

**EXPERIENCES OF WORKPLACE CLIENT-INITIATED VIOLENCE AGAINST
HEALTH SECTOR WORKERS IN ZAMBIA: A CASE STUDY OF
CHONGWE DISTRICT**

By

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Abstract

Violence among Zambian healthcare workers as reported in both electronic and print media. The World Health Organization, (1994, p.123) defines WPV as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”. In certain quarters workplace violence is often considered part of the job in the health sector and has, therefore, been more frequently overlooked than in other sectors until recently.

The purpose of the study was to investigate workplace client-initiated violence against health workers in Chongwe District of Zambia.

A case study using interview method was conducted to describe lived experiences of health workers in the workplace in Chongwe district.

Eight of the twenty targeted health workers consented to be interviewed from seven healthcare facilities in Chongwe district. The health workers included two clinical officers and six nurses. The results showed that types of violence experienced include verbal abuse, threatening behaviours, physical assaults, and sexual harassments. The violent incidents were perpetrated by patients/clients, by patients’ relatives, and at times by work colleagues. Health workers reacted to incidents of violence by reporting to supervisors, telling their friends, crying or, retaliating. Some of them also preferred to ignore the situation. Most of the health workers stated that violence had psychological and emotional effects on them, which consequently affected their work performance.

Violence against health workers is a problem in Zambia and the world at large which has the potential to compromise quality healthcare delivery. As such, it is necessary that measures are taken to curb the vice of workplace client-initiated violence against health workers, to create a safe working environment for them. In this light, topics on violence against health workers should be included in healthcare education programmes and provided during in-service training for qualified health workers to promote their assertiveness and to raise awareness on the existence of violence against them.

DECLARATION


I, **ABESHY CHILEMA**, hereby declare that the work on which this thesis is based is my original work (except where acknowledgement indicate otherwise) and that neither the whole work nor any part of it has been , is being, or is to submitted for another degree in this or any other University.

Signature: *ABhilema*

Date: *28th September, 2016*

APPROVAL

This Thesis by Abeshy Chilema is approved as fulfilling part of the requirements for the award of the degree of Master of Science Peace, Leadership and Conflict Resolution by the University of Zambia (UNZA) in association with the Zimbabwean Open University (ZOU).

Signed..........Date.....29/09/16.....

Signed.....Date.....

Signed.....Date.....

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DEDICATION

I dedicate this study to my beloved parents David Chumpila Chilema and Julia Kwandu Chungu for inculcating into me values of perseverance. I also dedicate this work to the Chilema lineage far and wide.

ACRONYMS

Cal/OSHA	California Occupational Health and Safety
CDC	Centres for Disease Control
CISD	Critical Incident Stress Debriefing
ED	Emergency Department
GAM	General Aggression Model
HCW	Healthcare Worker
HRH	Human Resources for Health
ICN	International Council of Nurses
JCAHO	Joint Commission on Accreditation of Healthcare Organisations
MoH	Ministry of Health
NHSP	National Health Strategic Plan
NIOSH	National Institute for Occupational Safety and Health.
OSH	Occupational Health Safety
PHC	Primary Health Care
PPE	Positive Practice Environments
PTSD	Post-Traumatic Stress Disorder
RHC	Rural Health Centre
USAID	United States Agency for International Development
WHO	World Health Organisation
WPV	Workplace Violence
ZUNO	Zambia Union of Nurses Organisation

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CHAPTER 1 INTRODUCTION

1.0 INTRODUCTION

This introductory chapter provides the background to the study, the statement of the problem, purpose of the study, objectives, study questions, and significance of the study. The terms patients, clients and care recipients are used interchangeably in this report.

1.1 BACKGROUND TO THE STUDY

The 2006 World Health Report, Working Together for Health, (WHO 2006) confirmed that Zambia is one of 57 countries worldwide suffering from a critical shortage of health care workers, and thus serves as one example of the global health workforce crisis. The reasons for the global crisis are complex and vary from one country to another but key to this are unhealthy, unproductive work environments which are characterised by occupational hazards, physical and psychological violence, unreasonable workloads, insufficient remuneration, limited career development opportunities, and a general deterioration of working conditions. Such poor work environments have an equally negative impact on the recruitment and retention of health professionals, the performance and cost-effectiveness of health facilities, and ultimately on patient outcomes.

There are key elements in the workplace that can strengthen and support the workforce and in turn have a positive impact on patient outcomes and organisational cost-effectiveness. These factors, when in place and supported by appropriate resources (both financial and human), go a long way in ensuring the establishment and maintenance of an effective professional health care workforce and ultimately the overall quality of health systems. Collectively they constitute the key elements of positive practice environments (PPEs). PPEs are cost-effective health care settings that support excellence and decent work, have the power to attract and retain staff and to improve patient satisfaction, safety and outcomes (PPE Campaign, 2009).

A national Human Resources for Health (HRH) Strategic Plan developed in 2006 frames the HRH crisis in Zambia as follows:

The Zambian health sector faces a major human resource crisis, with shortages of health workers at every level of service delivery. The health sector recognises that human resources are critical in the provision of quality health care and that to address the current crisis it is essential that it ensures an adequate and equitable

distribution of appropriately skilled and motivated health workers providing quality services (MoH, 2006, p.6).

There is only an estimated 24% of doctors who work in rural areas. The nurses/midwife to doctor ratio is 5:1 in urban areas and 20:1 in rural areas. The health worker/ population density is also very variable, ranging from 0.14 /1,000 in a small rural district to 2.7/1,000 in Lusaka district. In terms of nurses, two districts in Zambia had less than 10 nurses each, while three of the biggest urban districts in Zambia had on average more than 450 each. Similarly, the nurse to doctor ratio per district ranged from 11 districts with less than 10 nurses per doctor, to four districts with 50 nurses or more nurses per doctor (Herbst & Gijsbrechts, 2007).

Workplace violence in healthcare is a multi-layered problem that affects individuals in diverse ways, and requires a multifactor and organisational-wide approach to reduce the incidence of workplace aggression via prevention, appropriate assessment, its management and evaluation of interventions.

Prompted by the worldwide incidence and severity of workplace violence in healthcare, in 1996 the World Health Assembly challenged healthcare agencies internationally to achieve change using strategies to assess, prevent and manage workplace violence (WHO 1996). As one of three typologies of workplace violence, client-initiated violence is a highly prevalent workplace hazard in modern healthcare delivery (Mayhew & Chappell 2005).

Client-initiated violence has impacts on healthcare service quality and safety, client trauma and costs to the healthcare organisation; it affects workforce issues such as retention and recruitment, and results in trauma, and other personal costs to staff.

It is for this reason that this study is part of a broader worldwide movement that has approached workplace aggression with occupational health and safety framework in mind. Part of the approach was inclusion of existing ideas and knowledge to address workplace violence, and that information would be shared to obtain widespread adoption and improvement in Zambian healthcare services delivery within a broad country-wide approach.

1.2 STATEMENT OF THE PROBLEM

As demonstrated by the three studies so far undertaken (Kiragu et al. 2007; MoH 2007; Ngulube 2005), being employed as a health worker in Zambia brings with it obvious occupational hazards which are not matched by the attitudes towards ensuring a protective and safe work environment.

Safety in the workplace is not highly placed in the allocation of resources for health care delivery. It is, therefore, not surprising that a proportion of school leavers observed this and cited it as one of the reasons they will not consider joining the medical profession. Though several studies have been carried out on gender related violence; WHO Multi-Country study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses (WHO, 2005), there has been no studies on workplace violence undertaken to critically explore the type of workplace violence experienced by healthcare workers in rural health facilities in Zambia.

1.3 PURPOSE OF THE STUDY

The purpose of the study was to investigate workplace client-initiated violence against health workers in Chongwe District.

The specific objectives of the study were:

1. To determine the type of workplace client- initiated violence experienced by healthcare workers.
2. To identify the coping strategies healthcare workers employ when dealing with workplace client-initiated violence.
3. To find out how healthcare workers interpret workplace violence.

1.4 RESEARCH QUESTIONS

The study was guided by the following research questions:

1. What type of workplace client-initiated violence is mostly experienced by healthcare workers in rural settings?
2. What coping strategies do healthcare workers employ when dealing with workplace client-initiated violence?
3. How do professional healthcare workers interpret workplace violence?

1.5 SIGNIFICANCE OF THE STUDY

Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored. According to the Joint Commission, a major accrediting body for health care organisations, institutions that were once considered to be safe havens are now confronting "steadily increasing rates of crime, including violent crimes such as assault, rape, and homicide." (Harrell, 2009, p.345). On the other hand desk review has put together a situation

analysis of the professional practice environment in Zambia today, bringing out a picture of unhealthy, unproductive work environments. These manifest in the form of occupational hazards, physical and psychological violence and unreasonable workloads experienced by health workers in the public health sector.

To date, most research has been directed at quantifying the problem and attempting to profile perpetrators and their victims. The few studies that have focused on interventions to reduce violence have highlighted the unlikelihood of finding a simple, one-size-fits-all solution to prevent this violence. As in many countries, there are no comprehensive, national data sources on the prevalence, prevention or impact of workplace violence. As a consequence, the most reliable data on workplace violence are likely to be found in the research literature. However, The Zambia Union of Nurses Organisation (ZUNO) has been lobbying the government to ensure the safety of nurses and midwives by formulating stiff laws that will punish anyone who will physically or verbally abuse them during the course of their duty. This was in reaction to the recent cases of nurses and midwives countrywide being beaten and assaulted by members of the public and relatives of patients (MoH, 2013).

The study was based on the understanding that workplace client-initiated violence in the health care sector in Zambia has negatively impacted on healthcare service quality and safety, and therefore there is a growing need for context-relevant interventions. In other words the study intended to gain a better understanding of workplace client-initiated violence against healthcare workers. Among others, it sought to help policy makers and practitioners to come up with policies and strategies that would assist to limit workplace violence against healthcare workers and provide a platform for vulnerable healthcare workers. It was also intended to raise critical awareness on the seriousness of workplace violence amongst healthcare workers.

1.6 DELIMITATION OF THE STUDY

The study was limited to Chongwe district of Zambia and only focused on few health facilities. This study on the other hand explored only one risk factor which was the clients/patients and their families. Workplace violence is a multifaceted problem therefore the risk factors cannot be limited to patients and families only. However, reviewed literature indicate that such violence is primarily caused by them. This is because of the demanding nature, impatience, and diversity of patients and visitors have a critical influence on escalating workplace violence.

1.7 LIMITATIONS

Some research suggests that qualitative research on workplace violence (WPV) should interview both the victim and perpetrator. Given that this research used a single informant sample, the data relied on health care workers' accounts of the client-initiated violence. On the other hand some researchers have critiqued the use of self-reports altogether. For example, it is argued that client-initiated violence has significant negative consequences for the physical wellbeing and psychological health of both victims and perpetrators. Ultimately, they posit that both informants were likely to "under-or over-report" their experiences for a variety of reasons including social desirability and society's lack of awareness of worker-perpetrated violence. Hence, a limitation of this study was its reliance on single informants.

The single informant studies have argued that there is a general lack of consistency between reports on how victims and perpetrators report workplace violence and behaviour. They have also suggested that single person responses may be biased because of centered" or unique dispositions of that individual; a single respondent may also create a systematic measurement error. For example, each participant has defined violence differently.

However, it may be argue that the single informant sample is often necessary in order to examine data compiled in research that has neglected the use of victim's perspectives. The data in most studies on WPV classify workers as victimized (Caldwell et al. 2009; Johnson 2008). In other studies, reports have been averaged, usually predicting that victims are as violent as perpetrators (Swartz 2000).

It may also be stated that the participants in this study were honest on the account that some narrations were strikingly similar to those described in the literature relating to victims and perpetrators of WPV. Furthermore, given the diverse characteristics of the sample in this study, data from perpetrators was inaccessible for obvious reasons. The incidents happened sometime back and the victims were uncertain of the whereabouts of the perpetrators. Given the experiences of this sample, it was not possible to use a multiple informant sample (both victims and perpetrators). Despite these limitations, this study will generate information that could be useful for designing and implementing policies which are sensitive to the needs of health care workers who experience workplace violence.

1.8 OPERATIONAL DEFINITIONS

Before looking further at the prevalence of workplace client-initiated violence and its components, it is important to define what constitutes this phenomenon. The literature shows a lack of agreement and confusion regarding the definitions of what constitutes violence and what constitutes a workplace. In addition, studies on this topic have used various terms such as workplace violence, workplace aggression, or workplace victimisation to define the topic. For the purpose of this research, the terms workplace violence and workplace victimisation are used alternatively to describe this topic. The terms client and patient are as well interchangeably used.

1.8.1 Violence- For some authors, violence only includes actions that relate to physical harm inflicted on others or on oneself (Reiss and Roth, 1993), consequently excluding psychological/emotional violence and acts against properties. In addition, certain studies interchangeably use the terms violence and aggression, which would suggest that violence and aggression are similar and again would relate violence more specifically to physical harm neglecting its psychological aspect. As Budd (1999) suggests from her findings from the British Crime Survey, the experience of violence at work is still subjective to the perception of the victims. Some workers might see a situation as frightening and violent, while others may not. She also notes that victims of threats were as frightened, if not even more, than victims of assaults. This corroborates the importance to include psychological violence such as bullying and threats in the definition of violence.

1.8.2 Workplace- In regard to the workplace, again some definitions might be too specific and may exclude certain types of workplace. For instance, Chappell and Di Martino (2000) note that data collected for official crime statistics often only take into consideration violence that happened in offices, commercial premises, schools, or other physical settings. Therefore, mobile or geographically diverse employments such as taxi and bus drivers, journalists and law enforcement officers, workers whose work involves home visits like plumbers, postal officers, and people who work at home are not taken into account. The definition of workplace should then be much broader and include any type of work settings. The location where the victim considers him/herself “on duty” should then be defined as his/her workplace.

1.8.3 Workplace violence- Violence at work should include all types of violence occurring in all types of occupational settings. The European Commission agreed to define workplace violence

as: “Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health” (Leather, Brady, Lawrence, Beale, & Cox, 1998, p. 324). Therefore, workplace violence may involve a wide range of behaviours, which may overlap each other.

1.8.4 Post-traumatic stress disorder- This disorder may start at different stages for each person-experiencing trauma in their life but can adversely affect a person through reliving the event that created the stress. It is primarily an emotional sickness classified as an anxiety disorder and is the result of a frightening, life-threatening, or otherwise highly traumatic experience.

1.8.5 Traumatic Event - A traumatic event is usually a stressful experience that may cause physical, emotional, psychological distress, or harm to us. The event may be something that happens to you or something you witness that is terrifying or life threatening. It could also be a horrific traumatic event that was witnessed and resulted in death

1.9 CONCLUDING COMMENTS TO THE CHAPTER

This chapter has established the foundations for this study by providing the background to the research, introducing the research aims, questions and the significance of the problem and summarising the study’s methodology and the main findings. In the next chapter I provide a literature review that locates the study within the relevant contemporary research and literature.

CHAPTER 2

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter presents relevant literature on experiences of workplace client – initiated violence against health workers. Articles that were included in the literature review are those that discussed violence against health care workers including nurses in the workplace. The literature indicated that there is violence against health workers and there is also violence amongst health workers. This review highlights the main issues in respect of the nature and extent of violence against health workers, the forms of violence experienced by health workers, the settings and times when violence against health workers occurs, the health workers' lived experiences of being victims of violence at work places and the effects of such violence against health workers.

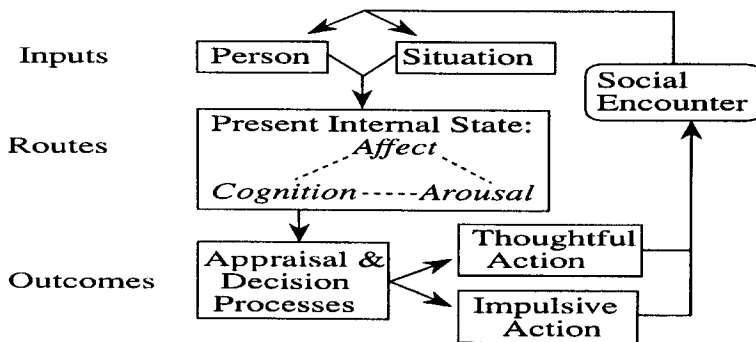
2.1 THEORETICAL FRAMEWORK

The theoretical framework provides a well-supported rationale to conduct the study, and helps the reader understand the perspective. A good theoretical framework assures the reader that the type of investigation proposed is not based solely on personal instincts or guesses, but rather informed by established theory and empirical facts obtained from credible studies. According to Bushman & Anderson (2001), the science of workplace violence can be advanced by an approach that is informed by the distinct, yet overlapping theories and practices of injury control, public health, industrial hygiene, product design, and criminal justice. The inclusion of environmental design in workplace violence prevention interventions is based on the notion that such programs should be based on site specific risk assessments that consider the environment, organisational, and clinical practices, and the interpersonal interactions in the delivery of care.

2.2 THE GENERAL AGGRESSIVE MODEL

This study is informed by the general aggression model (GAM). This theoretical framework was designed to integrate existing mini-theories of aggression into a unified whole. This model on the other hand has at least some notable advantages over smaller domain theories. First, it is more parsimonious than the set of existing mini-theories. Second, it better explains aggressive acts that are based on multiple motives, e.g., both instrumental and affect-based aggression (Bushman & Anderson 2001).

The General Aggression Model Episodic Processes



Source: Bushman & Anderson (2001)

GAM focuses on the “person in the situation,” called an episode, consisting of one cycle of an ongoing social interaction. The figure above presents a simplified version of the main foci of the model. The three main foci concern (a) person and situation inputs; (b) cognitive, affective, and arousal routes through which these input variables have their impact; and (c) outcomes of the underlying appraisal and decision processes.

2.3 INPUTS

Aggression research focuses on discovering what biological, environmental, psychological, and social factors influence aggressive behavior, and on how to use these discoveries to reduce unwarranted aggression. GAM indicates the types of underlying processes to examine how various inputs lead to aggressive (or nonaggressive) behaviour.

2.3.1 Person Factors

Person factors include all the characteristics a person brings to the situation, such as personality traits, attitudes, and genetic predispositions. Stable person factors are those that display consistency across time, across situations, or across both. In a very real sense, personality is the sum of a person’s knowledge structures. Together, person factors comprise an individual’s preparedness to aggress.

2.3.1.1 Traits

Certain traits predispose individuals to high levels of aggression. One recent breakthrough, for example, was the discovery that certain types of people who frequently aggress against others do so in large part because of a susceptibility towards hostile attribution, perception, and expectation biases.

2.3.1.2 Sex

Males and females differ in aggressive tendencies, especially in the most violent behaviors of homicide and aggravated assault. Laboratory studies often show the same type of sex effect, but provocation dramatically reduces sex differences in physical aggression, and specific types of provocation differentially affect male and female aggression. Males prefer direct aggression, whereas females prefer indirect aggression.

2.3.1.3 Beliefs

Those who believe that they can successfully carry out specific aggressive acts (self-efficacy) and that these acts will produce the desired outcomes (outcome efficacy) are much more likely to select aggressive behaviours than those who are not so confident of the efficacy of aggressive acts.

2.3.1.4 Attitudes

Attitudes are general evaluations people hold about themselves, other people, objects, and issues. Males prone to aggress against women are not generally aggressive against all people in all situations; rather, they specifically target women (but not men) who have provoked them (Anderson 1996).

2.3.1.5 Values

Values—beliefs about what one should or ought to do—also play a role in aggression preparedness. There is evidence that some youth gang violence results from similar codes of honour and personal respect.

2.4 SITUATIONAL FACTORS

Situational factors include any important features of the situation, such as presence of a provocation or an aggressive cue. Like the person factors, situational factors influence aggression by influencing cognition, affect, and arousal.

2.4.1 Aggressive cues

Aggressive cues are objects that prime aggression-related concepts in memory. More recently, the understanding of the weapons effect has been enhanced by the discovery that weapon pictures and words automatically prime aggressive thoughts. Other situational variables that increase

aggression, such as exposure to violent television, movies, or video games, also appear to do so via cognitive cueing effects.

2.4.2 Provocation

Perhaps the most important single cause of human aggression is interpersonal provocation. Provocations include insults, slights, and other forms of verbal aggression, physical aggression, and interference with one's attempts to attain an important goal, and so on

2.4.3 Frustration

Frustration can be defined as the blockage of goal attainment. More recent work has shown that displaced aggression, wherein the target of aggression is not the person who caused the initial frustration, is a robust phenomenon.

2.4.4 Pain and discomfort

General discomfort, such as that produced by sitting in a hot room, can also increase aggression; this effect appears to be mediated primarily by increasing negative affect, though there may be cognitive and arousal processes at work too.

2.4.5 Drugs

Various drugs such as alcohol and caffeine can also increase aggression. These effects appear to be indirect rather than direct; Bushman (1997) found that aggression-facilitating factors (e.g. provocation, frustration, aggressive cues) have a much stronger effect on people who are under the influence of drugs than on people who are not.

2.4.6 Incentives

The types of incentives that can increase aggression are as numerous as the number of objects that people want or desire. Indeed, the whole advertisement industry rests on the goal of making people want more things. Momentary appearance of an incentive, such as money left on a table, can also influence aggression in a less premeditated way.

2.5 ROUTES

Input variables influence the final outcome behavior through the present internal state that they create. The trait hostility and exposure to violent movie scenes interactively influence accessibility of aggressive thoughts, aggressive affect and aggressive behaviour.

2.5.1 Cognition

2.5.1.1 Hostile thoughts

Some input variables influence aggressive behavior by increasing the relative accessibility of aggressive concepts in memory. Frequent activation of a concept results in its becoming chronically accessible, whereas an immediate situational activation results in making the concept accessible for a short time. The temporary increase in the accessibility is often called priming. A host of factors, such as media violence, can prime aggressive thoughts.

2.5.2 Affect

2.5.2.1 Mood and Emotion

Input variables can also directly influence affect, setting the stage for later effects on aggressive behavior. For example, pain increases state hostility or anger (Berkowitz 1993, Anderson et al. 1998). Uncomfortable temperatures produce a small increase in general negative affect and a larger increase in aggressive affect (Anderson et al. 1996). Exposure to violent movie clips also increases hostile feelings (Anderson 1997, Bushman 1995, Bushman & Geen 1990, Hansen & Hansen 1990).

2.5.2.2 Expressive Motor Responses

Expressive motor responses are the automatic reactions that occur in conjunction with specific emotions, largely in the face. Even in early infancy, unexpected pain (e.g., immunization inoculations) quickly produces “a clear cut, full-faced anger expression” (Izard 1991). Berkowitz (1993) postulated that aversive experiences directly activate aggression-related motor programs that go beyond mere facial expression.

2.5.3 Arousal

Arousal can influence aggression in three ways. If a person is provoked or otherwise instigated to aggress at the time that increased arousal occurs, heightened aggression can result (Geen & O’Neal 1969). Excitation transfer theory suggests that this type of arousal effect may persist over a long period. A large number of situational variables influence both physiological and psychological arousal. Interestingly, changes in physiological and psychological arousal do not always coincide. Hot temperatures increase heart rate while simultaneously decreasing perceived arousal. This suggests that heat might increase aggression through the arousal route (Anderson et al. 2000).

2.5.3.1 Interconnections

The cognitions and arousal influence affect is an idea that goes back several generations, through Schachter & Singer (1962) and William James (1890). Affect also influences cognition and arousal (Bower 1981). Research has shown that people often use their affective state to guide inference and judgment processes (Forgas 1992, Schwarz & Clore 1996). At a theoretical level, one can view affect as a part of semantic memory that can be primed via spreading activation processes. Thus, hostile cognitions might make hostile feelings more accessible, and vice versa.

2.6 OUTCOMES

On outcomes, includes several complex information processes, ranging from the relatively automatic to the heavily controlled (Robinson 1998, Smith & Lazarus 1993). The more automatic processes are labeled “immediate appraisal,” whereas the more controlled processes are labeled “reappraisal.” The outcomes of these decision processes themselves determine the final action of the episode. Immediate appraisal is automatic, i.e., relatively effortless, spontaneous, and occurring without awareness. Depending on the circumstances, immediate appraisal may produce either an automatic trait or situational inference.

In view of the foregoing, if a person (target) has been thinking aggressive thoughts and is bumped by another person (actor), the target is likely to perceive the bump as an aggressive act by the actor. However, if the target has been thinking about how crowded the room is, the same bump is likely to be immediately perceived as an accidental consequence of the crowded situation. The present internal state determines, to a great extent, which type of automatic inference is generated. And of course, both person and situation factors determine the present internal state. Thus, hostile-attribution-bias children bring to the situation a readiness to see intentional affronts where none exists.

Appraisal involves searching for an alternative view of the situation. It can include a search for relevant information about the cause of the event, a search for relevant memories, and a search for features of the present situation. Reappraisal may include numerous cycles as alternatives are considered and discarded. At some point the recycling process ceases and a thoughtful course of action occurs. If reappraisal leads the person to believe that the bump was an intentionally harmful act, the person may well respond with a thoughtful aggressive action, which may be coldly

calculating or may still have hot affective characteristics. Indeed, the reappraisal can increase the level of anger as past wrongs are dredged up from memory or as the damage to one's social image becomes more apparent.

2.6.1 Personality Processes

Repeatedly exposing children to certain factors (e.g., media violence, poor parenting) produces aggressive adults. Such long-term effects result from the development, automatization, and reinforcement of aggression-related knowledge structures. Huesmann & Miller (1994) proposed a model of the long-term social and academic effects of repeated exposure to television violence. Repeated exposure to other situational factors that produce short-term increases in aggression, described earlier and are believed to produce long-term increases in a similar manner.

In sum, GAM provides a useful framework for understanding and integrating what is already known about human aggression. It provides the mortar and structure to hold together the current domain-specific aggression theories so they form a house rather than a heap of stones. It incorporates smaller domain-specific aggression theories. It organises recent theories of the development and persistence of the aggressive personality. It serves the heuristic function of suggesting important directions for future research designed to fill in theoretical gaps. I believe that theory-based aggression research can reduce the level of violence in workplaces by increasing our understanding of the causes of aggression and violence.

2.7 PREVALENCE OF WORKPLACE VIOLENCE

The prevalence of violence against health workers varies from country to country (Taylor & Rew, 2010). The prevalence of violence against health workers does not follow an obvious pattern that would make it easy to predict which countries are likely to have high rates of violence against health workers. It is suggested that such differences could be due to many factors among which are: setting; work load; working style; and attitudes to reporting the event by the victims (Kamchuchat, & Sangthong, 2008).

A possible reason why the prevalence of workplace violence against health workers varies from study to study is that surveys use different time frames in reporting (Taylor & Rew, 2010). Some studies report the prevalence of violence against health workers in the preceding week (Roche, Diers, Duffield, & Catling-Paull, 2009), some in the preceding three months (Hegney, Eley, Plank, Buikstra & Parker, 2006), some in the preceding six months (Shiao, Tseng, Hau, Cheng & Guo,

2010) whilst others in the preceding twelve months (Abbas, Fiala, Abdel Rhaman & Fahim, 2010). Although there is a general consensus that workplace violence against health workers exists in different countries, the inconsistencies in timeframes used significantly affects the reported prevalence of workplace violence (Taylor & Rew, 2010). This makes it difficult to understand the problem or compare the findings from study to study.

Whilst the issue of workplace violence has become a global concern, it seems violence against health workers is on the increase. Hegney et al. (2006) reported that there was an increase in workplace violence towards health workers in Australia. In their research, they compared results of two similar studies conducted in 2001 and 2004. The reason for such an increase in workplace violence against health workers is not well explained. There are differing opinions amongst researchers as to whether violence against health workers is increasing or decreasing. Ferns (2006) suggested that there is indeed an increase in violence against health workers which however remains undetermined due to underreporting of such incidents. In the case of Zambia, the prevalence issue has to be investigated before considering increase or decrease.

Hutchinson, Vickers, Jackson and Wilkes (2006) have argued that the high prevalence rates of violence against health workers exist because health workers passively tolerate or ignore witnessed workplace violence, normalising the behaviours as an acceptable part of their work experience. However, Hegney et al. (2006) counter argue that the observed increase may not necessarily be due to an increase in the levels of violence but rather due to the fact that health workers have become more assertive; health workers therefore recognise when they have been abused making them more likely to report having been victims of workplace violence.

It is also difficult to measure the actual prevalence of workplace violence for any particular period because most health workers who have been victims of workplace violence experience more than one incident of the violence within a period. A study in Hong Kong discovered that on average, health workers who had been victims of workplace violence experienced more than ten instances of different types of workplace violence in a year.

Bullying amongst health workers also occurs repeatedly and the offenders and victims are continuously the same (Hutchinson et al., 2006). It is possible that the percentage of health workers who report to have experienced workplace violence under-represents the actual frequency that violent incidents against health workers occur. Another reason why it is difficult to measure the

actual prevalence of workplace violence is that data is collected by interviews or questionnaires which are likely to bring recall bias.

Apart from experiencing workplace violence personally, health workers also witness incidents of violence against their colleagues (AbuAlRub et al., 2007). Witnessing of a violent incident is not an indicator of the prevalence of violence because it is possible that more than one health worker might have witnessed the same violent incident. It is however important to explore how witnessing such incidents affects the health workers.

2.8 TYPES OF WORKPLACE VIOLENCE

Health workers experience various forms of violence at their workplace; categorised broadly into physical violence or psychological violence (Kwok et al., 2006). Other terms used to describe workplace violence include “. . . physical assault, abuse, verbal abuse, harassment, kicking, punching, spitting, pulling hair, biting, stalking, sexual harassment, sexual assault, and acts of aggression or intimidation” (Taylor & Rew, 2010, p.561). The use of varying terminologies from study to study to describe workplace violence makes it hard to compare the findings or generalise findings from one study to a different setting for which in the Zambian context could be either rural or urban setting.

2.8.1 Physical Violence

The occurrence of physical violence at the workplace has been categorised into two areas: violence with a weapon or violence without a weapon (Kansagra, Rao, Sullivan, Gordon, Magid, Kaushal, Camargo & Blumenthal, 2008). McKinnon and Cross (2008) reported that the occurrence of physical violence with a weapon against health workers in Australia was low. A study conducted in the United States of America reported that guns or knives were brought into Emergency departments daily by patients and/or their visitors (Kansagra et al. 2008). However, there was no mention whether these weapons were used against health workers. Other reported forms of physical violence without a weapon were wrestling with a patient, being stalked and held hostage and being bitten by patient's dog (McKinnon & Cross, 2008).

2.8.2 Psychological Violence

There is a consensus in findings from studies that psychological violence occurs more often than physical violence. Celik et al. (2007) established that 91% of the respondents had been victims of

psychological violence before. They also found that of the 33% health workers who reported to have experienced physical violence, all of them had also been victims of psychological violence. A study in Kuwait reported that 48% of the participating had experienced psychological violence in the previous six months prior to the study, compared to 7% who experienced physical violence (Adib et al., 2002). Psychological violence occurs in many forms such as verbal aggression, bullying and sexual harassment (Senuzun Ergun & Karadakovan, 2005; Kwok et al., 2006).

Verbal aggression has been reported in a number of studies as the most common form of psychological violence against health workers Abe & Henley, 2007; Celik et al., 2007; Khalil, 2009; Rowe & Sherlock, 2005; Shields & Wilkins, 2009). A study conducted in Philadelphia, USA found that over 96 % of the 307 health workers who participated reported to have experienced verbal aggression at work (Rowe & Sherlock, 2005). In this study, the verbal aggression was reported to have been expressed as anger, judging, criticising, or condescension.

Khalil (2009) identified six types of workplace violence amongst health workers described as psychological, vertical, covert, horizontal, overt and physical. The study also found that covert violence mostly occurred in the form of gossiping. Horizontal violence (also referred to as lateral violence) relates to behaviours among individuals who consider themselves peers with equal power but overall without power within the system (Stanely, Martin, Michael, Welton & Nemeth, 2007). Horizontal violence occurred mostly in the form of bullying (Khalil, 2009). A study in Turkey found that the most common form of bullying that reported by health workers was being spoken to in a belittling manner (Yildirim & Yildirim, 2007). Other reported forms of bullying were being blamed for things that one was not responsible for and being controlled when working. Overt violence mostly occurred in the form of shouting in public (Khalil, 2009). Although there was a distinction made for the types of violence amongst health workers, covert, overt, vertical and horizontal violence all seem to fall under psychological violence.

2.9 PERPETRATORS OF WORKPLACE VIOLENCE

Incidents of sexual harassment against health workers have been reported. Sexual harassment can be in the form of physical or psychological violence (Nielsen, Bjorkelo, Notelaers & Einarsen, 2010; McKenna et al., 2003). Sexual harassment is reported by male and female health workers. The overall reported prevalence of sexual harassment is low. Other studies do not mention the occurrence of sexual harassment against health workers. Sexual harassment, however, is a

traumatising experience for the victims. Kamchuchat et al. (2008) suggested that the reason why sexual harassment is underreported could be because of fear of stigmatisation and the psychological effect of the event. It is therefore important to recognise that the prevalence of sexual harassment against health workers could be higher than it has been reported in most studies.

2.9.1 Patient related Violence

By and large violence against health workers in the workplace originates from various sources. Mullan and Badger (2007) found that 98% of violent acts experienced by health workers in aged care were perpetrated by patients. Similar findings where patients were the frequent perpetrators of violence have been reported by Senuzun Ergun and Karadakovan (2005) and Hegney et al. (2006). There are differing reports about whether male or female patients are more likely to demonstrate violence against health workers. Mullan and Badger (2007) established that male patients are the ones who are mostly violent against health workers whereas Weizzmann-Henelious and Osuutala (2000) reported that female patients were most likely to be violent. With such variations in findings, it remains inconclusive if the patients' sex is a determinant for being a risk for violence against health workers.

2.9.2 Patients' relatives/Visitor related violence

Patients' visitors/relatives are another common source of violence against health workers (Campbell, Kub, Agnew, Fowler, Sheridan, Deaton & Bolyard, 2011). A study in Iran found that 84% of violence incidents were perpetrated by patients' relatives (Esmailpour, Salsali & Ahmadi, 2011). The study also revealed that most incidents of violence occurred during visiting hours in the hospitals, a time when the patients' relatives and visitors were around.

2.9.3 Colleague/health worker related violence

Other reported perpetrators of workplace violence against nurses are fellow nurses, supervisors, doctors, and allied health professionals (Hegney et al., 2006). Co-workers were reported to be the most common source of sexual harassment against health workers compared to patients and patients' relatives (Kamchuchat et al., 2008). Doctors were reported to be most common source of violence in operating rooms than elsewhere (Celik et al., 2007). Although it has been established that workplace violence against health workers is perpetrated by various sources, there is no mention of the sex of these perpetrators except for the case with patients.

As aforementioned, health workers are sometimes perpetrators of violent incidents against fellow health workers (Abe & Henly, 2010; Johnson & Rea, 2009; Khalil, 2009). This applies to nurses of all cadres and positions. Violence amongst health workers mostly occurs in the form of bullying (Abe & Henly, 2010; Johnson & Rea, 2009). Most studies show that health workers were bullied by their seniors whilst a few were bullied by subordinates (Johnson & Rea, 2009). Abe and Henly (2010) in Japan found that health workers, who had been victims of workplace violence from fellow health workers, also experienced other negative acts at work such as someone withholding information, being humiliated, and being shouted at.

Khalil (2009) reported that professional health workers were identified as the main perpetrators of violence against fellow health workers Woelfel and McCaffrey (2007) condemned the occurrence of violence amongst health workers and argued that although there are explanations why violence occurs among health workers, it cannot justify the violence among people in a profession built on caring.

2.10 CAUSES OF WORKPLACE VIOLENCE

Violence against health workers occurs due to various reasons. Patients most likely to be violent are those with severe symptoms of their disease, or those who abused drugs and alcohol (Kamchuchat et al., 2008). May and Grubbs (2002) found that most of the violent incidents against health workers by patients were attributed to cognitive dysfunction caused by head injury; dementia and developmental delay. Substance abuse contributed to most of the incidents; seconded by those due to anger related to long waiting times and anger towards health workers related to enforcement of hospital policies such visiting hours or number of visitors per room (May & Grubbs, 2002). Reported reasons why patients' visitors have been violent against health workers include: anger towards staff members related to patients' situations; anger related to long waiting times; anger related to the health care system; substance abuse and cognitive dysfunction (May & Grubbs, 2002).

The origins of workplace violence amongst co-workers are believed to have been preceded by longstanding power struggle (Strandmark & Hellberg, 2007). Conflict in professional values between health workers and other health care professionals is a major source of workplace violence (Standmark & Hallberg, 2007). Differences in approach to patients such as the

biomechanical view by other health care professionals and psychosocial view by health workers are an example of such professional values which can result in violence. Some doctors have been violent towards juniors for refusing to carry out orders which the juniors found to be in conflict with their professional values (Kamchuchat et al., 2008).

Hutchinson et al. (2006) explained bullying amongst health workers from a qualitative study they conducted in Australia. Bullying amongst health workers was found to be a result of an informal power hierarchy which existed at the workplace. In this hierarchy, the bullies were at the top and the bullied were at the bottom (Hutchinson et al., 2006). The existence of bullying was denied by management and it became part of the work environment. The bullies made the bullied seem and feel incompetent by ignoring their efforts at work, criticising them, and sidelining them in activities at work (Hutchinson et al., 2006). Hutchinson et al. (2006) concluded that the understanding of workplace bullying is important in the management of bullying at an institution. Although the findings of Hutchinson et al. (2006) cannot be generalised to other settings, they provide a framework for the understanding of workplace bullying.

2.11 SETTINGS AND TIMES OF WORKPLACE VIOLENCE

There are significant differences in levels of workplace violence against health workers in various fields of health care (Hegney et al., 2006). Violence against health workers has been reported in a number of areas including correctional services, emergency departments, aged care hospitals, psychiatric units, private hospitals, community services, and maternity units (Khalil, 2009). Basically, there is some level of violence against health workers at any setting where health workers work. In most cases, the incidents of violence against health workers happen when they are on duty; however, there have been reports where health workers have been attacked away from work whilst off duty (Opie et al., 2010). The nature and extent of the violence is generally influenced by the nature of patients, availability of resources and interpersonal relations amongst co-workers (Bilgi, 2009).

Another setting in which high levels of violence against health workers occur is in emergency departments (Taylor & Rew, 2010). Kwok et al. (2006) established that most of the health workers working in the emergency department reported to have been victims of work place violence in the preceding twelve months. There are several factors that contribute to the high risk of workplace

violence in emergency departments. Some factors are staff related because the emergency departments are mostly under staffed, the risk of violence increases due to delay of services (Emergency Nurses Association, 2008).

2.11.1 Violence against Health Workers in relation to Time

The occurrence of workplace violence against health workers is also determined by the place within the unit and time of day. Esmaeilpour et al. (2011) found that for health workers working in emergency departments in Iran, most physical violence incidents occurred near the patients' beds while verbal abuse mostly occurred in nursing stations. AbuAlRub et al. (2007) found that violence against health workers mostly occurred during visiting hours. The relationship between workplace violence and time on duty is not clear due to conflicting findings. In an Egyptian study, working the night shift was said to have higher chance for being assaulted than working in the morning shift (Abbas et al., 2010). Estryn-Behar et al. (2008) also found that those working night shifts were more likely to be attacked than those who did not work night shifts.

2.12 ASSOCIATED RISK FACTORS FOR WORKPLACE VIOLENCE

2.12.1 Gender

A number of factors have been identified as risks for being a victim of workplace violence for health workers. One of the risk factors is being male (Esmaeilpour et al., 2011). McKinnon and Cross (2008) found that the male respondents had been victims of workplace violence compared to female respondents. In Egypt, Abbas et al. (2010) found that male nurses who participated in their study had mostly experienced workplace violence compared to the female nurses. Campbell et al. (2011) found that male health workers were twice as likely to have experienced workplace violence compared to female health workers.

High prevalence rates of workplace violence against male health workers by clients has been attributed to the fact that male health workers tend to be protective of their female counterparts and often are in the forefront when restraining aggressive clients (Shields & Wilkins, 2009). Kamchuchat et al. (2008) have argued that sex is not a significant determinant to the risk of workplace violence due to the predominance of females in the nursing profession. Johnson and Rea (2009) found no relationship between workplace violence and sex of the health worker. The relationship between gender of the health worker and being a victim of workplace violence is unclear and needs further research.

2.12.2 Work Experience

There are different findings from studies regarding the relationship between workplace violence and work experience and/or age of the victim. A study by Shields and Wilkins (2009) noted that health workers with less work experience reported higher frequencies of experiencing workplace violence compared to those with greater work experience. Being a victim of workplace violence for less experienced health workers has been attributed to their lack of skills to predict or manage violent situations (Shields & Wilkins, 2009).

However, it is difficult to compare work experience and risk of violence from study to study due to the use of different cut off points for years of experience. As noted above, some studies used ten years (Ghasemi et al., 2009), others eleven years (McKinnon & Cross, 2008) and yet others used five years (Shields & Wilkins, 2009). It therefore remains inconclusive whether more or less work experience is a risk factor for experiencing violence at work.

2.12.3 Race and Ethnicity

Race and ethnicity are said to create tension in the work place and contribute towards workplace violence against health workers (Campbell et al., 2011). In the USA, Campbell et al. (2011) found that health workers from other races (African American, Asian, and Pacific) were less likely to experience workplace violence than those of the white race. This is in contrast to the Johnson and Rea (2009) study which found no association between workplace violence against health workers and being an immigrant health workers or of a different race in the USA. The issue of race or ethnicity and violence is setting specific because of the variations of racial and ethnic groups in different countries. This can be better examined by conducting research in the specific population where one wants to identify the relationship.

2.12.4 Cadre of Health Workers

The relationship between the cadre of health workers and the risk of violence is difficult to ascertain because of the different categories, qualifications and number of health workers for each category in different countries. The general picture is that health workers belonging to a lower level cadre are more at risk of violent attacks as compared to health workers in a higher level cadre. Increased level of education for the health workers is found to decrease the risk of violence (Kamchuchat et al., 2008). Johnson and Rea (2009) however found no association between education level and the risk of violence.

2.12.5 Work load

Abbas et al. (2010) found that working in a place crowded with colleagues increased the odds of being exposed to a violent incident compared to working with low numbers of colleagues. In contrast, working in isolation has also been found to increase the risk of workplace violence for health workers (Shields & Wilkins, 2009). There is no trade-off point given as the appropriate ratio of health worker to patient to decrease workplace violence. Shields and Wilkins (2009) also found that health workers who perceived that staffing levels were inadequate were more likely to be victims of workplace violence.

It is difficult to verify the association between the number of health workers working and violence because the health workers -patient ratio of the facilities where the studies were conducted are not given. The HWs' perceptions are likely to differ from setting to setting and it is therefore important to research the context specific perceptions for health workers. Identifying these perceived reasons of increased workplace violence is one step towards the eradication of workplace violence.

2.12.6 Health Workers' Interpersonal Style

Health workers' interpersonal style is alleged to contribute to experience of aggressive behaviours from patients and patients' relatives (Bilgin, 2009). Health workers who were less sociable and less tolerant were more exposed to physical assault than those who were more sociable. The relevance of interpersonal style may be difficult to apply in settings with severe shortage of health workers like Zambia, where some of the health workers work on their own.

2.13 REACTIONS OF HEALTH WORKERS TO WORKPLACE VIOLENCE

2.13.1 Reporting the Violent Incident

Most incidents of workplace violence against health workers go unreported (Esmailpour et al., 2011; Farrel et al., 2006; Kwok et al., 2006; Senuzun Ergun & Karadakovan, 2005). Senuzun Ergun and Karadakovan (2005) found that most health workers who had been victims of workplace violence did not report the incidents because they felt that no legal action will be taken. There are several reasons why health workers do not report incidents of violence. Adib et al. (2002) found that health workers did not report incident of violence for the following reasons: "the incident remained under control; there was no harm meant or done; the victim did not believe

reporting is useful; the perpetrator apologised; the perpetrator was confused; the victim feared for her professional record”.

It has been suggested that another reason why incidents remain unreported is that health workers do not know the reporting procedures of incidents of violence (Hegney et al., 2006). Even in institutions where there are policies and guidelines on reporting and handling of violent incidents against health workers, only few health workers reported to be aware of the existence of such policies (Hegney et al., 2006). There is a need to investigate if the presence of such policies and guidelines, and health workers’ reported awareness of the guidelines helps to prevent or reduce workplace violence.

2.13.2 Seeking Help from Others

Health workers who have been victims of workplace violence do sometimes seek for help from other sources. Adib et al. (2002) found that of the respondents who indicated that they had experienced physical violence asked for help, while for those who experienced verbal violence only a few asked for help. The study in Hong Kong revealed that the health workers who had been victims of workplace violence confided in friends, family members or work colleagues (Kwok et al., 2006).

2.14 EFFECTS OF WORKPLACE VIOLENCE

2.14.1 Physical Effects

Violence against health workers has physical and psychological effects on the victims (Franz, Kuhnert & Nienhouse, 2010). A study in Australia explored the severity of physical effects that health workers’ experience as a result of workplace violence ranged from mild injuries such as bruises to serious injuries such as fractures (McKinnon & Cross, 2008). Major injuries reported were muscle tears and fractures (McKinnon & Cross, 2008). Physical reactions such as feeling tired, having headache, alterations in appetite and having gastrointestinal problems have also been reported in health workers who experience workplace bullying (Yildirim & Yildirim, 2007). Health worker who have been victims of sexual abuse are also at a high risk of contracting sexually transmitted infections (STI) from the assailants (Allsworth, Redding & Peipert, 2009).

2.14.2 Psychological Effects

Being a victim of workplace violence has been found to make the health workers feel extremely bothered by the event and to experience repeated disturbing memories, thoughts and images of the

attack (Esmailpour et al., 2011). Incidents of Post-traumatic stress disorder (PTSD) have also been reported in health workers who experienced violence at the workplace (Inoue, Tsukano, Muraoka, Kaneko & Okamura, 2006). Some health workers are reported to have attempted suicide or contemplated suicide as a result of being a victim to workplace violence (Kwok et al., 2006; Yildirim & Yildirim, 2007). In Hong Kong, a health worker attempted suicide following verbal and physical abuse (Kwok et al., 2006) and in Turkey, some health workers who reported to have experienced workplace bullying stated that they had contemplated suicide because of the bullying (Yildirim & Yildirim, 2007).

2.14.3 Work Related Effects

Workplace violence influences the work of the health workers who have been victims (Celik et al., 2007; Franz et al., 2010). Violence against health workers compromises the quality of care that health workers provide to their patients. Roche et al. (2009) found that an increase in violence against health workers resulted in an increase in medication errors and patient falls. Other reported effects of being a victim of violence at work by health workers from another study are anxiety, tension and having less fun at work (Franz et al., 2010).

Some health workers expressed the desire to leave the health care profession as a result of being a victim of violence (Farrel et al., 2006). Other health workers who have been victims of workplace violence seriously consider quitting their jobs or seeking alternative employment (Yildirim & Yildirim, 2007). Yet other health workers, have actually resigned from their work due to the experience of workplace violence (King & McInerney, 2006). It is therefore suggestive that workplace violence has an effect on the retention of health workers in the health care workforce and this is an issue which needs further research.

On the positive side, some health workers who had been victims of violence at their workplace became more careful when working so that they could not fall victim again (Franz et al., 2010). Yildirim and Yildirim (2007) also found that health workers who had been victims of workplace bullying reported that they started working more carefully, harder and became more organised to avoid criticism.

2.15 CONCLUDING COMMENTS TO THE CHAPTER

This qualitative study aims to further develop knowledge of the dynamics of WPV and contribute to an understanding of how these dynamics impact on experiences of health workers, irrespective

of whether they had experienced WPV. Researches done world over (i.e. America, Africa, Asia, Australia and Europe) provide evidence that health workers are victims of workplace violence. The extent of violence differs from country to country based on the type of perpetrators. The nature of violence experienced is largely psychological and to a lesser extent physical. Violence affects health workers' lives and performance at work. Health workers working in different health facilities and different speciality areas within these facilities experience different levels of violence and are affected differently by the violence.

All the above cited studies were conducted in institutions which have different staff levels, equipment and culture from typical Zambian rural health centres. This therefore makes it difficult to generalise the findings of these studies to the Zambian experiences. Furthermore, it is difficult to generalise these findings due to the use of different terminologies in defining violence. This study's aim was to investigate and describe the nature and extent of WPV against health workers and the perceived effects thereof on them in the health centres/posts of Chongwe district.

The next chapter details the research design and methodology of this study.

CHAPTER 3

METHODOLOGY

3.0 INTRODUCTION

The previous chapter evaluated existing workplace client-initiated violence literature and its applicability to health sector. This chapter will assess the adopted strategy for this research and will consider the methods of data collection, the sample selection of participants, ethical considerations and any limitations of the research.

3.1 RESEARCH DESIGN

Qualitative research methodology addresses the purpose of this study as it encourages detailed description and fits with the need to document impacts of workplace client-initiated violence in the health sector in Zambia. A qualitative approach also supports interpretive objectives. These objectives include determining the type of workplace client-initiated violence experienced by healthcare workers and identifying the coping strategies healthcare workers employ when dealing with workplace client-initiated violence. They also include finding out how healthcare workers interpret workplace violence.

The framework for this research is a case study, an in-depth exploration of a “bounded system” explored through detailed, intensive data collection involving multiple sources of information, both primary and secondary, rich in context (historical, economic, political and socio-cultural), (Creswell, 1998) . There are several definitions of case study as a research approach. First, case study is defined as a method to deeply observe the characteristics of individual unit such as a person, a group or a community, in order to analyse various phenomena in relation to that unit of study (Cohen & Manion, 1989 as cited in Bassey, 1999). Another description is written by MacDonald & Walker (1975) that case study is ‘the study of the instance in action’.

In response to this argument, Kemmis (1980 as cited in Bassey, 1999) explains that ‘case studies consist in the imagination of the case and the invention of the study...which are... cognitive and cultural processes.’ In addition, Stenhouse (as cited in Bassey, 1999) states that the task of case study is to produce reports of experience and to offer evidence, not to deal with generalisation.

In his review, Robert Yin identifies a case study as an ‘empirical enquiry to investigate a contemporary phenomenon in real-life context, especially when the boundaries between phenomenon and context are not clearly evident’. (2003). Yin also describes that case studies can

be qualitative or quantitative. Supporting this idea, Stake (2005) adds that qualitative case study often focuses on experiential knowledge of a certain case and closely related to the social, political influences. Moreover, the credibility of a case study might be obtained through continuously making descriptions and interpretations during the period of the study.

In light of the aforesaid, this case study includes an articulation of the research questions, a thorough description of the context, the identification of the issues related to workplace client-initiated violence and an analysis of the information and data gathered during fieldwork. The study required data collection from various sources. Interviews were conducted with healthcare workers from various rural health posts found in Chongwe district. On the other hand various documents and data from related studies both within Africa and beyond were carefully reviewed and analysed. Notes taken during interviews were analysed in light of the secondary information.

Development of this study drew upon qualitative research literature. Shank (2002), for example, identifies three approaches for “performing a case study [that] predominate within the current qualitative research literature”. He first highlights the work of Stake who focused on the importance of field observations for a case study, which should capture the details and nuances of a particular case. Stake also noted “the single case has to make its own case” and not attempt to be a proxy for multiple cases. This case study of workplace client-initiated violence in Zambia explores the nexus between rhetoric and reality, policy, and practice as the ends of the healthcare provision continuum are influenced by various trends.

I chose this study approach because a case study provides a holistic interpretation and always refers to a social context. Additionally, it does not involve any treatments, experiments or manipulated social settings. Consequently, the data was considered as natural phenomena in people’s real lives. Finally, I did not spend much budget as other methods such as experiments and surveys do, but it all depended on the type and the period of the research.

3.2 TARGET POPULATION

Population refers to an entire group of persons or elements that have at least one thing in common. Population also refers to the larger group from which the sample is taken (Kombo, 2006). In the context of research the term “target population” has been defined as all members of any well-defined class of people, events, or objects which have been designated as being the focus of an

investigation. The target population for the study comprised healthcare workers of Chongwe district which is quite convenient for me because I live in Chongwe.

3.3 SAMPLE SIZE

Thorne (2008) suggests that the more common a phenomenon, the smaller the sample size that is needed. While it is difficult to determine a qualitative sample size *a priori*, given that the phenomenon of client-initiated violence, as variously defined, is relatively common within the context of healthcare workplace, the estimated sample size for this study was 20 participants. However, the goal of sampling and recruitment was that it would continue until data saturation was achieved for the most significant themes that emerged.

Purposive sampling was used to select respondents for the study. Purposive sampling can be considered a form of stratified sampling in that the selection of the cases is governed by some criterion acting as a secondary control (Sidhu 2006). Eight healthcare workers drawn from seven health centres / posts spread over the district participated in this study. Chongwe district was chosen because of its proximity to the researcher. The participants were six nurses and two clinical officers working in rural settings with working experiences ranging from 5 to 11 years.

3.3.1 Recruitment

To acquire a purposeful sample of healthcare workers who had experienced client-initiated violence at some degree of intensity, a range of recruitment strategies were used and included: (1) convenience sampling of healthcare workers in health centres or posts located in Chongwe; and (2) snowball sampling.

The convenience sampling strategy for recruiting participants involved approaching healthcare workers working in the health centres/posts upon introducing myself with the documents: (see Appendices A and B). Permission to present this research project to the healthcare facilities had been obtained from the Director of Institute of Distance Education on the basis of being a student pursuing post-graduate programme. The healthcare workers were provided with a summary of the study and the inclusion criteria and subsequently consented to participate in the study through this recruitment method.

Given the requirement to locate an intensity sample, snowball sampling was also used as a recruitment strategy. Snowball sampling is a method of sampling in which each research participant is asked to recommend additional prospective participants, often when participants are difficult to reach (Boswell & Cannon, 2011). Snowball sampling also involves utilising experts

in the field to identify potential participants (Patton, 2002). This recruitment strategy resulted in identifying 8 healthcare workers who subsequently consented to participate in the study.

3.4 DATA COLLECTION

The primary method of data collection was the use of individual, semi-structured interviews conducted by myself on-one-to-one basis to ensure consistency of the delivery of the interviews. Semi-structured interviews are commonly used in qualitative research to allow the researcher to explore more deeply the social and personal phenomena under study and to create meaning with participants by exploring their individual perceptions of their experiences (DiCiccio-Bloom & Crabtree, 2006).

The semi-structured technique ensures that the researcher will obtain all of the information required, but at the same time, allow the participant freedom of responses and description to illustrate concepts (Morse & Field, 1996). Semi-structured interviewing begins with several pre-determined questions and probes with follow-up questions to elicit more information (DiCiccio-Bloom & Crabtree; Morse & Field, 1996; Walker, 2011).

The focus of the semi-structured interview was to gain an understanding of how healthcare workers define client-initiated violence and to capture their narrative experiences (stories) of this type of violence in the workplace. The interview involved collecting data for the purpose of defining the problem, conducting a needs analysis and completing a thorough practice analysis. A copy of the semi-structured interview guide is located in Appendix C.

Each participant was contacted in person and provided with information about the study (See Appendix B). This study chose to use this method to collect data due to feasibility of recruitment and accessibility for participants. Interview data were collected from May to June 2016. The interviews were on average an hour's in length. With the consent of the study participant, each interview was audiotaped. Only one participant declined to be recorded for reasons unspecified, but consented to the researcher taking detailed notes throughout the interview.

3.5 INTERVIEW TECHNIQUE

The researcher used the following technique for interview:

- The researcher conducted the interview with the participants using an interview guide with semi-structured questions (see Appendix C).
- The researcher maintained eye contact with the participants.

- The interview techniques of probing (verbal and non- verbal) were used. These included probing or “exploring”, silence, prompting as well as summarising. The researcher used phrases such as “Could you elaborate more on that point?” Maintained eye contact to encourage participants to continue speaking. The researcher summarised the last statements of the participants and encouraged more talk (Holloway & Wheeler 2002).
- The researcher used a semi-structured interview guide, but the line of questioning and responses from participants maintained flexibility and consistency.
- The researcher asked if there were more questions or comments. This assisted in closure of the interview. The researcher summarised the interview proceedings by restating in his own words the ideas and opinions of the participants, to ensure understanding. The participants were told of the need for follow-up interviews should there be any aspects that were not clear.

3.5.1 Note Taking During the Interview

According to Holloway and Wheeler (2002), note taking is an important activity, but it might disturb the participants. To limit this, the researcher informed the participants that notes would be taken during the interview. This method of collecting data acts as a back-up of the information obtained on the audiotape. Note taking was done discreetly to avoid distracting the participants.

3.6 DATA ANALYSIS

Data analysis means to organise, provide structure and elicit meaning. Analysis of qualitative data is an active and interactive process (Polit et al, 2001). Data analysis in qualitative research is an iterative process in which data are collected and analyzed concurrently (Creswell, 2007; Hewitt-Taylor, 2001). For this research study, data were analyzed inductively using a conventional content analysis approach (Hsieh & Shannon, 2005). This type of analysis is appropriate for a study design where the objective is to describe a multifaceted phenomenon, such as the phenomenon of client-initiated violence (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

The data were analyzed inductively as there was limited former knowledge and theory about the experience of client violence within the healthcare rural setting. With a conventional content analysis, data are collected primarily through interviews with the use of open-ended questions and non-specific probes. The analysis began by reviewing all of the collected data (transcripts)

repeatedly to become immersed within it and to identify areas needed for further exploration in subsequent interviews and sampling (Jacelon & O'Dell, 2005).

3.7 THE RESEARCHER'S ROLE IN DATA ANALYSIS

The researcher used reflexivity and bracketing to lay aside his preconceptions regarding the phenomenon under investigation. Data analysis occurs simultaneously with data collection (Holloway & Wheeler 2002). Field and Morse (1996) identify intellectual processes that play a role in data analysis:

Comprehending: The researcher wants to learn about what is going on. When comprehension is achieved, the researcher is able to prepare a detailed description of the phenomenon under study. Saturation is achieved when new data cannot be added.

Synthesising: This involves sifting data and putting the pieces together. This enables the researcher to make sense of what is typical regarding the phenomenon. The researcher makes general statements regarding the phenomenon and participants.

Theorising: This is the systematic sorting out of data. Alternative explanations of the phenomenon are developed by the researcher to determine their correlation with the data.

In this study meanings were formulated from extracted statements and then clustered into themes to provide full meaning of the experience. The participants were consulted to ensure or confirm the credibility of the description.

3.7.1 Establishing Rigour/Trustworthiness

According to Holloway (1997), "trustworthiness is the truth value of a piece of research". A research project is trustworthy when it reflects the reality and ideas of the participants (Krefting 1991). Streubert and Carpenter (1999) add that trustworthiness of the research depends on the extent to which it delves into the participants' experience apart from their theoretical knowledge. In this study trustworthiness was ensured by the researcher (who is a teacher by profession) laying aside his preconceived ideas about the phenomenon under investigation and by returning to participants to ascertain whether the description was a true reflection of their experience. Lincoln and Guba (1985) and Krefting (1991) state that trustworthiness involves the following elements: credibility, dependability, confirmability and transferability.

3.7.2 Credibility

According to Polit et al (2001), credibility refers to the confidence of the data. Credibility is similar to internal validity in quantitative research. Credibility exists when the research findings reflect the perceptions of the people under study. Polit et al (2001) affirm that validity and reliability are justifiable in research although qualitative researchers use different procedures to establish validity and reliability. Internal validity is important in qualitative research, as researchers are able to demonstrate the reality of the participants through detailed description of the discussion.

On the other hand Strauss and Corbin (1990) holds that theoretical concepts should have generalisability and transferability, meaning that concepts should be applicable to other similar situations. This stresses the significance of thick description so that the reader has the knowledge on which to base judgment. The following steps enhance credibility:

3.7.2.1 Prolonged involvement: This refers to “investment of sufficient time to learn culture”, test for misinformation, build trust and generally repeating the procedure central to the case study (Robson 1997).

3.7.2.2 Persistent observation: Specific situations regarding to the phenomenon under study were observed over a sufficient period to identify specific aspects relevant to it. The researcher observed workplace violence among healthcare workers having lived in Chainama Hospital compound for two years.

3.7.2.3 Triangulation: This refers to the use of multiple referents to draw conclusions. It involves evidence from different sources; different methods of collecting data and different investigators (Robson 1997). The use of triangulation enables the researcher to strive to distinguish true information. The researcher conducted a literature review to familiarise himself with the content of the phenomenon under investigation, collect data by means of interview to get in-depth information regarding the experiences of workplace violence among healthcare workers.

3.7.2.4 Peer debriefing: This refers to exposing the researcher’s analysis and conclusion to a colleague (in my case a workmate with a Master’s degree in Science Education was used to play this role) or other peers on a continuous basis for the development of both design and analysis of the study (Robson 1997).

3.7.3 Dependability

According to Polit et al (2001), this refers to stability of data over time and over conditions. Dependability can be likened to reliability in quantitative studies. According to Lincoln and Guba (1985), a dependable study should be accurate and consistent. Two methods of assessing dependability of data include stepwise replication and inquiry audit. Stepwise replication: This approach involves several researchers who can be divided into two teams to conduct separate inquiries with a view to comparing data as well as conclusions.

3.7.4 Confirmability

According to Polit et al (2001), confirmability refers to neutrality or objectivity of data. The issue of confirmability focuses on characteristics of the data. This means that the research findings are the result of the research and not the researcher's assumptions and preconceptions. The issue of confirmability focuses on the characteristics of data being dependable. According to Holloway and Wheeler (2002), inquiry audit can be used to trace the data to their sources. In this way the researcher's path of arriving at the constructs, themes and their interpretation can be followed.

3.7.5 Transferability

According to Holloway and Wheeler (2002), transferability means that findings of the research project can be applicable to similar situations or participants. The knowledge that was acquired in context will be applicable in another and researchers who undertake research in another context will be able to apply certain concepts that were originally developed. Transferability is similar to generalisability. Lincoln and Guba (1985) state that "as the naturalist cannot specify the external validity of an enquiry, he can only provide a thick description necessary to enable someone interested in making transfer to reach a conclusion about whether a transfer can be contemplated as a possibility". The researcher provided a thick description about the setting, the participants as well as the method of data collection.

3.8 ETHICAL CONSIDERATIONS

This research was considered non-invasive, involving minimal risk and included no vulnerable populations. The ethical principles of Respect for Persons, Concern for Welfare and Justice were exercised throughout this study.

3.8.1 Respect for Persons

This study demonstrated autonomy by ensuring that all participants were aware that participation was voluntary and that there were no consequences associated with withdrawing at any point in

time throughout the study. Appendix B containing comprehensive study details were provided to potential participants to better inform their decisions to participate. Furthermore, all participants were given the opportunity to ask questions about the research.

3.8.2 Concern for Welfare

Concern for Welfare is another core principle that is best demonstrated by researchers through efforts to minimize risk and protect participants (CIHR, NSERC, SSHRC, 2010). In order to demonstrate concern for welfare, any potential risks to participants were anticipated and strategies to mitigate them were generated. For example, in this study one potential risk was of exploring a distressing topic for participants. This risk was minimized by ensuring that the interview location was in a comfortable environment, participants were made aware of the voluntary nature of the study and that the interview could be terminated at any time and the researcher could have provided information for further assistance should participants have required or requested it.

Another potential risk was that of inconvenience and this risk was minimised again by ensuring participants were aware that their participation was voluntary and may be terminated at any time with no consequence. Interviews were conducted at both a mutually agreeable time and location of the participants' choice.

The last potential risk was that of a breach of privacy or confidentiality. This risk falls under the element of Respect for Privacy and Confidentiality within the ethical principle Concern for Welfare. Confidentiality is defined as “the obligation of an individual or organization to safeguard entrusted information” (CIHR, NSERC, SSHRC, 2010, p. 321). Participants were also made aware of the confidential nature of all interactions and study data collection.

3.8.3 Justice

The last ethical principle, Justice, is defined as a researcher's “obligation to treat people fairly and equitably” (CIHR, NSERC, SSHRC, 2010, p. 321). Recruitment and the potential power imbalance between researcher and participant are areas where the consideration of justice is important. To demonstrate awareness of justice, the sample inclusion criteria developed for this study did not exclude any participant arbitrarily as considerations were based on lived experiences.

3.9 CONCLUDING COMMENTS TO THE CHAPTER

This chapter has focused on the methodological and research design framework for this study. The use of a qualitative approach using The General Aggression Model was justified as the most suitable methodological framework for meeting the purpose and aims of this research. Non-

probability, particularly purposive and snowball sampling were discussed, along with the qualitative interviewing methods that were applied to generate health workers' accounts of their experiences of workplace client-initiated. An in-depth discussion of the ethical commitment to the principles of informed consent, confidentiality and anonymity, and safety from physical or emotional harm guiding the research process was as well presented.

This chapter provided an overview of methodology and the rationale for its appropriateness for this study, as well as presented a comprehensive description of this study's design, recruitment, sampling, data collection and analysis procedures. Ethical considerations related to this study were also explored.

This concludes the theoretical and research foundations upon which this research is based. In the following chapter, I present the themes generated from this research process and the data analysis.

CHAPTER 4 PRESENTATION OF FINDINGS

4.0 INTRODUCTION

The previous chapter discussed the methodology used in this study to explore the opinions, views and experiences of healthcare workers working in Chongwe district. The literature review identified that there has been little study into the extent and nature of workplace violence (WPV) towards those employed in rural areas, despite the fact that it is evident from the media that this is a significant issue. This chapter seeks to address this by examining primary data collected from a study involving the collation of reported incidents of workplace client-initiated violence towards healthcare workers staff and also personal experience and opinion gleaned directly from face to face interviews. The results of this primary research will be summarised and then discussed in the context of the findings of the earlier literature review.

This chapter presents a number of narratives of the findings which address the study objectives: (1) finding out how the health workers interpret WPV, (2) determining the type of WPV experienced by health workers, and (3) identifying the coping mechanisms or strategies used to curb the event. The chapter goes even further by highlighting a number of issues that emerged from the respondents' lived experiences.

4.1 HEALTHCARE WORKERS' INTERPRETATIONS OF WPV

4.1.1 How Healthcare Workers Defined Violence

Defining client-initiated violence was complex. No participant had the same definition of client violence. Participants very readily included physical violence in their personal definitions of client-initiated violence. Healthcare workers tended to include those types of violence that were most threatening or dangerous to their personal well-being in their definitions of violence over types of violence that were seen as more benign, such as swearing. For example, many participants initially remarked that verbal violence was such a common occurrence and thus not always considered to be a form of violence, as stated by this participant:

I guess because we work with patients we assume and forget that verbal violence is violence and so we don't take it serious, (HW03).

Four participants chose to specify that they only considered threats or intimidation as violence. One HW conceded that verbal violence was not worthy of being included in their definition of violence, but when asked to describe experiences with violence, freely discussed situations

involving verbal violence. However, several participants later on chose to expand their initial personal definitions to include more broad types of verbal violence as this HW highlighted:

I didn't really think of verbal threatening as violence, however I now recall that it can really be traumatising to see someone yelling and screaming in the most disturbing way, so yes, I do think that the yelling, verbal aggression would be classified as violence, (HW 05).

4.1.2 Did They Mean To Do It?

More complex, however, was the relationship between a client's intention and their expression of violent behaviour according to the healthcare workers interviewed in this sample. If the act, verbal, physical or other was perceived by the healthcare worker as intentional, or the client was viewed as doing it purposefully and not as a symptom of their illness, participants defined those actions as a form of client-initiated violence. However if the actions were viewed as unintentional, or a component of the patients' illness, three other participants stated that it could still be classified as violence depending on many factors including the situation, relationship with the client, specific actions, and whether it was bothersome or had noticeable impacts on the individual healthcare worker regardless of the type or intent of the action.

4. 2 CONTRIBUTING FACTORS TO CLIENT-INITIATED VIOLENCE

HWs in this study identified several client-related, healthcare workers-related, and environmental factors that they perceived as contributing to client-initiated violence. The patient-related factors identified were: (1) type of medical diagnosis or illness; (2) history of patient's previous violent behaviour, and (3) substance use. Healthcare workers-related factors were: (1) communication amongst staff; and (2) the quality of patient assessment. Finally, facility-related attributes were also perceived to play a role in client-initiated violence were; (1) the availability of healthcare staff and (2) physical space.

4.2.1 Client-Related Factors

In terms of client-related factors, often a client's diagnosis was considered to be a contributing factor to the violence the participants experienced. In the analysis of the narratives of healthcare workers' experiences, what emerged was that for physical violence, HWs described that patients who are diagnosed with a personality disorder contributed to the experience of violence, and participants further explained that this was due to the symptoms often exhibited with these illnesses such as experiencing perceptual disturbances and disturbed responses to involuntary stimuli. In

line with the General Aggression Model, the specific patient diagnoses that this sample of healthcare workers identified as being associated with an increased risk of violent behaviours were anti-social personality disorder and substance use. Meanwhile participants attributed not necessarily a specific diagnosis of a disorder to the experience of verbal violence, but to a patient's personality and ability to cope. As this participant explained:

Everyone behaves strangely and end up out of control. Maybe they haven't learnt a better way of coping, maybe these individuals have experienced trauma and maybe what they experienced was violent, maybe they experienced their parents being violent towards each other and that's how they learnt to cope and de-stress, (HW05).

4.2.2 Clients' Personalities

Regarding clients' personalities, general malevolence was also perceived as contributing to violence. A history of violence and substance use were also considered to contribute to verbal violence in a small number of participants' experiences. As HW02 pointed out, "*dangerous people at times with long criminal histories of violent behaviour so it's not surprising that they may regress and be violent in every other aspect of their life.*" If a patient was brought for treatment because of violence in the community, it was also perceived by some HWs as contributing to violence in the health sector.

For one participant, substance use was ascribed to be a direct contributing factor to the experience of verbal violence as the client had ingested substances prior to the abuse. For another HW, one of their narrated experiences involved a patient who had a long history of substance abuse and this may be an indicator of the patient's inability to cope with stress and thus be a contributing factor to the experience of client-initiated violence.

4.2.3 Healthcare Workers-Related Factors

Communication, specifically poor communication, amongst healthcare workers staff in the study was seen as worker-related factor contributing to client-initiated violence when it put workers into unsafe situations. Specifically HWs described poor communication around passing on risks or safety issues to colleagues or not having a well communicated plan to prevent and manage violence.

For example, for one participant, it directly contributed to the violence that she experienced. The HW was told by colleagues that the client wanted to speak with the HW, but they failed to communicate the client's high level of agitation and subsequently when the HW went to speak

with the client the HW was almost assaulted. Throughout data analysis it was also apparent that a lack of debriefing had several negative effects on both HWs and clients, and was perceived by healthcare workers as contributing to violence when they did not have the opportunity to provide or receive feedback, plan for other prevention measures or debrief with the client to gain an understanding of their triggers and coping skills.

4.2.4 Facility-Related Factors

Facility-related factors included physical space, and the availability of healthcare staff. Throughout HWs narratives of their experiences with client-initiated violence, the availability of staff on the facility played a role in contributing to violence. In most accounts, the healthcare staff complement was normal for the particular facilities, however often the workers were on breaks, or distracted by other tasks such as admissions and discharges, or assisting with other activities when the events occurred and thus not as attuned to other events on the facility. These reasons were also seen as causing a delayed response time of colleagues and having staff available to assist during a situation which was described as contributing to the experience of violence.

Other than healthcare staff, one participant directly contributed the experience of client-initiated violence to the unavailability of the medical doctor at the post for complicated cases.

If a medical doctor had been available at least some of the complicated cases could be dealt with on time rather than when it is too late to attend to the patient, (HW 05).

This demonstrates a lack of consistent access to care and assessment by physicians and other members of the healthcare team which puts HWs in a difficult and unsafe position to manage situations in which they have little control. Lack of physical space and crowding was another facility-related factor that was often alluded to in regards to contributing to violence. When space was limited, HWs described the possibility for interpersonal friction amongst patients. They also considered that space and crowding may impact clients' feelings of safety and have a ripple effect amongst the facility population as HW08 described:

You have all these different types of people with different types of problems and different manifestations in different medical conditions all within this confined space where people don't necessarily feel safe...And that actually has this kind of ripple effect.

4.3 HEALTHCARE WORKERS' COPING STRATEGIES

General strategies to protect one's own personal safety while at work held high importance with most healthcare workers in the study. These strategies were used routinely while at work, regardless of the risk of violence, and often these strategies were all within the realm of the workers' control and abilities. Some of the strategies, or the frequency to which certain strategies were used, depended on the culture and influence of other colleagues at the facility.

4.3.1 Awareness of Surroundings and Colleagues' Whereabouts

HWs made a point of knowing where exits were located in their immediate vicinities, knowing who else was around and where people were relative to themselves to ensure their own safety. They paid attention to the sounds and milieu of the facility at any given time, as well as being aware of what objects on the units could potentially be used as weapons and taking steps to reduce these risks, such as removing sharp objects. This was consistent for all participants.

They described the need to *"have eyes on the back of your head in terms of where people are positioned, where your colleagues are"* (HW01) and that this safety measure becomes *"second nature"* (HW01). For some participants, it was also perceived as something important to teach to new healthcare workers that gets passed down from more experienced colleagues.

Similarly, all HWs described the importance of telling their coworkers where and with whom they were attending to so that coworkers would keep an eye out for them in case of trouble, as well as when they were going on break to know how many staff were left on the facility. For example, this HW explained, *"I'll notify the other colleagues of where I am kind of thing when I'm not in the station especially if there is someone who has a history of aggression or violence"*, (HW07).

4.3.2 Existing Institutional Safety Supports

All participants reported working with and being supported by security personnel within their organisation, however the perceived degree of support and confidence in their skills and abilities varied. Three HWs (two of whom worked at the same organisation) identified that their security personnel were not trained to have any physical interactions with patients, which then limited their ability to assist and support HWs during a time of physical crisis, and subsequently lowered the workers' confidence in security personnel's skills and abilities to manage the crisis.

Our security staff are not very good. They're not very helpful. They show up only when it is too late which I think they're scared to intervene, (HW 02).

In this regard the healthcare workers' opinions about security personnel's value tended to show that their contribution didn't provide much.

4.4 ANTECEDENTS OF CLIENT-INITIATED VIOLENCE

Antecedents, also known in the literature as precursors or triggers, are events and/or conditions healthcare workers perceive that immediately precede and are responsible for initiating patient violence. Throughout the analysis of the narrative experiences, the antecedents reflected mostly interpersonal interactions, with some incidents reflecting intrapersonal, client-related precursors. The HWs in this study described their roles as being care providers to clients to assist in treatment and recovery, but within their role, they are also responsible for the safety and welfare of their clients, co-clients and colleagues on the unit which often required very different approaches. Healthcare workers' perceptions of clients actively experiencing perceptual disturbances, such as hallucinations or delusions, was also seen as a preceding event for violence and can be categorised as an intrapersonal, client-related antecedent. In several narratives, HWs believed their patients were experiencing active hallucinations or delusions as this participant demonstrates:

He believed he was a wrestler, therefore started to show us how it is done by first charging towards my colleague, but then he fell down and that's how we caught him and restrained him. (HW02)

In these examples, the participants attributed the clients to having psychotic experiences which directly preceded and led to the experience of violence. There were also several narratives that the healthcare workers in the study described in which the HWs could not determine what the antecedent to violence was.

Through exploring the antecedents and triggers to violent events it is apparent that HWs do not see themselves as being responsible for violence, but place emphasis on interpersonal interactions and client-related triggers.

4.5 INDIVIDUAL CLIENT-INITIATED VIOLENCE PREVENTION STRATEGIES

Healthcare workers spoke of the prevention of exposure to violence on a continuum from primary prevention strategies through to attempting to prevent further levels of escalation and violence (secondary and tertiary prevention). Primary prevention strategies are proactive. They are aimed at stopping violence before it occurs, and attempt to reduce the factors that put people at risk for experiencing violence. Secondary prevention focuses on the immediate responses to violence and tertiary prevention involves long term approaches that occur in the aftermath of violence which

also include lessening the emotional trauma to the victim (Centers for Disease Control and Prevention CDC, no date).

This section is outlined following this framework. Participants identified similar current individual practice strategies for both physical as well as verbal violence. Several strategies were consistently used regardless of an individual HW's background, workplace or experience level however which strategies used depended on the level of existing escalation of the client. As prevention measures moved throughout the continuum from primary to secondary prevention, the focus became less on the individual strategies and more towards a team approach to prevention.

The healthcare worker-centred strategies aimed at controlling the situation, self-preservation and one's own safety and back to client-centred strategies after the event occurred to prevent any further incidents. Despite the shift to more healthcare worker-focused strategies, HWs believed they were acting within the clients' best interests. While there were many strategies discussed and implemented while exploring HWs' narratives, many participants described these strategies as being ineffective at the time or not being able to implement anything in time before an event happened and the majority of HWs had difficulty in identifying strategies that they perceived to have been successfully implemented in their workplaces.

4.6 CLIENT-CENTRED STRATEGIES TO PREVENT VIOLENCE.

Along with knowing their surroundings, HWs made sure they used safe body positioning techniques such as watching how their back was turned. In terms of body language, participants ensured that their body language, including tone of voice, and position maintained an appearance of openness, respect and was non-threatening as this participant described, "I think the number one thing is to watch your body language and your tone of voice so that you maintain a respectful approach with the client" (HW02). Body positioning and body language are supported by concepts of de-escalation (Richmond, et al., 2012) as well as maintain one's own safety all the while signalling a caring approach.

In terms of communication and engagement with patients, four HWs described the importance of using empathy, and respect with their patients to prevent violence as well as engaging with the patient to discuss their needs and concerns before situations escalate. These four HWs also felt it important to allow clients to feel included in their own care and described it as being pertinent to not bring oneself to the client's level of violence or engage in a power struggle to prevent violence. As HW04 highlighted:

Empathy is the first thing that I see works. Other strategies to back that more would be to make sure that I'm letting them know I'm there for them...allowing them to feel included and not excluded, treating them like human beings.

Along with communicating and engaging with clients, many HWs expressed that knowing your client, including knowing their triggers for anxiety or agitation, what helps them relax, their body language, and their past history was important in building and improving the therapeutic relationship thus preventing violence as this participant summarises:

I think knowing strong histories and knowing triggers for clients, knowing your client is probably the best sign, getting to know what escalates [them], getting to know what calms them, really helps you predict what chances are taking away. Building up and building a rapport with individuals no matter what, (HW08).

Listening and de-escalation techniques, including the use of empathy, problem solving, allowing clients to vent their frustrations and concerns and be heard, were considered to be first line, client-centred strategies to prevent both physical and verbal violence however there was some skepticism around their effectiveness. Some participants believed that while this practice should always be attempted, some violent situations happened too suddenly for it to be effective or else felt that it would not always work despite their best attempts and other methods of prevention needed to be implemented instead, such as medication administration as this participant explained:

A lot of the time people will calm down when you try to address what the problem is with them. Sometimes they just want to be heard. There's something that's problematic that they don't see a solution to and that sometimes we can sometimes sit down and talk with the patient can help, (HW06).

This demonstrates that while initially participants are willing to use these techniques to convey a respectful, caring approach, some HWs in this study resorted back to more coercive approaches when order was not quickly obtained and individual safety was further threatened, and they remained skeptical of the usefulness and effectiveness of less coercive approaches. Leaving the area when violence was anticipated was identified by participants as another strategy that they implemented.

However, participants indicated that the reason for leaving the area differed by situation. This action occurred particularly with verbal violence as a means to signal the end of the conversation and the worker's willingness to be part of the violence as HW03 described, "*If you're going to talk*

to me that way, I'm not going to listen and the conversation is terminated and you are to leave the me or I will walk out of the room."

It was also used when HWs were not sure how to handle the situation or were feeling emotionally affected by the violence:

I, just kind of walk away for sometimes because I feel too weak to really confront the aggressor. More so it because I don't want to embarrass myself or them, (HW04).

Another participant described that when she did not know how to handle the situation, "that sometimes leaving the situation is helpful just to diffuse it.

For both verbal and physical violence, leaving the area was also a means to "give them space" (HW02, HW04) to cool off or for the healthcare worker to get out of what could become a dangerous situation. If the reason for leaving the area was to give the patient space to gain control of themselves or reduce stimulation, this could be viewed as demonstrating a caring, client-centred approach and empowering the client to gain their own control. If, however, the reason for leaving the area was to ensure their own safety, to signal intolerance to violence, or because their feelings have been allowed to affect the interaction, it coincides with a more nurse-centred approach for self-preservation.

Two participants believed that in order to prevent patient violence, it is important to teach clients coping skills in order for them to learn how to be able to remain in control. This individual tertiary prevention strategy focuses on empowering the client, not controlling the unit environment.

4.7 HEALTHCARE WORKERS-CENTRED PREVENTION STRATEGIES

Knowledge of the assessment for and use of medications, knowledge of legalities surrounding patient care, ability to recognize agitation and assess risk, ensuring novice healthcare workers with less knowledge or training were not put into potentially violent situations alone, and knowledge of de-escalation techniques were all described as important practice strategies for the prevention of client-initiated violence.

HWs referred to using medications as a method of prevention and containment. They justified the use of medications to calm patients in that they may prevent violence or harm to the patient or others and was thus in the patient's best interest. Medications were used to keep patients settled

and lessen any risk of violence as well as aid in their treatment. This HW explained the use of medications:

If we have a patient who has a violent history...our mode of taking care of that is to medicate. Usually when people are ill, and this is the biggest risk when they come on the unit, and as they get better, the chance of this kind of violence happening usually lessens. In that case, it's about medicating and containing them with medication, (HW06).

Medications were also used as chemical restraints when a client's behaviour was escalating and HW needed to intervene before a more serious event happened. This form of chemical restraint was viewed as the least coercive measure and attempted before any other more physical strategies were used such as seclusion or physical restraints as HW04 explained, "...making sure, in terms of least restraint, I would use medication before seclusion and use seclusion before restraints." When situations reached this intensity, medications were no longer an individual HW's response, but conducted as a team to enact this intervention. Principles of de-escalation include offering medication, but encourage clinicians to broach the subject as a discussion and a choice, and only forcefully as last resort when there is no other alternative (Richmond, et al., 2012).

4.8 UNIT/FACILITY AND TEAM VIOLENCE PREVENTION STRATEGIES

Similarly to individual-focused prevention strategies, HWs in this study described strategies to prevent violence on a unit and organizational level on a continuum focusing largely on primary and secondary prevention. These strategies were used for both physical and verbal violence. Unit and team prevention strategies focussed on addressing and understanding: (1) the unit's physical layout and structure or elements of the unit; (2) the team's dynamics and; (3) specific management strategies.

4.8.1 Physical Elements of the Unit

Another important consideration is that of physical space for patients. The lack of physical space can be an antecedent to violence, but having therapeutic space can have the opposite effect by giving patients somewhere quiet to go to settle and increase the likelihood they will have privacy. Several participants described having private rooms and encouraged patients to use this private space as a strategy to prevent patient violence as HW05 highlighted:

Patients could go to their own room as it gave them a quiet place to say "this is my space." I think that it helped immensely in decreasing violence because it was their own space and they didn't have to share with anybody and it gave us a quiet place to talk if we needed to go in and talk to a client.

For other participants, while they described using most of the nonviolent crisis intervention strategies in practice, their confidence in their ability to use these techniques varied. Institutional policies were often perceived as guidelines and how efficacious the policy was varied by participant. Some participants felt that the policies they identified were beneficial and provided HWs with more knowledge and assisted them in making decisions about managing patient violence, while others saw policies as being vague:

Within the protocols and policies...a lot of it is discretion. And you follow certain guidelines that are put forward by the unit and [government] health services on how you deal with certain situations, but a lot of it is the discretion of the HW that's working with that patient...(HW06)

4.8.2 Unit and Team Dynamics

Communication amongst the healthcare workers was considered by the participants to be highly important to the prevention of client-initiated violence especially when this communication was about a client's risk for violence, their known triggers or antecedents and specifics about their plans of care. HWs described the importance of communicating with colleagues about observations they have made about their colleagues' clients to ensure they are aware of what may be going on with a patient, and sharing with them any information which may help to assist their colleague in preventing patient violence as this HW further explained the importance of communication in healthcare delivery:

It's a strange profession because people are kind of their own entity with their own patient loads which affects everybody else's patient loads. We are kind of like our own little islands, but we are also affecting how other workers' are dealing with their patients so it's important to communicate with other staff, (HW06).

4.9 IMPACTS OF WORKPLACE VIOLENCE

Client-initiated violence, whether it is verbal or physical violence, had many perceived impacts on both HWs as well as on patients themselves. For healthcare workers, there were emotional and physical impacts as well as various impacts affecting healthcare workers' abilities to carry out their role as a HW at the unit. The effects of violence also varied depending on the type of violence, whether it was verbal or physical. The participants in this study also discussed their perceptions of how patients were emotionally or physically impacted after perpetrating a violent event.

4.9.1 Impacts on Healthcare Workers

There were a wide range of emotions expressed after incidents of physical client-initiated violence. In the moment, as the incident took place, HWs described remembering feeling fearful, in shock or numb, or alternatively, feeling nothing including sometimes not feeling pain arising as a result of physical violence. In the moment, when other staff or patients were involved in the situation, some participants described focusing their emotions and energy on protecting the other staff members, or even for two participants, protecting the patient.

Not only were participants afraid for their immediate safety, but they feared what could have happened if the situation had ended differently, and for future violence. Fear was most intensely described when nurses felt there was a chance they could not manage the situation, in situations that were perceived as being highly dangerous, and when the physical violence was directed primarily at them. In situations that involved body fluids, such as when participants were spat on, there were fears and worries of contracting illnesses from the patient as this HW described, *“I was worried...I checked her [the patient’s] chart to be doubly sure that she didn’t have anything like hepatitis...because she spat in my face and I got a little in my eye. I just needed to know”* (HW08). Along with fear was the feeling of helplessness for some participants. This occurred when healthcare workers perceived not being able to connect with the patient and when interventions seemed to fail. This experienced healthcare worker explained, *“No matter what we did, it was almost like a helplessness, because no matter what approach we used, it didn’t seem to be effective”*, (HW07).

Immediately after events occurred, and lasting for several days, to even months after, all participants described feeling a *“heightened sense of awareness”* (HW05) and hyper vigilance. These feelings of heightened awareness and hyper vigilance were not exclusive to occurring only in the workplace, but HWs described this as occurring outside of work as well.

Whether the experience impacted the ability to carry out one’s role as a nurse after physical patient violence depended on the perceived seriousness of the incident. Some HWs described difficulty concentrating on nursing tasks and thinking clearly after incidents, also being less trusting of the aggressor resulted in HWs keeping *“a little more distance”* (HW01). This may impact a healthcare worker’s ability to pick up on future cues of patient distress or agitation and therefore their ability to proactively prevent violence.

Participants expressed feeling less empathetic for their patients as this HW further explained, “*It makes you not be as skillful or compassionate with other patients*” (HW04). It also affected their level of confidence in being able to prevent and manage client-initiated violence. For some participants, they used their experiences as learning opportunities which motivated them to improve their skills at violence prevention.

4.9.2 Impacts of verbal violence on Healthcare Workers

Similarly with physical violence, verbal violence predominantly evoked feelings of fear. Much of the fear was driven by healthcare workers in the study feeling ill-prepared to manage verbal violence and thus feel helpless, vulnerable and afraid of the potential of what further violence could occur. HW01 explained:

The verbal violence can make you feel as assaultive and vulnerable as the physical violence and in some ways more scared. There's that grey area of what do you do with it? Where do you go, and how do you then react?

The more fear a participant felt around patient violence, the more distressing they perceived the incident to be. The participants described feeling angry and hurt when verbal violence was perceived as a personal attack about themselves as a person, their body or their role as a healthcare workers. Several of the participants described feeling “*belittled*” (HW04) when verbal violence was sexually inappropriate in nature or were comments regarding their bodies or attire.

With verbal patient violence, the most common impact on the ability to carry out the role of a healthcare worker was the ability to maintain the provider-patient relationship with the patient that was the aggressor. As the perceived severity of the verbal violence increased, so did the HWs desire to not want to work with the patient anymore, to avoid engaging with them and this often resulted in HWs requesting to change the patient assignment to avoid working with them.

4.9.4 Impacts on Patients as Perceived by HWs

Physical impacts on patients related primarily to when patients engaged in physical violence. HWs perceived most of these impacts as physical injuries to the patient such as bruises, head injuries potential fractures and bleeding noses. In many of the explored incidents, participants perceived the patients to not have experienced any injuries.

Non-physical impacts of patient violence were related to the healthcare worker-patient relationship, emotional experience, loss of privileges, discharge and follow-up services difficulty, and legal complications. Participants in the study frequently perceived that client-initiated

violence negatively affected the healthcare worker-patient relationship with the aggressor and thus impacted the patient's quality of care that they received.

For some patients, physically and verbally violent incidents led to privileges to leave the unit being revoked, longer length of admission, or oppositely, discharge from the health centre/post with subsequent difficulty finding appropriate follow-up services due to the violence displayed in facility, and even involvement with the police and charges being laid. For other patients that were not the aggressors, patient violence was perceived to interfere with their treatment by taking time and resources away from their care.

4.10 RESPONSES TO PATIENT VIOLENCE

The reactions and responses to verbal and physical violence in the short term are explored from the healthcare workers' and institutional perspectives.

4.10.1 Healthcare Workers

Immediately following the experience of patient violence, HWs sought out support from both formal and informal supports. Management was most often identified as providing formal support as follow-up to the incident however participants more consistently identified seeking out informal supports through colleagues, family, and friends after the incidents regardless of whether it was verbal or physical violence.

Incident reports were also required to be completed soon after the incident, but institutional safety incident reports were not consistently reported by the nurses as being completed. Participants most often identified filling out reports for incidents involving physical violence resulting in injury, but often disregarded completing reports for physical violence that did not result in injury or verbal violence despite acknowledging their understanding of it being an institutional obligation. One participant explained that "*violence was probably the one [incident report] that would be least filled out because how do we define it?*" (HW05) demonstrating some of the difficulties staff healthcare workers have relating to reporting violence. Other identified barriers to completing incident reports were described as workload, time, and seeing the benefits of filling out incident reports.

This was a similar response for both physical and verbal violence. With verbal violence, some participants felt that the more times you interacted with a patient, the more opportunities that were given to them to be verbally violent as this HW explained,

Sometimes you do spend less time with the patient because spending more time with them gives them more opportunities for verbal violence and nobody really should be exposed to that, (HW02).

Some HWs refused to work with the aggressor all together after the incident and their colleagues took over the patient's care and for other participants, the incident happened right before they were scheduled for time off and working with the patient in the short term was avoided. Even though participants felt that they needed the distance from the aggressors for their own safety and mental health, they recognized that it negatively impacted the nurse-patient relationship and subsequently the quality of care the patients received.

Another HW felt similarly motivated and described having a desire to help patients even more after violent incidents because he recognized that this was the time when they were most in need of support, and recognized that often the worker-patient relationship is affected as he explained:

They're not in their right mind, they're not in a place where they are making appropriate decisions and it's not fair. What if I was in that situation? I wouldn't want someone to just give up on me. (HW03)

As a result of incidents with client-initiated violence, healthcare workers in the study described changing their own behaviour, such as being more likely to resort to using medications, and other more coercive measures as a way to contain violence and maintain their own safety, or oppositely being less likely to use hands-on approaches to try to avoid violence, being more cautious around patients and for verbal violence, trying to think logically and be more objective of the situation to avoid taking the violence personally.

4.10.2 Colleagues

Colleagues responded by assisting with client-initiated violence and sometimes even taking over the care of the patient or providing first aid measures to the HW experiencing patient violence. Most often, however, they provided informal emotional support to the HW. This participant explained, *we turned to each other to find that safe place to vent and comfort each other, (HW05).*

4.10.3 Management

The issue of workplace violence in the health sector is not mentioned directly in the ministerial orders of the Ministry of Health. Based on the findings of this study, there is no particular policy or regulation regarding workplace violence in any hospitals or health facility in Zambia. When

there is an incident, management will follow the regulation for civil servants (Penal Code) regarding the issue of misconduct. Punishment for misconduct is stipulated clearly in the Civil Service Act. It is mandated for supervisors to investigate such cases.

In the study some HWs described having a good relationship with their supervisors, and thus had found them to be very supportive following an incident, but more importantly participants in the study felt most supported when the supervisor acknowledged and did not trivialise the event as this HW explained,

just having the event recognised as something that was critical and you know, it was traumatic and ...they weren't trivialising it and actually embracing it as something that was not acceptable, (HW06).

On the other hand, many described feeling very angry, unsupported and blamed by their supervisors. Some HWs never even heard from their supervisors following events of client-initiated violence, while others described receiving a phone call or a brief conversation, which was felt to be thoughtful, but not supportive enough.

4.11 THEMES

The findings presented above are intended to provide a rich description of how healthcare workers in rural settings in Chongwe district understand client-initiated violence, the process to prevent and manage client-initiated violence and the impacts that this violence can have on not only HWs, but their patients and the institution. To further understand the experience of client-initiated violence, thematic patterns have been interpreted from the findings.

4.11.1 “Part of the Job”

Participants in the study perceived the culture of healthcare provision as one where client-initiated violence should be accepted as part of the job and many felt this belief was unavoidable. This was especially true of verbal violence and many HWs in the study identified the routine nature of violence as not only part of the job, but something no longer worthy of reporting. At the same time they did not want to accept that reality nor accept that violence was tolerable

4.11.2 Healthcare Workers s' Health and Safety versus Client Care

Throughout the narratives, HWs were often conflicted between their role of acting as the health care provider who needed to deliver care in the best interest of their clients versus acting in a way that would protect their own health and safety. The HWs in the study often struggled to balance the decision to carry out their role in providing therapeutic care with the idea that “*it's not part of*

my job to be hurt” (HW05) and engaging in self-preservation activities which caused internal stress.

In physical situations driven primarily by fear and low confidence in their ability to prevent and manage patient violence, participants most often chose to preserve their own health and safety at the expense of patient care. For verbal violence, if it was unrelenting, threatening or were personal attacks, HWs again chose to protect their own health and safety. The role conflict experienced when HWs had to decide between their patients’ needs over their own safety may add to the impact of the experience for healthcare workers.

4.12 NEEDS FOR PREVENTION

4.12.1 Individual needs

In terms of primary prevention, further education related to preventing violence was the most commonly identified need. Participants described wanting further education around a wide variety of topics including mental health diagnoses, identifying triggers, learning more strategies to prevent violence, learning awareness of self within relationships, emotional intelligence along with how to self-regulate and then how this can impact the therapeutic relationship, awareness of the power imbalance between healthcare providers and clients, what the definition of violence (including verbal violence) is, and “healthcare workers need to know that violence shouldn’t be expected just because you work on psychiatry. Incorporating evidence-based violence education into orientation for new healthcare workers to avoid HWs learning skills entirely from colleagues was also a suggested strategy.

4.12.2 Health Centres/Posts Facility Needs

Participants in the study perceived a variety of needs at the health centre level for prevention of client violence. In terms of the unit environment itself, participants described the unit needs as related to facility staffing, regardless of the institution where HWs were employed, participants routinely described wanting more staffing which would assist with a lower staff to patient ratio, as well as a safe ratio of experienced and novice healthcare workers. Participants felt the lower staff to patient ratio would assist in preventing violence by allowing healthcare workers time to meaningfully engage with their clients and colleagues.

4.13 CONCLUDING COMMENTS TO THE CHAPTER

This chapter has built a further layer on to the story of WPV as told by the health workers in this study. The centrality of the dynamics of their encounters irrespective of type of violence has

emerged as a consistent theme in the workers' lives. This chapter articulated how WPV that was described in Chapter two extended into the unproductive work lives. The health workers recounted how their aggressors' acts impacted on them as well.

This chapter provided a description of the study findings including the healthcare workers' perceptions and experiences of patient violence. It also explored prevention strategies at the individual, health centre/post and institutional levels. As well, the findings described the emotional and physical impacts of the experiences responses of the HWs and patients as well as the thematic patterns.

The next chapter will highlight the key points of the research thereby discuss the research findings. It will also propose a number of recommendations as to future workplace violence approaches.

CHAPTER 5

DISCUSSION

5.0 INTRODUCTION

This chapter discusses the findings of the study. The discussion covers experiences of workplace client-initiated violence in the health sector in Zambia, a case study of Chongwe District which is rural setting.

5.1 THE PREVALENCE OF WPV IN CHONGWE DISTRICT

This study reveals that WPV is prevalent in Chongwe district and Zambia at large. Furthermore, this study found that the majority of violent episodes were underreported. As one of the few if any studies scrutinising WPV among Health workers, it helps to give an overview of Workplace Violence towards health workers in the Zambian economic, political and cultural contexts. Although a large number of health workers thought that they were at fault for being victims of Workplace Violence in this study, aggressive behaviours towards health workers might be the consequence of various factors.

The prevalence of WPV as confirmed from this study shows that health workers are highly exposed to violence from clients while on duty; this risk of Workplace Violence among health workers is even comparable to that of policemen. This study indicates that clients (including their relatives and guardians) are committing violence towards health workers in Zambia; this situation is quite surprising, as Zambian society is traditionally a nonviolent society and health workers have been highly respected in Zambian society. Although detailed data regarding the perpetrators' gender and age were not available as this study did not investigate them, it would be worthwhile to discuss who the perpetrators were in order to work toward prevention of Workplace Violence. The most common type of aggressive behaviour found in this study was verbal aggression, providing further information that interpersonal relationships between clients and HCWs are sometimes poor in the Zambian context. The prevalence of verbal aggression found in this study is somewhat similar to that found in previous studies that demonstrated a higher level of WPV towards health workers. One study found that 57.9% of Palestinian doctors and nurses experienced verbal aggression. Along this line, another study carried out in Pakistan reported that 72.5% of nurses and doctors were victims of verbal aggression.

It is difficult to compare statistics regarding Workplace Violence across countries because of the differences that might exist in the definition of the concept of WPV. However, it is relatively easy to compare physical violence at work across countries as compared to verbal violence and harassment because of the clarity of the definition regarding physical violence. Possible reasons for the difference in prevalence regarding physical violence in this study and studies carried out in other parts of the world might be related to the difference in cultural backgrounds.

In this study very few of the violent episodes were reported to a supervisor, this being a common finding reported by researchers elsewhere when studying Workplace Violence in general. A study of nurses in the Canadian provinces of Alberta and British Columbia also showed underreporting of aggressive behaviors, with only 30% being reported (Lee, Kim, Park, 2014).

As Milczarek, (2010) suggested, health workers thinking that a violent attack on them is their own fault plays a crucial role in the underreporting of Workplace Violence. In regard to sexual harassment, incidents might not be disclosed for cultural reasons; usually people in Zambian society are afraid to talk about sex-related matters because of the sensitivity of the subject. Another more likely reason that might contribute to underreporting is the seriousness of the problem; if the health workers think that a problem is not serious, they might not report it.

5.2 IMPACT OF WORKPLACE VIOLENCE IN ZAMBIA'S HEALTH SECTOR

The impact of the prevalence of Workplace Violence found in this study can also be discussed in regard to its interference with the quality of health care and the shortage of health workers that most countries are facing. The prevalence of Workplace Violence in Zambian health workers is putting an extra burden on the already insufficient Zambian health-care system, which is losing HCWs, as many are migrating to other countries in search of greener pastures as alluded to in the abstract, (see page i) . In this regard, Workplace Violence towards health workers is a threat that might contribute to a decline in the number of health workers and a lowering of the quality of patient care in terms of increasing the risk of errors.

The study results show that workplace violence against health workers is considered a problem in Zambia just like other countries. The study results concur with those reported by Estryng-Behar (2008) in Europe; Farrel et al.(2006) in Australia; Feringa (2008) in Botswana; Khalil (2009) in Cape Town, South Africa and Shield and Wilkins (2009) in USA. This confirms that violence against health workers is a global concern as has been suggested by Needham et al. (2008).

The period prevalence of reported workplace violence against health workers in the sampled health centres reported to have experienced workplace violence in the twelve months preceding this study. High rates of violence against health workers have been attributed to the predominance of women in the healthcare profession worldwide, who generally have a submissive character (Ferns, 2006; Kwok et al., 2006). Similarly in Zambia, a large proportion of the health workers are females, estimated at 75% according to WHO (2006). Traditional norms in the countryside expect women to be gentle and submissive which could in turn make the health workers vulnerable to being victims of workplace violence from various sources.

Both psychological and physical forms of violence were reported to have been experienced by the health workers who participated in the study. The form of violence reported as being the most prevalent was psychological violence and this is consistent with findings from preceding studies (Celik et al., 2007; Senuzun Ergun & Karadakovan, 2005). Psychological violence was experienced in the form of: verbal abuse; threatening behaviour; sexual harassment; and feeling that their voice or concerns are not heard by supervisors. Verbal abuse was found to be the most commonly experienced form of psychological violence in all health centres and this is consistent with findings from other studies (Abe & Henley, 2007; Celik et al., 2007; Khalil, 2009; Rowe & Sherlock, 2005; Shields & Wilkins, 2009).

The prevalence of sexual harassment for this study was relatively low. Other studies have also found the reported prevalence of sexual harassment to be low (Astrom et al. 2002; Kamchuchat et al. 2008). The prevalence of sexual harassment may be much higher than reported, as people tend to be reluctant to report the experience of sexual harassment for fear of stigma (Kumchuchat et al., 2008). Both male and female health workers had been victims of sexual harassment with a higher proportion of the victims being female. In all cases of reported sexual harassment the perpetrators were of the opposite sex to the victim. Although the reported prevalence of sexual harassment was low, it has detrimental physical and psychological effects. It suffices to say that sexual abuse such as rape can lead to transmission of sexually transmitted infections to the victim (Allsworth et al., 2009).

The reported incidents of physical violence in this study like other studies elsewhere have also found that violence against health workers was low (AbuAlRub et al., 2007; Kansagra et al., 2008; McKinnon & Cross, 2008). Although the prevalence of physical assaults (with or without a

weapon) was low, it is very dangerous. Take for instance in the USA there have been media reports where physical assaults at the workplace had resulted in the loss of nurses' lives (Carrol, 2008). The observed forms of violence were: verbal abuse, threatening behavior, sexual harassment and oppression.

A notable finding in this study by one respondent was the mentioning of witchcraft as a form of violence. This is an area of violence that may be specific to traditional societies and is worth further investigation. Observing violence occurring against work colleagues could be threatening and can have psychological effects to the health workers. In Hong Kong, Kwok et al. (2006) found that health workers working in community services were most susceptible to violence. The forms of violence that were experienced by health workers in the community health care centres were mostly verbal abuses and threatening behaviours. Most of these violent incidents were perpetrated by patients, and some incidents by patients' relatives.

The community health care centres in Zambia operate on an outpatient basis. Each of these facilities in this study attend to over 50 clients a day, with just one or two clinical officers and 2-4 nurses on duty per day. Therefore, it is possible that long waiting times may be a reason why service users become angry and violent towards health workers. In the USA, May and Grubbs (2002) reported that anger due to long waiting times is one of the reasons why patients and/or their visitors become violent towards health workers.

5.3 PERPETRATORS OF WORKPLACE VIOLENCE

Most perpetrators were clients because they are certainly the first people to witness errors or unethical actions performed by HCWs; accumulation of a degree of frustration by clients can probably lead to violence. This is consistent with findings by Esmaeilpour et al. (2010) in Iran where incidents of physical and psychological violence against health workers working in emergency departments were mostly perpetrated by patients' visitors. In Iraq, AbuAlRub et al. (2007) also came to the conclusion that incidents of physical violence against healthy workers working in hospitals were mostly perpetrated by patients' visitors.

In USA, May and Grubbs (2002) found that patients' visitors tend to be violent against health workers. In addition, the relationship between aggressive behaviours and mental illness cannot be ignored. Some clients might have psychiatric health problems and might therefore be more likely to be predisposed to perpetrate violence towards health workers especially when the health

workers do not react adequately to their needs. In this context, health workers have to be trained to improve their skills to identify clients who are predisposed to perpetrate aggressive behaviours and to recognise situations that could lead to aggressive behaviours. The reasons most cited were anger related to the patient's situation, long waiting times and towards the health care system in general. These reasons may also be similar in the current study however this was not specifically investigated.

The study found out that the most incidents of violence were reported to have occurred involving maternity cases with patients' relatives being the main perpetrators. The form of violence mostly experienced was verbal abuse. The existence of violence in maternity cases has also been reported by Khalil (2009) in Cape Town hospitals. Farrel et al. (2006) in Australia also found that verbal abuse by patients or their visitors was the most common form of violence experienced by health care workers in the maternity/midwifery setting. Maternity units in Zambia are consistently full and busy. With the inadequate staffing, this could be a contributing factor for the reported violence experienced in health centres in Chongwe district.

In light of the foregoing I can say that this study provides a 'snap shot' of healthcare workers' experiences of Workplace Violence in rural settings and thus the ability to generalise the findings to the rest of Zambia's countrywide contexts may be limited. However, this study endeavoured to explore in some detail health sector workers' coping strategies following episodes of Workplace Violence and as such offers new knowledge and insights into this phenomenon. The findings indicate that health sector workers' reactions to their experiences of Workplace Violence can be explained in terms of Taylor's (1983) theory of cognitive adaptation to traumatic events. All of the health workers in this study (all of whom have continued to work) had adapted to their experiences of Workplace Violence by finding meaning, gaining mastery and enhancing themselves.

Finding meaning required these participants to be able to tell of their experiences in a sequential way and make direct attributions as to what caused the episode of Workplace Violence. These included what and why the event happened, and who was to blame. It is noteworthy that except for their lack of experience, the healthcare workers in the study ascribed causes that they considered they had little or no control over. For example, the healthcare workers felt that they

could not control which patients were accessing healthcare services, long waiting times for patients to be seen by a health provider, inadequate skill mix of staff, or the offenders' substance abuse.

Taylor asserts that individuals identify causes of life threatening events that are controllable, either immediately or in the future. It can be argued that this assumption is not necessarily correct because even though the healthcare workers in the study considered that they could not control many of the actual causes of Workplace Violence they still managed to find strategies that enabled them to regain mastery of the event such as seeking counselling and reporting the incident to the relevant authorities.

Lastly, in conclusion those engaged in health service delivery face and have to accept a level of risk in order to carry out their necessary and important task. However it is essential that the risks are ameliorated through good management practice and strategy, being constantly mindful of the changing dynamics and attitudes within society. It is not just a matter of issuing a uniform and a capability to issue a treatment to an individual. An important service is being provided by a human being in difficult circumstances and this should be acknowledged in its widest sense.

5.4 WORKPLACE VIOLENCE COPING MECHANISMS

Health workers were very clear that the repercussions of violence and abuse affected them in their private lives in a number of ways. They were more vigilant, often more fearful, and more irritable and easily frustrated by normal day-to-day life. Overall, the health workers clearly did recognize that the violence and abuse they experienced at work had an effect on their functioning in their private lives. The converse side of this notion concerned the health workers' accounts of how their private lives affected who they were as health workers.

Overall, the major coping skill that health care workers used at work once they experienced either verbal or physical abuse can be characterised as consciously being more careful and mindful of their safety, both emotional and physical. This overall goal was achieved through a variety of strategies that included such things as; consciously working towards becoming more assertive, being more careful about physical positioning in relation to a patient, consciously cultivation of inner strength, being firm, and, one which several health workers reported as their primary response, avoiding the individual concerned as much as possible.

Many of the health workers had personal experiences of violence in their private lives, either before they began work careers or ongoing during the time they were interviewed, that they recognized

as influencing their work. No matter whether health workers had or had not experienced violence and abuse as private people, when they encountered in the work context, they needed to feel supported by management and most of these workers did not. Two of the most consistent complaints regarding lack of administrative support were lack of timely and efficient critical incident stress debriefing (CISD) and lack of regular education and practice on de-escalation techniques.

5.5 CONCLUDING COMMENTS TO THE CHAPTER

In this chapter I have synthesised the findings from the data chapter and have understood that despite the various legal and research definitions of WPV and all of its 'forms', it has been the experience of all the workers I interviewed. The implications of conceptualising Workplace Violence in this manner are discussed in the next and final chapter of this thesis.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.0 INTRODUCTION

In this chapter I summarise the findings of this study in light of the initial aim, purpose and research questions outlined in Chapter One. The implications of the findings for the legal response to domestic violence, and social work knowledge and practice are then discussed.

6.1 MOTIVATION FOR THE STUDY AND CONCLUSION

This study was motivated by my experiences as a resident of Chainama Hospital community for two years hearing what my elder brother a clinician by profession was going through prompted me to carry out this study. The purpose of the study was to investigate workplace client-initiated violence against health sector workers that is prevalent in Chongwe District. The specific objectives focused at determining the common type of workplace violence, identifying the coping strategies and to finding out how healthcare workers interpret workplace violence.

The results of this study should assist in the development of appropriate policies and strategies to deal with workplace client-initiated violence against healthcare workers. These strategies should be implemented for specific populations and facilities, as each of them have different requirements. Healthcare workers who have been exposed to both physical and psychological violence hope for protection from further suffering through the enactment of legislation. For those who have been exposed to psychological violence, target training may be useful to prevent violence. For those who have been exposed to physical violence, organisations should reinforce staff with back-up support. For those who have been exposed to both types of violence, organisations should improve their violence reporting systems, statistics, and interventions. Security forces should be strengthened. Organisations and society should provide additional support to prevent workplace violence.

6.2 LIMITATIONS

This study has evitable and inevitable limitations. First, as mentioned earlier, from a sample point of view, certain results cannot be generalised to larger populations. The rural health workers sample being fairly small and dominated by female nurses could have possibly biased some of the results. In this regard the gender effect might have biased some of the results. Second, in studying the prevalence of Workplace Violence and its determinants, several researchers (Lee, Kim, Park,

2014) have reported that it is difficult to compare and contrast statistics from different countries for several reasons, such as the discrepancy in the concepts being studied, inconsistencies in the methods used and cultural differences in the experience of violence ((Chappel and Di Martino, 2006; Waddington et al., 2006).

As I could not find previously published research in the literature regarding Workplace Violence in Zambia, my findings were therefore cautiously compared with studies in countries where health-care systems, workplace environment, and cultural background regarding the understanding of verbal violence and harassment might be different from those of Zambia; examples of such differences include male nurses working in the female patient wards, wartime conditions in the country and cultural differences relating to the understanding of verbal violence or harassment.

However, despite cultural differences concerning the definition of verbal violence and harassment, the fact that the concept of violent behaviours used in this study was defined according to previous international studies allows me to compare this study with studies in other countries. Second, I did not assess Workplace Violence committed by coworkers; from my experience, however, there is no reason not to accept the possibility that co-workers are also committing violence against HCWs. Despite this fact, we assume that these results can reveal the reality of the current Workplace Violence situation in Zambian health-care facilities. These limitations would not change the magnitude of the problem given the fact that the Zambian health-care system faces many challenges; the working conditions of Health Workers are still precarious, especially in rural health facilities as confirmed from the narratives of the health workers in Chongwe District

6.3 RECOMMENDATIONS/FUTURE DIRECTIONS

Implications from this research involve opening new avenues for future research on workplace client-initiated violence. This research has only barely examined the topic and many other aspects of this type of offence need to be investigated. Stanko (2003 in Waddington) noted that four components were essential when investigating workplace violence in order to fully understand its meaning: 1) the act of violence itself; 2) the relationship of the participants to each other; 3) the location of the act; and 4) the consequence or resultant injury. The present research was intended to investigate two of these components, the act itself and the location (rural settings). However, future research is needed on the relationship of the participants to each other as it might have an impact on workplace violence understanding and prevention.

In conclusion, more research is needed on other components specific to workplace violence namely types of offender and occupation risk. Research on workplace violence is very descriptive and mostly very specific in the sense that usually only one specific form of violence is studied or only one specific occupation is looked at. Although most occupations have been examined and all types of offenders have been studied, more research comparing one type of offender to another or occupational effects is needed. More comparative studies are needed in order to have a global picture of workplace violence's victims, perpetrators, situational risk factors, and cultural differences.

6.4 CONCLUDING COMMENTS TO THE CHAPTER

This study addressed the impacts of WPV have on the health workers in rural settings extending into the lives of clients or patients themselves as they seek healthcare services. The findings of this study have generated a conceptualisation of WPV as a product of aggressive acts that are based on multiple motives of both the victim (the health worker) and aggressor (the client).

The complex decisions and challenges faced by the health workers in this study revolved around how to continue working effectively after the traumatic experience. The cost to workers of being productive despite the negative effects of the experiences suggests the need for interventions in all events of Workplace Violence in the health sector.

The conclusions drawn from this thesis suggest that critical to understanding the dynamics underlying WPV allows the formulation of occupational policies and practices that can facilitate non- traumatic work environments for health sector workers in Zambia.

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