational Health News* 40 (1992), pp. 219-28; Bensley, L., N. Nelson, J. Kaufman, B. Silverstein and J. Kalat, *Study of Assaults on Staff in Washington State Psychiatric Hospitals: Final Report*, (Seattle: Department of Labor and Industries, December, 1993); Cahill, C.D., G.W. Stuart, M.T. Laraia and G.W. Arana, "Inpatient Management of Violent Behavior: Nursing Prevention and Intervention," *Issues in Mental Health Nursing* 12 (1991), pp. 239-52; Carmel, H., and M. Hunter, "Staff Injuries from Inpatient Violence," *Hospital and Community Psychiatry* 41, 5 (1989), pp. 558-60; Craig, T.J., "An Epidemiologic Study of Problems Associated with Violence Among Psychiatric Inpatients," *American Journal of Psychiatry* 139, 10 (1982), pp. 1262-6; Lanza, M.L., "The Reactions of Nursing Staff to Physical Assault by a Patient," *Hospital and Community Psychiatry* 34 (1983), pp. 44-7; Lanza, M.L., "Predictors of Patient Assault on Acute Inpatient Psychiatric Units: A Pilot Study," *Issues in Mental Health Nursing* 9 (1988), pp. 259-70; Larkin, E., S. Murtagh and S. Jones, "A Preliminary Study of Violent Incidents in a Special Hospital (Rampton)," *British Journal of Psychiatry* 153 (1988), pp. 226-31; Rosenthal, T.L., N. Edwards and R. Rosenthal, "Hospital Violence: Site, Severity, and Nurses' Preventive Training," *Issues in Mental Health Nursing* 13 (1992), pp. 349-56.

10. Mahoney, B.S., "The Extent, Nature, and Response to Victimization of Emergency Nurses in Pennsylvania," *Journal of Emergency Nursing* 17 (1991), pp. 282-91. Keep, N., and P. Glibert [1990-1991 California ENA Government Affairs Committee], "California Emergency Nurses' Association's Information Survey of Violence in California Emergency Rooms," *Journal of Emergency Nursing* 18, 5 (1992), pp. 433-9; Lavoie, F.W., G.L. Carter, D.F. Danzl and R.L. Berg, "Emergency Department Violence in United States Teaching Hospitals," *Annals of Emergency Medicine* 17 (1990), pp. 1227-33. The *Journal of Emergency Nursing* did a special issue on the topic in October, 1991 (Volume 17, 5). The Emergency Nurses' Association has a position statement on violence in the emergency setting (*Journal of Emergency Nursing* 17, 6 [1991], p. 32A).

11. Although they are important, other studies of sexual harassment/assault were not reviewed; they are beyond the particular scope of this paper. Kushnir Pekrul's review

of the literature (see references) led her to conclude that, although it might be expected, there was little information about sexual harassment in the health care system.

12. An Ontario community college professor concerned with violence in his workplace made this point to the author.

13. It is complicated by the fact no author defines the tasks done or differences amongst nursing staff work. They assume readers know what "nurses' aides," "nursing assistants" and "orderlies" do, that the titles have similar meanings everywhere and that those with these titles do the same kind of work in different workplaces and countries.

14. The U.K. work is rarely referred to in North American materials and some Canadian quarters, so wheels are re-invented and useful problem-solving approaches remain unfamiliar to North Americans. The recent California guidelines for health care and community service workers (see references), is a good example of this omission. Canadian Union of Public Employees (CUPE) is one of the few organizations using the materials extensively.

15. Health and Safety Commission, *Violence to Staff in the Education Sector*, (London: HMSO, 1990); Health and Safety Executive, *Prevention of Violence to Staff in Banks and Building Societies*, (London: HMSO, 1993); Joint Departmental-Trade Union Working Party, *Violence to Staff: Policies and Procedures*, (Glasgow: Social Work Department, Strathclyde Regional Council, 1986), the document also includes an evaluation of incident reports; Department of Health and Social Security, *Violence to Staff: Report of the DHSS Advisory Committee on Violence to Staff*, (London: HMSO, 1988); Poyner, B., and C. Warne, *Violence to Staff: A Basis for Assessment and Prevention*, (London: Health and Safety Executive, 1986); National Association of Local Government Officers (NALGO) Safety Representative, *Violence—A Work Hazard*, (London: NALGO, 1985); Poyner, B., and C. Warne, *Preventing Violence to Staff* (London: Health and Safety Executive, 1988). In earlier documents, the Tavistock Institute authors called the work environment "the situation".

16. CUPE materials, and materials from one of its sister American unions, the Service Employees International Union (SEIU), in a 1993 package entitled, "Assault on the job. We can do something about it."

17. This is true if the source of the exposure is beyond the employer's contractual control, ie. the staff. However, violence at work is also about abuse from co-workers and management. This narrower definition does not invalidate the framework.

18. Lanza, M.L., "The Reactions of Nursing Staff to Physical Assault by a Patient," *Hospital and Community Psychiatry* 34 (1983), pp. 44-7; Atkinson, J. "Worker Reaction to Client Assault," *Smith College Studies in Social Work* 62, 1 (1991) pp. 34-42; Poster, E., and J. Ryan, "At Risk of Assault," *Nursing Times* 89, 23 (1993), pp. 30-3; Wykes, T., and R. Whittington, "Coping Strategies Used by Staff Following Assault by a Patient: An Exploratory Study," *Work and Stress* 5 (1991), pp. 37-48.

19. Kushnir Pekrul, op. cit.; Pizzino, A., *Report on CUPE's National Health and Safety Survey of Aggression Against Staff* (Ottawa: CUPE, 1994), this was part of the union's "Checking violence at work" campaign; McCaskell, L., "Dealing with Nurse Abuse," *Nursing Report* 27 (1990), pp. 25-33; CUPE Nova Scotia Task Force for Homes for Special Care, *Safety Concerns and Working Conditions in N.S. Homes for Special Care*, (Halifax: CUPE, 1990).

20. This is not reported in the literature, but it is clear from my personal experience that this is a common reason for under-reporting other occupational hazards.
21. Lipscomb and Love, op. cit.; Green, E., "When Caring is Your Only Defence: Management of Violent Behaviour," *Journal of Emergency Nursing* 17, 5 (1991), pp. 336-9; Cal/OSHA, Medical Unit, Division of Occupational Safety & Health, Department of Industrial Relations, *Guidelines for Security and Safety of Health Care and Community Service Workers*, (San Francisco: Cal/OSHA, 1993); Children's Aid Society of the District of Sudbury and Manitoulin, *Employee Safety Manual*, (Sudbury: Children's Aid Society, 1993); Ontario Nurses Association, *Violence in the Workplace: A Guide for Members*, (Toronto: Ontario Nurses Association, 1991); Splawn, G., "Restraining Potentially Violent Patients," *Journal of Emergency Nursing* 39 (1991), pp. 316-7.
22. Morrison, op. cit; Health and Safety Executive, op. cit.; Ryan, J., and E. Poster, "When a Patients Hits You," *The Canadian Nurse* (Sept. 1991), pp. 23-5; Dawson, J., M. Johnson, N. Kehiayan, S. Kyanko and R. Martinez, "Response to Patient Assault. A Peer Support Program for Nurses," *Journal of Psychosocial Nursing* 26, 2 (1988), pp. 8-11, 15; Flannery, R.B., P. Fulton, J. Tausch and A.Y. DeLoffi, "A Program to Help Staff Cope with Psychological Sequelae of Assaults by Patients," *Hospital and Community Psychiatry* 42 (1991), pp. 935-8; Lewis, G., "Managing Crises and Trauma in the Workplace: How to Respond and Intervene," *American Association of Occupational Health News Journal* 41 (1993), pp. 124-30; Murray, G., and J.C. Snyder, "When Staff are Assaulted: A Nursing Consultation Support Service," *Journal of Psychosocial Nursing* 29, 7 (1991), pp. 24-9; Flannery, R., "Assaults on Staff," [Response to a letter to the editor], *Hospital and Community Psychiatry* 43 (1992), pp. 286.
23. British Columbia Nurses' Union, *Briefing Paper: Violence in the Workplace*, (Vancouver: B.C. Nurses' Union, 1991); CUPE Action Kit: *Help Check Violence at Work*, (Ottawa: CUPE, 1994); CUPE, *Health and Safety Guidelines: Stopping Violence at Work*, (Ottawa: CUPE, 1987); The Canadian Nurses' Association (50 The Driveway, Ottawa, Ontario, K2P 1E2) has information and materials from across the country.

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**La santé des
travailleuses**

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Sous la direction de**
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1995