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EDITORIAL

Workplace Violence in the Health Care Facility

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INTRODUCTION

In different countries the meaning of workplace violence is embedded in different socio-political realities.

The biggest problem at all levels of analysis is the lack of a consistent definition of workplace violence.

In terms of both the scope and consequences of workplace violence, a broad rather than a restrictive definition is needed, the World Health Organization (WHO) defined workplace violence as "The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury [1].

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A conceptual model:

The existing literature for conceptual models on workplace violence includes three levels of factors individual organizational and societal [2-6].

A. Individual factors:

1. Worker characteristics

Previous studies reported that males have increased risk of work place violence [7] and a majority of victims were practical nurses with special training in mental health or psychiatry [8].

2. Perpetrator characteristics

The factors include demographic (male, age under 45 years, low socio-economic status, low level of education, non-white race [9], psychological and/or behavioral disorders [10], and personality factors e.g., negative affectivity.

Type A behavior, hostile attribution style, locus of control [2].

B. Interaction factors:

It reflects the tendency to interpret the actions of others in a negative or threatening manner.

This variable is likely important to both workers and perpetrators as they attempt to interpret the actions of the other; misattributions of intent could lead to confrontation.

C. Organizational factors:

Hot temperatures, high humidity, extreme cold, poor lighting and air quality, high noise levels, and crowding all have been linked to increased levels of human aggression [5].

There was a widespread acknowledgment of the importance of safety personnel, especially well-trained personnel as a deterrent.

The nurses also believed that understaffing placed them at increased risk for violence, partly because it increased patient wait times, and partly because it left them alone with patients [11].Low workgroup harmony, low supervisor support, a late-night work schedule, and having professional status were associated with increased risk for having been personally threatened at work [12].

Increasing diversity within the workplace, employee monitoring, changes in management, pay cuts or freezes, and use of part-time help were all associated with having experienced aggression in the workplace [13].

D. Community/neighborhood factors:

Community factors such as the level of violent crime, illegal drug use, and gang activity can affect both the types of patients that are treated and the problems that they present [11].

Community factors such as high poverty rates and high percentages of minority cultures may have strained relationships with healthcare facilities that are staffed by primarily majority cultures.

Low levels of community resources may affect the quality of the care received through the inability of the healthcare system to provide adequately for all who are in need. This, in turn, may increase levels of distrust and suspicion [11].

E. Societal factors:

Some of the factors that have been noted include increased workplace diversity [14-11-6], changing norms surrounding the acceptance of aggression [10-5], downsizing, global competition, constantly changing technology [14], financial stress due to lack of the means to maintain a chosen lifestyle, shifting family structures, and social isolation [10].

Currently, many quantitative research methods have been done in the field of violence research.

We recommend researchers who have an interest in workplace violence to undertake qualitative research methods and this will increase our understanding of the various forms of workplace violence and will help to know how perceptions of violence and their antecedents may vary between individuals.

The other research gap was the impacts of workplace violence especially on a victim’s personal life and financial situation, coping strategies, costs of absenteeism/time away from work, etc.

REFERENCES

1. WHO. *Violence: a public health priority*. Geneva: World Health Organization, 1995.
2. Beugre CD. Understanding organizational insider-perpetuated workplace aggression: An integrative model. In S.B. Bacharach, P.A. Bamberger & W.J. Sonnenstuhl (eds.) Research in the Sociology of organizations. Deviance in and of organizations, 1998. pp. 163-196. Stamford CT: JAI Press, Inc.
3. Folger R, Baron RA. Violence and hostility at work: A model of reactions to perceived injustice. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. American Psychological Association, Washington, DC, USA, 1996; pp 51-85.
4. Levin PF, Hewit, JB, Misner ST. Insights of nurses about assault in hospital-based emergency departments. Image. *J Nurs Scholarsh*. 1998. 30: 249-254.
5. Neuman JH, Baron RA. Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *J Manag*. 1998; 24: 391-419.
6. Paul RJ, Townsend JB. Violence in the workplace – a review with recommendations. *Empl Responsib Rights J*. 1998; 11: 1-13.
7. Schulte JM, Nolt BJ, Williams RL, Spinks CL, Hellsten JJ. Violence and threats of violence experienced by public health field workers. *Am J Public Health*. 1998; 280: 439-442.
8. Arnetz JE. The Violent Incident Form (VIF): A practical instrument for the registration of violent incidents in the health care workplace. *Work Stress.* 1998; 12: 17-28.
9. Mossman D. Violence prediction, workplace violence, and the mental health expert. *Consult Psychol J Pract Res.* 1995; 47: 223-233.
10. Kelleher MD. *Profiling the lethal employee*. Praeger Publishers, Westport, CT, USA, 1997.
11. Levin PF, Hewitt JB, Misner ST. Insights of nurses about assault in hospital-based emergency departments. Image. *J Nur Scholarsh*. 1998; 30: 249-254.
12. Cole LL, Grubb PL, Sauter SL, Swanson NG, Lawless P. Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scand J Work Environ Health*. 1997; 23: 450-457.
13. Baron RA, Neuman JH. Workplace violence and workplace aggression: Evidence on their relative frequency and potential causes. *Aggress Behav*, 1996; 22: 161-173.
14. McClure LF. Origins and incidence of workplace violence in North America. In T.P. Gullotta and S.J. McElhaney (eds.) Violence in homes and communities: *Prevention, intervention, and treatment.* Sage Publications, Thousand Oaks, CA, USA, 1999; pp 71-99.

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