Workplace Violence Isn't Always Physical: A One Year Experience of A Group of Registered Psychiatric Nurses

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Summary

Overview

In the summer of 2007 a mail-out survey was sent to 400 Registered Psychiatric Nurses (RPN) across Saskatchewan. The study examined workplace exposure to physical violence, verbal abuse, and mobbing and bullying among this group of health care employees. It also explored the relationship between the various types of violence and other factors including; physical and mental health, and perceptions of the work environment. This research was approved by the Research Ethics Board at the University of Saskatchewan (U of S) and was conducted by Bobbi Stadnyk, a doctoral candidate at the University of Regina (U of R), Department of Psychology. Funding was provided by the Registered Psychiatric Nurses Association of Saskatchewan (RPNAS). Included in the mail-out packages were: the Demographic and Exploratory Questionnaire (Appendix A), the Glossary of Definitions Appendix B, the Posttraumatic Stress Diagnostic Scale (PDS) (Appendix C), the Work Environment Scale (WES) (Appendix D), Symptom Assessment -45 Questionnaire (SA-45) (Appendix E), and three sections of the World Health Organization Violence in the Health Care Workplace Survey [(Physical Assault, Verbal Abuse, and Bullying/Mobbing)(Appendix F)].

One hundred and twenty-one individuals (30%) responded to the survey and these constituted the participant base. The participants reported a mean age of 47.0 years, a mean of 23.4 years of work experience in the health care sector and a mean wage of $66,611 (Table I). The sample was primarily Caucasian (90%) and female (84.3%). RPNs who participated in the study identified being employed in four main work areas including: Hospital (26.4%), Personal Care Home/Long-Term Care (25.6%), Community Mental Health (13.2%), and Corrections (10.7%). In addition 13.2% reported working in other areas and 9.9% reported working in more than one area. There were 99 (81.8%) full time employees and 67 (55.4%) were shift workers (Table II).

For purposes of data analyses employees who responded were often divided into two groups based on whether or not they identified exposure to any violence in the workplace including exposure to any one of the three specific types of violence or whether or not they could be defined as having probable PTSD. Comparisons were then made between the different groups on numerous factors including: perceptions of the work environment, and physical and psychological symptom levels. Additionally, comparisons of some factors were made between the overall sample and normative samples.

The findings in this study are noteworthy for several reasons. The vast majority of RPNs reported exposure to a violent or traumatic event in the workplace over their previous 12 months of work. Each type of violence examined during the course of this study provided a unique profile in terms of who perpetrated the abuse, how the employee viewed the incidents, and how they responded. Regardless of these differences, this research revealed that the impact of violence on the lives of the nurses was extensive and multifaceted. Given these findings, it is posited that the societal cost could be considerable and the personal cost inestimable for RPNs who are exposed to workplace violence.

Four Major Areas of Concern

Information from the survey yields four major areas of concern regarding the work experience of Registered Psychiatric Nurses in the Province of Saskatchewan.

- Exposure to violence in the workplace is high among RPNs. Nearly 75% of RPNs in this study reported being exposed to some form of violence in the workplace in the previous 12 month period. Moreover, the average number of violent workplace incidents personally experienced by employees during the previous two month period was 1.4 per person. The mean for the number of events witnessed over two months was 2.5 per employee. Incidents of physical assault and verbal abuse tended to be initiated primarily by patients, whereas bullying and mobbing was mainly instigated by coworkers, supervisors, and managers. RPNs were less likely to report bullying behaviours than physical violence and they often attributed this to being afraid of the consequences. The degree of exposure to violence reported by Saskatchewan RPNs in this study was greater than the exposure reported by health care sector employees in six out of seven countries in the World Health Organization's study on violence in the health sector (di Martino, 2002).

    - Thirty-three nurses reported being physically attacked at work in the previous year. Of these, only one individual felt that this was **not** a typical incident in their workplace. All physical attacks were attributed to patients.

    - 64% of nurses in this study reported being verbally abused in the workplace in the previous 12 month period. Of these, 89.6% felt that this was a typical incident in their workplace. 30% of this type of abuse was attributed to staff members.

    - 27.8% of the study participants reported being bullied or mobbed in the workplace in the previous year. Of these, 84% identified a coworker or supervisor as the perpetrator of the abuse.

- As the exposure to various types of violence in the workplace increased so did psychological and physical symptoms experienced by nurses. RPNs who reported exposure to aggression in the preceding 12 month period (violence exposure group) also reported more anxiety, depression, interpersonal sensitivity, and somatic complaints (ie headaches, chest pain, muscles aches) than those who did not report exposure to aggression in the preceding 12 month period (violence non-exposure group). There was a relationship between bullying and probable PTSD such that nurses who were bullied were also more likely to have PTSD as assessed by the PDS[1].

- 18.2% (N=22) of the nurses in this sample reported symptom levels of PTSD suggesting a probable clinical diagnosis of the disorder. The prevalence rate of the disorder in this group of workers was found to be in excess of both lifetime[2]

[1] A diagnosis of PTSD cannot be made based on a written instrument alone
[2] The number of people who have ever had the disorder

and current[3] prevalence rates found in the general population in other studies (American Psychiatric Association, 2000; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Robins & Reiger, 1991). RPNs who reported probable PTSD also reported increased physical and psychological symptoms. Moreover, there was a relationship between workplace absenteeism and increased PTSD symptoms. There was also a relationship between PTSD and physician visits such that nurses who reported probable PTSD were also significantly more likely to have visited a physician in a one month period.

- Results of WES analyses indicate that there are significant differences in workplace perceptions between the current sample of RPNs and the standardized norms found in a large sample of health care workers. In addition, there were were even more significant differences in perceptions of the workplace between nurses who had been exposed to violence in the workplace and those who had not.

  When compared to norms RPNs identified problems within Relationship Dimensions and System Maintenance and Change Dimensions. Specifically, this sample of RPNs reported less supervisor support, and less commitment to the job than what has been found in a large sample of health care workers. They also reported that their workplace placed less of an emphasis on variety, change, and new approaches in the work environment than what was identified in the normative sample.

  Comparisons between the violence group and the non-violence group suggest that those who were exposed to violence felt that they were under more pressure while at work, reported less commitment to the job, and less supervisor and coworker support. They also were less likely to feel encouraged to be self sufficient and were less inclined to feel that their workplace placed an emphasis on good planning, efficiency, and getting the job done than those who did not report exposure to violence. RPNs who were not exposed to violence were more confident that they knew what to expect with regard to rules and policies and from their daily routine than the violence exposure group.

[3] The number of people who have the disorder at the time of a particular study

Table I
Demographic Variables: Age, Health Care Sector Employment, and Wage

	Range	Mean (SD)
Age	24 - 68	47 (8.75)
Employment (Yrs.)	1- 42	23.4 (9.6)
Wage (Overall Sample)	20,000 – 120,000	65,234 (15,011)

Table II
Demographic Variables: Sex, Ethnicity, Work Area, Shift Work, and Work Status

		Frequency	Percentage
Sex			
	Male	16	13.4
	Female	102	84.3
	Not Identified	3	2.5
Ethnicity			
	Caucasian	109	90.1
	Métis	1	.8
	Asian	2	1.7
	Not Identified	9	7.4
Work Area			
	Hospital	32	26.4
	Personal Care Home/Long Term Care	31	25.6
	Community Mental Health	16	13.2
	Other	16	13.2
	Corrections	13	10.7
	>One Area	12	9.9
Shift Work			
	Yes	67	55.4
	No	52	43.0
	Not Identified	2	1.7
Work Status			
	Full-Time Employees	99	81.8
	Part-Time Employees	16	13.2
	Not Identified	6	5.0

Violence and the Work Environment

General Information

An extensive body of literature has examined workplace aggression, incivility, violence, and bullying (Mikkelsen & Einarsen, 2002; Barling, 1996; Chen & Spector, 1991; Keashly, & Rogers, 2001; Keashly, Trott, & MacLean, 1994; Neuman & Baron, 1997) and the resulting consequences for employees. Workplace aggression has been described broadly as any behaviour that causes harm to an individual within an organization (Baron & Neuman, 1996). More specifically, workplace aggression is "any act against an employee that creates a hostile work environment and negatively affects the employee, either physically or psychologically" (Kaufer & Mattman, 2002). Workplace aggressive behaviours have included, but are not limited to, harassment, physical abuse, verbal abuse, and mobbing (Mikkelsen & Einarsen, 2002; Barling, 1996; Chen & Spector, 1991; Keashly, & Rogers, 2001; Keashly, Trott, & MacLean, 1994; Neuman & Baron, 1997). Other associated constructs include assault, threats, intimidation, victimization, and bullying (Canadian Association of University Teachers, 2004; Canadian Centre for Occupational Health and Safety, 2006; Schat, et al, 2006).

The prevailing public perception is that aggression in the workplace is physical in nature (New York State Nurses Association, 2006). When people hear the expressions workplace violence or workplace aggression, there is an assumption that the event being discussed involves physical assault (Schatt, et al, 2006; New York State Nurses Association, 2006). This is, in part, because the most extreme forms of workplace violence, such as homicide, garner the bulk of media attention and consequently contribute to colouring public opinion (Schat, et al, 2006). The popular media has been instrumental in focusing ongoing awareness on situations that involve murder in the workplace. This exposure has raised public consciousness of work-related homicide to the point that employees in almost every workplace recognize that there is a potential for extreme aggression to occur in either their own workplace or in another work environment (Kelloway, Barling & Hurrell, 2006). For example, the term *going postal* has become one that the general public recognizes immediately as being a reference to an employee who has acted out violently (Schat, et. al., 2006).

Although admittedly a disturbing and dramatic occurrence, the murder of an employee in the workplace is extraordinarily rare (Schat et. al., 2006). In reality, other types of aggression are much more common and employees who work in problematic environments invariably find that they must contend with verbal abuse and the threat of physical violence and mental abuse. As with physical abuse, these non-physical forms of workplace aggression tend to be both vaguely defined and underreported (New York State Nurses Association, 2006).

Research has been conducted worldwide on the prevalence rates of these aggressive behaviours in many work settings including numerous studies within the health care milieu. It is clear from this extensive body of work that the cost of exposure to various types of violence is both personal and systemic. It is becoming more apparent that victims of workplace abuse, other employees, managers, clients, and the work environment in general suffer as a result of ongoing abuse.

The latest statistics on workplace violence in the U.S. were published in the National Crime Victimization Survey (NCVS) in 2001. According to the NCVS there were "an average of 1.7 million violent victimizations per year" between 1993 and 1999 in the American workforce (Bureau of Justice Statistics, 2001). Schat, et al (2006) conducted an extensive review of the literature on violence in the workplace in the U.S. Schat et al. found that the number of employees who experienced workplace violence varied from study to study. The lowest rate in a one year period was identified by the Bureau of Justice Statistics (1.2%) while the highest rate (5%) was reported by the National Centre on Addictions and Substance Abuse at Columbia University.

Aggression in the workplace is frequent in Canada as well. The International Crime Victims Survey (ICVS; International Working Group, 2003) reported that out of 32 industrialized countries, Canada ranked fourth in terms of acts of aggression in the workplace over a 12 month period. The largest union in Canada, the Canadian Union of Public Employees (CUPE), has more than a half million members. Among others, it represents emergency services, health care, social services, transportation, and education employees. In a survey of their membership in 1993, the union received responses from 2,134 individuals who reported on their experience of aggression over the course of their careers. Of these, 40% claimed to have been physically struck or slapped and 30% indicated that they had been grabbed or scratched at work (Queen's University, 2000).

The General Social Survey (GSS) is conducted by Statistics Canada at five year intervals and includes input from 24,000 households. In 2004, the fourth wave of the GSS survey was completed. The survey included components that were designed to question Canadians over 14 years of age about their perceptions of crime in general and more specifically what they have experienced in terms of being victims of crime. Within this context, questions were asked concerning violence in the workplace. The GSS included only physical assault, sexual assault, and robbery as potential incidents that could be endorsed by participants. In spite of that limitation, there were more than 356,000 violent workplace incidents formally reported across Canada in 2004 (Canadian Centre for Justice Statistics, 2004). Labrador and Newfoundland reported the highest rates of workplace violence with 40% of all violent episodes reported in those provinces happening at work. Comparatively, Saskatchewan was much lower with only 20% of all violent incidents that took place in the province happening at work.

Violence in the Health Care Sector

Violence in the health care sector has been recognized as problematic globally. In 2000 the World Health Organization, the International Labour Office, the International Council of Nurses, and Public Service International initiated a large scale investigation into violence in the health sector. A country case study report was issued in 2002 examining responses from thousands of participants in seven countries. Part of the report reviews prevalence rates of physical or psychological violence that health care employees experienced over a one year period. The percentage of employees from each country who reported one or more such incidents was: Bulgaria: 75.8%, Australia: 61%, Portugal, 60% in health centers and 37% in hospitals, Thailand: 54%, and Brazil: 46.7 (di Martino, 2002).

Studies that examine violence specifically in Canadian health care facilities confirm the high rates of violence that Canadian health care providers are being exposed to on a regular basis. In 2001 the Canadian Journal of Nursing Research published a large scale study that examined nurses' experience of violence in Alberta and British Columbia hospitals. RNs from 210 hospitals in the two provinces responded to questions concerning their exposure to violence in their last five shifts. Out of the 8,780 respondents 46% reported experiencing one or more types of violence during that time (Duncan, Hyndman, Estabrooks, Hesketh, Humphry, Wong, Acorn & Giovannetti, 2001). To complicate this picture, violence against nurses in the health care sector often goes unreported (Fernandez et al, 1999; Gates, 2004; Hesketh et.al., 2003). Nurses frequently state that it is to be expected and that it is simply part of their job (di Martino, 2002; International Labour Organization, 2005; Mayhew & Chappell, 2003).

Psychiatric nurses have been found to be especially vulnerable to incidents of aggression and are often victims of violence in the workplace (Lanza, Zeiss & Reirdan, 2005). In a review of the literature on the prevalence of violence against psychiatric nurses Lanza, et al (2006) noted that "workplace violence is a virtually normative experience for the (psychiatric) nurse". They also concluded that "Psychiatric nurses are typically found to report the highest, or among the highest, levels of violence among all nursing specialties".

It is difficult to access information concerning the number of violent incidents that take place within healthcare facilities in Saskatchewan. Additionally, it is not easy to gauge the impact that such incidents have on Saskatchewan nurses in terms of physical and psychological symptoms and perceptions of the work environment. In part, this is because there is little, if any, empirical evidence regarding violence against health care employees in Saskatchewan that has been reported in peer reviewed literature. However, employee self-report information contributed by Saskatchewan LPNs during a previous study (Stadnyk, 2006) and information contributed by Saskatchewan RPNs during the course of this study indicate that violence is as common in health care settings in Saskatchewan as it is in other parts of Canada. This corroborates the global picture of the commonality of violence in the health care workplace overall (Arnetz, Arnetz & Soderman, 1998; di Martino, 2002).

Consequences of Workplace Violence

Workplace violence can have personal, organizational and societal consequences. In a hostile work environment, the employee may develop physical and psychological symptoms while the organizational costs can include an increase in sick days used and lowered productivity (Einarsen, 2000). Employee attitudes towards their workplace can be negatively affected causing a decrease in commitment to the job, and a perceived lack of support from coworkers and supervisors (Stadnyk, 2006; Stadnyk, 2007) Societal costs can include unemployment, retraining, rehabilitation and health care costs (Hoel, Sparks, & Cooper, 2001).

Increased absenteeism has previously been found to be associated with psychological distress (Hardy, Woods, & Wall, 2003; Stadnyk, 2007). For example, Richter & Berger (2001) reported that employees in psychiatric facilities took more time off work following an assault. This increase in absenteeism as a result of violence in the workplace

was also supported in a large scale European study (Hoel, et al, 2001). In the European study, commissioned by the International Labour Organization, researchers from the University of Manchester Institute of Science and Technology concluded that there was a relationship between the amount of time employees missed work and violence within the workplace. Increased psychopathology, including elevated prevalence rates of PTSD, has been associated with exposure to workplace aggression. In addition, research has indicated a relationship between increases in workplace violence and increased physical symptoms such as headaches, stomach and chest pain, and aching muscles (Stadnyk, 2006; Stadnyk, 2007).

Violence as Experienced by RPN Participants in the Current Study

- **Overview**

The survey package that was mailed to RPNs in this study included a glossary of definitions with regard to violence. Each type of violence was clearly defined (Appendix B).

- Nearly 75% (n = 90) of RPNs in this study reported experiencing an incident of physical or psychological violence in the workplace in the previous 12 month period (Table III).

- Those who reported experiencing, witnessing or hearing about violent events tended to have had multiple experiences (Table IV).

- The mean number of violent workplace incidents reported as personally experienced over two months was 1.3 per person. In other words, this would equate to more than eight violent events personally experienced by each employee in a one year period on average (Table IV).

- In addition to the events experienced they reported witnessing an average of 2.3 violent incidents per employee over the preceding two months and hearing about 4.7 violent workplace incidents per employee over the same time frame.

- There was a relationship between violence and increased physical and psychological symptoms such that as nurses report an increase in exposure to violence at work they also report more of both types of symptoms.

- **Physical Violence, Verbal Abuse & Bullying/Mobbing**

- Participants in the present study identified incidents of physical and psychological abuse that had taken place in their work environments. In some instances perpetrators were primarily individuals while at other times groups were responsible for the abusive behaviour. Perceptions of the incidents in terms of how typical they were of the environment, who the perpetrators were, and how the nurse responded varied depending on the type of violence. This pattern held true when RPNs answered questions regarding what actions were taken against the perpetrators, and whether or not it was preventable in the first place. In order to conceptualize responses for the three types of violence (physical assault, verbal

abuse, and mobbing/bullying), each has been analyzed separately. Note that not all nurses who were abused in the workplace answered each question that related to the abuse they experienced. Percentages given are based on the number of nurses who responded to any given question. ***Please note that all frequency distribution bar charts for the following sections are included in Appendix G.***

- **Physical violence**

  - The majority of nurses who participated in the study (97.5%) answered the question on whether they had been physically attacked in the workplace over the previous year. Twenty-seven percent of them had been (Chart I).

  - Out of the 33 nurses who had been physically attacked 97% felt that this was a typical incident in their workplace (Chart II).

  - All physical attacks (100%) were attributed to patients (Chart III).

  - Approximately 90% of nurses who were attacked took two or more actions in response to the attack (Chart IV) and over 70% had, in fact, reported the attack to management in some way.

  - 78.8% did not feel that the incident could have been prevented (Chart V).

  - Only 21.2% were aware of any action being taken to investigate the cause of the violent incident. 51.5% reported that no action had been taken and 21.2% did not know whether or not any action had been taken (Chart VI).

  - Sixteen out of 33 participants responded to the question "What were the consequences for the attacker"? Of these, 50% said there weren't any consequences, 18.8% said the attacker was given a verbal warning, while 12.5% said they didn't know whether or not there were any consequences (Chart VII).

  - When nurses were asked how satisfied they were with how the incident was handled on a scale of 1 to 5 with 1 being very dissatisfied and 5 being very satisfied 9.4% were very dissatisfied. Very few nurses (12.5%) reported being very satisfied. The majority (37%) reported being neither satisfied nor dissatisfied (Chart VIII).

  - Among the reasons for not reporting the incident were that it wasn't important (37.5%), it was useless (12.5%), and the

RPN was afraid of the consequences if they reported (37.5%) (Chart IX). It is difficult to interpret the meaning of this finding as the vast majority of nurses did not respond to this question.

- In addition to reporting incidents of physical assault that they had personally experienced 53% of nurses in this study responded that they had witnesses physical violence in the workplace within the last 12 months (Chart X).

o **Verbal abuse**

- 66% of the participating nurses reported being verbally abused in the workplace in a 12 month period (Chart XI).

- During that time, of those who were verbally abused, 72.2% stated that they were verbally abused sometimes, while 19% indicated they were verbally abused all of the time (Chart XII).

- Whereas the vast majority of physical assaults were attributed to patients the picture of verbal abuse was one where many more incidents (31%) were perpetrated by staff members. (Chart XIII).

- Again, as with physical assaults, most nurses (89%) considered the last episode of verbal abuse they experienced to be typical of their workplace (Chart XIV).

- Many nurses (47.4%) responded to the verbal abuse by taking more than one action including reporting it to management in some way. Nearly 4% took no action whatsoever and 10% took action that did not include reporting the incident to management (Chart XV).

- In terms of whether or not participants believed the incident could have been prevented, a large number (65%) did not think it could have been (Chart XVI).

- 73.1% reported that no action had been taken to investigate the cause of the abuse and 16.7% didn't know if anything had been done. Only 10% reported that they were aware of action being taken to investigate the verbal abuse (Chart XVII).

- 38% of nurses were dissatisfied with how the incident was handled, 34% were satisfied, and 23% were neither satisfied nor dissatisfied (Chart XVIII).

- When compared to physical abuse the three main reasons expressed for not reporting were the same but were differently distributed. Less nurses (25%) felt that the verbal abuse was not important. More nurses (15.6%) felt that it was useless to report it and less (31.3%) were afraid of the consequences if they were to report (Chart XIX).

o **Bullying/ Mobbing**

- Some of the more alarming findings in the study were those that related to bullying/mobbing. The information gathered in this survey with regard to bullying indicated that the identity of the majority of perpetrators (fellow employees) was different than the majority of perpetrators of physical and verbal abuse (clients). Responses to the behaviour and the reasons for not reporting also differed.

- An alarming 26.4% of the participants reported being bullied/mobbed in the last 12 months in their workplace (Chart XX).

- Most nurses (70%) reported that the incidents happened more than once (i.e. sometimes) during the 12 month period, while 13.3% stated they were bullied or mobbed consistently (all of the time) in the workplace. The minority (16.7) identified the abuse as a one time incident (Chart XXI).

- Whereas physical assault and verbal abuse were primarily committed by patients, the picture changed dramatically with mobbing and bullying where staff was found to be responsible for 84% of the abuse. Of the 84% who identified a staff member as responsible for the last bullying incident, 19.4% was attributed to a manager or supervisors. 34% of the abuse was identified as having come from more than one source (including employee(s), for example coworkers and supervisors or employees and clients (Charts XXII).

- 76.7% of individuals who had been bullied and who answered the question on whether or not this behaviour was typical of their workplace said that it was (Chart XXIII).

- Overall, nurses were less likely to tell management about the abuse or to seek help when they were bullied as compared to when they experienced physical abuse. Only 50% of participants who were bullied reported to management (Chart XXIV whereas 69.7% of nurses who

experienced physical abuse reported it to the employer in some way.

- Most participants felt that the situations involving physical and verbal abuse could not have been prevented. When it came to bullying, however, nearly half (48.4%) felt that the incident could have been prevented (Chart XXV). It may be that since bullying is perceived as an internal and systemic problem being primarily committed by fellow employees it is perceived as one that can be stopped by the employer.

- It appears that at this time RPNs feel that little action is being taken to investigate the cause of all types of workplace abuse and this is particularly true with regard to bullying. 63% of nurses who were bullied reported that nothing had been done to investigate the incident and 28% were not aware of whether or not anything had been done. Very few employees (6%) indicated that action had been taken to address the bullying incident (Chart XXVI).

- Given the overall picture of bullying it is unsurprising that 60% of the RPNs were either dissatisfied or had neutral feelings concerning with the manner in which the incident was handled (Chart XXVII).

- Of the nurses who had been bullied and did not report it 16% did not know who to report to, 21% felt it would be useless, and 5% did not know who to report to. Perhaps more distressing is the fact that if there was more than one reason for not reporting fear of consequences tended to be one of the factors that nurses identified (32%). In fact, many nurses were afraid of the consequences for reporting all types of abuse, however, this was much more of an issue when the type of violent behaviour involved bullying (Chart XXVIII).

❖ A significant number of RPNs did not report the three types of work related violence that they encountered to a supervisor or other management representative (Chart XXIX, Chart XXX, and Chart XXXI). It is possible, therefore, that a large percentage of Saskatchewan nurses, in general, are not reporting the violence that is taking place in the health care work environment.

Table III
Number of RPNs Who Reported Experiencing Abuse in a 12 Month Period

	Frequency	Percent
Total RPNs	121	100
Yes abuse	90	74.4
No abuse	31	25.6

Table IV
Violent Workplace Incidents Reported by RPNs Over a Two Month Period

	Trauma events experienced 2 months	Trauma events witnessed 2 months	Trauma events heard about 2 months
Mean per person	1.3 (N=96)	1.83 (N=88)	3.11 (N=90)
S.D.	2.5	3.9	7.4

Posttraumatic Stress Disorder

PTSD Overview

PTSD is a disabling anxiety disorder that may occur after experiencing, witnessing, or hearing about a traumatic event. Frequently it is exposure to violence that has been associated with an increased risk of developing the disorder (O'Brien, 1998). It has been linked with impairment in social, occupational or other principal areas of functioning which can make daily living difficult. When an individual develops PTSD there are three hallmark clusters of symptoms that are present.

The first of these is re-experiencing of the event through such things as dreams, hallucinations, or feelings that the event is reoccurring. The second group of symptoms includes those that are related to avoidance and numbing. Individuals who have these symptoms tend to avoid stimuli that are reminders of the trauma, including people, situations, and places. They may exhibit avoidance behaviours with regard to thoughts, feelings activities, and conversations that trigger memories (American Psychiatric Association, 2000). There can be a diminished interest in activities, feelings of detachment from others, and a sense of impending doom that prevents the individual from establishing long-term goals and initiating and implementing future plans. They are often unable to enjoy the activities they had formerly taken pleasure in (American Psychiatric Association, 2000). Eventually, the person may emotionally disconnect from others and cease to function socially (Freeman, 2000).

The third symptom cluster is one wherein increased arousal manifests. This can result in a failure to be able to concentrate along with a related inability to complete tasks. The person may be unable to fall asleep or stay asleep. In addition, there may be an exaggerated startle response and/or feelings of irritability and anger (American Psychiatric Association, 2000).

Higher than normal prevalence rates of PTSD have been reported in high-risk groups of individuals, and the relationship between recurring exposure to traumatic events and increased PTSD symptoms has been well established in the literature (Kessler, 2000). When people are employed in high-risk jobs, the work environment itself can become the primary source of ongoing trauma. In fact, certain jobs have clearly been identified as placing employees at increased risk for developing PTSD. Individuals who develop PTSD will often also suffer from one or more co morbid psychiatric disorders. In the Canadian workplace the fastest growing category of long-term disability claims are those filed due to psychiatric problems (Canadian Mental Health Association, 2002).

PTSD General Facts

- Two of the largest epidemiological studies conducted in the U.S. the Epidemiological Catchment Area Study (ECA) and the National Comorbidity Survey (NCS) found the current prevalence rate of PTSD to be 1.9% and 3.6%, respectively, in the general American population (U.S. Department of Health and Human Services, 1999).

- Community based studies of American adults reveal an 8% lifetime prevalence rate of PTSD (American Psychiatric Association, 2000).

- Researchers have shown that police officers (Robinson, Sigman & Wilson, 1997), fire fighters (Lange, Lange & Cabaltica, 2000), corrections employees (Corrections Services Canada, 1992), military personnel (Schlenger, Fairbank, Jordan, & Cadwell, 1999) and emergency medical workers (Cudmore, 1996) have all reported prevalence rates of PTSD that in excess of what is reported in the general population.

- The cost of PTSD, in terms of lost productivity when left untreated was estimated to surpass that of all other anxiety disorders (Greenberg et.al., 1999).

- Greenberg et.al. (1999) created a human per capita model of anxiety disorders to examine their societal cost. They found that the highest health care service rate use was ascribed to panic disorder and PTSD with PTSD cost exceeding that of all other anxiety disorders.

- Chronic PTSD leads to intrapersonal problems (e.g. violent behaviour) (Baker & Alfonso, 2003) as well as interpersonal difficulties (e.g. family dysfunction) (Beckham, Feldman & Kirby, 1998).

- It has been estimated that up to 80% of those with PTSD suffer from some type of co morbid disorder, including depression, generalized anxiety disorder, panic disorder, and substance abuse (Lange, et al, 2001).

- PTSD has been associated with more physical complaints including increased respiratory, cardiovascular, musculoskeletal, and neurological symptoms (McFarlane, Atchison, Rafalowicz & Papay, 1994). In addition, research has identified a relationship between increased PTSD symptoms and anemia, arthritis, kidney disease, and eczema (Weisberg, Bruce, Machan, Kessler, Culpepper & Keller, 2002).

- Symptoms associated with PTSD contribute to work-place absenteeism, illness, and social isolation (Hidalgo & Davidson, 2000).

- Individuals who suffer from PTSD utilize more health care services (e.g. take more medication and see their physicians more frequently)

- Up to one third of those who develop PTSD will continue to be symptomatic at a clinical level after 10 years (Lange, et al, 2000).

PTSD as Experienced by RPN Participants in the Current Study

- The current probable prevalence rate of PTSD in RPNs in this study was 17.4% (Table V).

- In this study employees with probable PTSD reported significantly more physical symptoms according to the Symptom Assessment-45 Questionnaire (SA-45) than employees without PTSD including; muscle soreness, hot or cold spells, numbness or tingling in parts of the body, weakness in parts of the body, feelings

of heaviness in the arms or legs, headache, and pains in the heart or chest. The only physical symptom that the two groups did not differ on was pain in the lower back.

- RPNs who missed work more often than the group mean in a one month period had significantly higher PTSD scores than RPNs who missed work less frequently than the group mean in a one month period (Table VI).

- RPNs in this study who reported probable PTSD also reported significantly higher symptom levels in eight out of nine of the SA-45 symptom domains (Anxiety, Depression, Hostility, Obsessive Compulsive, Somatization, Interpersonal Sensitivity, Paranoid Ideation and, Psychoticism) (Table VII).

- RPNs who were bullied were also significantly more likely to report probable PTSD than those who were not (Table VIII).

- RPNs who reported probable PTSD were also more likely to visit a physician in a one month period (Table IX)

Table V
Probable PTSD in a Sample of Saskatchewan RPNs

	Frequency	Percent
No PTSD	85	70.2
PTSD	21	17.4
PDS not completed	15	12.4
Total	121	100.0

Note. Probable PTSD was assessed using the Posttraumatic Stress Diagnostic Scale

Table VI
Comparison of Illness in One Month and PTSD Scores

	Number of participants	Mean group score (PTSD symptoms)	Minimum individual score	Maximum individual score
[1] Group one	61	5.5	0	32
[2] Group two	32	10.3	0	30

[1] RPNs who were ill less frequently than the group mean in 1 month
[2] RPNs who were ill more frequently than the group mean in 1 month

Table VII
PTSD Group Compared to Non-PTSD Group on SA-45 Symptom Domains

	PTSD	Number of participants	Mean group score	Std. Deviation	Sig.
Anxiety	Yes	21	9.2	2.0	**
	No	94	6.5	1.8	
Depression	Yes	20	11.7	4.4	**
	No	95	6.8	2.3	
Obsessive Compulsive	Yes	19	9.6	2.4	**
	No	94	7.1	2.1	
Somatization	Yes	20	12.1	3.3	**
	No	94	7.8	2.8	
Phobic Anxiety	Yes	21	5.5	.81	
	No	94	5.1	.44	
Hostility	Yes	21	6.8	1.7	**
	No	94	5.5	1.1	
Interpersonal Sensitivity	Yes	21	9.6	3.5	**
	No	94	6.4	1.8	
Paranoid Ideation	Yes	20	9.2	3.3	**
	No	95	6.3	1.9	
Psychoticism	Yes	21	5.3	.48	*
	No	94	5.1	.26	

*** Correlation is significant at the $p < 0.05$ level**
**** Correlation is significant at the $p < 0.01$ level**

*** The PTSD group is composed of those who have probable PTSD according to the Posttraumatic Stress Diagnostic Scale**
**** The non-PTSD group is composed of those who are not likely to have PTSD according to the Posttraumatic Stress Diagnostic Scale**
Mean group scores represent symptoms so that the higher the mean group scores the more symptoms

Table VIII
Contingency Table For Bullying and Probable PTSD

Bullying	PTSD	No PTSD
Yes	10	22
No	12	71

*** significant at the $p < 0.05$ level using χ^2**

Table IX
Comparison of Physician Visits in One Month and PTSD Scores

	Number of participants	Mean group score (PTSD symptoms)
[1] Group one	48	5.7
[2] Group two	37	9.2

[1] RPNs who visited physicians in 1 month
[2] RPNs who did not visit physicians 1 month

RPNs and the Work Environment

The Work Environment Scale

- Form R of the WES has been used by consultants, clinicians and program evaluators to help employees describe their work environment at a particular time (Moos, 1994).

- The three dimensions of the WES consist of 10 sub-scales. These are defined as follows in the Work Environment Scale Manual (Moos, 1994):

  - A) Relationship Dimension sub-scales:
    1) Involvement: The extent to which employees are concerned about and committed to their jobs.
    2) Coworker Cohesion: How much employees are friendly and supportive of one another.
    3) Supervisor Support: The extent to which management is supportive of employees and encourages employees to be supportive of one another.

  - B) Personal Growth Dimension sub-scales:
    1) Autonomy: How much employees are encouraged to be self-sufficient and to make their own decisions.
    2) Task Orientation: The emphasis on good planning, efficiency, and getting the job done.
    3) Work Pressure: The degree to which high work demands and time pressure dominate the job milieu.

  - C) System Maintenance and Change Dimension sub-scales:
    1) Clarity: Whether employees know what to expect in their daily routine and how explicitly rules and policies are communicated.
    2) Managerial Control: How much management uses rules and procedures to keep employees under control.
    3) Innovation: The emphasis on variety, change, and new approaches.
    4) Physical Comfort: The extent to which the physical surroundings contribute to a pleasant work environment.

The Work Environment as Experienced by RPNs Participants in the Current Study*:*

- **RPNs Compared to Health Care Employee Norms**

The results of this study suggest that RPNs in this sample are experiencing significantly more problems than other health care employees (based on normed samples) in two out of three WES dimensions (Graph I). The relationship dimension appears to be the most problematic. It is also worth noting that RPNs in this research do not feel as controlled by their supervisors as do other health care workers.

❖ In the Relationship Dimensions RPNs were significantly more likely than other health care workers to report the following:

- a lack of support and encouragement from their supervisors and managers
- less concern about and commitment to their jobs

❖ Two categories in the Systems Maintenance and Change Dimensions were significantly different from norms.

- When compared to WES norms, RPNs reported feeling less controlled by management through the use of rules and procedures
- RPNs also reported that in their work environment little emphasis was placed on innovation, change or new ways of doing things

- **RPNs Who Experienced Workplace Violence Compared to RPNs Who Did Not**

The nurses who reported witnessing, hearing about, or being told of workplace violence (violence group) were distinguished from the nurses who did not report such exposure (non-violence group) and comparisons were made between the two groups on all 10 WES sub-scales. The violence group reported significantly more problems in all three WES dimensions than the non-violence group (Graph II).

❖ In the Relationship Dimensions the violence group reported:

- less concern about and commitment to their jobs
- less support from co-workers
- less support and encouragement from their supervisors and managers

❖ On the Personal Growth Dimensions the violence group:

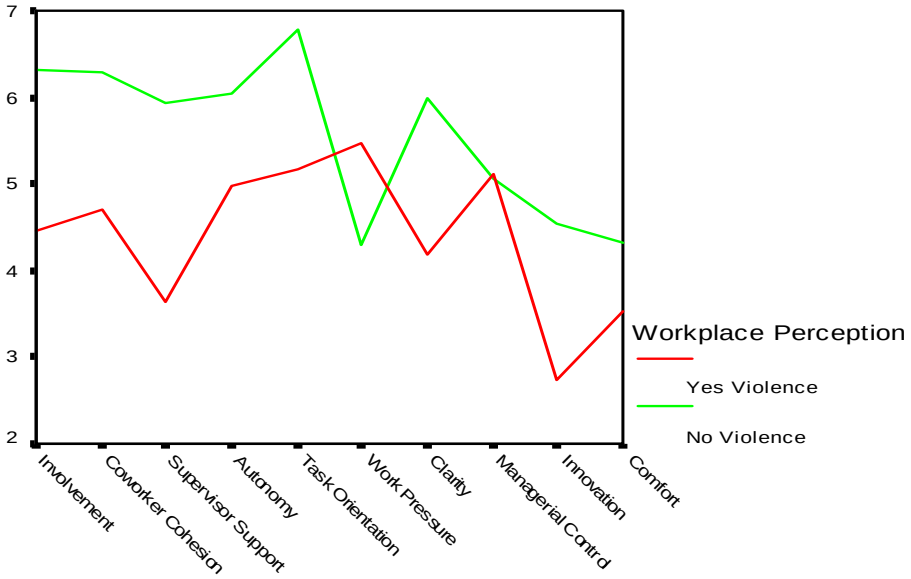
- were more likely to report that they felt there was less of a focus on planning, efficiency and getting the job done in their workplace
- reported an increase in the perception of higher work demands and time pressure within the workplace

❖ In the System Maintenance and Change Dimensions the violence group reported:

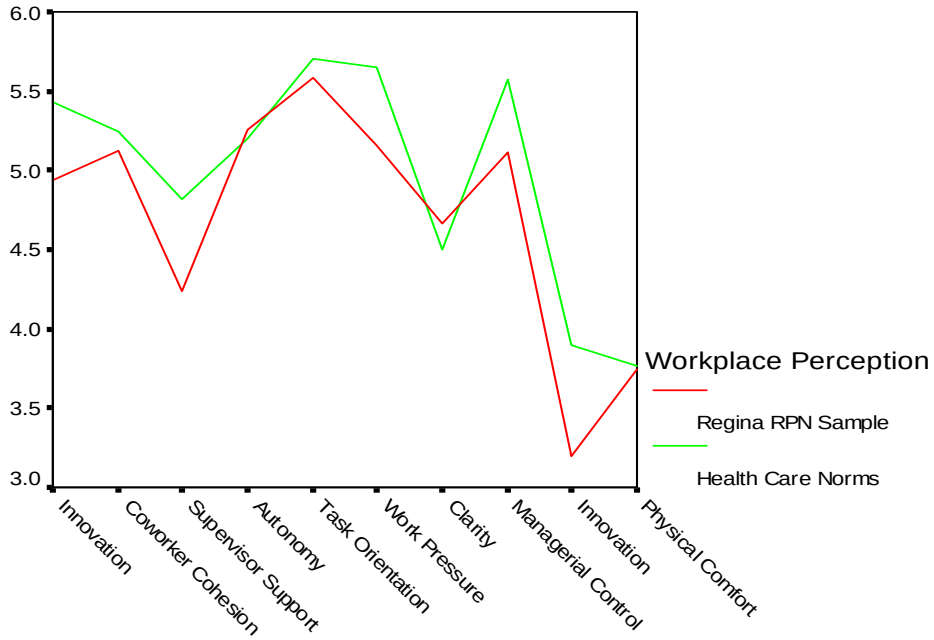
- less clarity in expectations of daily routines and more uncertainty with regard to the communication of rules and policies than the non-violence group.

Overall, the work environment, for this sample of RPNs, appears to be characterized by significant problems in several domains when compared to WES norms. In addition, the group of RPN who report experiencing violence in the workplace report significantly more problems in numerous domains compared to the group of RPNs who did not experience violence.

Graph I
Comparison of Workplace Violence Group and Workplace Non-Violence Group on Work Environment Sub-Scales



Graph II
Comparison of RPNs in Current Sample and Health Care Sector Population Norms on Work Environment Sub-Scales



Additional Analyses

Overall, both, male and female RPNs reported either the same or lower mean scores on the nine sub-scales of psychopatholgy in the SA-45. The only exception was the Somatization sub-scale where both male and female RPNs reported higher mean scores by gender than those found in nonpatient normative samples. As a group this sample of RPN males reported less symptoms than the general population in the Psychoticism sub-scale of the SA-45. As noted earlier they did report higher Somatization sub-scale scores. As a group this sample of RPN females reported less symptoms than the general population in three of the SA-45 sub-scales (Psychoticism, Phobic Anxiety and Hostility). As with Male RPNs the females also reported higher somatization sub-scale scores (Table X).

Table X
Comparison of SA-45 Results Between Population Norms and Current RPN Sample

SA-45 Results	Mean	S.D.	Sig
Phobic Anxiety			
Norm Females	5.55	1.75	**
RPN Females	5.12	.55	
Hostility			
Norm Females	6.05	2.40	*
RPN Females	5.75	1.34	
Somatization			
Norm Males	7.00	3.00	**
RPN Males	9.38	2.85	
Norm Females	7.15	3.00	**
RPN Females	8.40	3.23	
Psychoticism			
Norm Males	5.65	.28	**
RPN Males	5.07	1.85	
Norm Females	5.45	1.40	**
RPN Females	5.13	.34	

*** Significant at the $p < 0.05$ level**
**** Significant at the $p < 0.01$ level**

Higher mean scores represent an increase in symptom scores for each category

Future Considerations

Although there are overlapping areas of interest, there are certain items that may be of greater concern to specific stakeholders. That having been stated, it is likely that each group of stakeholders will find interest in all categories.

Of Interest to Regional Health Authorities

1. It has been found that prevention of mental health problems and early treatment of symptoms lowers societal cost and personal distress related to psychiatric disability (American Psychological Association, 2003). Timely identification of pathology and treatment of symptomatic nurses would decrease the probability of disorders becoming chronic and subsequently more difficult to treat (Doyle, et al, 2001). With early symptom management both quality of life and ability to function could be improved.

2. Various departmental policies, procedures, and management practices should be reviewed to assist with the conceptualization of possible workplace interventions in the area of workplace violence. Potential interventions that include front line manager participation should be designed to mitigate the negative perceptions nurses have of their work environment and their supervisors. Base line scores on the WES could be compared to post-intervention scores to determine effectiveness.

3. The findings of this study could be used as the basis for discussions related to the recommendation of or the putting into practice methods intended to decrease workplace violence. Furthermore, these research findings could be used in creating educational strategies designed to assist employers and employees in identifying symptoms of psychological disorders more specifically those disorders that have been found to be problematic in the work environment (eg anxiety, depression, PTSD, etc.).

4. Employees need to be encouraged to be aware of the importance of workplace trauma and the potential impact this could have on their mental and physical health. In any workplace training regarding employee traumatization an emphasis must be placed on the necessity of reporting of events.

5. Employees need to be encouraged to be aware of the importance of workplace violence and the potential impact this could have on their mental and physical health. Reporting at work should be a clearly defined process and follow up should take place. Follow up should always include reporting to victims of workplace violence any actions that have been taken against the perpetrator.

6. Employees who become symptomatic following exposure to traumatic or violent events should be encouraged to report the exposure to their primary care physician. In addition, health care professionals who come in contact with these employees must be apprised of the significance of recognizing and defining client trauma histories and the relationship this would have to treatment plans and client referrals.

Of Interest to Regional Health Authorities and Sask Health

1. Improved recognition of the workplace problems faced by nurses, particularly as they relate to violence, should be considered, possibly in the form of the development of a provincial central registry of workplace incidents. With the development of such a registry employers and employees will have a method that enables them to easily and quickly review occurrences and in so doing define what constitutes the parameters of violent events in the health sector. A formal classification of definitions would make possible the implementation of a standardized method of recording incidents. This would also facilitate simplification of methods used to access both specific and general information concerning work-related violence. Ultimately this information could be used in the characterization, classification and mapping of trends related to violence in Saskatchewan health care facilities.

Of Interest to Regional Health Authorities and Unions

1. Problems related to mental health are contributing to rising disability rates within the North American labor force. This represents a sizeable business cost and restricts workplace productivity (National Mental Health Association, 2006).

2. Depression will rank second only to heart disease as the leading cause of disability worldwide by the year 2020 (Murray, & Lopez, 1996).

3. Because they are so common, anxiety disorders have a major economic impact. Anxiety disorders affect 12% of the population, causing mild to severe impairment (Public Health Agency of Canada, 2005). They contribute to lost productivity due to both time away from work and unemployment. Other associated costs include claims on disability insurance (Adult Mental Health Division, British Columbia Ministry of Health. The Provincial Strategy Advisory Committee for Anxiety Disorders. A Provincial Anxiety Disorders Strategy, 2002).

4. Employers and unions have previously taken the initiative with regard to well-being in the areas of human rights, workplace safety, and employee assistance programs. The findings in this study suggest that interest in employee well-being must be extended to mental health issues including (without limiting to) the allocation of funds and resources that would allow for ongoing education and therapy for workers who suffer psychological injuries in the workplace.

5. In addition, it is imperative to understand the evolution of trauma history within the context of the cumulative effects of repeated exposure to critical or violent situations. More specifically, consideration must be given to the potential that multiple incidents have for psychiatric repercussions.

Of Interest to Researchers

1. It was not within the scope of this study to examine the effects of vicarious traumatization, however, it is a factor that has been found to impact nurses. In the course of their daily work routine they often encounter an element of vicarious traumatization through witnessing and hearing about the aftermath of traumatic events that clients and co-workers experience (Clark & Gioro, 1998). Therefore, it would be prudent to develop research in this area.

2. A number of participants in this study may have sub-clinical levels of PTSD and may, in fact, be suffering from considerable dysfunction because of this. Dysfunctional behaviour, workplace absenteeism and quality of life are factors that should be studied in those who have sub-clinical levels of the disorder.

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APPENDIX A

DEMOGRAPHIC & INFORMATION SHEET

Age: ____ Gender: Male____ Female____

Ethnicity: Caucasian ☐ First Nations ☐ Metis ☐ Asian ☐ East Indian ☐ If other please specify: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common-law ☐

Approximate personal income per year: _____

Approximate family income per year: _____

Work History: Amount of time employed in the health care sector: Months_____ Years_____

Agency of employment:: Hospital ☐ Community Mental Health ☐ Personal Care Home/Long Term Care☐ Residential Care ☐ Corrections ☐ Other _____

Present job classification: _____ Length of time in this position_____

Are you employed: Full time ☐ Part time ☐ Average number of hours worked per week:__ _____

Do you work shift work? Yes ☐ No ☐

Approximately how many days have you worked over the last month? _____

Approximate number of work days you have missed due to illness over the last: Month_____ Two months _____Six months _____

Approximate number of physician visits you have had over the last: Month _____ Two months_____ Six months _____

The Glossary that has been included in this package defines traumatic event, violence, and verbal abuse . Please read the definitions before completing the remainder of this document.

Have you experienced a traumatic event in the workplace? Yes ☐ No ☐ Don't know ☐

If yes to above did the employer provide you with debriefing? Yes ☐ No ☐ Don't know ☐

Were you satisfied with the debriefing? Yes ☐ No ☐ Don't know ☐

If debriefed approximately how long after the event? Number of: Hours_____ Days_____ Weeks_____

Over the ***last month*** that you worked how many violent workplace incidents have you: personally experienced ___ _____ witnessed_____ heard about_____

Over the ***last two months*** how many violent workplace incidents have you: personally experienced ___ _____ witnessed_____ heard about_____

How worried are you about violence in the workplace? 1 = not worried at all; 5 = very worried

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Is there encouragement to report workplace violence? Yes ☐ No ☐

If yes, by whom? Management / Employer ☐ Colleagues ☐ Union ☐ Family / Friends ☐ Association ☐ Other (please specify) _____

Do you have access to an employee assistance program? Yes ☐ No ☐ Don't know ☐

Have you used your workplace employee assistance program? Yes ☐ No ☐ Don't know ☐

If yes to above how satisfied were you with this program? 1 = Not satisfied at all; 5 = Extremely satisfied

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have you ever experienced a traumatic event in your life that ***was not*** work related? Yes ☐ No ☐

If yes to the above, how long ago was the last traumatic event? Number of: Weeks _____ Months _____ Years _____

Please complete both sides of this form

Have you experienced a traumatic event in your life that *was* work related? Yes ☐ No ☐

If yes to the above, how long ago was the last traumatic event? Number of: Weeks _____ Months _____ Years _____

Approximately how many traumatic events have you experienced in your life so far? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5 ☐

Please identify the past traumatic event that you found most disturbing (e.g. assault [sexual or non-sexual], serious accident, life threatening illness, death or life threatening illness of a loved one, motor vehicle accident, natural disaster).

_____

Please put a check mark beside each of the following that is applicable. At some time in my life I have had a physician diagnose me with:

1) Cancer ☐
2) Cardiovascular disease (e.g. high blood pressure, heart disease, stroke) ☐
3) Asthma ☐
4) Headaches (e.g. tension, stress, migraine) ☐
5) Bowel disease (e.g. irritable bowel, colitis, Crohn's disease) ☐
6) Other significant disease (please specify) _____

Do you smoke? Yes ☐ No ☐ If yes number of cigarettes per day_____

Do you drink alcoholic beverages? Yes ☐ No ☐ Number per day_____ week_____ month_____

Please use this sheet for any comments that you might have. Your opinions are valuable to this study.

_____
_____
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_____

Please complete both sides of this form

APPENDIX B

Glossary:

Violence appears as physical violence or psychological violence in different forms, which may often overlap. Terms related to violence are defined in the following glossary:

<table>
<tr><td colspan="2">Physical Violence
The use of physical force against another person or group that results in physical, psychological, or sexual harm. Includes beating, kicking, slapping, stabbing, shooting, pushing, biting, pinching among others. [4]</td></tr>
<tr><td colspan="2">Psychological Violence (Emotional abuse)
Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development.
Includes verbal abuse, bullying/mobbing, harassment, and threats.[5]</td></tr>
<tr><td>Abuse</td><td>Behaviour that humiliates degrades or otherwise indicates a lack of respect for the dignity and worth of an individual. [6]</td></tr>
<tr><td>Bullying/ Mobbing</td><td>Repeated and over time offensive behaviour through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or group of employees.[7]</td></tr>
<tr><td>Threat</td><td>Promised use of physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups.</td></tr>
<tr><td colspan="2">Traumatic Event
A traumatic event is an experience that causes physical, emotional, psychological distress, or harm. This event may be personally experienced, witnessed, or heard about. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease.[8]</td></tr>
</table>

[4] Adapted from WHO definition of violence
[5] Adapted from WHO definition of violence
[6] Alberta Association of Registered Nurses
[7] Adapted from ILO-Violence at Work
[8] The Diagnostic and Statistical Manual of Mental Disorders

APPENDIX C
DESCRIPTION OF THE POSTTRAUMATIC STRESS DIAGNOSTIC SCALE

The Posttraumatic Stress Diagnostic Scale. The Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995) was used to measure the presence and severity of PTSD symptoms.

The PDS is a 49-item self-reporting scale that was developed to assist in the diagnosis of Posttraumatic Stress Disorder using the DSM-IV criteria for PTSD (Foa, 1995). It has proven to be useful in specific populations for estimating PTSD prevalence rates. The PDS can be completed in 10-15 minutes and an eighth grade reading level is considered necessary. Participants rate frequency of symptom experience on a 4-point rating scale in questions 22-38. Symptom severity is then defined in terms of cut-off scores as follows: 10 or less = mild, 11–20 = moderate, 21-35 = moderate to severe and 36 or more = severe. The level of impairment is determined according to responses given in items 41 through 49 which asks individuals to identify areas of their lives in which they have experienced impairment. Calculations are made as follows: zero yes responses = no impairment, 1-2 yes responses = mild, 3-6 yes responses = moderate and 7-8 yes responses = severe. A yes response to question 49 alone would also constitute severe impairment. The PDS has shown good validity and reliability.

The normative sample was recruited from Veterans Administration hospitals, emergency and trauma centres, ambulance corps, residential rehabilitation centres, anxiety disorder and PTSD clinics, Fire halls, and women's shelters located within the USA. Items 22-38 (used to assess symptom severity) had a calculated Chronbach alpha of .92. The symptom severity score was determined to be highly correlated with other measures including the Beck Depression Inventory (BDI) (.79) and the Impact of Event Scale (IES) Intrusion and Avoidance scales (.80 & .66 respectively) indicating convergent validity. Re-administration of the test was conducted with 110 participants at an average interval of 16.1 days to determine test-re-test reliability. Good agreement was indicated by a kappa of .74 (Foa, 1995).

APPENDIX D
DESCRIPTION OF THE WORK ENVIRONMENT SCALE

The Work Environment Scale (WES) is a social climate scale consisting of 10 sub-scales that were designed to measure the actual, preferred, and expected social environments of work settings (Moos, 1994). For the purposes of this study the real form is being utilized to help employees describe the actual work environment. The sub-scales examine Relationship Dimensions (Involvement, Co-worker Cohesion, Supervisor Support), Personal Growth Dimensions (Autonomy, Task Orientation, Work Pressure), and System Maintenance and Change Dimensions (Clarity, Managerial Control, Innovation, Physical Comfort).

For this study only the 3 relationship dimensions (Involvement, cohesion and support) were considered for analysis. Level of employee commitment to the job was measured using the Involvement sub-scale, employee perceptions of co-worker friendliness and support was measured using the Coworker Cohesion sub-scale and the perception of management support of employees and encouragement of employee support of one another was measured by using the Supervisor Support sub-scale.

The sub-scales of Normative data were established for 8,146 employees from general work groups and health related work groups. Test-retest reliability was calculated by administering the test to the same group of employees ($\underline{n} = 75$) twice in a one month period. The range was from .69 (Clarity) to .83 (Involvement). The WES has been extensively utilized to focus on the determinants and outcomes in work milieus. Findings in these studies have supported the construct, concurrent and predictive validity of the WES (Moos, 1993).

APPENDIX E
DESCRIPTION OF THE SYMPTOM ASSESSMENT -45 QUESTIONNAIRE

The Symptom Assessment-45 Questionnaire (SA-45) (Strategic Advantage, Inc., 2000) is a 45 question self-report measure designed to measure psychiatric symptomatology by using forty-five questions that encompass nine domains (anxiety, hostility, obsessive-compulsivity, phobic anxiety, somatization, depression, interpersonal sensitivity, paranoid ideation, and psychoticism). Indices for Global Severity and Positive Symptom total can also be calculated. It was developed for use with individuals over 13 years of age and takes approximately 10 minutes to complete. Symptom severity is rated on a five-point Likert scale with a range of "not at all" = 0 to "extremely" = 5. This scale has been extensively used and has a normative database consisting of over 18,000 persons. Group specific normative data is provided for males and females as well as for inpatients and non-patients.
Internal consistency reliability was evaluated for each of the nine sub-scaled using

Chronbachs alpha. In adult samples ranges were from .71 (Psychoticism, in a follow-up sample) to .92 (Depression, in a termination sample). Test-retest reliability was established in a non-clinical group of adults (n = 60) who were tested one to two weeks apart. Reliability coefficients ranged from .42 (Anxiety) to .88 (Somatization). Statements on the SA-45 were derived from the Symptom Checklist-90 (SCL-90) and were designed to maintain the symptom domain integrity. When compared using adult and adolescent inpatient samples the correlations on domains were .95 or higher with the exception of Psychoticism (correlation = .88-.90) indicating good convergent validity.

APPENDIX F

PHYSICAL WORKPLACE VIOLENCE

Please Note: Physical violence refers to the use of physical force against another person or group, that results in physical harm, sexual or psychological harm. It can include beating, kicking, slapping, stabbing, shooting, pushing, biting, and/or pinching, among others.

PV 1 In the last 12 months have you been physically attacked in the workplace?
☐ Yes…Please answer questions 1.1 – 1.13
☐ No…If NO, please go to question PV 2, next page

1.1 If yes think of the last time that you were physically attacked in your place of work. How would you describe this incident?
☐ Physical violence without a weapon ☐ Physical violence with a weapon

1.2 Do you consider this to be a typical incident of violence in your workplace?
☐ Yes ☐ No

1.3 Who attacked you?
☐ Patient/client ☐ Relative of patient/client
☐ Staff member ☐ Management/supervisor
☐ External colleague/worker ☐ General public
☐ Other
If the abuser was a staff member, what was their employment position (e.g. nurse, physician)?_____

1.4 Where did the incident take place?
☐ Inside health institution or facility ☐ At patient's/client's home
☐ Outside (on the way to work / health visit / home

1.6 How did you respond to the incident? *Please tick all relevant boxes*
☐ Took no action ☐ Reported to a senior staff member
☐ Told friends/family ☐ Sought help from union
☐ Told a colleague ☐ Completed a compensation claim
☐ Told person to stop ☐ Completed incident/accident form
☐ Tried to defend myself physically ☐ Other _____

1.7 Do you think that the incident could have been prevented?
☐ Yes ☐ No

1.8 Were you injured as a result of the incident?
☐ Yes ☐ No
If NO please go to question 1.10

1.8.1 If YES did you require formal treatment for the injuries?
☐ Yes ☐ No

1.9 Did you have to take time off from work after being attacked?
☐ Yes ☐ No
If NO please go to question 1.10

1.9.1 If YES for how long?
☐ 1-3 days ☐ One week ☐ 2-3 weeks
☐ 1 month ☐ 2-6 months ☐ more than 6 months

1.10 Was any action taken to investigate the cause of the incident?
☐ Yes ☐ No ☐ Don't know
If NO or DON'T KNOW please go to question 1.11

1.10.1 If YES by whom?
☐ Management / employer ☐ Union
☐ Association ☐ Police
☐ Other, please specify_____

1.10.2 What were the consequences for the attacker?
☐ None ☐ Verbal warning issued ☐ Care discontinued
☐ Reported to police ☐ Aggressor prosecuted ☐ Don't know
☐ Other _____

1.11 Did your employer or supervisor offer to provide you with:
☐ Counseling
☐ Opportunity to speak about it / report it
☐ Other support
☐ None of the above

1.12 How satisfied were you with the way the incident was handled?
(*Please rate: 1 = very dissatisfied, 5 = very satisfied)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

1.13 If you did not report or tell about the incident to others, why not?
Please tick every relevant box
☐ It was not important ☐ Felt ashamed
☐ Felt guilty ☐ Did not know who to report to
☐ Afraid of negative consequences
☐ Felt it would be useless
☐ Other, please specify _____

PV 2 In the last 12 months, have you witnessed incidents of physical violence in your workplace?
☐ Yes ☐ No
If NO, please go to question PV 3

2.1 If YES, how often has this occurred in the last 12 months?
☐ Once ☐ 2-4 times ☐ 5-10 times
☐ Several times a month ☐ About once a week ☐ Daily

PV 3 Have you reported an incident of workplace violence in the last 12 months? (witnessed or experienced)
☐ Yes ☐ No
If NO please go to section: PSYCHOLOGICAL VIOLENCE, next page

3.1 If YES, have you been disciplined for reporting an incident of workplace violence?
☐ Yes ☐ No

PSYCHOLOGICAL WORKPLACE VIOLENCE (EMOTIONAL ABUSE)

Please note: Psychological violence is defined as; Intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral, or social development. Psychological violence includes verbal abuse, bullying / mobbing, harassment, and threats. These terms are explained in the glossary.

For the purposes of this study two forms of psychological violence, verbal abuse, and mobbing / bullying will be addressed separately with the same questions in the next two sections. This is important for getting a detailed understanding of the workplace violence you experienced. Please answer at least the first question of each section. In case of a "NO" answer (indicating that you have not experienced verbal abuse or mobbing / bullying) you will not be required to complete the remainder of that particular section.

VERBAL ABUSE

VA 1 In the last 12 months have you been verbally abused in the workplace?
☐ Yes…Please answer the following questions
☐ No…If NO, please go to the section on bullying and mobbing

VA 2 How often have you been verbally abused in the last 12 months?
☐ All the time ☐ Sometimes ☐ Once

VA 3 Please think of the last time that you were verbally abused in your place of work. Who verbally abused you?
☐ Patient/client ☐ Relative of patient/client
☐ Staff member ☐ Management/supervisor
☐ External colleague/worker ☐ General public
☐ Other
If the abuser was a staff member, what was their employment position (e.g. nurse, physician)?_____

VA 4 Do you consider this to be a typical incident of verbal abuse in your workplace?
☐ Yes ☐ No

VA 5 Where did the verbal abuse take place?
☐ Inside health institution or facility ☐ At patient's/client's home
☐ Outside (on the way to work / health visit / home ☐ Other _____

☐ VA 6 How did you respond to the verbal abuse? *Please tick all relevant boxes*
☐ Took no action ☐ Reported to a senior staff member
☐ Told friends/family ☐ Sought help from union
☐ Told a colleague ☐ Completed a compensation claim
☐ Told person to stop ☐ Completed incident/accident form
☐ Other _____

VA 7 Do you think that the incident could have been prevented?
☐ Yes ☐ No

VA 8 Was any action taken to investigate the cause of the verbal abuse?
☐ Yes ☐ No ☐ Don't know
If NO or DON'T KNOW please go to question VA 9

8.1 If YES by whom?

☐ Management / employer ☐ Union
☐ Association ☐ Police
☐ Other, please specify_____

8.2 What were the consequences for the abuser?

☐ Abuser prosecuted internal ☐ Abuser prosecuted external
☐ Don't know ☐ None
☐ Other _____

VA 9 Did your employer or supervisor offer to provide you with:

☐ Counseling
☐ Opportunity to speak about it / report it
☐ Other support
☐ None of the above

VA 10 How satisfied were you with the way the incident was handled?
(*Please rate: 1 = very dissatisfied, 5 = very satisfied)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

VA 11 If you did not report or tell about the incident to others, why not?
Please tick every relevant box

☐ It was not important ☐ Felt ashamed
☐ Felt guilty ☐ Did not know who to report to
☐ Afraid of negative consequences
☐ Felt it would be useless
☐ Other, please specify _____

BULLYING / MOBBING

BM 1 In the last 12 months have you been bullied / mobbed in your workplace?

☐ Yes…Please answer the following questions
☐ No

BM 2 How often have you been bullied / mobbed in the last 12 months?

☐ All the time ☐ Sometimes ☐ Once

BM 3 Please think of the last time that you were bullied / mobbed in your place of work. Who bullied / mobbed you?

☐ Patient/client ☐ Relative of patient/client
☐ Staff member ☐ Management/supervisor
☐ External colleague/worker ☐ General public
☐ Other

If the abuser was a staff member, what was their employment position (e.g. nurse, physician)?_____

BM 4 Do you consider this to be a typical incident of bullying / mobbing in your workplace?

☐ Yes ☐ No

BM 5 Where did the bullying / mobbing take place?

☐ Inside health institution or facility
☐ Outside (on the way to work / health visit / home
☐ At patient's/client's home
☐ Other _____

BM 6 How did you respond to the bullying / mobbing? *Please tick all relevant boxes*

☐ Took no action
☐ Told friends/family
☐ Told a colleague
☐ Told person to stop
☐ Other _____
☐ Reported to a senior staff member
☐ Sought help from union
☐ Completed a compensation claim
☐ Completed incident/accident form

BM 7 Do you think that the incident could have been prevented?

☐ Yes ☐ No

BM 8 Was any action taken to investigate the cause of the bullying / mobbing?

☐ Yes ☐ No ☐ Don't know

If NO or DON'T KNOW please go to question BM 9

8.1 If YES by whom?

☐ Management / employer
☐ Association
☐ Other, please specify_____
☐ Union
☐ Police

8.2 What were the consequences for the abuser?

☐ Abuser prosecuted internal
☐ Don't know
☐ Other _____
☐ Abuser prosecuted external
☐ None

BM 9 Did your employer or supervisor offer to provide you with:

☐ Counseling
☐ Opportunity to speak about it / report it
☐ Other support
☐ None of the above

BM 10 How satisfied were you with the way the incident was handled?
(*Please rate: 1 = very dissatisfied, 5 = very satisfied)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

BM 11 If you did not report or tell about the incident to others, why not?
Please tick every relevant box

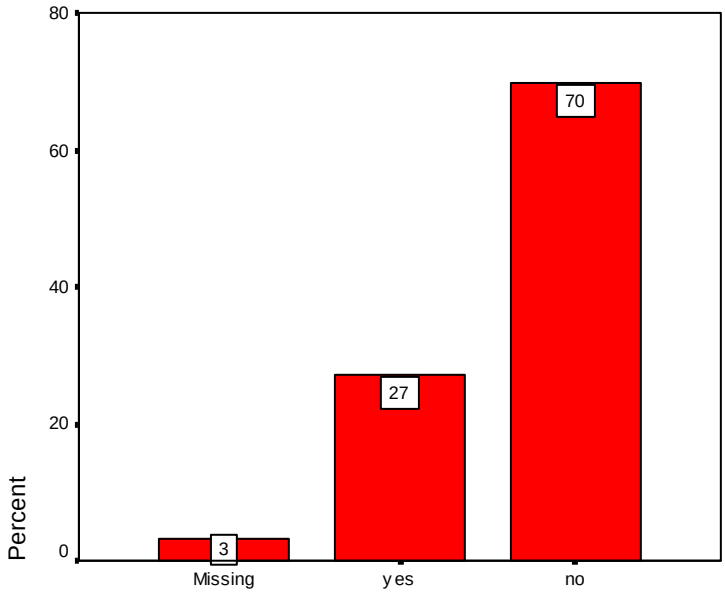
☐ It was not important
☐ Felt guilty
☐ Afraid of negative consequences
☐ Felt it would be useless
☐ Other, please specify _____
☐ Felt ashamed
☐ Did not know who to report to

PLEASE ENSURE THAT YOU HAVE COMPLETED BOTH SIDES OF THE FIRST TWO PAGES OF THIS DOCUMENT FOR A TOTAL OF 5 PAGES

APPENDIX G
BAR CHARTS I THROUGH XXXI FOR PHYSICAL VIOLENCE, VERBAL ABUSE & BULLYING / MOBBING

Physical Abuse

Chart I
In the last 12 months have you been physically attacked in your workplace?



The following graphs on physical abuse include answers from only those who experienced physical abuse.

Chart II
Do you consider this to be a typical incident of violence in your workplace?

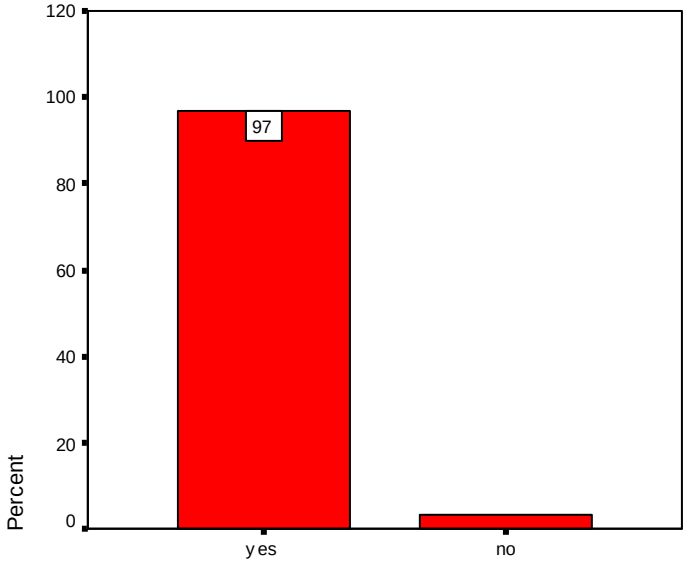


Chart III
Who attacked you?

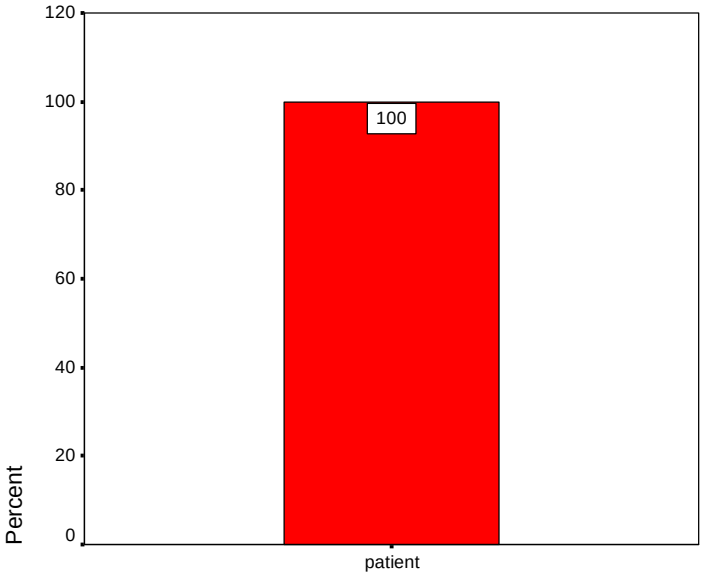


Chart IV
How did you respond to the incident?

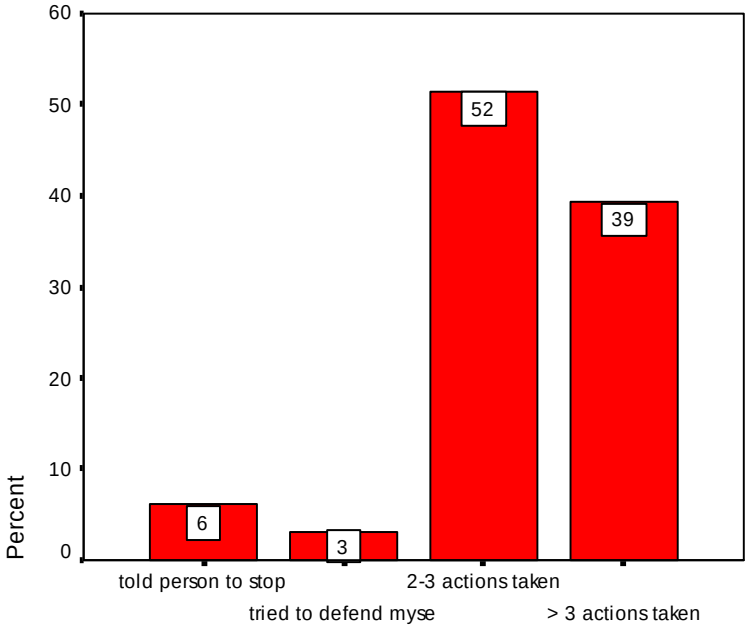


Chart V
Do you think that the incident could have been prevented?

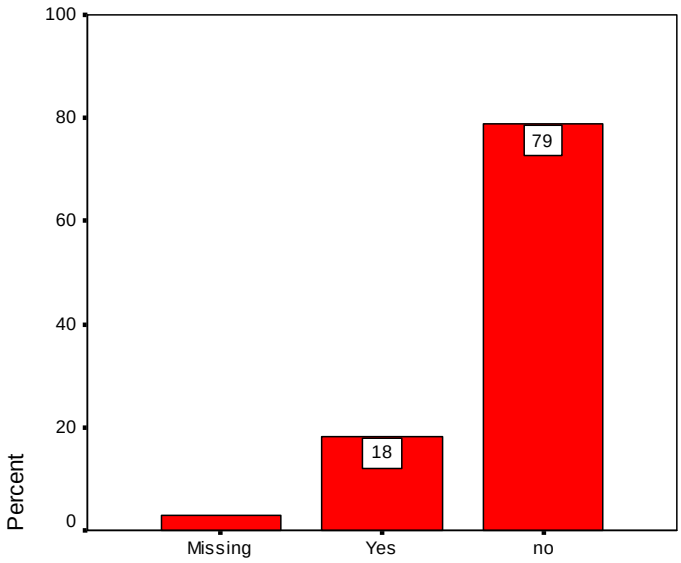


Chart VI
Was any action taken to investigate the causes of the incident?

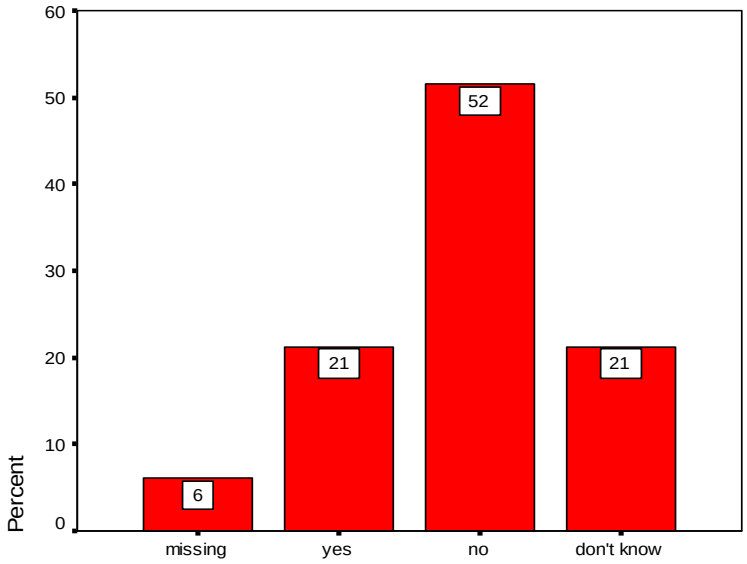


Chart VII
What were the consequences for the attacker?

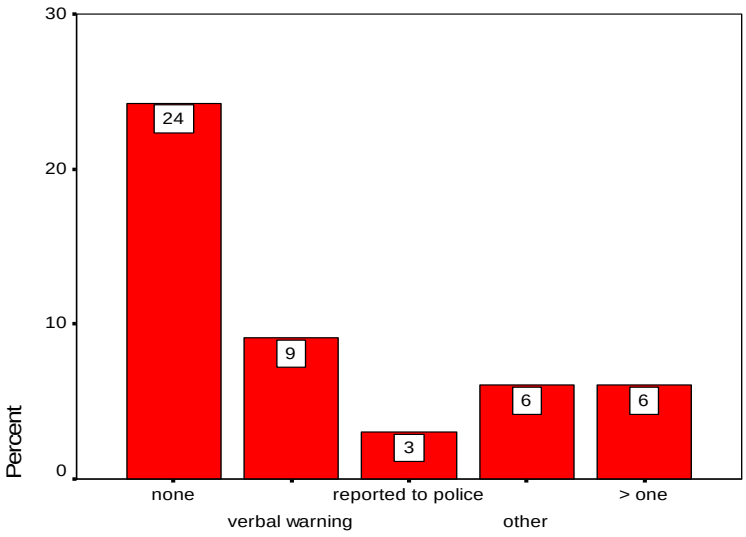


Chart VIII
How satisfied are you with the manner in which the incident was handled?

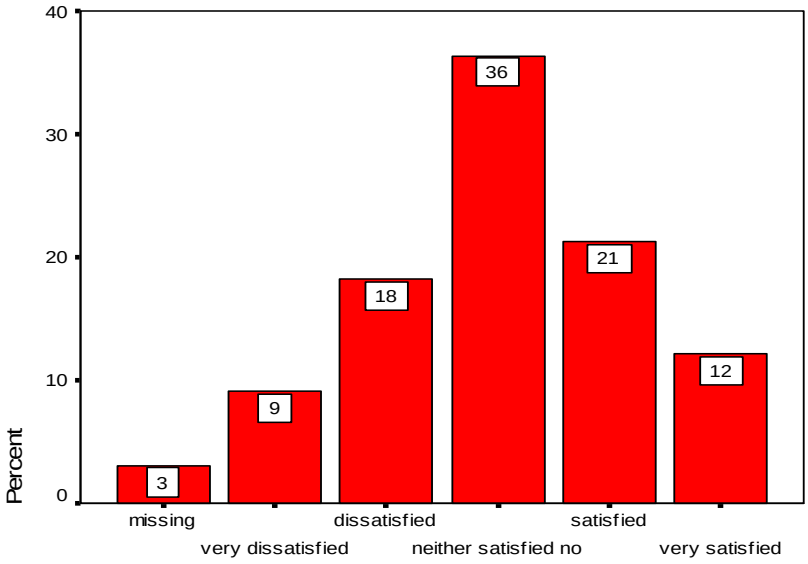


Chart IX
If you did not report the incident to others, why not?

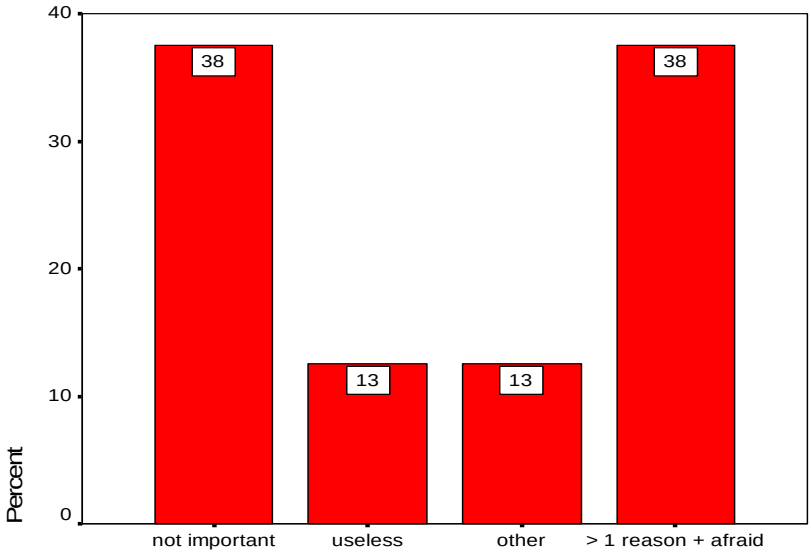
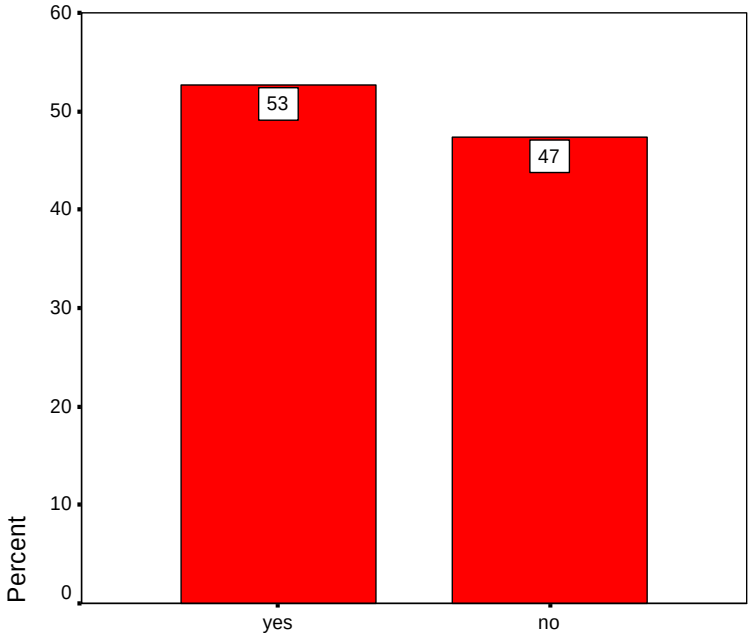
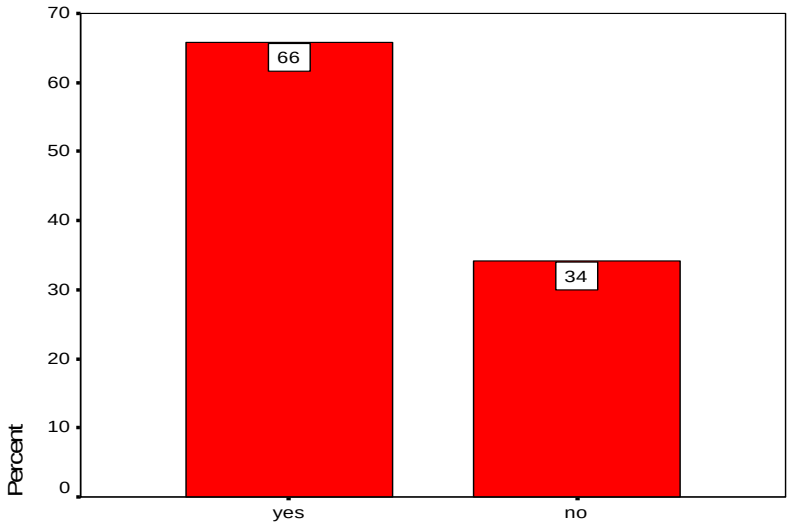


Chart X
In the last 12 months, have you witnessed incidents of physical violence in your workplace?



Verbal Abuse

Chart XI
In the last 12 months, have you been verbally abused in your workplace?



The following graphs on verbal abuse include answers from only those who experienced verbal abuse.

Chart XII
How often have you been verbally abused in the last 12 months?

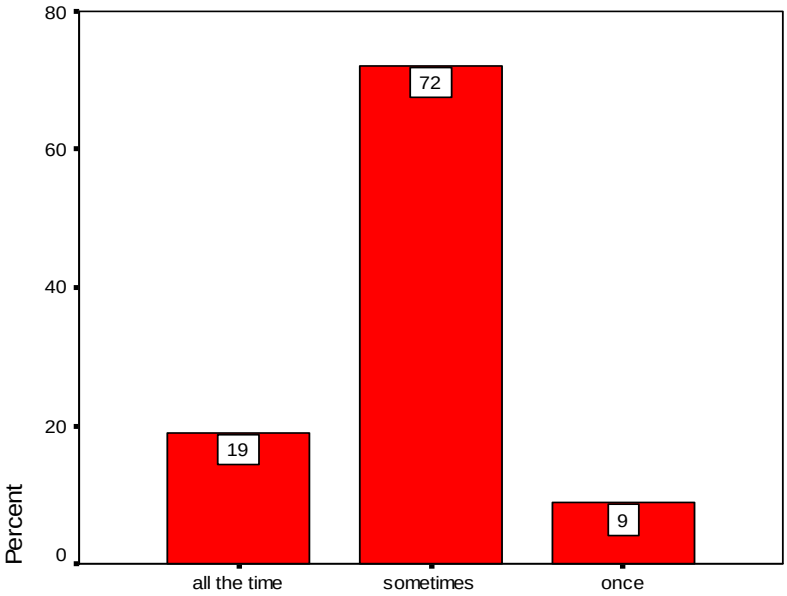


Chart XIII
Was management involved in the verbal abuse?

Chart XIV
Do you consider this to be a typical incident of verbal abuse in your workplace?

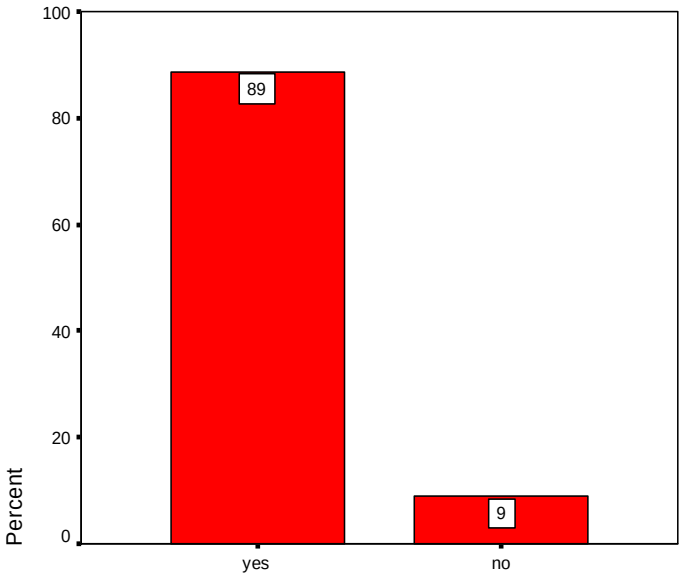


Chart XV
How did you respond to the verbal abuse?

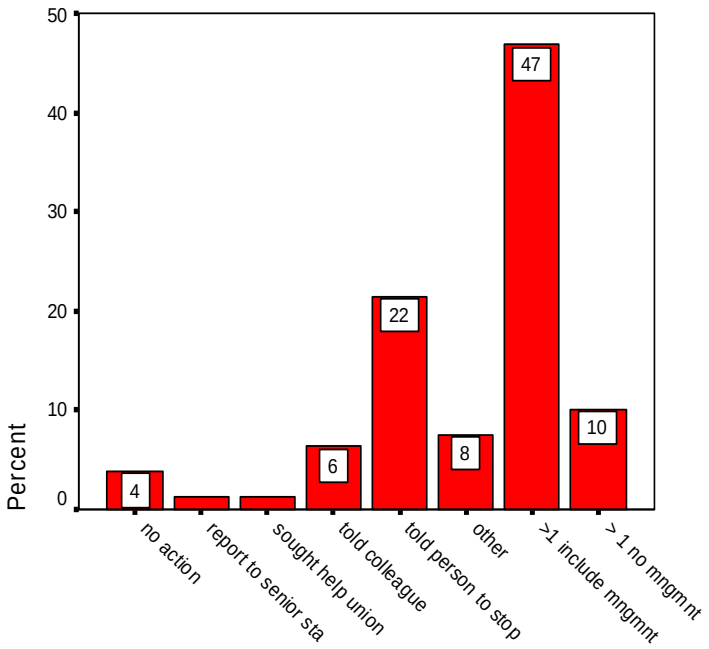


Chart XVI
Do you think the incident could have been prevented?

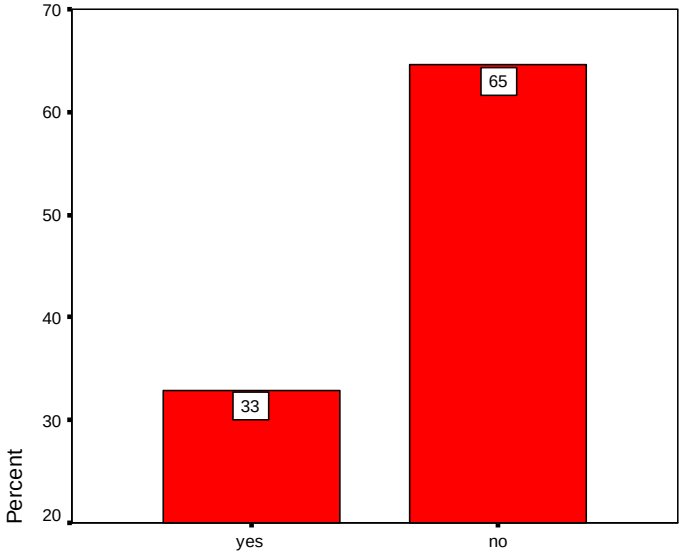


Chart XVII
Was any action taken to investigate the verbal abuse?

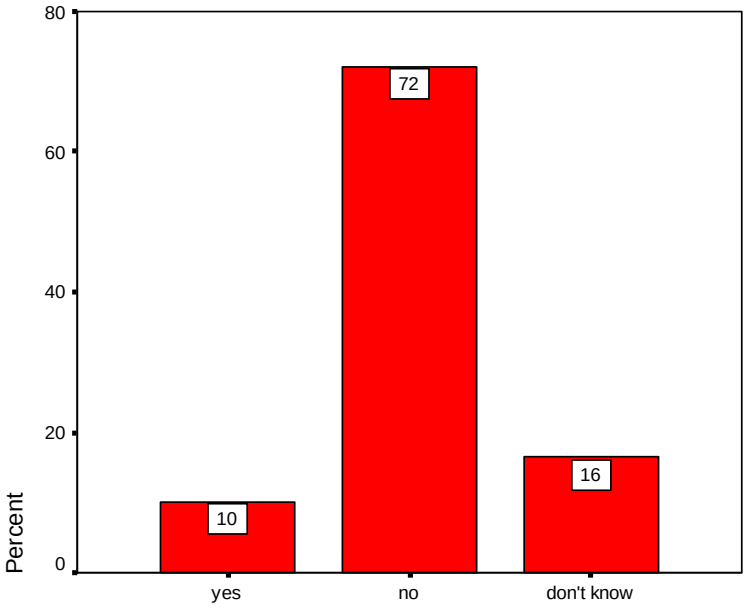


Chart XVIII
How satisfied are you with the manner in which the incident was handled?

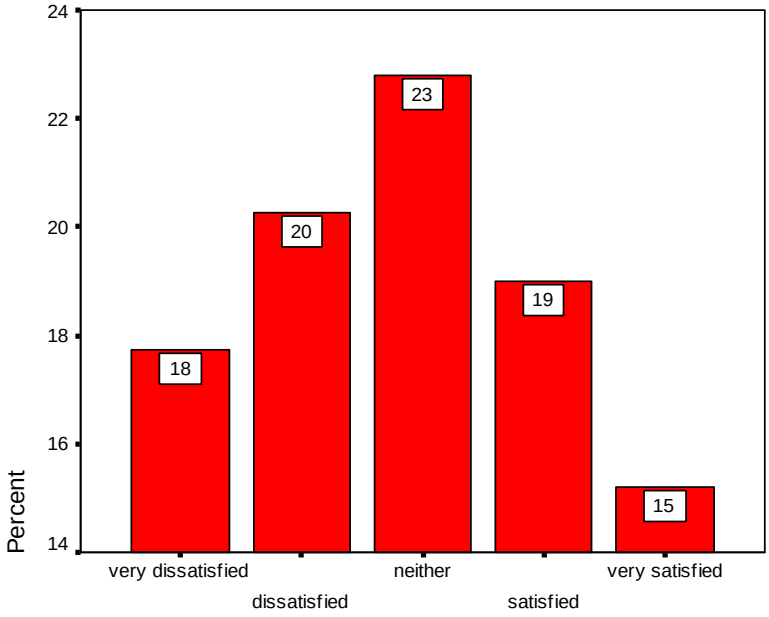
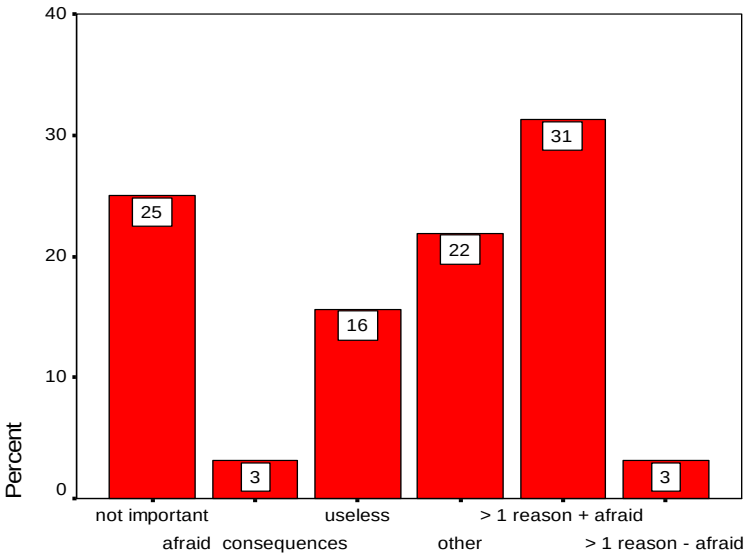
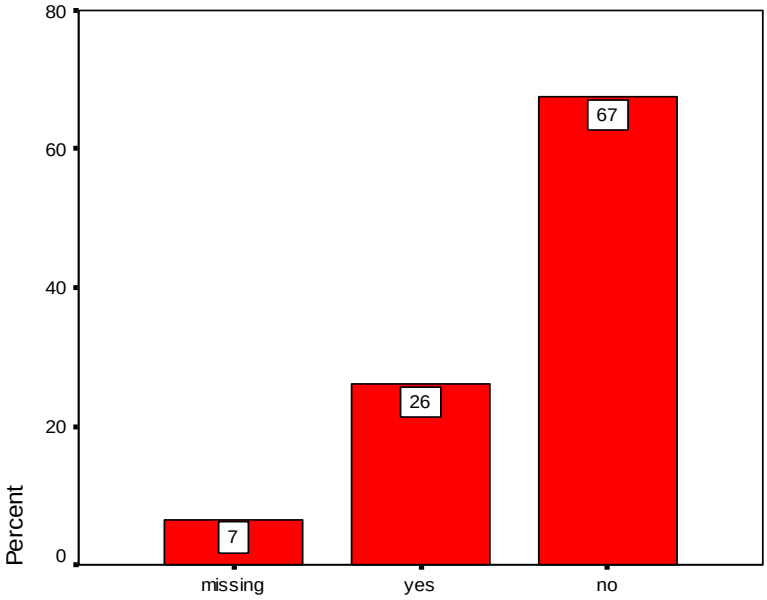


Chart XIX
If you did not report the incident to others, why not?



Bullying/Mobbing

Chart XX
In the last 12 months, have you been bullied/mobbed in your workplace?



The following graphs on bullying include answers from only those who experienced bullying.

Chart XXI
How often have you been bullied/mobbed in the last 12 months?

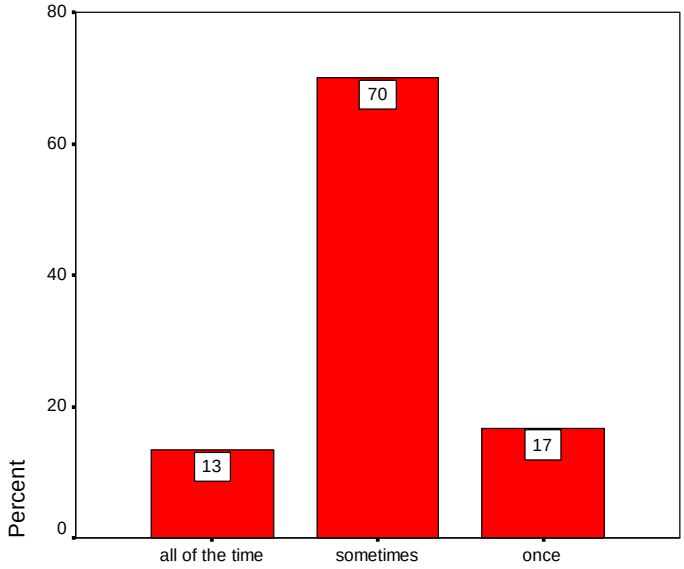


Chart XXII
Please think of the last time you were bullied/mobbed in your place of work. Who bullied/mobbed you?

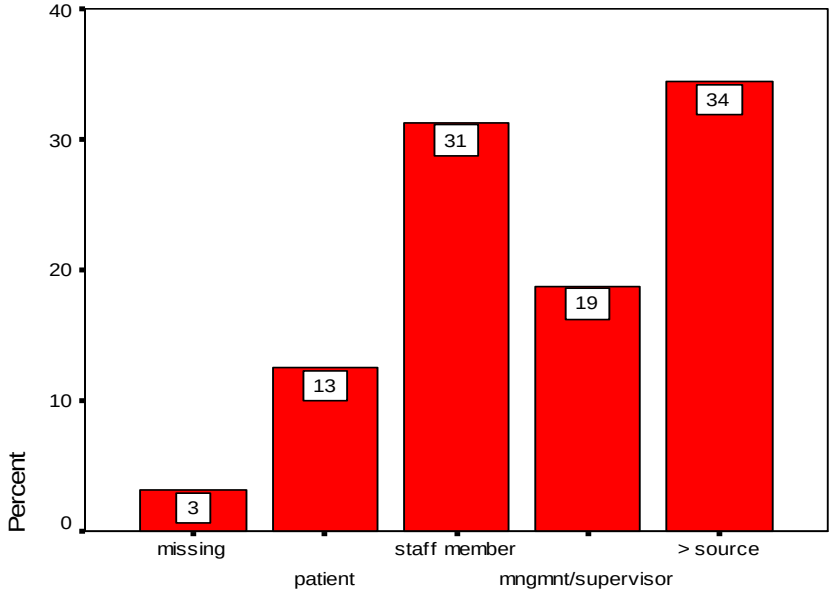


Chart XXIII
Do you consider this to be a typical incident of bullying/mobbing in your workplace?

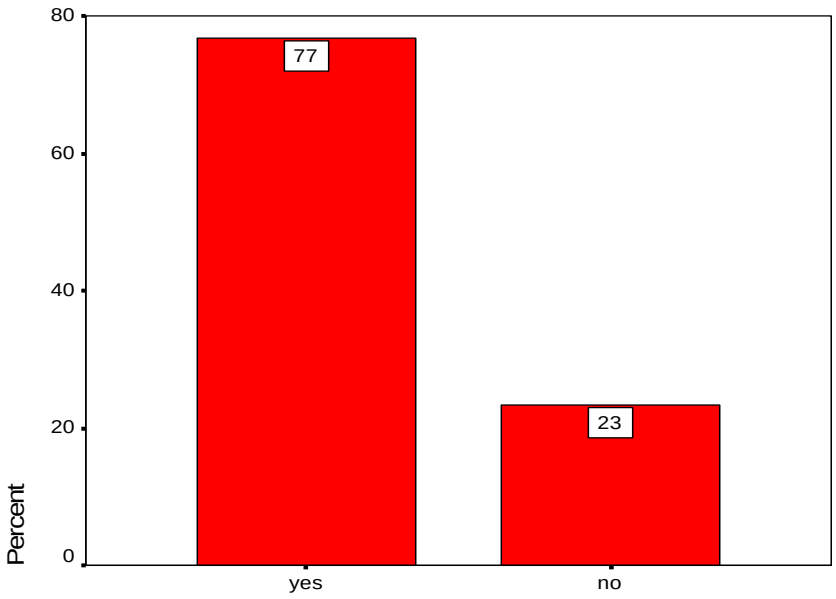


Chart XXIV
Was the bullying reported to management?

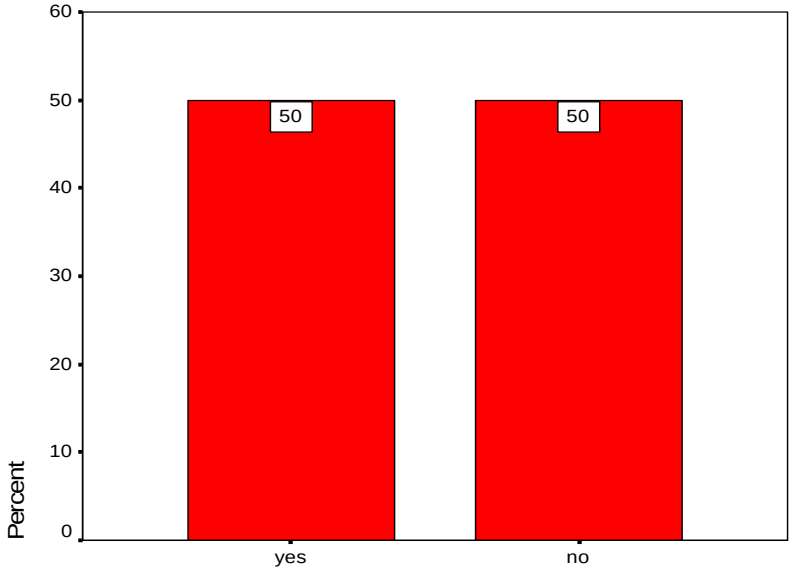


Chart XXV
Do you think the incident could have been prevented?

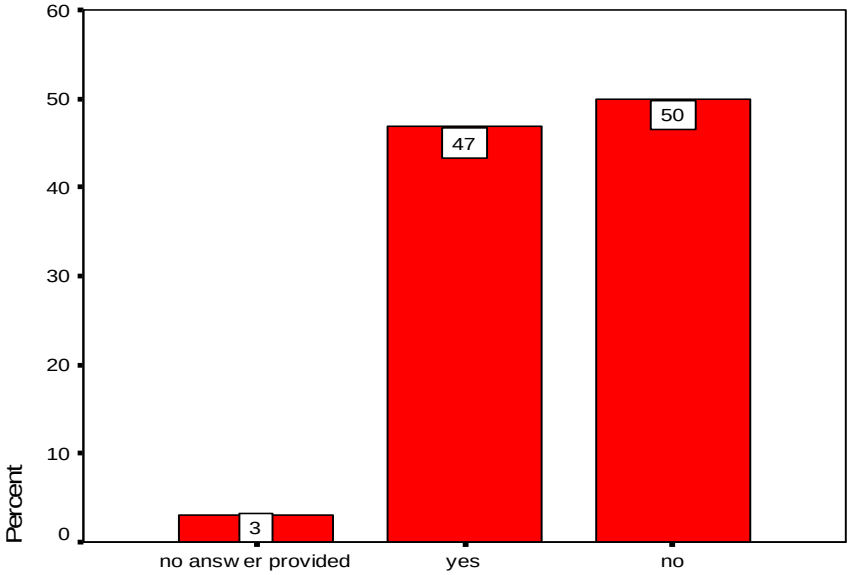


Chart XXVI
Was any action taken to investigate the causes of the bullying/mobbing?

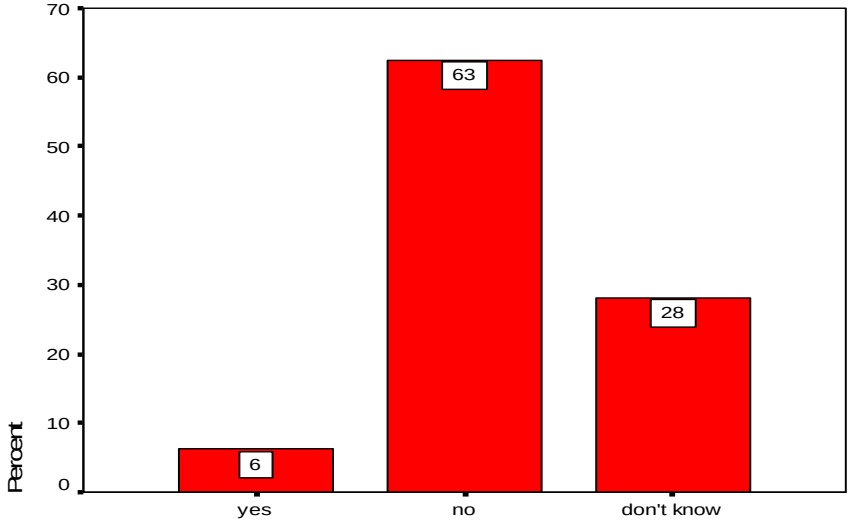


Chart XXVII
How satisfied are you with the manner in which the incident was handled?

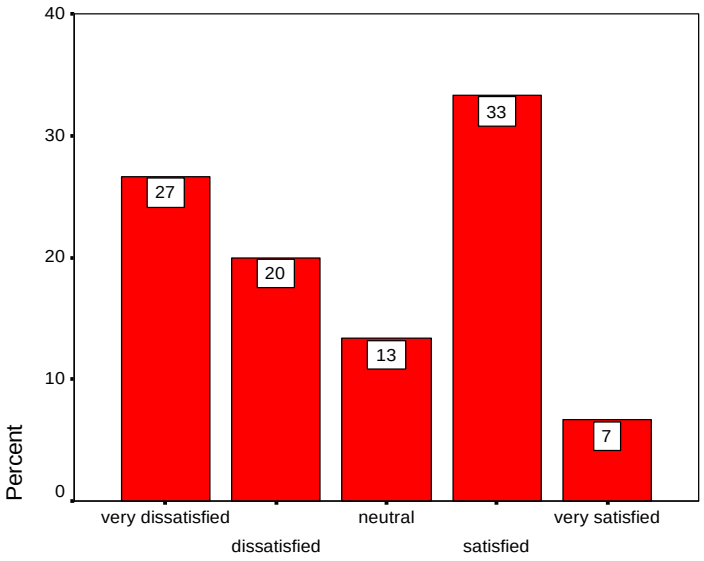


Chart XXVIII
If you did not report the bullying/mobbing incident to others, why not?

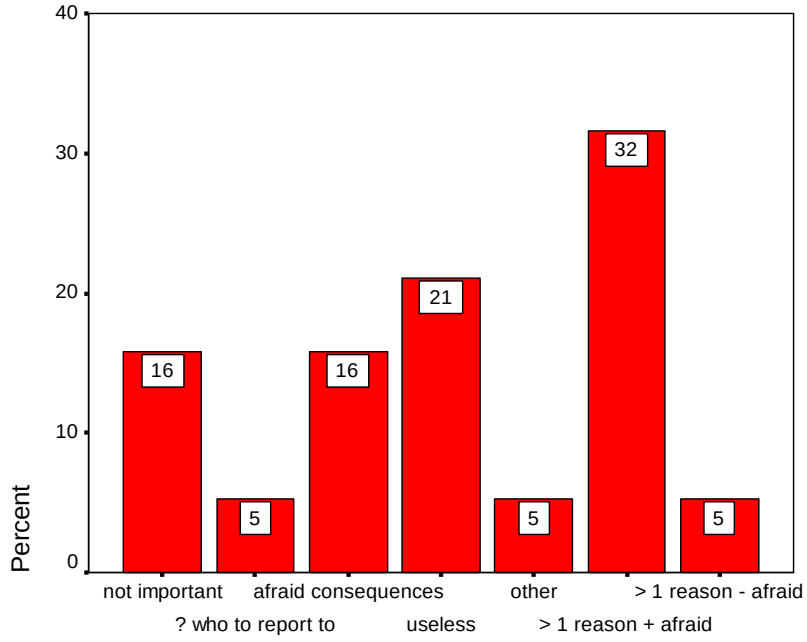


Chart XXIX:
Percentage of Physical Assaults Identified as Reported to Management

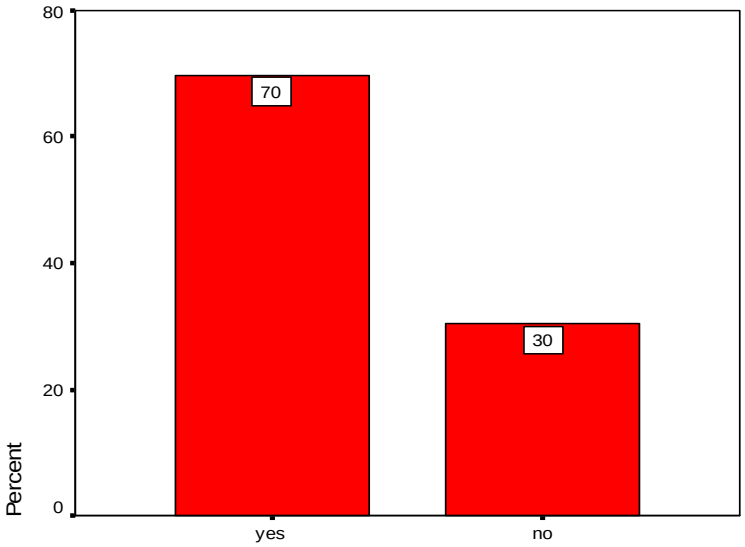


Chart XXX
Percentage of Verbal Abuse Identified as Reported to Management

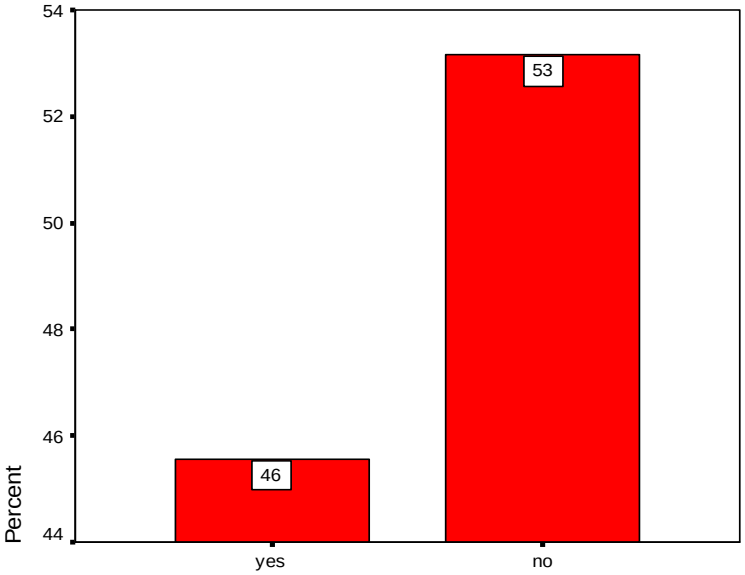


Chart XXXI:
Percentage of Bullying/Mobbing Identified as Reported to Management