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Résumé

Les cas de violence au travail rapportés par les infirmières canadiennes

Lucie Lemelin, Jean-Pierre Bonin et André Duquette

Cette étude avait pour but de déterminer la prévalence, les causes et les formes de la violence au travail, en prenant appui sur les cas rapportés par des infirmières évoluant dans un milieu de soins actifs, dans la province de Québec, au Canada. Le système de santé québécois connaît actuellement une pénurie d'infirmières qualifiées, ce qui a donné lieu à un environnement de travail oppressif, marqué par la violence envers les infirmières. L'étude, de nature descriptive, se fonde sur un échantillon de 181 infirmières (sur une possibilité de 300). Les données ont été recueillies en 2003 à l'aide d'une traduction française du questionnaire Workplace Violence Events. Elles montrent que 86,5 % des infirmières ont été victimes d'un incident violent à plus d'une reprise. Ces actes avaient un caractère physique (10,6 %), psychologique (86,4 %) ou sexuel (30,7 %); ils ont été infligés par un collègue (65,9 %), un supérieur (59,6 %) ou un médecin (59,1 %). Les infirmières devraient être sensibilisées à la prévalence de la violence au travail. Il faudrait aussi instaurer de toute urgence des mesures préventives pour veiller au bien-être de tous les membres de la profession.

Mots clés : oppression, violence, infirmières, milieu de travail

Workplace Violence Reported by Canadian Nurses

Lucie Lemelin, Jean-Pierre Bonin, and André Duquette

The purpose of this study was to determine the prevalence, origins, and forms of workplace violence reported by nurses working in acute-care settings in the Canadian province of Quebec. The Quebec health-care system is currently undergoing a shortage of qualified nurses that has resulted in an oppressive work environment marked by violence towards nurses. A descriptive study design was used with a sample of 181 nurses (out of a possible 300). The data, collected in 2003 using a French translation of the Workplace Violence Events Questionnaire, show that 86.5% of the nurses were victims of violent incidents on more than 1 occasion. The nature of the abuse was physical (10.6%), psychological (86.4%), or sexual (30.7%), inflicted by a colleague (65.9%), a superior (59.6%), or a physician (59.1%). Nurses should be made aware of the prevalence of workplace violence. Preventive measures are urgently needed for the well-being of the nursing profession.

Keywords: oppression, violence, work safety (security), Freire, nurses, workplace, working conditions

Introduction

Several studies have identified work-related health problems in the nursing population, including physical trauma (Baumann et al., 2001; Bourbonnais & Mondor, 2001; Langerstrom, Hansson, & Hagberg, 1998) and resulting in increased absenteeism (Baumann et al., 2001; Bourbonnais & Mondor, 2001; Burke & Greenglass, 2001) and burnout (Duquette, Kérouac, Sandhu, & Beaudet, 1995; Healy & McKay, 1999). It has been shown that nurses are affected both psychologically and physically by their work and that they present more work-related health problems than other health professionals (Baumann et al., 2001). A direct link has been established between nurses' work environment and their work-related health problems (Baumann et al., 2001). The studies cited above have identified several structural and instrumental factors related to nurses' malaise, including the organization of work, workload, degree of professional autonomy, recognition of efforts made, and scheduling flexibility. Based on these results, nurse managers have attempted to reorganize nurses' work to achieve a more efficient distribution of the workload among nurses and other care providers and thus reduce the level of work-related health problems. However, work dissatisfaction has persisted (Bourbonnais, Brisson, Malenfant, & Vézina, 2005). This situa-

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tion can be explained by a difficult work environment resulting from budget cutbacks and the workplace disruptions of the 1990s (Baumann et al., 2001).

Some authors argue that workplace dissatisfaction can be explained by other elements, beyond the known structural and instrumental factors (Bent, 1993; Gordon Clifford, 1992; Kutlenios & Bowman, 1994; Roberts, 1997). The characteristics of oppression within the nursing profession include a rigid management hierarchy, with most power residing with doctors — a situation that can result in vertical violence (Goertz Koerner, 1994). The abuse inflicted on nurses is believed to result in unexpressed anger or passive-aggressive behaviour that is manifested in depression, workplace dissatisfaction, and violence-tinged behaviour. After repeated exposure to abuse and domination, members of an oppressed group may use violence in an attempt to dominate their colleagues, resulting in horizontal violence (Roberts, 1997). Several studies on workplace violence have concluded that women are the victims of violence more often than men (Arnetz, Arnetz, & Söderman, 1998; Björqkvist, Österman, & Hjelt-Bäck, 1994; Spratlen, 1995). However, few studies have measured the extent of internal violence, or violence that is inflicted by members of the same organization or profession, which in the case of nursing is composed mostly of women.

Guided by Freire's (1971) theoretical framework, this study was intended to determine the extent of internal violence experienced by nurses. This framework offers a new perspective, in that it permits a description of the origins and forms of workplace violence. This approach also promotes general awareness of the problem, allowing those involved to reflect on their situation.

Freire's (1971) model uses a sociological approach to both analyze the interactive and oppressive forces behind violence and raise awareness about these factors among the general public. For Freire, violence is defined by domination and oppression, occurs when any group or person takes advantage of another group or person and prevents them from asserting themselves, and can be physical, emotional, psychological, or economic. While Freire's framework has been used previously (e.g., Roberts, 1997, 2000), this study is the first of its type to use it.

Background

Workplace Violence

Two different types of aggressors can perpetrate violence in the workplace. The first is the external type, which refers to clients or people outside of the organization. The second is the internal type, or those working within the organization. The data available in Canada come

almost exclusively from investigations commissioned by labour organizations, rather than from independent scientific studies (Centrale de l'Enseignement du Québec, 1998; Damant, Dompierre, & Jauvin, 1997; Pizzino, 1994; Quebec Federation of Nurses, 1995).

In an exploratory study, Damant et al. (1997) found that 57% of the violent incidents reported by interviewees were perpetrated by an internal aggressor. Arnetz et al. (1998) state that 31% of their respondents reported violence in the workplace and that nurses experienced more violence than other respondents. Braun, Christle, Walker, and Tiwanak (1991) compared the verbal abuse experienced by nurses with that directed towards paramedics. They found that 96% of nurses suffered verbal abuse, compared with only 69% of paramedics.

In a quantitative study, Cox (1991) demonstrated that 82% of nurses experience verbal abuse. The Quebec Federation of Nurses (1995) conducted an inquiry into occupational violence experienced by nurses in Quebec. The results were compiled using a non-standardized questionnaire and reveal that 78% of nurses had suffered internal violence in the workplace. It appears that internal violence in the workplace is an integral part of the reality of the health-care system currently and that nurses are frequently exposed to it.

Vertical Violence

A hierarchical structure predisposes its members to use violence (Björqkvist et al., 1994; Keashly, Trott, & MacLean, 1994). In a study by Björkqvist et al. (1994), 55% of respondents who reported being victims of workplace violence identified their aggressor as someone in a position superior to their own. These results are comparable to those reported by Quine (1999), who found that 54% of the cases of intimidation in the workplace were caused by superiors and 34% by colleagues. Damant et al. (1997) estimate that 20% of workplace violence is perpetrated by superiors.

Certain factors appear to play a role in fostering violent behaviour. Leymann (1996) and Spratlen (1995) maintain that a rigid hierarchy, an authoritarian management style, and an uncertain leader are factors that may lead to violent behaviour in the workplace. Baron and Neuman (1998) found that superiors were responsible for 31% of reported violent acts. They claim that frustration with vertical violence is positively correlated with aggression towards others as well as hostility and sabotage behaviour. Unjust treatment by a superior can cause frustration, which may in turn lead to aggressive behaviour. Baron and Neuman also note that incidents of verbal abuse can lead to resentment; the incidents they report on mostly involved superiors (35%), colleagues (22%), and to a lesser extent doctors (7%). The literature does not specify a magnitude of

vertical violence in the workplace for nurses. However, studies with other groups of professionals have shown that vertical violence accounts for over 40% of internal violence in the workplace (Anderson, 2002; Baron & Neuman, 1998; Björqkvist et al., 1994; Boyd, 1995; Kutlenios & Bowman, 1994; Quine, 1999; Skilling, 1992).

Horizontal Violence

Horizontal violence is defined as hostility and aggressive behaviour perpetrated by one member of a group towards another. According to Hastie (2003), such violence is a phenomenon that is endemic to the work environment. Horizontal violence is rarely physical; it manifests through other hostile behaviours (Duffy, 1995; Freire, 1971) and is a symptom of the oppression and lack of power of certain groups in the workplace. A case study by Lee and Saeed (2001) supports the idea that nurses engage in horizontal violence as a result of the oppression inflicted upon them. Skilling (1992) defines horizontal violence, in the context of nursing, as conflicting relationships between nurses. The conflicts grow out of oppressed group strategies and are thought to originate in dissatisfaction and lack of power. The dissatisfaction results from the patriarchal medical system and the rigid hierarchy of nursing management. Wilson (2000) concludes that nurses who are victimized by a lack of control and power become frustrated, developing anger and defensiveness towards an environment that is hostile towards them.

Medical Violence

Uneven power distribution is the key element in explaining difficult relations between doctors and nurses (Manderino & Berkey, 1997). Aggressors gain power over others mostly through verbal abuse. Manderino and Berkey (1997) report that 90% of the nurses they interviewed said that they had been victims of verbal abuse inflicted by a doctor. These results are similar to those obtained by Cox (1991), who found that 78% of nurse respondents reported that the verbal abuse they experienced was inflicted by doctors. Braun et al. (1991), however, estimate a lower incidence of doctor-driven verbal abuse (28%). In a quantitative study, Diaz and McMillin (1991) found that 64% of surveyed nurses had been victims of verbal abuse inflicted by a doctor. It should be noted that the same study found that 30% of nurses were victims of abuse of a sexual nature, 5% received threats, and 2% suffered physical abuse.

An investigation led by the Quebec Federation of Nurses (1995) found that relationships between doctors and nurses were marked by contempt and abuse of power and that the dominating role of doctors confined nurses to a role of carrying out orders. Many of the studies that

have looked at workplace violence have identified three forms of abuse: physical, psychological, and sexual. However, few studies of internal violence in the workplace have specifically examined nurses. These few studies have nevertheless demonstrated that nurses are victims of workplace violence (Arnetz, Arnetz, & Patterson, 1996; Arnetz et al., 1998; Braun et al., 1991; Cox, 1991; Graydon, Kasta, & Khan, 1994).

The literature review revealed that workplace violence is indeed a reality and that it takes several forms, both horizontal and vertical. Several studies have attempted to describe different forms of violence, but few of these were carried out in Quebec and of those that were, some were commissioned by labour organizations or employed small samples (Lee & Saeed, 2001). This is the first study to describe internal workplace violence affecting Quebec nurses.

The Study

Aim

The aim of the study was to determine the prevalence, sources, and forms of occupational violence reported by Quebec nurses working in acute-care facilities. The specific research questions were: 1. *What is the prevalence of the horizontal violence perceived by nurses, whether physical, psychological, or sexual in nature?* 2. *What is the prevalence of the vertical violence perceived by nurses, whether physical, psychological, or sexual in nature?* 3. *What is the prevalence of the doctor-driven violence perceived by nurses, whether physical, psychological, or sexual in nature?* 4. *What are the sociodemographic factors (sex, age, years of nursing experience, education level, workplace type, work shift) associated with occupational violence inflicted on nurses?*

Design

A descriptive, self-report postal survey was administered to members of the Quebec Order of Nurses in April and May 2003.

Instrument

The survey used the Workplace Violence Events Questionnaire by Anderson (2002). Minor changes were made, as the survey was originally written in English (reliability = .84) but was administered in French. A back-translation method was used to ensure translation reliability (Vallerand, 1989). The reliability of the translated survey presented a Cronbach's alpha coefficient of .88 and the instrument was pretested with a group of six nurses. The translated instrument demonstrated good content validity. The pretest also showed that the survey could be completed within an acceptable time frame (approximately 30 minutes).

Participants

Quebec's total nurse population is approximately 20,000. The inclusion criteria were: (1) providing direct patient care in a hospital unit and membership in the Quebec Order of Nurses; (2) practising in a general or specialized health facility; (3) working part-time (approximately 15 hours per week) or full-time on day, evening, or night shift; and (4) understand French.

Data Collection

A random sample of 300 nurses was generated from the electronic database of the Quebec Order of Nurses. Using the program GPOWER (Erdfelder, Faul, & Buchner, 1996), we determined that 252 respondents were needed for a medium effect size (.25; alpha = .05; power = .95). Of the 300 nurses approached, 181 responded, for a response rate of 63.3% and an effect size of .30, which is considered moderate (Cohen, 1992).

Ethical Considerations

The study was approved by the research approval committee for the nursing faculty and the ethical research committee for health science studies at the Université de Montréal.

Data Analysis

The descriptive statistics, such as frequency distributions of discrete variables, as well as central tendency and variability of continuous variables, are presented below. The inferential statistics used were: *t* test for dichotomous variables, ANOVA for other sociodemographic variables, and Pearson correlation for continuous variables. All the statistical calculations were performed using on SPSS for Windows, Version 8.0, and the statistical tests were considered significant when $p = < 0.05$.

Results

Analysis of the sociodemographic variables showed that the average age of respondents was 32.63 years (ET = 10.18), 65.0% of respondents had less than 10 years of nursing experience, and 68.5% of respondents had college-level nursing education, which is similar to the rate found in the general population of nurses in Quebec.

Almost 87% of respondents reported being exposed to at least one of three forms of violence (physical, psychological, or sexual). The results show that 65.9% of respondents were victims of horizontal violence, while 59.6% had experienced vertical violence and 59.1% had been victims of violence inflicted by a doctor. These figures represent incidents that occurred more than once in the preceding 3 months.

Table 1 ***Frequency of Vertical Violence Inflicted by a Superior***

Number of Violent Incidents	Frequency	%
Physical (*n* = 180)		
0	175	97.2
1 to 4	5	2.8
Psychological (*n* = 181)		
0	74	40.9
1 to 3	54	29.8
4 to 20	53	29.3
Sexual (*n* = 179)		
0	149	83.2
1 to 3	27	15.1
4 to 6	3	1.7
Total[a] (*n* = 178)		
0	72	40.4
1 to 3	40	28.1
4 to 25	56	31.4

[a] The sum of physical, psychological (verbal), and sexual abuse inflicted by a superior.

Table 2 ***Frequency of Horizontal Violence Inflicted by a Co-worker***

Number of Violent Incidents	Frequency	%
Physical (*n* = 181)		
0	173	95.6
1 to 3	8	4.4
Psychological (*n* = 181)		
0	64	35.4
1 to 3	50	27.6
4 to 21	67	37.0
Sexual (*n* = 179)		
0	147	82.1
1 to 3	27	15.1
4 to 20	5	2.8
Total[a] (*n* = 176)		
0	61	34.1
1 to 3	50	27.9
4 to 29	70	39.8

[a] The sum of physical, psychological (verbal), and sexual abuse inflicted by a co-worker.

Table 3 ***Frequency of Violence Inflicted by a Doctor***

Number of Violent Incidents	Frequency	%
Physical (n = 181)		
0	174	96.1
1 to 3	7	3.9
Psychological (n = 177)		
0	76	42.9
1 to 3	54	30.5
4 to 15	47	26.6
Sexual (n = 180)		
0	150	83.3
1 to 3	27	15.0
4 to 12	3	1.7
Total[a] (n = 176)		
0	72	40.9
1 to 3	53	30.1
4 to 17	65	36.9

[a] The sum of physical, psychological (verbal), and sexual abuse inflicted by a doctor.

The results show that 86.4% of respondents had suffered psychological abuse, 10.6% physical abuse, and 30.7% abuse of a sexual nature.

Two independent variables, gender (r = –.17; p = .05) and education level (r = .16; p = .05), yielded weak but significant correlations with psychological violence inflicted by superiors, doctors, and colleagues (Pearson correlation). Women seemed to be exposed to psychological abuse more than men. It appears that, for men as well as for women, more advanced education resulted in less exposure to workplace violence. It was also found that, compared to older nurses, younger nurses were exposed to more physical abuse, as well as abuse of a sexual nature inflicted by colleagues. No correlations were found with any of the other sociodemographic variables.

Overall, significantly more women than men reported having experienced all types of violence combined. For psychological abuse, education level appeared to be the dominant variable, with three cases of psychological violence significantly associated with education level, namely being made to feel bad by a colleague (r = .18; p = .05), being ridiculed or humiliated by a colleague (r = .17; p = .05), and having a doctor slam a door during a disagreement (r = .18; p = .05).

The results of simple correlation show that psychological violence had a weak relationship with the nurses' amount of experience (r = –.13;

p = .05), with more experience being associated with less exposure to psychological violence. Physical violence, however, was linked to age (r = .13; p = .05). As for sources of abuse, violence inflicted by doctors was associated with age (r = –.15; p = .02) and education level (r = 0.13; p = .04). Younger nurses were more exposed to doctor-inflicted violence than older nurses. Finally, violence inflicted by colleagues was related to number of years of experience (r = –.12; p = .05). Less experienced nurses were more exposed to workplace violence.

Discussion

Extent of Workplace Violence

The extent of violence revealed in this study is greater than that found in previous studies. This finding may be partly explained by the fact that the respondents were approximately 10 years younger than the average Quebec nurse. Arnetz et al. (1998), Boyd (1995), Diaz and McMillin (1991), and Spratlen (1995) all note that younger nurses are at higher risk for violence. The number of years of nursing experience seems to be a determining factor as well, since more experienced nurses are older and thus less exposed to violence (Diaz & McMillin, 1991). Anderson (2002) and Graydon et al. (1994) attribute a lower prevalence of violence to better problem-solving abilities, which could be related to higher level of education.

Of the respondents, 86% had experienced more than one form of internal violence. In general, more incidents of violence were reported in this study than in other studies (Arnetz et al., 1998; Damant et al., 1997; Graydon et al., 1994). This could be related to the young age of the sample or to the dearth of resources available within the Quebec health-care network (Bourbonnais, Comeau, Vézina, & Dion, 1998), which suggests that rationing could serve to increase the incidence of workplace violence and place co-worker relations under stress. Future studies should analyze the organizational factors associated with internal workplace violence.

Forms of Violence

These results underscore the high level of psychological violence present in the workplace. Psychological violence was the form of abuse most frequently reported, which is consistent with the findings of Jauvin (1999). The incidence of psychological violence (86%) is similar to that reported in the literature (Braun et al., 1991; Cox, 1991; Quebec Federation of Nurses, 1995).

Of the respondents, 30.7% stated they had been victims of sexual abuse. The Quebec Federation of Nurses (1995) found that 44.8% of sur-

veyed nurses had been victims of sexual abuse at some point in their careers, but that survey covered a longer period of time. This study reports results similar to those of other studies with regard to the prevalence of sexual abuse (Diaz & McMillin, 1991; Duncan, Estabrooks, & Reimer, 2000).

Duquette and Delmas (2001) found that nurses' work can cause intense stress and that interpersonal conflict is one of the stressors. This type of conflict can bring nurses dangerously close to emotional burnout and can lead to professional burnout. It is in nurses' best interest to be aware of these potential consequences of psychological violence and to search for ways to eliminate it.

Sources of Violence

Fifty-nine percent of respondents reported being victims of violence inflicted by a superior in the preceding 3 months. This rate is slightly higher than that reported by other studies (Björqkvist et al., 1994; Quine, 1999; Spratlen, 1995). This may be explained by the restructuring of the Quebec health-care system, which nurse managers are responsible for implementing. According to Roberts (2000), nurse managers make up a marginalized elite of the nursing workforce. Once they have access to power, they tend to maintain a climate of group dominance — a culture inherited from the medical system. Roberts (1997) explains that this behaviour relates to the fact that nurse managers actually have little power. In order to maintain their leadership and the limited power they do have, they turn to dominating behaviours, which leads to vertical violence in the workplace. Management style should not be underestimated in health-care organizations; these organizations exert considerable pressure on nurse managers to improve performance and efficiency.

Turning to doctor-driven violence, 59% of respondents claimed to have been victims of this type of abuse. Studies of doctor-driven violence have focused primarily on verbal abuse (Cooper, Saxe-Braithwaite, & Anthony, 1996; Cox, 1991; Diaz & McMillin, 1991; Manderino & Berkey, 1997). Kutlenios and Bowman (1994) describe the phenomenon of doctor-driven violence as a product of domination by the medical team in the health-care sector. The current health-care system is paternalistic, while nursing is predominantly a profession chosen by women. Nurses work in a health-care system run and dominated by the men who make up the medical teams. This domination is endorsed and reinforced by hospital administrators, who depend on doctors to treat the hospital's clients. Doctor-driven violence could be exacerbated by the lack of experience and/or training among young nurses, making it difficult to meet the increasingly complex demands of health-care institutions.

According to Kutlenios and Bowman (1994), nurses' typical response to domination and intimidation by doctors is anger, which can lead to verbal abuse among co-workers. Co-worker violence is the form of violence that should raise the most concern. The results of the present study ought to serve as a red flag, since they indicate that the rates of violence against nurses are higher than those reported in the literature (Baron & Neuman, 1998; Damant et al., 1997; Quine, 1999). The lack of qualified personnel, as well as the rationing of resources in the Quebec health-care system, may help to explain the prevalence of horizontal violence found in this study. Horizontal violence is also a symptom of the domination of nurses within a paternalistic health-care system run by doctors, administrators, and a small number of nurse managers (Freshwater, 2000; McCall, 1996; Roberts, 1997; Skilling, 1992). According to Freshwater (2000), McCall (1996), Roberts (1997), and Skilling (1992), horizontal violence is a result of oppression, and for the victims it acts as a form of release from this oppression. In summary, horizontal violence is the result of frustration and repeated conflict on the part of the victim.

Study Limitations

The generalizability of the findings is limited because of a possible self-selection bias, which is inherent in any study that relies on volunteers. The nurses who volunteered to participate in the study may have been more exposed than other nurses to incidents of workplace violence. It is also possible that the ongoing changes taking place within Quebec's health-care system exacerbated relational tensions on the wards. In addition, the instrument used is rather new and may need more validation.

Conclusion

The prevalence of violence in nurses' workplaces in Quebec gives cause for concern. Less experienced nurses and nurses with lower levels of education seem to be at particular risk of falling victim to such violence. These results offer a glimpse into the nature and extent of the phenomenon of workplace violence within the context of nursing, deepen our understanding of what nurses experience in their daily work lives, and identify issues that need to be addressed in nursing practice, management, and research. It is crucial that nurses realize that their professional well-being is influenced by the workplace climate and by the expression of violent behaviours.

Nurses are strongly advised to denounce violence and refuse to tolerate it. They should be encouraged to speak out about the violence that they experience and to take action that will promote good relationships with their co-workers. A sense of solidarity should be developed in order

to counteract the violence. Value should be placed on loyalty and the need to rally to the defence of a co-worker who becomes the victim of workplace violence.

Nurse managers are urged to intervene with nurses who appear to be in distress and encourage them to denounce the violence around them. It is important to offer any support that victims may require and also to make it easier for them to denounce all forms of workplace violence. It is advisable to address all specific situations and conflicts manifesting within the workgroup. Nurse managers must be creative in developing initiatives to address workplace violence, by establishing prevention programs, identifying risky situations, preventing the escalation of existing conflicts, and educating staff (Jauvin, 1999; Quebec Federation of Nurses, 1995).

Nurse managers might consider identifying key factors that favour the development and implementation of programs aimed at preventing workplace violence. Various violence-prevention programs are already available, some implemented by trade unions or occupational health and safety services. However, these programs need to be better publicized, because in many cases employees are not even aware of them.

Future research should focus on examining the origins of the psychological violence that is so common among colleagues and on identifying factors that are likely to defuse this type of violence.

Finally, we underscore the importance of implementing the above recommendations, so that nurses may become increasingly aware of the violence they face. These recommendations are meant to help the entire nursing workforce to combat occupational violence. They are ultimately designed to foster quality care delivery in an environment that is empathic and respectful.

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