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Review Article

Violence in the workplace: some critical issues looking at the health sector

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Abstract

Background: The literature on occupational violence and even more the literature on violence against nurses in health settings have evidenced inconsistencies regarding how workplace violence has been conceptualized.

Purpose: To review and discuss some inconsistencies regarding how workplace violence against nurses in health settings has been conceptualized paying special attention to the challenges posed to the health of nurses stemming from patients, visitors or co-workers.

Method: Review of data of the European Working Conditions Surveys, and National Surveys on Working Conditions in Spain.

Discussion: It is necessary to overcome these conceptual inconsistencies on violence in order to carry out intervention programmes based on solid theoretical grounds.

Conclusions: Violence against nurses takes place within an organisational climate defined by role relationships. The organizational climate can either reduce the likelihood of violence or, on the contrary, instigate violent behaviors.

Keyword: Health profession

1. Introduction

Interpersonal violence is an ubiquitous event in human history, at least since 436.000 years ago (Sala et al., 2015). Part of this violence occurs in the workplace and has evolved in becoming a global problem, and in many countries, it represents a national epidemic (Center for Disease Control, 1992). Through voluntary acts of physical and verbal violence and intimidation at work, violence threatens the well-being of the workers as well as that of the organization they belong (Robinson and Bennett, 1995, p. 556). It affects the dignity of millions of people worldwide, causes emotional injuries among the victims (Chappell and Di Martino, 2006, p. 17), and becomes the “major source of inequality, discrimination, stigmatization and conflict at the workplace” (International Labour Office, International Council of Nurses, World Health Organization & Public Services International, 2002, p. 1). Some of these violent acts are directed against those professionals who are in charge of our health care. These professionals, frequently, are “among the first to see victims of violence” (Resolution WHA49.25. World Health Organization, 2002, p. xx), for all in the Emergency Departments (e.g., Ramacciati, et al., 2018) and in the Psychiatry Departments (e.g., Spector et al., 2014). Ironically, helping people at risk and providing health to others becomes a dangerous occupation for the providers (e.g., Anderson and West, 2011; Flannery, 1996). Consequently, health-care settings become violence-prone workplaces, and health workers are frequently “assaulted and unheard” (Brophy et al., 2017) becoming their “wounded heroes” (Angharad et al., 2018, p. 18), but heroes without glory, and in most cases without support from the organization.

This, of course, supposes that on this sector, as in many other research realms, there are open questions that are amenable to debate. In this article we will deal with the following three: a) the concept of violence itself; b) the critical view of the cultural background as a framework to analyze data culled from different countries; and c) the need to pay special attention to the challenges posed by violence stemming from patients, visitors or co-workers to the health of nurses. All of these issues come together in one practical application: all of them are necessary for the design and implementation of effective intervention programmes.

2. Main text

2.1. The need to clarify the concept of violence

One of the open questions on workplace violence goes back to the definition of the concept. Many outstanding scholars of workplace violence (e.g., Chappell and Di Martino, 2006; Hershcovis et al., 2007; Schat et al., 2006) as well as of violence in health settings (e.g., Farrell, 1997; Hahn et al., 2008; Taylor and Rew, 2010) note the inconsistencies in the literature regarding how workplace violence has

been conceptualized and operationalized (Ferns, 2007, for instance, list 11 theories to address the aggression in the Emergency Departments). It is, then, difficult to compare, with some degree of confidence, the data gathered in the last twenty years of research in order to carry out intervention programs. This is the point: if we have as the main objective to implement prevention or intervention strategies to deal with the violence in health settings, the understanding of theories can help staff, managers, and social and political leaders to gain an insight in two areas: the personal motivation that drives violent behaviour, and organisational strategies to manage the risk factors (Ferns, 2007, p. 194). However, in spite of the inconsistencies in the literature, if we take as a starting point the work of significant scholars in the study of violence in such fields as political science (e.g., Tilly, 2003), ethology (e.g., Hinde, 1974), psychology (e.g., Anderson and Bushman, 2002; Berkowitz, 1993), criminology (e.g., Farrington, 2007) or sociology (e.g., Elwert, 2003), these inconsistencies begin to dissipate. Among these authors, there is a growing consensus in defining violence by taking into account the following criteria: intentionality, hurt, the role of the situation, intergroup and intercategory dynamics, the normality of the perpetrators, and the underlying ideology. Three of these criteria are particularly relevant when trying to explain violence against health workers who are at special risk during their professional career, in particular nurses.

Of the above, the most important is harm. Harm characterizes violence as a specific type of aggression: “the most basic definition of violence is behaviour that is intended to cause, and that actually causes physical or psychological injury” (Farrington, 2007, p. 19) challenging the safety, well-being and health of the nursing professional (European Agency for Safety and Health at Work, 2010, p. 16), and also the functionality of the organization (Chappell and Di Martino, 2006, p. 32. See also Neuman and Baron, 1998; Robinson and Bennett, 1995).

Secondly, a significant part of our behaviors fall squarely within the context of an intergroup or inter-category framework of reference (Tajfel, 1981). Patients and visitors (the main actors in the occupational violence inside the health sector) perceive health professionals (nurses and doctors) as people belonging to a particular group that perform distinct tasks. Thus, violence against health professionals, and in particular against nursing professionals, is staged in an intersubjective arena where role relationships are played out. For this reason, and in consonance with World Health Organization (2002, p. 215), violence against nurses can be considered as a form of violence perpetrated by people who identify themselves as members of a transitory group (especially patients and/or relatives) against another individual who is clearly perceived as belonging to the health staff in order to achieve specific objectives.

Role performance always occurs within a specific social environment. The relationship between violence and the social climate inside the work organization becomes

the third feature of workplace violence in health settings. The perceived climate of a work setting (Spector et al., 2007, p. 119) may create conditions that can facilitate or inhibit violence and aggression in the work place (Kessler et al., 2008, p. 108). Thus, the social environment can become a significant predictor of the antisocial behavior. There is ample evidence that underscore how, in some instances, the organisational climate can reduce the likelihood of violence and, in other instances, how some organisational features or environment can prompt violent behaviors (e.g. Agervold and Andersen, 2006; Hepworth and Towler, 2004; Kessler et al., 2008). Workplace aggression does not occur in a social vacuum. It happens in relation to the organizational and psychosocial factors (organizational climate, supervisory style, interpersonal relationships, etc.) that contribute to its occurrence (e.g., Camerino, et al., 2008; Hahn et al., 2008; Hershcovis et al., 2007).

The role relationships, the organization patterns, the social climate in health settings, the supervisory style, the interpersonal factors, among other characteristics, all shape the main theories that have addressed the study of violence against nurses in emergency settings (Ramacciati et al., 2018). After reviewing many studies these authors conclude that the majority of violent incidents arise “from the interaction of a number of factors related to the ED, the institutional organization, the situation, the staff member, the perpetrator and the interaction between them” (p. 11). This position is consonant with the psychosocial tradition that undergirds this article.

In sum, violence in the health sector against nurses refers to intentional verbal and physical actions (verbal abuse, physical assaults, harassment, bullying, intimidation, threatening, discrimination, etc.) while the health care professional is at work that occurs within a specific organizational climate. Often, it also involves psychological harm for it directly affects the individual’s personal safety, well-being, health, and sense of security. Moreover, the harm accrues to the organization itself for it menaces its own well-being and functioning.

2.2. Method

To address the second aim of this paper, we have reviewed data arising from the European and Spanish surveys. Due either to the lack of quantitative data or to the difficulty in comparing them stemming from major differences the between the monitoring systems of the various member states (Paoli, 1992, p. XI), from 1992 the European Foundation for the Improvement of Living and Working Conditions, a tripartite European Union Agency, has begun conducting studies on the environment and working conditions found in the member states of the EU. Since 1997, a section on occupational violence has been included in these studies. For the same reasons (need for a comprehensive information on working conditions), Spain, has begun conducting “*Encuestas sobre Condiciones de Trabajo*” (National Surveys

of Work Conditions) since 1987. Nonetheless, it is not until the Fifth Survey that violent conducts in the work place have been taken into consideration.

Because of the large numbers of participants, its cross-cultural nature, the sampling technique utilized, the abundant and pertinent data and the wide multi-country institutional support, the data from the European Working Condition Surveys (EWCS) are unique and of major import. These studies have become a necessary referent when examining occupational violence. Beyond that, from a theoretical viewpoint, the survey is worth to take into account for it calls attention to violence in the work-place and to the working conditions of different occupational settings.

2.3. Findings

While not all of them have been taken into account jointly, throughout the years the following adverse behaviors have been analyzed: verbal abuse, physical violence, threats, intimidation, discrimination, bullying/harassment, humiliating behavior, unwanted sexual attention, and sexual harassment. If we take as a reference point the latest EWCS (43,850 participants from 35 European countries), the present landscape emerges: a) the rate of physical violence shows a decrement (2%) with respect to previous surveys where the rate fluctuated between 4–5%; b) the levels of threats and intimidation remain between 5–6% and 8–9%, respectively; c) age is identified as the main motive for discrimination in the last twenty years; d) gender is clearly implicated: “all adverse social behaviours are experienced by women to a much greater extent than by men, except for threats” (Eurofound, 2016, p. 68); e) verbal violence (11%) is considerably more frequent than physical violence (2%); and f) health professionals are the most exposed to adverse social behaviors. These professionals, together with social services workers, become special targets of verbal abuses (20%), unwanted sexual attention (3%), humiliating behaviors (8%), physical violence (7%), sexual harassment (2%), and bullying (8%) (Eurofound, 2016, p. 68–70). As a whole, one can conclude from these data that workplace violence is not a widespread practice and that, overall, the situation has remained unchanged over the last twenty years.

2.3.1. The scope of the problem

While these data do not correspond exactly with those presented by Mayhew and Chappell (2007) in Australia, and those cited by Chappell and Di Martino (2006) in the US, all of these studies converge decisively on the following: health care professions entail a special risk factor, anywhere in the world. They constitute front-line service professions that demand a special direct relationship with patients, and deal with people under stress while working with what is probably the most valuable possession people have, their health. The second finding stems from specific research conducted in the health field: world-wide, nurses constitute the group that is most

affected by violence (e.g., Camerino, et al., 2008; Cornaggia et al., 2011; Hahn et al., 2008; Spector et al., 2014). This has remained unchanged since the pioneer research of Marilyn Lanza (1985), with few exceptions worth noting (e.g., Eker, et al., 2012; Soares et al., 2000).

The same occurs in Spain. According to the Spanish sample that participated in the VI EWCS (3344 workers): a) there is a higher level of verbal violence (7,7%) than physical one (1,2%); b) as is the case in other European countries, health and social services professionals along with public administrators and educators, continue to be the most exposed to verbal aggression (17.9%), gossip or social isolation (12.1%); c) these professionals (9.6%) and those of the public administration (7,8%) are also the most exposed to threats of physical violence, and to physical violence stemming from patients and visitors (6,4% y 5,1% respectively) (Eurofound, 2016).

There are, however, notable differences between countries. Broadly speaking, the rate of workplace violence is higher in Northern European countries than in Southern countries in the following expressions: intimidation (15% in Finland, and 4% in Portugal), sexual harassment, gender and ethnic discrimination (Paoli and Merllié, 2001, p. 28). Bullying and harassment range from 17% in Finland and 12% in the Netherlands to 2% in Italy and Bulgaria (Eurofound, 2007, p. 36). The rate of workers subjected to violence or threats to violence is higher in Scandinavian countries and the Netherlands (10,5% for threats and 8,2% for violence) than in Southern European countries (3,6% and 3,5% respectively) (Eurofound, 2007, p. 36). Levels of exposure to adverse social behaviors are the lowest in Kosovo (3%), Turkey (5%), Cyprus (7%) and Italy (8%), and the highest in Austria (22%) and Finland (21%) (Eurofound, 2012, p. 57).

2.3.2. Damage to health: the main issue

The damage caused for being exposed to violence is its major feature. In the EWCS, the data on the impact of working conditions on health have been collected through several questions. The most relevant for the purpose of this paper are the following: perceived impact of work on health, perception of health and safety risk because of work, and level of satisfaction with working conditions. According to data gathered from different studies, the rate of workers that perceive a negative impact of work on their health has varied: 31,1% in all of the European Union in the I EWCS (1992); 57% en the II EWCS (1997); 60% in the III EWCS (2001), and 25% in the latest EWCS (2016). However, the perception of whether health and safety are at risk in the workplace, and the satisfaction with working conditions has remained constant and at high levels throughout the years. According to the latest EWCS, 78% of workers are satisfied with their working conditions, and the rate of workers reporting very good (53%) and good (25%) health is really high. Regarding subjective well-being (measured through WHO Well-Being Index -WHO-5), the overall average

score for workers in the EU28 is 69 out of a maximum score of 100 —three points higher than in 2010- with men scoring slightly higher than women (70 compared to 68) (Eurofound, 2016, p. 109). Here also we observe striking differences between countries. In the V EWSC, the highest level of low mental well-being are reported in Lithuania (41%), Albania (39%), Turkey (37%), the Czech Republic (32%) and Latvia (32%), and the lowest in the Netherlands, Norway and Spain (10%), Ireland (9%), and Denmark (7%) (Eurofound, 2012, p. 118). It is surprising that countries where the rate of adverse social behaviors is the lowest in the EU are those where workers perceive the greatest risk to their general health and subjective well-being due to the work they do. While the rate of workplace violence in Finland is 15% and in Portugal is 4%, the perception of health and safety at risk in both countries is 35% among women and 20% among men in Portugal, and 17% among women and 15% among men in Finland (Eurofound, 2012, p. 118). In Cyprus, on the other hand, while the workers subjected to adverse social behaviours are around 7% (Eurofound, 2012, p. 57), the perception of health and safety at risk rise up to 22% (p. 118). It is worth noting the positive association between all job quality indices analyzed in the VI EWCS (physical environment, work intensity, working time quality, social environment, skills and discretion, prospects and earnings) and general health and subjective wellbeing. The Social Environment Index plays the most important role in subjective wellbeing, satisfaction with working conditions, overall health, and work engagement (Eurofound, 2016, p. 40). By contrast, transport and health workers report the poorest social environments (adverse social behaviors, and social support from immediate supervisors and colleagues (p. 78).

In the several “Encuestas Nacionales sobre Condiciones de Trabajo” (National Surveys on Work Conditions) carried out in Spain, the study of damage to health have been analysed according to four criteria: occupational accidents, occupational diseases, demand for health care, and the presence of perceived symptoms related to stress. Social services and health and veterinary workers show the highest level of symptoms associated with stress (sleep disturbances, continuous feeling of tiredness, headaches, lack of concentration, memory losses, and irritability). In the III ENCT (1997), that percentage rose up to 16.6%. In addition, the stressors with the greatest impact were poor relations with bosses and partners (Instituto Nacional de Seguridad e Higiene en el Trabajo, 1997, p.195). In the VI ENCT, 22.5% of the workers considered that work was negatively affecting their health, a percentage that increased to 28.8% in the case of health professionals, and to 33.1% between truck drivers, taxi drivers and other drivers (Instituto Nacional de Seguridad e Higiene en el Trabajo, 2007, p. 134). Furthermore, health professionals showed the highest level of sleep disturbances (20.2%), headaches (15.3%) and irritability (14.7%) (p.139), all of them symptoms correlated with stress. Regarding the Spanish labour force, 23,3% in the health and social services sector perceive their health status as regular, bad or

very bad, with a clear difference by gender (21.3% of women and 14.2% of men) (Instituto Nacional de Seguridad e Higiene en el Trabajo, 2011, p. 53).

2.4. Discussion

Health care professionals and, in particular, nurses are the workers that are most exposed to occupational violence. There is a growing agreement between significant scholars in different research areas to view violence as an intentional action that has physical, psychological and social harm as its goal. To qualify as “sterile” the descriptions offered by those scholars (Albert Bandura, Leonard Berkowitz, David Farrington, Charles Tilly or Robert Hinde, for instance), as Farrell (1997, p. 502) does, is risking not knowing what we are referring to when we talk about violence. To trust only the mere perception and subjective interpretation of the violent act by the victims themselves (Farrell, 1997; Luck et al., 2007; O’Connell et al., 2000), puts us perilously at the border of an extreme psychological reductionism where reality is confused with what people think about it. In the case of the perpetrators, on the other hand, to accommodate reality to what they think about it (i.e. to ideology) has left a malevolent path throughout history.

2.4.1. Challenge to professional nursing and challenge to the health organization

Violence in the workplace has become a global problem crossing country borders and threatening the wellbeing of persons and organizations alike, as we have noted, independently of how many professionals have negative social and psychological outcomes on account of their work. The damage stems both from physical and psychological violence. All physical harm is accompanied inevitably by psychological harm and, in many cases moral harm and a damage to social identity (e.g., Blanco and Blanco, 2019). The systematic review carried out by Needham et al. (2005) identified indeed four types of effects: a) bio-physiological (fear, anxiety, headache, irritability, etc.); b) cognitive (disbelief, threat to personal integrity, and transformed perception; c) emotional (anger, apathy, guilt, helplessness, sadness, etc.), and social (insecurity at work and impaired relationship with colleagues and patients) (p. 286–287). Taken as a whole, these consequences can lead, in certain cases, to PTSD (Needham et al., 2005, p. 285). This is especially true for those professionals who are exposed repeatedly to acts of violence (Winstanley and Whittington, 2002), as is the case with nurses in psychiatric hospitals. Lanza (1985) y Whittington and Wykes (1992) in a couple of seminal articles already alerted us to the emotional impact on this group of professionals. But the damage to the health workers carries with it a damage to the health organization. There is an intimate interdependence and mutual influence between the challenge to the safety, well-being and health of staff, and the harm to the organization. Whenever

a worker is hurt, the functionality of the organization (absenteeism, work dissatisfaction, counterproductive behaviors, desires to quit the job, dismissals, etc.) is affected (e.g., Neuman and Baron, 1998; O'Leary et al., 1996; Pinded and Spector, 2016). For this reason, the European Foundation for the Improvement of Living and Working Conditions highly recommends to take social climate (organizational justice, role clarity, mutual trust between management and employees, recognition and good cooperation) into account as “an important aspect of organizational management, as it results in positive outcomes both for the organization and the workers” (Eurofound, 2016, p. 70).

2.4.2. *Cultural differences and intercultural coincidences*

Data from the different EWCS and the Spanish ENCT accompany the even more conclusive findings of Pinker (2011). Taken as a whole, these studies point to a decrease of violence in different settings of everyday life. However in the studies carried out in health care settings a different picture emerges: violence has increased in society and there has been a similar increase in the health settings (e.g., Aydin et al., 2009; Flannery, 1996; May and Grubbs, 2002; O'Connell et al., 2000). This is not the place to enter into this rather complex debate but, in order to support the first assertion, one has to question Pinker's data. Otherwise, we would find ourselves trapped by the silent and comfortable force of media-fed stereotypes. In reference to the second of our assertions —the increase in violence in the health sector—we are in agreement with two noted authors in the field of violence against nurses: it is obvious that there is an increment in reported incidents, while admitting that “it may be the reporting which is increased rather than the violence” (Winstanley and Whittington, 2004, p. 4. See also Arnetz et al., 2011, p. 930). Most likely, this occurs not only in the UK but in many other countries as well.

In fact, underreporting may be one of the keys in understanding and interpreting some of the most common findings: the notable cross-cultural differences. To invoke such differences may simply be an excuse wielded by some public powers and not a few health managers and supervisors, simply to leave things as they are, due to the difficulties and the political cost in changing them. To interpret these differences as simply cultural differences may betray a comfortable and conservative attitude that prevents finding solutions to real problems linked to violence.

It may be true that some violent acts in health settings are considered an unpleasant part of the job, especially in the psychiatric sector (Poster, 1996), as “normal or unavoidable, as an inevitable risk” (Brohpy et al., 2017, p. 18). It may also be true that violence can be seen as a functional/comprehensible and protective phenomenon (Aberhalden et al., 2002, p. 114), and even that some mental health nurses have a positive view of aggression as is found in China and in UK (Whittington and Higgins, 2002). But all this does not protect from the effects produced by it. Neither

are the consequences neutralized by appealing to the common place and obvious assertion that the meaning of workplace violence is embedded in different social or personal realities. More than “descriptive account of nurses’ collective wisdom” [Farrell \(1997, p. 502\)](#), it is of utmost importance to know what and how nurses feel vis-a-vis specific behaviors exhibited by patients and their relatives, their co-workers and managers. There are sufficient and powerful reasons to conclude that anywhere nurses are victims of violent behavior when feel they threatened, humiliated, despised, harassed, independently of whether they might think that violence is part of their work or is culturally accepted. Cultural meanings can hide and justify actions that militate against the dignity of the person.

Cultural differences related to the meaning of violence should not hide some significant coincidences. The first of them comes from the study conducted by [Hahn et al. \(2010\)](#) in general hospitals in Switzerland: only 7.6% of participants (400 nurses) knew that their hospital had an official policy to deal with patient and visitor violence (p. 3538). This is quite revealing of what occurs in health organizations: not every professional knows of the existence of an official policy against violence; and those that do, do not trust its effectiveness. A second coincidence is provided by the study performed by [Ceramidas and Parker \(2010\)](#): in Australia there are not many health organizations that provide their workers with practical assistance or support in dealing with violent incidents (p. 256). It is quite possible what occurs in Australia may not constitute an exception but the norm in many other countries. In the study carried out by [Eker et al. \(2012\)](#) we find another possible coincidence: 31,7% of the health providers working in state hospitals said they were informed about violent incidents that they suffered, but only 1% report having received adequate support from managers or the institution (p. 24). In short, there is a wide transcultural evidence that reporting an incident is extremely time consuming and, most likely, would not result in any action taken by the hospital managers (e.g., [Hibino et al., 2006](#); [May and Grubbs, 2002](#); [Martínez-León et al., 2012](#); [Natan et al., 2011](#); [Sato et al., 2013](#); [Tan et al., 2015](#)).

2.5. Recommendations

1. As we have already noted, violence against nurses should be understood as a way of collective violence ([WHO, 2002, p. 215](#)). In this case the emotional impact should be defined as psychosocial trauma ([Blanco et al., 2016](#)) rather than a strictly psychic trauma, as it is presently construed.
2. Even though the hurt and emotional impact of violence on health workers has not commanded the attention of many researchers (e.g., [Hills and Joyce, 2013](#)), in the future this should be a central research topic.

3. It should be put in place institutional policies of assistance and support against violence and, above all, to endow them with real effectiveness. In other words, it is of utmost importance to recover the trust of nurses in health institutions and organizations they belong or where they work, something that the present research has found wanting in most countries.
4. Following the European Foundation for the Improvement of Living and Working Conditions (Eurofound, 2016) is highly desirable to take organizational climate as a framework to explore original forms of intervention.

3. Conclusions

To move ahead, nursing knowledge demands not only data, but levelheaded reflection on some core theoretical issues. One of them is the definition of violence in the health setting. Some clarification concerning the inconsistencies that surround the definition of violence can be achieved if we take into account the proposals of respected scholars in the field.

As any other social action, violence against health professionals and specially, against nurses as the main victims, takes place within an organizational space defined by status and role relationship. Cultural differences should not be an obstacle to hide or to justify the harm that violence produces against health professional, especially against nurses.

Research effort as well as the interest of health institutions and organizations should direct attention on analyzing the damage produced by violence against health providers and furnish means to implement intervention programmes.

If we take into consideration that violence against health professionals can be better understood within the framework of collective violence, it is, then, necessary to approach the consequences of violence from the theoretical perspective of psychosocial trauma.

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