Violence in the Healthcare Workplace

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- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
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Faculty
Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure
Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience
This course is designed for physicians, nurses, social workers, therapists, mental health counselors, pharmacists, and other allied health professionals at risk for workplace violence.

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NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

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Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

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Course Objective

Violence or abuse experienced in the workplace among healthcare workers, social workers, mental health workers, and other human service workers is a critical issue that many organizations face. The purpose of this course is to provide healthcare professionals with information so they may better recognize, address, and prevent violence in their workplaces.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define workplace violence.
2. Identify the different forms of workplace violence.
3. Describe the scope of workplace violence in various human service sectors including nursing, social work, and counseling.
4. Discuss factors that place individuals at increased risk or impede victims from reporting workplace violence.
5. Identify emotional, psychological, economic, and social consequences of workplace violence.
6. Discuss the ethical and legal issues involved in workplace violence and the process for assessing risk of violence.
7. Outline assessment and intervention strategies targeted to victims and perpetrators of workplace violence.
8. Describe recommended occupational policies addressing workplace violence.

Pharmacy Technician Learning Objectives

Upon completion of this course, you should be able to:

1. Define various types of workplace violence and its impact on health care, including risk factors.
2. Discuss ethical, legal, intervention, and administrative strategies to prevent or address workplace violence.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

In the United States each year, there are 20,000 to 30,000 injuries directly related to workplace violence and 450 to 700 victims of workplace homicide; healthcare workers have a much higher risk of experiencing intentional injury by another person than workers in other occupations [34; 135; 136]. During 2021–2022, the Bureau of Labor Statistics documented 57,610 cases of nonfatal workplace violence resulting in lost days of work or transfers [108]. It has been estimated that up to 50% of clinical practitioners, including nurses, social workers, psychologists, psychiatrists, and other human service workers, have been assaulted at their workplace at some time during their professional career [1]. The National Institute for Occupational Safety and Health (NIOSH) estimated that among nonfatal assaults that occur in the workplace, 70% were in the healthcare and social assistance industries and 48% were perpetrated by a patient or client of the service provider [2]. Workplace violence is highest in healthcare and social service fields compared to any other private sector, at 14.2% in 2021–2022 [108]. In a national study with 1,338 counselors, 51% reported workplace violence by a client [137].

The magnitude might be even larger, dependent upon the definition of workplace violence used. In 2000, the U.S. Department of Labor found that the incidence rate of violence in any private sector workplace was 2 per 10,000 full-time workers [7].

Healthcare professionals had a significantly greater incidence rate of 9.3 per 10,000 for injuries resulting from assaults and violent acts. The rate for social service workers was 15 per 10,000, and for nursing and personal care facility workers the rate was 25 per 10,000 [7]. Hospital nurses, physicians, and other staff have reported a significant increase of verbal threats and physical violence throughout the COVID-19 pandemic; almost 70% of emergency nurses reported being hit or kicked at work, while 44% of all registered nurses reported experiencing physical violence on the job [171].

Healthcare professionals are at increased risk due to their contact with patients or clients who have serious mental illnesses and/or history of violence as well as working in occupational environments marked by stress, burnout, and high turnover. In emergency departments, where there is often a large flow of traffic of patients, family members, and other individuals from the general public, 50% of physicians and 70% of nurses report having been physically assaulted [3]. Ultimately, these nonfatal workplace assaults have tremendous economic ramifications to organizations, causing approximately $250 to $330 billion each year in lost wages, legal costs, lost productivity, and loss of reputation [172]. Nationally, workplace violence is estimated to cost $324.9 million annually in staff turnover, disability, and absenteeism [138]. Not surprisingly, there is a relationship between turnover and frequency of exposure of workplace violence. Healthcare professionals who are frequently bullied are three times more likely to resign, even after controlling for age, health, and work conditions [45].

This course will provide an overview of the different types of workplace violence, risk factors, emotional, social, and behavioral ramifications of workplace violence, and specific interventions and policies that have been implemented by organizations to address workplace violence and enhance practitioners' safety.

DEFINITIONS OF WORKPLACE VIOLENCE

The definition of workplace violence is complex, multifaceted, and ambiguous. The challenges in establishing tracking and monitoring systems inevitably lead to an under-reporting of workplace violence, which can then have ramifications in developing clear policies in the workplace [4]. The terms used are confusing and can contribute to a lack of consensus regarding an overall definition. For example, terms used in the literature include: workplace bullying, workplace aggression, workplace abuse, workplace harassment, horizontal violence, and mobbing [5]. In this course, a workplace is defined as a location where an employee, whether employed on a temporary or long-term basis, performs tasks related to his or her job description [5].

Although the general public usually equates aggression with violence, there are differences. Aggression constitutes intentional behavior, and the goal is to ultimately harm or injure another party physically or psychologically [139]. Some have further categorized aggression into two types: hostile aggression and instrumental aggression [6]. Hostile aggression refers to aggressive behaviors triggered from feelings of anger or frustration. Instrumental aggression focuses around the intention to hurt someone psychologically or physically to achieve some goal, not merely to inflict pain [6]. The dilemma with these definitions is that nurses, social workers, and other human service professionals deal with clients or patients who may not be fully oriented. In these cases, the question about their intent is raised [6]. However, this does not mitigate the psychological and emotional consequences of the victims who experience workplace violence [6].

One definition of workplace violence includes physical assaults and threats of physical assault aimed at employees in their occupational setting or while on duty [7]. Other definitions address not only physical violence but also psychological violence, abuse, bullying, harassment (racial, sexual, and psychological),

obscene phone calls, and/or verbal assault [7; 8]. The Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers, and visitors" [109]. The U.S. Department of Labor defines workplace violence as "an action (verbal, written, or physical aggression) that is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property" [110]. Other instances that may be overlooked are incidents in which there are unintended victims. Such a case, as described by Keyes and Keim, is one in which an employee who is berated in front of co-workers later sabotages equipment, resulting in personal injury and damage to property [4]. While many equate the term "violence" with physical force or physical injury, for the purposes of this course, workplace violence will refer to any act of aggression, physical or nonphysical, that takes place while the victim is working. This is consistent with a 2023 systematic review and meta-analysis in which investigators noted that studies generally defined workplace violence as any violent incidence in which there is a threat to an employee's safety, well-being, or health at their location of work; it can include physical, verbal or psychological abuse [173]. The term "workplace aggression" is often used in the mental health literature, while the term "workplace violence" is preferred in the healthcare literature [139]. For the purposes of this course, the two terms are used interchangeably.

Some experts have posited that workplace violence falls into three categories: internal violence (i.e., the perpetrator and victim are employees), external violence (i.e., the perpetrator is a stranger and the victim is an employee), and client initiated (i.e., the perpetrator is a patient and the victim is an employee) [87]. Of these types, client-initiated workplace violence is the most frequently encountered in the healthcare setting [91].

Overall, these incidences of workplace violence are characterized as specific, time-limited, and unanticipated. They may also trigger feelings of loss of personal safety and emotional well-being [9]. Workplace violence ultimately consists of persistent, offensive, unwanted, and intimidating behaviors that are used to control or exert power over an individual [5].

OTHER TERMINOLOGIES

As noted, the fact that various terminologies have been used complicates the process of coming to a consensus about the definition of workplace violence. Terminologies that are commonly employed include [10; 11; 12; 111; 139; 174; 175]:

- Bullying: Involves a series of incidences of overt and subtle forms of aggression that are usually non-physical in nature but can be characterized as controlling. Bullying behaviors include spreading rumors, withholding information, blocking an individual's promotion, and using psychological abuse to exclude someone. Some experts have more specifically defined bullying as specific types of behaviors that occur at least twice per week for a minimum of six months. Bullying can be perpetrated face-to-face or via technology (e.g., cyberbullying).
- Horizontal violence (or lateral violence): Nursing literature has utilized the term "horizontal violence" to describe a specific form of bullying involving non-physical acts of aggression or hostility. It may be either blatant or covert. Examples of horizontal violence, also referred to as inter-group conflict, are criticizing, insulting, infighting, scapegoating, sarcastic comments, ignoring, undermining, withholding information, and bickering. This type of violence usually occurs between colleagues in a similar hierarchal position, typically when both parties have experienced a situation in which they perceive they have been oppressed. Instead of dealing with it on an organizational level, feelings of anger and resentment are internalized and ultimately manifested in aggressive behavior.

- Mobbing: The term "mobbing" was first coined by Konrad Lorenz, an animal psychologist. He observed a smaller group of animals attacking a single animal and termed this phenomenon "mobbing." Later, the term was used to refer to children's destructive behavior toward a single child. Nursing literature utilizes the term to describe the negative behaviors of a group directed at a single employee. In some cases, the perpetrators may be those who have more professional power (i.e., doctors, nurse supervisors) than the victim. Mobbing usually takes the form of psychological abuse in the workplace, involving an individual who is bullied by colleagues or supervisors through rumors, intimidation, and humiliation.
- Insidious workplace behavior: A broad term used to signify dysfunctional behaviors that may or may not be aggressive

FORMS OF WORKPLACE VIOLENCE

It is important to identify the different types of workplace violence. Lipscomb et al. highlighted four distinct types of workplace violence perpetrators [13; 14]:

- Stranger: The perpetrator is not known to the victim(s) and has no reason to be at the workplace. An example of this type of workplace violence is robbery.
- Customers: The perpetrator is an individual who has been provided some sort of service; the victim may be the individual or caregiver who has provided the service. A patient who assaults the nurse conducting rounds is an example of this type of violence.
- Colleague or former worker: The perpetrator is a current or former employee. This type of violence is often the result of a perceived injustice, and the violence committed is in retaliation for that injustice. An example of this type of violence might involve a former staff person who was laid off and returns to hurt the employer. Physicians who verbally abuse the nursing staff would be another example of this type of violence.
- Personal relationship outside of the workplace: The perpetrator is known to the victim outside of a work or professional relationship. The aggressive act is usually motivated by perceived difficulties in the social relationship. An example of this type of workplace violence would be a boyfriend who comes to his girlfriend's workplace to hurt her and/or others (i.e., domestic violence or intimate violence).

These perpetrator types parallel the categories identified by OSHA. OSHA has differentiated workplace violence perpetrated by strangers (Type I), co-workers (Type II), or service recipients (Type III) [7]. In a meta-analysis study, workplace violence was most likely to be perpetrated by patients and their family members, colleagues, and superiors [176].

In addition to perpetrator types, workplace violence may also be categorized by the quality of the behaviors. Workplace violence may be classified according to the type of behavior and manner in which harm is inflicted [16; 140; 176]:

- Physical or Verbal: On one end of the continuum, there are acts or behaviors that involve a physical component, such as shoving, pushing, or kicking. Conversely, violence may be verbal, involving behaviors that utilize words to threaten or imply harm. In fact, verbal abuse is the most common type, followed by physical assault.

- Active or Passive: In some cases, harm may be produced using some form of active (or overt) behavior, whether it is physical or verbal. The opposite end of this continuum is the passive dimension, consisting of harm produced by withholding, such as not releasing important information that would inevitably affect an employee's performance or failing to act in assistance of the victim.
- Direct or Indirect: In cases of direct workplace violence, the intent to harm is perpetrated directly at the target. Indirect aggressive acts are inflicted through roundabout means, such as spreading rumors.

Part of the difficulty in developing a consensus regarding the definition of workplace violence, or even the related terms, is that the criteria for acceptable behavior are based on implicit and unwritten assumptions that vary across organizations, contexts, and individuals [17]. These perceptions are influenced by a host of factors on individual, organizational, cultural, and social levels [18]. The challenge of establishing a definitional consensus is problematic for policy makers, researchers, and workers [139].

PREVALENCE OF WORKPLACE VIOLENCE

HEALTH CARE

It has been estimated that healthcare workers are sixteen times more likely to experience an incident of workplace violence compared with other employees, including prison guards, police officers, bank staff, retail employees, and transport workers [19; 20]. In total, 12,390 workplace assaults occurred in healthcare settings and 2,160 assaults occurred in social assistance settings in the United States in 2019 [135]. An estimated 19% of all traumatic occupational injuries sustained by healthcare workers are the result of workplace violence [133]. In an international study, researchers found that the majority of perpetrators of workplace violence were patients, and the victims were usually nurses and other staff working in contained environments [112]. In a study with 61 primary care physicians, participants reported that verbal abuse was common [113]. The most common type of verbal abuse was being bullied to write a prescription, which was reported by 60.7% of physicians. Approximately 40% of the respondents indicated they had called security or the police to have a patient removed from their office [113]. In a study of New York City hospitals, 66% of residents reported experiencing at least one incident of physical violence during their shift in the emergency department. In addition, 52% experienced sexual harassment and 97% stated they experienced verbal threats [141].

Other studies have indicated that nurses may be at higher risk compared with other caregivers in the helping professions [21]. Rates for past-year workplace violence range from 24.7% to 88.9% [142; 177]. Nurses are often in the forefront of service delivery and tend to have direct interactions with patients and their family members. They are also exposed to patients dealing with issues related to substance abuse, domestic violence, human immunodeficiency virus (HIV), mental illness, and other social problems that place them in situations that are potentially more dangerous [14]. A survey of 762 practicing registered nurses sought to examine incidents of violence in the nursing workplace [14]. The nurses who participated worked in a variety of clinical settings and were diverse in age and work experiences; however, they were primarily female and White. Findings indicated the most common form of workplace violence experienced in the past year was verbal abuse by patients, experienced by 54.2% of respondents. Nearly 30% had experienced some sort of physical abuse by patients. It is important to note that differences in reported perpetrators or types of violence may arise as a result of the implied or given definitions of "aggression" and "violence."

Nurses in certain settings may be at higher risk given the population they serve. A multinational study of psychiatric nurses found that 75% reported that they had been assaulted at least once during their nursing career [22]. In 2009, the Emergency Nurses Association published a survey that indicated more than 50% of emergency department nurses had experienced some form of physical violence from a patient, with more than 25% having experienced 20 or more incidences of violence at work in the last three years [23]. Emergency departments are inherently at higher risk of workplace violence due to the use of these services by patients having mental health and substance use issues. The crisis nature of the issues presented in emergency departments, often accentuated by long wait times, makes heightened emotions a regular occurrence [173].

The most common root causes of sentinel events such as rape, assault, and homicide in the healthcare workplace are failures in communication, inadequate patient observation, noncompliance with workplace policies, and lack of or inadequate behavioral assessments [134]. Patients are the source of 80% of violent incidence, followed by other client/customer (12%), students (3%), and coworkers (3%) [20].

Homecare/Residential Care Settings

Studies have not yielded definitive conclusions about the magnitude of workplace violence when service workers provide care in the homes of patients. It is believed to be more prevalent than other sectors because, although workplace violence is a hidden problem in general, it is even less visible for caregivers working in residential care settings or in private homes. It has been estimated that nursing home workers experience more aggressive incidents while caring for their patients, leading to more lost workdays compared with human service professionals in other sectors [24]. The "behind closed doors" nature of the work for homecare workers can exacerbate the sense of isolation, fear, and anxiety for those who experience workplace violence, and working in patients' homes offers no immediate organizational structure or available support [6; 25]. In one study, approximately 28% of home healthcare workers experienced workplace violence during the lifetime of their work, most often verbal abuse perpetuated by a patient [178]. However, a study conducted by Büssing and Höge in Germany offered a different picture [6]. A total of 1,314 surveys were mailed out to 105 home care services. From this initial contact, 721 questionnaires were returned from 97 home care services, which represented a response rate of 55%. Compared with studies conducted among other healthcare sectors, the majority did not rate high agreement to experiencing general workplace violence and aggression. The authors speculated that perhaps their definitions of workplace violence affected the results. Furthermore, there is a possibility that the higher degree of autonomy among patients living at home compared with a hospital or residential setting might minimize the amount of violence perpetrated.

In residential facilities, workplace violence may be overlooked. In some cases, aggressive behaviors are minimized or overlooked because the violence is unintentional and/or the perpetrators are patients who have dementia or other cognitive disorders [26]. In a study with 87 social workers in residential care facilities, 81% stated they had been either threatened or assaulted by clients in the facility in the past year [114]. In another study, researchers found that 34% of nursing assistants in residential settings had experienced a physical injury by a patient in the previous year [92]. In 2019, the Bureau of Labor Statistics reported 5,650 intentional injuries and 2,170 unintentional or unclear-motive injuries to nursing and residential care facility personnel [135].

In a study conducted by Snyder, Chen, and Vacha-Haase of 76 certified nursing assistants working in geriatric residential care facilities, 4,833 incidents of workplace violence in which the perpetrator was a patient occurred during the two-week study period [27]. Interestingly, 95% of total incidents were not reported to human resources or the proper workplace authority. Incidents of verbal abuse were reported most often (11.9%), while only 2.1% of physical incidents were reported. When questioned regarding their decision not to report the incidents, the most common response was the patients' lack of intent or understanding. Most violence experienced by caregivers in residential facilities occurs when the caregiver is providing basic care, such as assisting the patient/client in dressing, washing, feeding, or changing [26]. In a study conducted by Gates et al. of 138 nursing assistants working in nursing homes, 43% of violent incidents occurred while the patient was being dressed [26]. In a retrospective study of 3,919 nursing home care providers, more than 66% reported having experienced verbal abuse by residents and 42% experienced physical aggression. When staff sensed there was sufficient staffing and resources, they were also perceived less workplace violence [143].

International Workplace Violence

Internationally, workplace violence among nurses has received an increasing amount of attention. It is impossible to review every international context; however, this section should provide a sense that workplace violence is not unique to any particular country. One systematic review and meta-analysis compared workplace violence in different regions and found that studies conducted in Europe and Pacific regions showed the highest prevalence rates of workplace violence, followed by North America, the Middle East, and North Africa [179]. In a survey study with Lebanese nurses, workplace verbal and physical abuse was reported by 62% and 10% of respondents, respectively [115]. In an Italian survey, researchers found that 34% of nursing students and 43% of nurses had experienced at least one episode of physical or verbal abuse in a clinical setting during their lifetime [93]. The nurses tended to experience violence perpetrated by patients or patients' family members, while the nursing students reported more verbal abuse perpetrated by colleagues and staff.

In a survey study with 521 Taiwanese nurses, 19.6% disclosed experiencing physical violence and 51.4% reported experiencing verbal abuse at work [94]. The majority of the perpetrators were patients. Shift also appeared to have an impact on the type of violence experienced, with those who worked the night shift more likely to report sexual harassment [94]. This was partially attributed to lower staff-to-patient ratios and more alone time with patients at night. A survey of 850 nurses in Hong Kong found that 44.6% had experienced workplace violence in the preceding year. Verbal abuse was the most common type, and perpetrators were more often patients. In this study, male nurses were more likely to be victims than female nurses [144].

A survey of nurses working in Tehran, Iran, found that 19.1% had been victims of physical (non-weapon-related) violence at work in the last year [95]. In addition, 91.6% reported having experienced verbal abuse in the last year. In this study perpetrators were predominantly family members of patients and the most common setting for the abuse occurred was at the patient's bedside or at the nurses' station. In a cross-sectional survey study with 601 physicians and other healthcare workers in North India, 75% reported having experienced some type of workplace violence and more than 30% expressed discomfort with reporting the incidence(s) [180].

Although the majority of research on international healthcare violence focuses on nurses, physicians are also affected. In a study of 1,015 physicians in central China, almost two-thirds reported experiencing some sort of workplace violence in the preceding year [145].

SOCIAL WORK

Every year, 18.3 out of every 10,000 social service workers had at least one day of work missed due to an incident of workplace violence [96]. Several national studies have been conducted to ascertain the scope of workplace violence in the field of social work. Beaver conducted a study with members of the National Association of Social Workers (NASW) and found that more than one-half of the sample had been verbally abused and almost one-fifth (19.9%) experienced physical assault by a client [29]. Jayaratne, Vinokur-Kaplan, Nagda, and Chess conducted a national study with social workers focusing on aggression perpetrated by clients or service recipients (i.e., type III violence as defined by OSHA) [30]. Forty-two percent of the sample disclosed that they had been verbally abused by clients; 17.4% had been threatened physically, and 2.8% had been physically assaulted.

In a 2005 study, Ringstad randomly sampled 3,000 members from the NASW; a total of 1,029 social workers responded to the survey [31]. In this study, Ringstad asked both about abuse perpetrated by and against clients. Consistent with earlier studies, 86% of the sample stated they had experienced some type of violence from their clients during their social work career.

Again, psychological forms of violence, such as verbal threats, abuse, and property damage, were the most common types of violence experienced. Overall, 85% stated that they experienced psychological violence perpetrated by clients during their career, with 62% reporting psychological violence in the last 12 months. Finally, 30% had experienced physical assaults by clients at some point during their career; 14.7% had experienced physical assaults by clients in the last 12 months [31]. In a longitudinal study of 1,501 child protection workers, 75% reported non-physical violence perpetrated by clients in the first six months of their employment, 37% of which involved threats of physical violence [146].

The figures for social workers admitting to perpetrating violence or abuse toward clients were lower. It is not clear whether this was due to their reluctance to disclose such incidences. For example, approximately one-quarter of the sample disclosed to perpetrating an aggressive act toward a client during their career; 13% admitted to having engaged in an aggressive act within the last 12 months [31].

In an Australian study, 67% of surveyed social workers reported being the victim of at least one form of violence in the last year. Like many other studies, verbal abuse was the most common form, followed by intimidation [116]. An integrative review of literature about social workers, particularly child and family social workers, confirmed that verbal abuse was the most common form of workplace violence [117]. In another study with child welfare workers, 10% reported workplace bullying by their supervisors, and more than 75% experienced workplace violence by their clients [181].

PSYCHIATRIC SETTINGS

Psychiatric personnel are also at an increased risk for workplace violence, particularly in facilities involved in the care of patients experiencing illnesses that involve hallucinations and delusions [182]. According to the U.S. Department of Justice, mental health occupations had the second highest average rate of workplace violence between 2005 and 2009 [118]. Lawoko et al. noted that psychiatrists often become victims of workplace violence perpetrated by their clients when they are perceived as having the power to make decisions regarding care, particularly when services are deemed poor [21]. Nurses in psychiatric settings have reported that peak times of patient-perpetrated violence occurred during the time of admission, a relapse, or when a discharge plan had to be modified [182]. In a study that involved Veterans Health Administration psychiatric units, a higher case load of patients with personality disorders was a predictor of significantly higher risk of verbal and physical aggression against nurses [119]. In one meta-analysis, predictors of patient violence perpetrated against healthcare workers in psychiatric inpatient facilities included schizophrenia diagnosis, younger age, a history with alcohol and drug use, and a history of violence [147].

EVIDENCE-BASED PRACTICE RECOMMENDATION

In order to anticipate violence and aggression in inpatient psychiatric wards, the National Institute for Health and Care Excellence recommends recognizing how each patient/client's mental health problem might affect their behavior (e.g., their diagnosis, severity of illness, current symptoms, past history of violence or aggression).

(https://www.nice.org.uk/guidance/ng10. Last accessed July 17, 2025.)

Strength of Recommendation: Expert Opinion/ Consensus Statement

DOMESTIC VIOLENCE IN THE WORKPLACE

Another type of violence that may occur in the workplace is domestic violence, also referred to as intimate partner violence. Domestic violence is a worldwide problem and predominantly affects women. Although women can be perpetrators of domestic violence and violence does occur in some same-sex relationships, the World Health Organization (WHO) confirms that the overwhelming burden of partner violence is borne by women at the hands of men [88]. Therefore, this section of the course will focus on domestic violence against women. Results of 50 different population surveys around the world show that, at some point in their lives, 10% to 50% of women experience physical violence perpetrated by an intimate male partner [32]. Worldwide, the World Health Organization reports lifetime domestic violence rates ranging from 25% to 75% [148]. In 2010, the Centers for Disease Control and Prevention (CDC) conducted a large-scale survey and found that 35.6% of women and 28.5% men in the United States had been raped, stalked, or physically abused by an intimate partner [97]. Among victims of rape and sexual assault in the workplace, 80% are female and 20% are male. In 2003, homicide was the second leading cause of death on the job for women [35]. Overall, domestic violence incidents account for slightly more than one-quarter of all workplace violence incidents [35].

When domestic violence extends into the workplace, it becomes a concern for businesses and other organizations. It can interfere with the victim's job performance and/or lead to disruptions at work, including the abuser harassing the victim at their place of employment [183]. A large-scale Canadian study examined the level of awareness of domestic violence in the workplace among 8,429 men and women [120]. Approximately 40% of participants recognized someone at their workplace as being a domestic violence victim, based on identification of at least one warning sign. Of these participants, half believed that it had an adverse impact on their colleagues' work. In a survey study involving 1,390 employees at 32 companies, more than 50% of female workers and almost 25% of male employees disclosed having experienced intimate partner violence [149]. In total, 16% of all employees surveyed had experienced partner abuse in the past year [149]. In a 2023 study, approximately 50% of their participants experienced work loss due to domestic violence and stalking [183]. On an annual basis, lost productivity and healthcare costs due to domestic violence are estimated to be $8 million in the United States alone, translating to 7.9 million lost workdays annually [36; 150; 184].

Injuries stemming from domestic violence are approximated to yield healthcare expenses of about $4.1 billion, most of which is paid by employers [37]. Among employees who reported lifetime intimate partner violence, 41% acknowledged it negatively affected their work performance (resulting in late arrivals, absenteeism, and disruption/violence at the workplace) [149]. Other workers may also be reluctant to work near the affected individual(s), which may then result in additional indirect costs on the organization [35]. Domestic violence in the workplace is also a liability issue for employers. It is estimated that, in the United States, $1.2 million have been awarded to individuals as the result of civil lawsuits regarding lack of workplace security [36].

Legal cases associated with domestic violence in the workplace have included charges of negligent security, failure to warn when an employer is aware of a specific threat made to an employee, or violations of OSHA and Title VII of the Civil Rights Act [38].

Domestic violence victims do have legal rights that affect the workplace. In some states, there are statutes that provide guaranteed leave from the workplace, albeit unpaid, so victims can seek medical, legal, and social services due to domestic violence [98]. However, in some states, the employer has the right to ask for certification of their need to take a leave [98].

Other victims may utilize the Family and Medical Leave Act (FMLA), a federal law that offers job-guaranteed leave. Although it was created specifically for domestic violence victims, it may be used by victims who require time to heal from the consequences of violence, deal with child care issues, or to obtain legal services [98]. However, for those who cannot afford to lose income, the FMLA may not be a feasible option, because it protects leave, but not necessary pay [184]. The American Disabilities Act (ADA) may also be a resource, but it also has limitations. For example, the ADA only covers disabilities that make it difficult for an employee to perform the essentials of their job; it does not cover those who can continue working but at a diminished capacity or whose injuries or mental health conditions are less severe [184]. States may also have specific laws protecting victims from workplace discrimination. For example, in California, an employer is not allowed to terminate an employee who is a domestic violence victim for taking time off (as much as 12 weeks) to obtain medical, counseling, and/or legal services, in accordance with the California Survivors of Domestic Violence Employment Leave Act [121].

REPORTING WORKPLACE VIOLENCE

As noted, the magnitude of workplace violence in various human service sectors may be underestimated because incidences of workplace violence are typically under-reported. Research indicates that workplace violence incidences are typically reported less than half of the time [185]. Ergün and Karadakovan's study with nurses who have experienced workplace violence indicated that the majority opted not to report the incident [28]. In the United States, approximately 50% of workplace violence incidences are not reported [99]. In some cases, reporting is done informally and verbally instead of via a formal procedure [100]. The most common process for those who did report the incidents was submission of a formal, written statement to the administration. Results of a study conducted by Rowett, who examined social workers' views about reporting client violence, showed that only 5% of incidents of physical violence against social workers were reported to management [39]. Rowett speculates that lack of disclosure may be due to stereotypes of social workers who are assaulted by their clients, stating [39]:

Both assaulted and non-assaulted social workers painted a common picture of the typical assaulted social worker as someone who sought out riskier situations, confronted the client, challenged unnecessarily, was more demanding and less flexible, and less able to detect potentially violent situations and handle them once they had arisen.

Extensive literature reviews have highlighted reasons that workplace violence is under-reported [40; 99; 122; 151]:

- Lack of clear definition of workplace violence
- Fear of being blamed for the incident or of the incident somehow being attributed to the victim's negligence

- Belief that workplace violence is a normal occupational hazard
- Fear that the perpetrator might retaliate
- Fear of jeopardizing one's job or position
- Dissonance between the service providers' professional role and being a victim
- Embarrassment
- Belief that the incident is too minor to report
- Belief that violence is part of the job
- Belief that reporting the incident is futile
- Excusing the perpetrator's behavior

It has also been speculated that the ideology of various helping professions might influence reporting behaviors. For example, it has been suggested that the pervasive ideology in the field of social work has been client-driven, which is reinforced by the emphasis of consumerism in our society, and this might explain why social workers are reluctant to disclose and report incidents of client violence [41].

Perceived time constraints can also contribute to the under-reporting of incidences of workplace violence. If it is perceived that reporting is a laborious process and will take a significant amount of time in addition to a practitioner's heavy workloads, reporting may be avoided [100].

In a study conducted by Macdonald and Sirotich, of 171 social workers in Ontario, Canada, a large majority (88%) reported that they had been verbally abused by a client during their careers [42]. Additionally, 66% reported being threatened with physical assault, and 28% experienced a physical assault by a client. The top three reasons social workers in this study gave for not reporting incidents of violence were:

- The incident was not serious enough to warrant such an action.
- Violence is just part of the job.
- Nothing would come out of reporting it.

Other studies have found similar motivations for failing to report, with other concerns including fear of retaliation and lack of support [178; 182; 186].

There is a culture of acceptance of violence in many workplaces [152]. For example, emergency department nurses who are victims of workplace violence are often discouraged by hospital administrators from pursue legal action, or administrators may be reluctant to implement steps to mitigate risk factors for workplace violence (e.g., disruptive patients, long wait times). Similar conclusions were found in a 2015 study with 538 nurses in an international university-based hospital. The nurses in the study reported that the responses from superiors were not always supportive. They also tended to believe that reporting was useless, with no formal reporting mechanism and no system for following up legally [123].

In an interesting qualitative study that sought to examine the process by which individuals, specifically women, label and identify workplace bullying, Lewis interviewed 10 women from a range of professional fields (e.g., teacher, counselor, nurse, police officer, university lecturer) [18]. Nine of the 10 participants reported being bullied by their managers. Lewis found that when they initially experienced various forms of workplace bullying, the victims tended to minimize the behaviors [18]. Although the study participants perceived the behaviors as stressful, they framed them as an interpersonal problem and did not recognize the patterns of bullying. All of the women acknowledged that the behaviors escalated. Because the definition of workplace bullying is ambiguous, the women felt they could resolve the problem on their own. In part, this was related to preserving their sense of self and sense of professional competence.

Similar results were found in a qualitative study conducted by van Heugten [43]. The 17 social workers in the study who had experienced workplace bullying reported having attempted to minimize the seriousness of the bullying. Similar to Lewis' study, these participants also did not recognize the negative behaviors they experienced as workplace bullying.

When they were finally able to put a name to the behaviors, the shame gradually ebbed. Prior to the behaviors being identified as workplace bullying, the social workers reported experiencing negative physical health symptoms [43]. These studies are very small, and generalized conclusions about the profession should not be made based on the results. However, they do provide some insight into how individuals respond to and report perceived violence.

RISK FACTORS FOR WORKPLACE VIOLENCE

OCCUPATIONAL SETTING

Characteristics associated with a specific job are correlated to risk of experiencing workplace violence. Research indicates that employees who work nighttime hours (e.g., 3 p.m. to 11 p.m.) are more likely to experience all types of workplace violence than those working daytime hours (e.g., 7 a.m. to 3 p.m.) [44; 119; 153; 154]. Findings of another study of emergency departments in Turkey also indicated that working a night shift increased the risk for experiencing violence [28]. Periods of increased activities and less surveillance, such as visiting hours or mealtimes, are another risk marker. In a study conducted in a university hospital, units with greater turnover, downsizing, and night shifts were associated with increased risk of workplace violence [187]. Working in a geographically isolated area is also a risk factor [155].

Lack of security is also a risk factor [154; 182]. In a focus group study with 22 nurses, the participants identified the presence of security as instrumental in preventing workplace violence [55]. The nurse participants emphasized the importance of security staff who were specifically hired by the organization (and not by an outside organization) and trained to the unique issues related to the grounds of the organization. Other security-related factors include unsecured doors, areas with poor visibility or lighting, and non-functioning alarms [155]. Overall, environments that are vulnerable to patient-perpetrated workplace violence are those with easy public accessibility, high noise levels contributing to the perceived chaos of the environment, fear and stress emanating from crisis situations, such as difficult diagnoses and prognoses, unexpected complications, and long wait times [91; 188].

Long wait times are another predictor to violence perpetrated by patients and family members. In one study, researchers found that freestanding emergency departments have fewer incidents of workplace violence compared with hospital-based emergency departments. Hospital-based emergency departments take in more patients, which then creates longer wait times and leads to higher levels of patient anxiety and frustration [156]. Inconsistent policies for patients can also trigger violence [182].

Finally, health and mental health professionals' work often entails having one service provider solely assessing or providing a service to a client/patient. This in itself increases the risk of violence or assault [7].

ORGANIZATIONAL ENVIRONMENT

The organizational environment can also act as a risk factor for workplace violence. For example, environments that are overcrowded, like residential wards or working environments experiencing budget cuts or freezes, are more vulnerable to workplace violence [46; 47]. Organizations that do not have clearly specified staff roles may also be a risk marker. In a study conducted by Gates et al., the researchers found that there was a relationship between frequency of experiencing assaults and role ambiguity, role insufficiency, and occupational strain among nursing assistants in residential care settings [26]. Nursing assistants, for example, who experience greater levels of vagueness about their work expectations and priorities, feel that their training is not appropriate to the job, and perceive occupational stress and strain were more likely to experience assaults from their patients than those who were confident in the expectations and training [26]. Experts have suggested that healthcare professionals may not be able to concentrate on caring for difficult and challenging patients when they feel unappreciated, overwhelmed, or stressed [26].

A 2015 study found that Finnish employees who reported higher levels of job demands were four times more likely to experience workplace bullying compared with those with low levels of job demands [124]. However, it is important to remember that the relationship between job strain and workplace violence may be bidirectional [125]. Overall, workers who feel dissatisfied with their jobs and who do not experience belonging with their colleagues are more likely to perpetrate bullying [154].

Supervisors' leadership styles also play a role in workplace bullying. Those who work under an individual with a constructive leadership style were less likely to experience workplace bullying [124]. Supervisors who provide supportive, direct, and constructive feedback are more likely to have employees with high work satisfaction, which can then lead to better patient care. Ultimately this can lead to a more positive work environment [157]. Work settings characterized by instability, such as changes and shifts in management, and the perception that policies and procedures are unfair are associated with increased workplace violence [47; 157]. Aggressive acts against supervisors are often attributed to the perpetrators' perceived injustices and their views that their work environments were controlling [48; 157]. Perceived injustices may be organizational, interpersonal, or related to company policies or procedures. Perceived interpersonal injustices are related to employees' views about how they are treated; employees may feel that they are being treated disrespectfully or rudely by those who are responsible for administering procedures [49]. Prolonged periods of layoffs or downsizing and witnessing others' career successes while seemingly being overlooked oneself can adversely affect one's sense of worth and self-esteem, which can trigger feelings of victimization [101].

Other researchers have similarly categorized injustices into two categories: procedural injustices and interactional injustices. Procedural injustices refer to the perceived fairness of the organization's decision making, formal procedures, and other mechanisms to determine outcomes [50]. Interactional injustices refer to the employees' perceptions about the quality of the interpersonal treatment they received when policies and procedures are carried out [50].

It has also been speculated that organizational settings with an identifiable predominant social group may breed bullying in the workplace. Certain fields, for example, may be traditionally male- or female-dominated, and an individual who represents the social minority may then be in an exposed position [51]. In other words, minority groups within a workplace may carry an elevated risk of being socially excluded from the workgroup [86]. Some studies have shown that men in female-dominated sectors were more likely to experience workplace bullying; conversely, in male-dominated fields, women who are viewed as gendered forerunners were more likely to be sexually harassed [52].

INTERPERSONAL FACTORS

Certain personality characteristics of perpetrators or victims can be risk markers for workplace violence. For example, a psychiatric diagnosis has been identified as increasing the likelihood of perpetrating violence [53]. Of course, not all individuals with psychiatric disorders will perpetrate violence; however, certain diagnoses, including schizophrenia, schizoaffective disorder, bipolar disorder, and major depression, are associated with an increased risk for violent behavior [89; 90]. Alcohol consumption and a history of aggression are also associated with violence against a healthcare provider or co-worker [48]. Jockin, Avery, and McGue found that individuals with low tolerance to stress and frustration are more likely to experience or perpetrate a nonfatal aggressive incident in the workplace [54]. Age is also a predictor of being a victim of workplace violence. Several studies have found that younger nurses, physicians, and other staff were more likely to be exposed to workplace violence than older workers [126; 127].

Personality variables are also related to likelihood to engage in bullying in the workplace. In a 2017 study, workers who exhibited higher levels of conscientiousness were less likely to bully at work [158]. Those who demonstrated greater conscientiousness were better able to self-regulate frustration. Similarly, agreeableness was negatively correlated with bullying perpetration. However, those who exhibited higher levels of neuroticism were more likely to report high stress levels and to perpetrate in bullying [158]. However, a separate study found that lower scores in agreeableness were a consequence of exposure to workplace bullying, not an antecedent [159].

FACTORS ASSOCIATED WITH HEALTH AND SOCIAL SERVICE SETTINGS

OSHA has identified specific characteristics typically associated with health and social service settings that might contribute to the risk of workplace violence [7]. As jails and detention centers become increasingly crowded, hospitals have become temporary holding places for violent and disturbed individuals. In Levin, Hewitt, and Misner's focus group of 22 nurses, many felt that the police were using emergency rooms as a "holding tank" for patients who were intoxicated and volatile until they sobered up or calmed down [55]. In social service settings, negative perceptions of social workers are common, with persistent stereotypes of unsupported removal of children from families or withholding of services [189].

Individuals generally seek health and social services due to health distress or emotional, family, and/or psychological problem. Some patients are experiencing a crisis, and with this comes heightened emotional states, which can result in feelings of fear, loss of control, and anxiety. These emotions are associated with an increased risk of using violence as a coping mechanism [91].

Some argue that adverse events that occurred earlier in life may cause biologic changes leading to a hyperarousal state. Although individuals' heightened arousal states may initially be a self-protection mechanism, these persons may tend to overreact to stressful situations (e.g., long wait times, noise, crowds), in some cases becoming violent [160]. Because persons who often seek social services are more often in distress, in crisis, and/or highly vulnerable, these arousal states may be heightened [189].

The overall emphasis on community mental health treatment has also contributed to the problem of workplace violence. With the shift of psychiatric and mental health treatment and provision of services from in-patient psychiatric hospitals to community-based mental health organizations, volatile psychiatric patients are released home for additional treatment and may experience continued symptoms of their disorders [56]. Although the majority of individuals with severe mental disorders are not dangerous, the unpredictable nature of their illness poses a risk to service professionals providing care.

Because hospitals, health clinics, and mental health centers keep medications and drugs at their facilities, there is also a risk for robbery. This, coupled with long waits that can exacerbate patients' already low tolerance for frustration, can increase the risk for violence [7]. Furthermore, clinicians and other service professionals may be perceived as authority figures and, therefore, targets for persons acting on their frustrations [57].

CONSEQUENCES OF WORKPLACE VIOLENCE

Not unlike victims' experiences with other types of violence, such as family violence, domestic violence, or witnessing a traumatic act of violence, there are a host of emotional, somatic, and psychological reactions associated with experiencing workplace violence. Research also indicates that secondary victims of all types of violence (i.e., those who do not experience the violence directly but who hear about or witness it) experience similar stress responses. Fear reactions are common, and these responses can then lead to more serious psychological disorders, such as depression and anxiety, and an array of somatic symptoms, such as sleep and gastrointestinal disturbances [58]. Suicidal ideation is also twice as likely to occur among those who have experienced workplace bullying compared with those who have not experienced workplace violence [161]. In a systematic review of 137 studies, sadness, shock, embarrassment, and stress symptoms were common in the short term [128]. Most research has focused on the emotional impact of workplace violence [190]. Victims of workplace violence often experience irritability, stress, fear, anxiety, depression, anger, decreased self-esteem, shame/embarrassment, and lowered resilience. On a longer-term basis, avoidance of the workplace was common, which also resulted in loss of work days as well as loss of confidence and good working relationships with peers and colleagues. In a longitudinal study, those who had been exposed to physical workplace violence were 1.67 times more likely to have an increased number of visits to a physician after seven years compared with those who were not exposed to physical workplace violence [162].

Post-traumatic stress disorder (PTSD) and acute stress symptoms are also common. Interestingly, Rogers and Kelloway found that fear symptoms surrounding future workplace experiences appear to play a role in triggering a host of mental health and physical symptoms [59]. There also appears to be an association between nurses' productivity levels and exposure to patient violence. Although nurses indicate that they are generally able to continue working at their usual pace after the violence, they have more difficulty remaining focused after the incident [102].

With more insidious examples of workplace violence, such as workplace bullying or mobbing, similar physical and psychological responses are also common. Leymann has identified potential effects that mobbing may have on the victim(s) [11]:

- Inability to communicate: Through verbal threats, the victim is silenced and may feel unable to communicate with coworkers or supervisors.
- Inability to maintain social contacts: Colleagues may avoid the victim in order to avoid getting involved or because they have been told to stay away from the victim. In essence, this isolates the victim.
- Detriment to reputation: Due to the gossiping and ridiculing, the victim's personal and professional reputations are negatively impacted.
- Detriment to occupational satisfaction: The victim is given meaningless tasks at work.
- Detriment to health: The victim's health suffers due to harassment.

This categorization offers a context to understand the consequences of workplace violence, bullying, or mobbing. In a qualitative study of 10 women who experienced bullying behaviors, the symptoms associated with workplace bullying were initially attributed to other factors [18]. The symptoms were attributed to individual health, ultimately pathologizing the symptoms and causing the participants to feel even more inadequate.

Studies have shown that the presence of social support for victims can alleviate some psychological and somatic symptoms. In a survey study of 229 workers in a healthcare setting, researchers found that instrumental support, defined as support available from coworkers, supervisors, and management after the violent event, was a positive factor in alleviating psychological problems (e.g., loss of well-being) and somatic symptoms (e.g., sleep disturbance, gastrointestinal problems) [85]. In another study, coworker support was found to be a protective buffer against workplace bullying and psychological distress, albeit relatively small [163]. Instrumental and emotional support have been suggested to moderate burnout stemming from workplace bullying [164].

It is important to note that feelings of isolation are typical in the aftermath of a traumatic event. The victim may feel that no one understands what he/she is going through regardless of the amount of support available. In one study, for example, some nurses revealed that they did not want to disclose to their family members for fear of worrying them nor did they feel comfortable talking to co-workers [55]. It is therefore vital that instrumental support, having a network at the work setting that provides a formal and informal venue for the victim to express their feelings, be made available.

Providing training on how to deal with workplace violence, also referred to as informational support, has been associated with a decreased level of somatic symptoms and negative feelings [85]. However, social support does not appear to influence the fear of future violence or neglect of one's job duties [85]. Fear of future violence has not been found to affect an individual's level of commitment to their workplace and organization [59]. These findings are a bit perplexing; however, it is important to note that workplace violence was not categorized in these studies to differentiate aggression perpetrated by a stranger and aggression initiated by co-workers. When LeBlanc and Kelloway took this into account, they found that aggression perpetrated by co-workers adversely affected emotional and psychosomatic well-being and level of organization commitment; however, it did not influence fear of the future or intent to quit [60]. Workplace aggression perpetrated by a stranger or patient increases the likelihood of future violence, as individuals are then more likely to bring weapons to work for self-defense [44]. Finally, public-initiated aggression also increased the likelihood of an employee leaving the organization [60].

In addition to the adverse emotional and health consequences a victim of violence experiences, there are also organizational consequences, including increased job dissatisfaction, reduced level of work performance, higher amounts of sick leaves taken and absenteeism, reduced commitment, and leaving the job or even the profession [190]. These organizational consequences can in turn lead to economic ramifications. Figures vary depending upon how one defines workplace violence and how one calculates "cost." In 1994, it was approximated that 1.751 million workdays were lost, resulting in $55 million in lost wages [61]. However, this does not take into account litigations filed against the organizations, medical expenses incurred, and negative morale, which may influence job satisfaction, triggering future attrition and turnover.

ETHICAL AND LEGAL ISSUES

Confidentiality and the limits it imposes are key ethical issues that emerge when discussing the topic of workplace violence. Generally, healthcare professionals and other clinicians cannot disclose information learned in a clinical setting. Yet, the question is: Should protecting the privacy and maintaining the confidence of a patient's disclosure outweigh the greater social good?

The duty to protect is related to the Tarasoff legislation. Although the act of violence that resulted in the Tarasoff Law did not occur in the healthcare workplace, it has clear implications for any case in which a practitioner suspects an individual is capable of violence. This law resulted from a case in 1968,

involving a male student, Prosenjit Poddar. Poddar met Tatiana Tarasoff at a school function, where she declined his romantic interests. Poddar had a history of depression and had visited the university's health services. Soon after meeting Tarasoff, his depression worsened. He disclosed to his counselor that he had thoughts of harming and even killing a girl whom he met, and Poddar's description clearly matched Tarasoff. Poddar was committed to a hospital, and the police were contacted. However, when the police interviewed Poddar, they found him lucid and issued a warning. Ultimately, the hospital where Poddar was sent did not commit him. Two months later, he shot and killed Tarasoff after missing several counseling appointments [62]. Tarasoff's parents sued, which resulted in the Tarasoff Law. This law states that therapists, clinicians, and other mental health counselors have the duty to protect third parties from harm. The case was reheard in 1976, resulting in a change in terminology, from "duty to warn" to "duty to protect" [63]. As a result of this legislation, clinicians have a duty to protect the third party by warning the targeted victim or others who can then warn the intended victim, notifying law enforcement, and implementing other steps to protect the potential victim [63].

Healthcare workers and other helping professionals are obligated to promote good and avoid harm (i.e., adhere to the ethical principle of beneficence). Demeaning, threatening, and humiliating are often the underlying motivations in bullying behaviors, all of which violate the principle of beneficence [165]. The codes of ethics of various professions explicitly discuss the relationship practitioners are to have with their colleagues. For example, the Code of Ethics for Nurses outlines the necessity for extending respect and integrity for all individuals—colleagues as well as patients [129]. In the Code of Ethics of the National Association of Social Workers, the respectful relationships social workers are to have with their colleagues and how to resolve disputes are outlined [130].

ASSESSING RISK

Borum and Reddy argue for the need to have a fact-based line of inquiry when clinicians work with patients who may be a risk to others [63]. They maintain that clinicians should consider: Is the client on the path towards violence? If the answer is affirmative, how fast is the client moving and where can one intervene? Although this line of inquiry was not specifically developed for the workplace, it can be applied to workplace violence perpetrated by patients or clients. To help answer these two questions, further assessment may be conducted and information garnered in six areas, which may be remembered by the acronym ACTION [63]:

- Attitudes: The clinician should assess the strength of the patient's conviction that use of violence toward the intended victim will accomplish his/her goals. To what extent does the patient feel that the potential use of violence is justified? What violent fantasies does the patient hold? What expectations does the patient have that he/she will be successful using violence?
- Capacity: It is necessary to ask whether the patient has the capacity to carry out the violence and potential harm. In other words, does the patient have the physical, emotional, and intellectual capacity to carry out his/her threat? To what extent does the patient know the intended victim's routine?
- Threshold crossed: This factor pertains to the patient's previous history of violence. Has the patient broken any laws? Has the patient previously used violence to accomplish his/her goals? What are the patient's future plans with the intended victim?

- Intent: This dimension refers to whether the patient merely has a thought or if plans have been made to execute the behavior. Again, does the patient have a plan, and can the plan be executed?
- Other's reactions: It is important to obtain collateral information from individuals who know or who are acquainted with the patient. What are their perceptions of and experiences with the patient? What are their opinions about the patient's capacity to harm?
- Noncompliance with interventions: What is the extent of the patient's willingness to work with the clinician (and other professionals) to reduce the risk of using violence? To help assess this, the clinician may examine the patient's previous history regarding use of medications and other therapies and his/her beliefs about the efficacy of the interventions.

Another violence assessment tool has been created to assist in specifically identifying potentially violent patients in emergency departments [103]. Cues that indicate a patient is more likely to resort to violence include [103]:

- Prolonged staring at nurse or practitioner
- Sharp or caustic tone of voice, including rapid speech, sarcasm, rudeness, and swearing
- Anxiety exhibited in behaviors such as flushed appearance, tense posture, clenched fists, and dilated pupils
- Mumbling (e.g., talking under breath, slurring, repetitive questions)
- Pacing and fidgeting

Another acronym used to assess a patient's behavioral cues as indicators of potential violence is STAMP [191]. STAMP stands for:

- Staring and eye contact
- Tone and volume of voice
- Anxiety
- Mumbling
- Pacing

Additional tools targeted to assessing patients at risk of violence are available at https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit6_8.

None of these behaviors above are definitive indicators of a violent patient, but if taken as part of the holistic assessment, they can be used to alert practitioners of potential at-risk situations.

Administrators should assess the work environment for factors that might make the workplace more vulnerable to violence by asking the following questions [166]:

- What policies and protocols exist to discipline employees who engage in workplace violence?
- What are the reporting protocols for workplace violence incidents?
- What type of security is in place to prevent violence (e.g., guards, panic buttons, video surveillance)?
- How is traffic flow monitored (e.g., badges, electronic keys/passes)?
- What is the level of employee and/or patient stress?
- What are the wait times for patients and family members?
- Where are frustration levels high (e.g., crowding, uncertain outcomes)?

PREVENTION AND INTERVENTION

Many experts maintain that the occurrence of any type of violent or abusive incident, including workplace violence, is not necessarily a single incident but can be conceptualized as a chain of events [64]. In terms of healthcare workplace violence, this cycle is most applicable to violence perpetrated by patients/clients or service recipients (OSHA's classification Type III). Understanding the phases and stage-specific characteristics of violence or aggressive behaviors can assist clinicians and other helping professionals to determine the appropriate tasks and interventions for each stage of the crisis. It may also help to reduce the tendency to pathologize the perpetrator, ultimately promoting autonomy and dignity.

The first phase of the perpetrator's cycle of violence involves experiencing rising emotions. This phase is characterized by a sense of unspecified panic or anxiety. The perpetrator may not necessarily be able to name his or her feelings or associate these emotions to the event (whether real or imagined) [64]. The goal in this phase is to help the individual identify and discuss the problem. If the perpetrator is unable to identify and address the problem in the first stage, he/she then enters the second stage.

The second phase is characterized by an escalation of inner anxiety and a mounting feeling of loss of control. This causes the individual to attempt to regain control through the use of threats, abuse, and/or verbal intimidation [64]. During this phase, clinicians should assist perpetrators in redirecting their feelings toward arenas in which they feel some degree of control. Practitioners often miss or fail to recognize anxiety and stress cues [152]. Work should also be continued in identifying and discussing the problem. At this point, staff and other relevant persons should be alerted to the situation [64].

The third phase of the cycle of violence is called the crisis stage. In this phase, the individual uses aggressive behaviors to regain a sense of control. McAdams and Foster note that this may also symbolize a "primitive plea for external intervention" [64]. Clinicians should take steps to ensure the individual's safety as well those around him/her. Interventions must be clear and firm in regards to what is needed and expected [64].

The fourth stage is recovery and involves a decline in the individual's crisis symptoms. However, the individual may continue to feel angry or frustrated and may be resistant to interventions. Therefore, clinicians should continue working to ensure the individual's safety and to identify a resolution [64].

The fifth and final stage is characterized by the perpetrator feeling emotionally and physically exhausted. Feelings of guilt may also be evident, with the perpetrator wanting to make reparations to victims. The task of clinicians in this phase is to assist the individual in making reparations and to discuss the triggers for aggression. It may then be possible to identify prosocial mechanisms to deal with frustrations in the future [64].

COUNSELING THE VICTIM

Debriefing

After a critical incident, it is imperative for agencies to help in the victim's recovery by providing support, education, and referral services. A critical incident is defined as the acute stress response normally experienced after a traumatic event. During a crisis, the range of physical and psychological responses is often so overwhelming and intense that it taxes the individual's normal coping experiences; anxiety and numbness often follow [9]. Debriefing is a crisis intervention that aims to reduce stress symptoms [65]. This, along with defusing (e.g., giving the traumatized individual an opportunity to vent emotions about an event) may be helpful for many victims [104]. However, debriefing is not considered a replacement for psychotherapy [9]. The debriefing and defusing process should begin within 24 to 72 hours of the incident [66; 104].

The process typically consists of sessions, either group or individual, led by a mental health professional to discuss the traumatic experience, normalize feelings, and process emotions [65].

Antai-Otong identified seven phases of debriefing that occur in a group format [9]:

- Introductory phase: In this first phase, the goals of the sessions are reviewed, client confidentiality is discussed, and the client is encouraged to talk about the incident.
- Fact phase: In this phase, the client is encouraged to describe the trauma and to describe his/her sensory experiences.
- Thought phase: It is recommended that the client share his/her feelings and describe how thoughts and feelings have affected his/her sense of self-esteem, confidence, and sense of self.
- Reaction phase: This phase is characterized by a focus on the individual's reactions to the trauma. The mental health professional should carefully assess the individual's emotional state during this phase.
- Symptom phase: The objective of this stage is to help the individual move from an emotional to a cognitive level in understanding his/her symptoms.
- Education phase: The sixth phase consists of education about responses to stress and the normalcy of the individual's feelings, experiences, and reactions.
- Re-entry phase: The debriefing is brought to a closure in the re-entry phase, in which the clinician determines how helpful the debriefing was to the individual. Finally, if needed, referrals for continued services are made.

Career Counseling

Not only is workplace violence harmful to victims' mental health and physical health, it may also have a negative impact on their careers [67]. Part of the career counseling that should follow an occurrence of workplace violence involves discussing whether the victim should make a job change. If the individual decides to make a change, feeling anxious about the future is common. It may also be necessary to work with the client on concrete tasks like updating resumes, obtaining letters of reference, and general support.

Bibliotherapy

Lewis, Coursol, and Wahl have recommended bibliotherapy for victims of violence, which involves providing educational information, such as books and pamphlets about workplace violence [67]. Information regarding available sources for this information is provided later in this course. Bibliotherapy is done within the context of the therapeutic experience.

Personal Reflective Narrative

After a traumatic event, one may cope with the stress by writing a reflective narrative that documents the event and the associated emotions [104]. This should be done as soon as possible after the event. Ideally, it provides an opportunity for the victim to examine the event holistically and review the entry with a supervisor, reflecting on how the crisis affected his/her life on a professional and personal level.

Cognitive Therapy

The goal of cognitive therapy for individuals who have experienced workplace violence is to reduce symptoms of depression, post-traumatic stress, trauma disorder, anxiety disorders, and substance use disorder, all of which are common following workplace violence [192]. In a quasi-experimental design with 405 participants who had experienced workplace bullying, a cognitive-behavioral intervention was found to be effective in reducing systems of depression and anxiety and facilitating return to work compared with a waitlist control group [193].

Considerations for Non-English-Proficient Victims

Because the population of the United States is constantly diversifying, it is important for clinicians to consider each victim's cultural and linguistic limitations when it comes to reporting violence. When a victim does not speak the same language as the clinician, a professional interpreter should be consulted to ensure accurate communication. Use of professional interpreters has been associated with improvements in communication (errors and comprehension), utilization, clinical outcomes, and satisfaction with care. Individuals with limited English language skills have indicated a preference for professional interpreters rather than family members or friends.

SAFETY TRAINING FOR EMPLOYEES/STAFF

Several experts emphasize the importance of safety training for healthcare and human service professionals [56; 68]. Training must be ongoing, beginning at new employee orientations and continuing at staff meetings and in-service training. By raising staff's awareness of their immediate surroundings, training can increase professionals' sense of competence and control and lessen feelings of helplessness. Some topics that have been recommended as part of safety training are environmental assessment, techniques for de-escalation of violence, and self-awareness.

Environmental Assessment

Environmental assessment entails service providers evaluating the work environment, such as office spaces, cars, and for those professionals who conduct home visits, their clients' residences and neighborhoods, for violence risks and potential opportunities for self-defense [56]. For example, when healthcare or human service professionals conduct patient interviews in their offices or interview rooms, several questions regarding the environment should be raised. This includes determining the most effective room layout so the professional can exit quickly if there are visual cues that the patient is getting angry or violent. The office should be scanned for items that can easily be used by a potentially violent patient to cause harm; for example, books, ashtrays, and furniture can potentially be used as weapons [69; 194]. In addition, evaluating what in the environment can be used as a barrier (e.g., tables, shelves) is equally vital [194]. It is also important to determine the extent of which the interviewing or evaluation office is visible to others. This requires a delicate balance, because it is important to promote the privacy and confidentiality of the client, but simultaneously, it is also important for the clinician to be safe [69].

The environment of waiting rooms can be potential breeding grounds for patient violence [131]. Organizations should evaluate the mechanisms in place to manage patients' emotions and safety. For example, what can be done to keep the environment peaceful and calm? What mechanisms are in place to reduce waiting times or to communicate waiting times most effectively [131]? What security measures are in place (e.g., cameras, patrols) [132]?

Workers' vehicles are often taken for granted. However, maintenance issues are important, particularly for staff who work late at night or who conduct home visits in unfamiliar neighborhoods [56]. Staff members should have their keys readily available when they walk to their cars, and they should check the back seats before getting in their vehicles. Items that place a car at risk of being vandalized, such as a supply of psychotropic medication, should be put away or not left in the vehicle.

When going on home visits, knowledge of neighborhoods is a prerequisite to safety. The following questions may be helpful in determining the risk associated with certain neighborhoods [7; 56; 57]:

- Do workers know which neighborhoods or areas are unsafe at night?
- Do workers know where to find secure parking and easy exits?
- Are workers apprised of recent incidents of violence or drug-related activities in the neighborhood?

- Is it possible for a worker to be accompanied by another staff person on home visits or rounds?
- Is there a clear plan for workers who conduct home visits to communicate their whereabouts and a protocol to follow if a worker does not report as expected?
- Is it possible for workers in the field to carry hand-held alarms or noise devices?

Twenty-three social workers participated in a study conducted in rural areas in Australia. The study consisted of a forum to identify safety concerns and for workers to convey their experiences with abuse and violence with clients while working [70]. A prominent theme that emerged was the risk involved in conducting home visits and transporting clients from one location to another. In some cases, agencies did not have the resources for radios, mobile phones, security papers, and duress alarms. Even when the equipment was available, it was unreliable in remote locations. As a result, issues of personal safety were a paramount concern for many of these rural social workers.

Techniques for De-Escalating Violence

De-escalation involves defusing potentially agitated patients and reducing maladaptive behaviors using conflict resolution methods, limit-setting, and calm and empathic verbal strategies [71; 167]. Ultimately, this depends upon the clinician's ability to negotiate and use conflict resolution [71; 72]. One of the goals of de-escalating potentially aggressive patients is to promote autonomy and dignity by providing options [73]. To achieve this goal, clinicians must learn to recognize the warning signs of agitation. Behavioral cues may include increased pacing, increased volume and tempo of voice, flushed face, or agitated body movements [71].

Verbal de-escalation strategies can be effective. The National Association of Therapeutic Schools and Programs recommends that clinicians remain calm and convey an attitude of respect by listening to the patient [72]. The patient should be viewed as an individual requiring support or help versus someone with a condition or who is resistant or misbehaving [195]. Next, it is important to identify what is provoking the individual, and then to assist the individual to use prosocial means to express his/her feelings. Clinicians should approach the client calmly [69]. It is important not to convey any cues that may be perceived as confrontational. For example, clinicians should not maintain unrelenting or persistent eye contact. Permission should be given to express feelings of frustration and anger without interruption. It is also important to avoid using terms like "you should" when speaking [195].

Verbal strategies to de-escalate tension in cases in which clients have weapons can also be effective. When clinicians talk to clients in a calm and rational manner, both clinicians and the clients suffer less physical injury or property damage than when clinicians opt to use verbal or physical aggression [74]. Active listening skills are helpful and involve appropriate eye contact and body language, empathizing, and paraphrasing to convey understanding [69]. Clinicians should also be aware of their tone, volume, rate, and rhythm of speech, also referred to as paraverbals. If not careful, paraverbals can convey the opposite of what is communicated verbally [75]. Empathetic listening and communication can help to de-escalate violent situations [105]. Instead of trying to suppress emotions, listening and talking through the frustration can help mitigate potentially violent anger.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The National Institute for Health and Care Excellence asserts that if a service user becomes agitated or angry, a staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner. Emotional regulation and self-management techniques should be used to control verbal and nonverbal expressions of anxiety or frustration (e.g., body posture, eye contact) when carrying out de-escalation.

(https://www.nice.org.uk/guidance/ng10. Last accessed July 17, 2025.)

Strength of Recommendation: Expert Opinion/ Consensus Statement

Redirection is another effective de-escalation strategy [76]. In some cases, this may simply involve changing the topic. Alternately, it can be as concrete as offering a patient a glass of water or cup of coffee. This conveys to patients that the clinician is aware of and sensitive to their needs [76].

The use of de-escalation techniques as early intervention results in more therapeutic gains for patients as opposed to using more restrictive management techniques to deal with aggressive behaviors [71]. Clinicians who successfully use de-escalation techniques report improved relationships with patients and increased feelings of self-efficacy, which can lead to greater job satisfaction [71]. It is vital that the environment supports patient self-management of anxiety [168]. Facilities can promote this by providing access to massages, relaxing sounds, aromatic oils, comforting blankets, guided imagery, and other soothing techniques.

In summary, the following best practices for de-escalation have been recommended [196]:

- Respect the patient/client's personal space
- Avoid provoking
- Be brief and clear
- Establish eye contact
- Engage in active listening by listening to the patient/client's needs
- Identify and empathize with their feelings
- Agree to disagree
- Establish clear expectations and consequences
- Offer options
- Debrief with staff about their feelings, experiences, and what worked well and did not

Training to Increase Self-Efficacy and Confidence

Workers should be given an arsenal of tools to increase their sense of confidence and self-efficacy. Practitioners who work with patients who can become highly volatile and violent should be aware of the warning signs of potential violence and physiological overview to agitation. They should also be taught calming communication approaches, restraining techniques and when to use them, de-escalation techniques, and medical evaluation and triage [91; 131; 167; 195]. For example, tone of voice and use of eye contact can be employed to calm potentially violent or aggressive patients [91]. Using traditional and simulated trainings, practitioners can also learn how to prepare for violent situations and learn self-defense techniques [169].

Clinician Self-Awareness

Clinicians should also be attuned to their own feelings and reactions. If they sense that a client will be violent, a safety plan should be implemented immediately. Not only should clinicians be aware of their feelings, but they must be aware of how their body language and facial expressions mirror their feelings. For example, if they feel fear and anxiety, these reactions should be masked so as not to communicate the fear to their patients [69]. If patients sense fear, open communication, trust, and rapport can be negatively impacted [69].

When employees are trained to assess their environment, encouraged to listen and be aware of their feelings and reactions toward patients and their environment, and to report potentially violent incidences, their responses will differ dramatically compared with those who have not been trained [106]. According to a 2011 study, employees who have been educated will initially express a startled reaction/response to a violent incident, but they are more likely to prepare themselves and others to address the act appropriately than untrained employees, who are more likely to panic, deny the incident, and feel helpless.

General Training

In addition to training about safety, healthcare providers may also be given guidance regarding trauma-informed care and the use of different standardized assessment tools (including standardized behavioral observation tools) to evaluate a patient's or client's risk of violence [194]. If everyone in the organization uses the same standardized assessment(s), this will ensure consistency in definitions and measurements.

Counterbalance training and Tactical Approach to Caring Training (TACT) may also be useful tools. TACT refers to evidence-based techniques that focus on skills to maintain composure and a calming presence to manage a patient/client's emotional distress [194].

All staff members should receive training about the channel of communication. Communication strategies that emphasize giving patients/clients the space and time to think and process information and emotions are paramount. For example, providers should be encouraged to use silence, empathy, and language that are clear and supportive [194].

SELF-CARE FOR EMPLOYEES/STAFF

For some practitioners who witness workplace violence, compassion fatigue, secondary traumatization, and burnout are typical consequences. Compassion fatigue is a relatively new term, coined in 1992, and is meant to convey a nonpathologic concept [77]. It is a natural consequence of the emotions that stem from either witnessing or knowing about a traumatic event or daily continual contact with those who are suffering [77]. Secondary, or vicarious, traumatization is defined as "transformation of the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" [78]. Vicarious traumatization can cause emotional and cognitive arousal symptoms, such as increased emotional sensitivity, lack of well-being, intrusive thoughts, and difficulty concentrating [79]. Finally, burnout has been defined as physical and emotional symptoms that are linked to the workplace experience, ranging from working with clients to environmental components of the workplace [79]. The practitioner experiencing burnout feels exhausted and, at times, emotionally detached from clients [79]. In one study, Levine, Hewitt, and Misner found that nurses withdrew from their patients after an incident of workplace violence [55].

Self-care is integral to the prevention of negative symptoms such as burnout, secondary traumatization, and compassion fatigue. Twemlow suggests a self-care plan for persons at risk for these effects that includes cognitive and stress management techniques, such as biofeedback or hypnosis [76]. In addition, nutrition and regular physical exercise are vital. Maintaining social and familial relationships is also crucial.

Self-care may be conceptualized along a continuum, with proactive planning and reactive intervention on either ends of the continuum [79]. Self-care includes an array of activities that touch on the following domains [79]:

- Physical (e.g., exercise, nutrition, sleep)
- Recreational (e.g., play activities, vacation time, hobbies)
- Social support (e.g., interaction with friends, family members)
- Spiritual/religious (e.g., prayer, meditation)

On the organizational level, administrators can create a culture of promoting self-care in organizations. Practitioners should be discouraged from skipping breaks and lunches in order to catch up on work. Built-in supervision and support can also reduce burnout [33]. An organizational culture with strong leadership that endorses and promotes respect, support, and care for oneself and each other is key to helping clinicians cope after experiences with workplace violence [197].

Practitioners should not merely consider these activities in passing but spend time asking themselves about the self-care activities they are currently undertaking [79]. Practitioners must view self-care as proactive rather than reactive [79].

Practitioners who have experienced workplace violence may also consider going to their employee assistance program (EAP) to obtain assistance, if available. Counseling and mental health services are free and confidential through EAPs.

OCCUPATIONAL POLICIES

It is important to view occupational policies regarding workplace violence in the context of the range of different types of organizational responses to incidents of workplace violence or bullying. Ferris divided organizational responses into three categories: "See no evil, hear no evil, and speak no evil" [80]. Organizations that fall into the "see no evil" category acknowledge the existence of workplace violence or bullying but normalize the behavior. When affected staff members approach the employer, they are told to toughen up and to learn how to deal with the behaviors [80]. Organizational responses identified as "hear no evil" acknowledge the problem but frame it as an interpersonal conflict. The victim is often blamed for somehow triggering the negative behaviors due to his or her personality [80]. The third and final response is classified as "speak no evil." These organizations acknowledge the problem and its deleterious effects. Consequently, they take allegations seriously, follow up with an investigation, and take action against the bullying or violent individual. Ferris noted that the "speak no evil" organizations had learned from previous encounters of workplace violence that had resulted in lawsuits [80]. Organizations may ask where their current policies would be categorized based on this system.

Mandates for the development of zero-tolerance violence policies have been set for healthcare organizations [7]. This sends a clear message to employees that all types of workplace violence, including harassment, are not tolerated [66]. Such behaviors should be followed up with the appropriate disciplinary action [81]. The main premise of zero-tolerance policies is that workplace violence is reduced by promoting open communication of acceptable behaviors [81]. However, it is crucial for organizations to remember that a zero-tolerance policy itself does not prevent workplace violence [167].

After implementing zero-tolerance policies, mechanisms must be implemented to support the organizational message. First, a reporting, monitoring, and documentation system should be in place. Having a mechanism for reporting and documenting allows the type of aggressive violence and abusive behaviors to be identified and discipline enacted uniformly [82; 132; 198]. This should minimize under-reporting and send a clear message about where and how to report various types of violence. A monitoring system would also allow for collection of data and identification of risk factors to be utilized in training and the development of intervention strategies [66; 82]. Furthermore, evaluating the effectiveness of these prevention and intervention strategies is vital to not only help build the knowledge base but enhance transparency [198].

It is recommended that an interview be conducted with the victim and witness(es) as soon as possible after the event. The American Federation of State, County, and Municipal Employees recommends questions covering [83]:

- Location, date, and time of the incident
- Description of the perpetrator and relationship to victim (e.g., stranger, client/patient, colleague)
- Type of aggressive behavior (e.g., physical assault, use of weapon, verbal threat)
- Was the worker alone when the incident occurred?
- Prior incidences (e.g., threats prior to the incident)
- Other witnesses (e.g., security guard)
- Factors or circumstances leading up to the incident
- Any reports to the employer about previous incidents

Ultimately, post-incident debriefing helps to increase staff awareness and future reporting of workplace violence events [167].

Another recommendation is for employee assistance programs to take a more active role in helping to prevent workplace violence. EAPs can address certain stressors, whether they originate in the individual, the home, or work, that may precipitate workplace violence. Voelker found that when the U.S. Postal Service worked to improve their employee assistance programs' counseling services, their incidence of workplace violence was reduced [81].

Security measures should also be a key priority. Certain sectors, such as hospitals, operate on a 24-hour-a-day basis, with a constant flow of patients/clients, family members, and staff. Many healthcare organizations have implemented more stringent and secure entry identification mechanisms; some facilities require staff to wear badges with photos or require the swipe of an electronic identification card to enter certain areas [84]. Security cameras may be installed in key areas, panic buttons installed for easy access, and patient waiting areas be clearly visible to staff and security guards [196].

OSHA has established the following recommendations for organizational policies for decreasing workplace violence and promoting the safety of employees [7; 107]:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions. Ensure that managers, supervisors, coworkers, patients, and visitors know about this policy.
- Ensure that no employee who reports or experiences workplace violence faces reprisals.
- Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.
- Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery.

Post-incident interventions encompass immediate medical and psychological care, counseling services for staff who both directly experienced and witnessed the violence, and debriefing procedures to learn from the incident in order to revise internal policies and procedures, as needed [195; 196]. Although healthcare facilities are busy, it is essential that debriefing not be postponed [195].

It is also recommended that organizations implement grievance mechanisms that allow employees a forum or venue to voice their concerns. Some studies have found that perceived injustices are related to precipitations of workplace violence [48; 49]. The opportunity for an employee to voice his/her opinions and to be heard by an unbiased third party might mitigate the frustration level, which could then reduce the likelihood of a violent incident [81]. Some states mandate that certain facilities (e.g., hospitals, home health agencies, emergency medical services, correctional facilities) have a written prevention plan outlining how they will protect employees from workplace violence [155]. Good workplace violence reporting policies and prevention plans are key in sustaining an environment that is productive and safe [170].

RESOURCES

The following resources are offered to provide more information about workplace violence. As discussed, education is vital in order to ensure that workplace violence is identified and reported.

Occupational Safety & Health Administration
https://www.osha.gov/workplace-violence

National Institute for the Prevention of Workplace Violence
https://www.workplaceviolence911.com

Office of Justice Programs
Office for Victims of Crime
https://ojp.gov/ovc

Canadian Initiative on Workplace Violence
https://workplaceviolence.ca

Futures without Violence
https://www.futureswithoutviolence.org

The Joint Commission
https://www.jointcommission.org/our-priorities/workforce-safety-and-well-being/resource-center/workplace-violence-prevention

National Institute for Occupational Safety and Health (NIOSH)
About Workplace Violence
https://www.cdc.gov/niosh/topics/violence

Workplace Bullying Institute
https://www.workplacebullying.org

Workplace Fairness
https://www.workplacefairness.org/workplace-violence

CONCLUSION

Workplace violence is primarily a hidden social problem, with negative ramifications for victims and other employees. These ramifications also extend to organizations and agencies in the form of lost productive work days, increased sick time, decreased staff morale, and staff turnover. Workplace violence is a social problem that warrants attention from employees, researchers, and policy-makers.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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Evidence-Based Practice Recommendations Citation

National Institute for Health and Care Excellence. *Violence and Aggression: Short-Term Management in Mental Health, Health, and Community Settings*. Edinburgh: National Institute for Health and Care Excellence; 2015. Available at https://www.nice.org.uk/guidance/ng10. Last accessed July 17, 2025.