An Evaluation of the Management of Violence in the Workplace Training Programme:

The Dr Yusuf Dadoo Hospital Experience

by

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Declaration

I hereby declare that the research study titled**:**

An Evaluation of the Management of Violence in the Workplace Training Programme: The Dr Yusuf Dadoo Hospital Experience

is my own work and that as far as humanly possible all sources and quoted references in this study have been fully acknowledged.

Marion Borcherds
April 2015

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Acronyms and abbreviations

WHO:	World Health Organisation
ILO:	International Labour Office
PSI:	Public Services International
ICN:	International Canadian Nurses
EAP:	Employee Assistance Programme
EWP:	Employee Wellness Programme WPV: Workplace Violence
VETO:	Against Violence, an educational, training operational toolkit
Dr:	Doctor
EAPA-SA:	Employee Assistance Association of South Africa
HR:	Human Resources
SPSS:	Statistical Package for Social Services
GDP:	Gross Domestic Product
MDR-TB:	Multi-drug resistant tuberculosis
XDR-TB:	Extreme drug resistant tuberculosis

Summary

South Africa is a violent society. We see evidence of this daily via the popular media, with incidents being broadcast worldwide. It is evidenced in the public space such as the highly publicised case of Andries Tatane (city press [sa]), who protesting against poor service delivery was killed by police in an incident that was broadcast all over the world, and the privacy of homes, such as the internationally publicised Oscar Pistorius trial, a SA sporting icon who shot and killed his girlfriend, Reeva Steenkamp (news24 [sa]).The workplace is but a microcosm of this violent society. Despite the violent nature of our society, workplace violence as a phenomenon is perhaps not well understood and further academic and scientific scrutiny is required, in particular in relation to programmes and interventions addressing this scourge. Internationally, scholars and academics have completed a number of research studies highlighting the plight of the bullied worker. This has escalated awareness of the issues, mainly in the developed world. In developing countries, such as South Africa, the phenomenon has received some attention, judging by the research over the last few years but incidents are still mostly unrecorded and interventions require evaluation, in order to assess true impact.

The one sector in which workplace violence has received some attention is the healthcare sector. There are many reasons for this, such as the fact that the healthcare sector is female-dominated. Service users are sometimes mentally disturbed, and locations are often in dangerous, crime-ridden areas. The sector is thus vulnerable to workplace violence.

The literature study revealed significant levels of workplace violence across the world, with Hinchberger (2009:37) noting that the epidemic of violence against nurses globally is of growing concern. Health care workers generally are exposed to a number of factors that increase their risk for physical and verbal violence notes Gillespie, Gates, Faan, Miller & Howard (2010:177) such as working with the public, age, gender, working hours and working with psychiatric patients.

The Gauteng Department of Health decided to tackle this phenomenon of workplace violence and, in 2006, introduced a programme for managing workplace violence. This programme was positioned in the Employee Wellness programme of the department, and included a component on training.

The aim of this research study was thus to evaluate the impact of this Management of Workplace Violence training programme. The research problem, therefore, was the fact that the lack of evaluative knowledge on the management of workplace violence programmes results in uncertainty as to the effectiveness of interventions. The study made use of both quantitative and qualitative research approaches.

The overall findings of the study revealed that the Management of Violence in the Workplace training programme and factors relating to it contributed to a positive shift in knowledge on aspects like policy being a driver of reporting, costs associated with workplace violence, and knowledge of the potential role-players responsible for managing workplace violence. The training was less effective in increasing knowledge on other issues, such as measures for mitigating workplace violence.

The training programme was also effective in positively shifting attitudes relating to workplace violence, especially on issues of whether workplace violence is a serious phenomenon, whether verbal abuse constitutes workplace violence, whether the health sector is a vulnerable sector and whether training is an effective measure for mitigating workplace violence. It was, however, less effective when it came to changing the attitudes and beliefs relating to insight into the participants' own behaviour as far as workplace violence is concerned. In addition, it also appeared to be less effective in persuading participants that they could have a significant influence on the mitigation of workplace violence through a number of key interventions and changing some basic behaviour that was within the realm of their daily functioning.

The training programme had a lesser impact on skills development in that, after the training, participants did not believe that it had equipped them with skills for actively managing workplace violence.

It is thus strongly recommended that training should form but one component of a comprehensive workplace strategy. The latter would include a multi-level focus on policy, procedures, leadership, organisational culture, awareness, security measures and reporting and recording. The EAP, under the leadership of HR, could be a reporting structure for such an initiative.

CHAPTER 1

General Orientation to the Study

1.1. Introduction

South Africa as a country is known locally and internationally to be a violent society. This violence permeates every aspect of society. Violence on the roads in the guise of road rage and bullying at schools receives much media coverage. The phenomenon of violence in the workplace as an academic and scientific concept is receiving increasing attention but as a phenomenon is still largely misunderstood. The increasing attention is largely due to the fact that certain scholars and academics around the world have conducted a number of research studies highlighting the plight of the bullied worker, which has escalated awareness of the issues, mainly in the developed world. However, in developing countries like South Africa, the phenomenon and incidents have mostly gone unrecorded. Nguluwe, Havenga & Sengane (2014:71) noted that nurses explained the effects of violence as physical pain and emotional distress and it can be concluded that these experiences of violence have a negative effect on their mental health.

Di Martino (2002:2) noted that “up to recently, no national study on the health sector has been made available, no comparative analysis has been developed, and very limited coverage has been provided for the developing world”. His comments on the developing world included the situation in South Africa. Since 2002 and Di Martino’s pronouncements there have been a number of studies on health care workers specifically and workplace violence experienced by health care workers. Some of the studies noted are Nguluwe et al (2014) who examined workplace violence against nurses in a psychiatric setting, Kennedy & Julie (2013) who studied workplace violence against nurses in a trauma and emergency department in SA and Gillespie et al (2010) who studied workplace violence in a paediatric emergency department .The phenomenon of workplace violence is thus at best known but requiring more examination.

There is some national research on workplace violence in the health care sector. In a study conducted by Steinman (2003:21) in the greater Johannesburg Metropolitan

Region, 61% of all health care workers experienced at least one incident of workplace violence in the year prior to the study. Howerthorn Child & Mentes (2010:89) indicated that nurses working in emergency departments and psychiatric wards are the most vulnerable. Because psychological effects cannot be seen and are not visible to by the naked eye, it is often easier to ignore them or remain unaware of them. The symptoms of psychological distress may vary from person to person and may take the form of, inter alia, sleep disturbance, nightmares, anxiety, tearfulness, anger, shock or depression.

Cooper (2001:vi) has expounded on factors that contribute to the prevalence of violence in the healthcare sector workplace, viz. it is a female-dominated industry exposed to patients suffering from mental illness or alcohol or drug abuse. Poor environmental factors, such as lighting, have also been noted. The fact that healthcare facilities are often situated in communities rife with gangs and violence which inevitably spills over into the facility has also been noted.

Many South African nurses, lured by promises of better incentives and working conditions, are leaving the country to work in the developed world. In addition, many other nurses are leaving the public sector to work in the private sector. The remaining cadre of nurses is consequently burdened with high caseloads, work overload and poor working conditions, which lead inevitably to burnout. The health sector environment is thus definitely conducive to the eruption of violence

The health sector is beset by many problems – viz. high attrition rates, high staff turnover, high burnout rates and poor morale, to name but a few. These problems all have global relevance and are not uniquely South African. In a behavioural risk audit conducted as part of the EAP, the following facts on the Yusuf Dadoo Hospital emerged, the chosen site for the empirical study. Conflict at work was reported to be high or very high by one in three respondents. This was related to reports of poor communication. This situation is extremely conducive to the eruption of workplace violence (ICAS Behavioural Risk Management Report, 2005).

Definitely not to be underestimated are the socio-economic realities of life in developing countries. In a country like South Africa, with its high levels of violence, one could almost argue that violence has been normalised, which results in an attitude that

seeks to minimise the incidence of violence. Steinman (2003:4) introduces the concept of a “threshold”, which suggests an upper limit or “acceptability level” of workplace violence and suggests that this acceptability level is dependent on legal, cultural, religious, emotional, social and political factors. The health care sector in South Africa, being but a microcosm of a violent society is thus a sector which is ripe for workplace violence to erupt. Cilliers (2012:7) reports on how victims of workplace violence expressed their feelings in response to the incident/s. They described exhaustion, being worn down, confusion, isolation, hopelessness and worthlessness. Some employees reported feeling incompetent or stripped of their worth and even acute symptoms of learned helplessness.

The very definition of workplace violence must be considered before embarking on any research or application models. Leather (2001:8), has highlighted the fact that the meaning of workplace violence is embedded in different socio-political realities, which gives rise to the nature and character of the problem itself. What constitutes violence? What is normal and what is abnormal? In a country such as South Africa, where violence levels are high and are virtually part of daily life, it is easy to minimise the issues of workplace violence and adopt a cavalier attitude. Such an attitude would perceive such violence as part of the daily reality of life in a society that has learned to cope with and adjust to abnormally high levels of violence. Given this, there are some who insist on a very restricted, narrow definition of workplace violence (Kraus, Blander & McArthur, 1995: 355-379), but others who would use a far broader definition (WHO, 2002:30). Cowman& Bowers (2008:1346) suggest that an accurate account of workplace violence is unavailable as it is defined inconsistently, inadequately documented, underreported and normalised. The definition used is thus quite important.

Because of the processes preceding this study, which relate to the management of violence in the workplace in the Gauteng Department of Health, with Dr Steinman introducing the concept a few years earlier as part of a research project, consistency was maintained and the WHO definition was once again used, viz. “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (WHO

Publication, 2002:30). A broader definition of workplace violence certainly allows for a more holistic view of the issues and components to be considered, while a limited definition offers certain restrictions that may hamper a fuller exploration of the phenomenon of workplace violence. For this reason, the researcher favoured a broader, more comprehensive definition. The broader definition does not limit the study, but explores both psychological and physical violence. It also includes patient-on-staff and staff-on-staff violence**.** A broader definition has thus been favoured and will be used in this study. Organisational factors contributing to workplace violence have been analysed extensively in a study conducted by Grubb, Roberts, Swanson, Burnfield and Childress (2005:37-59). Based on results from a nationally representative Sample of USA companies, this study found that bullying is more prevalent in larger companies and in not-for-profit companies, a finding the writers Say is consistent with the European literature. They postulated that providing services to the public allows more opportunity for interpersonal conflict. They also found that bullying was more likely to be reported in unionised companies, as this environment may both increase awareness levels and provide mechanisms for lodging complaints. They further noted that companies reporting incivility were more likely to have monthly team meetings, which, if held frequently, provide more opportunities for interpersonal conflict.

The European literature on this topic suggests that the nature of the team is crucial and that, as more of the workforce begins working in self-directed teams, conflict may increase, particularly if there is team competition (Grubb et al., 2005:53-54). Other factors noted by this team were that organisations reporting bullying and incivility were characterised by micro-management and close supervision, a lack of flexibility in completing tasks and the inability to participate in the decision-making process. Employee/management relations were generally poor, which indicates a poor psycho-social climate. This often resulted in poor communication, and they concluded that bullying and incivility were associated with adverse indicators of the quality of work life, such as formal complaints about sexual harassment and racial problems, as well as age and disability discrimination. It therefore seems that bullying and incivility coexist with a number of other indicators of a hostile work environment. In addition, bullying and incivility coexist with a number of other indicators of a hostile work environment,

which could signal deeper interpersonal relationship problems in the organization, or an underlying climate that either encourages or fosters such behaviour.

Deane (2006:8) indicates that workplaces which have adopted a zero tolerance approach and have introduced policies and programmes to combat workplace violence are, linter alia, making distinct efforts to deal with conflict occurring in the workplace and among personnel by applying disciplinary procedures. .

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The health sector is beset by many problems – viz. high attrition rates, high staff turnover, high burnout rates and poor morale, to name but a few. These problems all have global relevance and are not uniquely South African. In a behavioural risk audit conducted as part of the EAP, the following facts on the Yusuf Dadoo Hospital emerged, the chosen site for the empirical study. Conflict at work was reported to be high or very high by one in three respondents. This was related to reports of poor communication. This situation is extremely conducive to the eruption of workplace violence (ICAS Behavioural Risk Management Report, 2005).

Definitely not to be underestimated are the socio-economic realities of life in developing countries. In a country like South Africa, with its high levels of violence, one could almost argue that violence has been normalised, which results in an attitude that seeks to minimise the incidence of violence. Steinman (2003:4) introduces the concept of a “threshold”, which suggests an upper limit or “acceptability level” of workplace violence and suggests that this acceptability level is dependent on legal, cultural, religious, emotional, social and political factors.

Bullying, incivility and workplace violence are phenomena which can be influenced positively by the introduction of workplace programmes. But such programmes require a natural location that would support implementation. Employee assistance programmes are concerned with organisations and the well-being of employees. The

definition by the Standards Committee of EAPA-SA (2010:1) of the concept employee assistance programmes is the following:

An EAP is the work organisation's resource, and is based on core technologies or functions to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues.

In order to understand the role of the EAP in relation to the management of violence in the workplace, the researcher wishes to refer to the seven core technologies of EAP according to Beidel (2003:3-4).These are:

- Consultation with, training of, and assistance to work organisation leadership seeking to manage the troubled employee, enhance the work environment, improve employees' job performance, and outreach to and education of employees and their family members about the availability of EAP services.
- Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance.
- Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.
- Referral of employee clients for diagnosis, treatment and assistance, plus case monitoring and follow-up services.
- Consultation for work organisations in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts.
- Consultation for work organisations to encourage the availability of and employee access to health benefits covering medical and behavioural problems, including, but not limited to alcoholism, drug abuse and mental and emotional disorders.
- Identification of the effects of EAP services on the work organisation and individual job performance.

Employee assistance programmes are thus well positioned to integrate and manage effects of workplace violence and are also capable of introducing some proactive

programmes to address this issue. De Falco (2001:191) notes that “In response to an increase in workplace violence, employers are looking to EAPs for damage control”.

However, in a review of employee assistance literature between the 1980s and present day, there is very little to suggest that these professionals have been instrumental in curbing the scourge of workplace violence. The EAP focus has been largely one of counselling and advice management after an incident or a threat. In actual fact, some of the literature produced may not have inspired or motivated EAPs to become involved in the area of workplace violence. Greene (1995:15), for example, asks whether an EAP’s involvement widens an organisation’s window of liability.

However, Greene (1995:15) does provide some insight into intervention strategies that would be appropriate and would relate well to the “high road” response advocated by Di Martino (2003: viii). They are summarised as follows:

- Limit your risk by relying on specialists to conduct risk assessments;
- This exercise requires time, attention and research;
- Development of workplace violence policies and procedures that are consistent with legal obligations;
- Use a task force comprised of security, human resources, operations, public relations, medical, risk management and the EAP to develop an appropriate workplace response;
- Find a law firm with a track record, experience, and a focus on workplace violence.

Employee assistance programmes are concerned with individuals, organisations and the general well-being of the organisation and its employees. Because workplace violence impacts negatively on individuals and organisations, it follows that employee assistance programmes may engage in workplace anti-violence strategies.

De Falco (2001: 191) also notes that partnerships between EAPs, HR and Security seem to focus very specifically on domestic violence and the spill-over into the workplace, as well as trauma management. Once again one is aware of the limited focus of these models of implementation. Very little attention is given to an overall

approach, which would have broader organisational implications for the climate and culture of the organisation.

In conclusion, workplace violence is receiving more and more attention as a phenomenon in the developing world. A deep understanding of the phenomenon from a scientific and academic point is still worthy of pursuit. Knowledge and awareness levels have increased, but this has not automatically led to an increase in models of intervention. In addition, the EAP as a profession has not really been as active in mitigating the effects of workplace violence as it has been with other issues like, inter alia, trauma management. A benchmarking exercise undertaken by the researcher in 2014 on workplaces where bullying or workplace violence formed a component of the EAP revealed very little evidence to this effect. At most, some companies had made an attempt to introduce a policy.

If one were to review the interests of an EAP and the interests of the management of violence programmes, major areas of overlap would emerge which could allow for the EAP to form a strong framework for the integration of such a programme. The readiness of the system to introduce new solutions into a new programme definitely sets the stage for an aggressive implementation strategy. Employee Assistance Programmes could definitely expand and extend their repertoire by adopting a more comprehensive approach to the management of workplace violence through training and evaluation. This approach would align well with the core technologies of EAP and would be innovative**.**

1.2. Theoretical framework

The above evaluation and study were completed in the context of a large organization, the Gauteng Department of Health. This Department could best be described as a monolithic system of hospitals and clinics. Within this system, one component, a particular hospital, was identified, the Dr Yusuf Dadoo Hospital. This hospital is one of about 60 state hospitals in in the Gauteng Province. The target group is all the hospital employees. This hospital formed the basis of the study under review and is a good example of a sub-system within the broader health care system. The health care system should thus be viewed as the system, with the Dr Yusuf Dadoo hospital as the sub-system.

The study was thus premised on the systems theory framework. General systems theory proposes a model for the design, behaviour, and development of social Systems (Bridgeforth, 2005:54). Bridgeforth (2005:57) referenced Von Bertanfly, who had introduced systems theory in the 1960s. This theory evolved over time to the model proposed by Bridgeforth (2005:540), which proposes a three dimensional Model. The initial premise of systems theory, which holds that the behaviour of an individual or simple system affects the greater system, is, however, relevant for this Study. The seminal works which dates back to the thirties and further expounded in the nineties albeit it quite old are seminal works in the field of Systems Theory. For purposes of this study, the researcher has thus included these older references and focused on systems theory from a Social sciences perspective (Bahg:1990). Parsons (1937) divided the system of action very specifically into four sub-systems, the social system, the cultural system, the personality of the individual and the behavioural organism. He emphasized the analysing structure and functions of the system and posited that balance could be maintained in society through self-adjustment. Buckley (1967) built on the work of Von Bertanfly and Wiener and criticized Parsons' social system because of its lack of emphasis on conflict, competition and devaluing change. The work by Buckley (1967) lends a theoretical framework for the current study, as he posits that the individual personality emerges as a potential system of actions and those social meanings emerges out of individuals' every day, face-to-face interaction. We need to consider the internal and external environment and the macro- and micro-level. A system such as the Dr Yusuf Dadoo Hospital develops mechanisms to cope with its environment and even responds to an issue such as workplace violence. New social forms and structures are generated, sometimes slowly, sometimes abruptly, at other times with either less or more conscious effort and purpose.

One of the components of the Workplace violence programme is the training programme which this study used as the unit of analyses. Bridgeforth (2005:55) maintains that, in the current age, organisational discussions centre on changes in policies, programmes, charters and governance. In addition, he notes that other authors have focused on concepts like projects, the deployment of key people, trust, fairness in management practices, organisational openness, mutual dependence, reciprocity, a sense of predictability and refined leadership. However, it is not enough to envisage the system as a linear progression of events. According to Arbib and

Cornelis, (1981:375), Wiener had emphasized that it is not enough to imagine a one-way flow of control, where the controller would decide what needed to be done, tell the system what to do and the system would do it. This is not enough if we want to analyse a complex system. Bridgeforth (2005:58) credits both Chandler (1969) and Bartlett et al. (1994) with having identified the universal components of social systems as purpose, strategy, people, systems, structure and process. Organisational culture comprises these six interdependent components and their relationships.

The study under review, which is aimed at assessing the impact of the Workplace Violence Training Programme on the organisation, is underpinned by this theoretical framework. The work of Wiskow (2003:14), which refers to a multi-factor phenomenon requiring a multi-dimensional solution to workplace violence, is relevant here. The researcher postulates that a multi-factor approach aimed at purpose, strategy, people, systems, structures and processes addressed this matter. Kitson (2009:218) has argued that the spread of knowledge into practice is a slow and unpredictable process and that much time has been spent on why individuals, teams, and whole organizations do not embrace change and new practices and processes, with specific focus on the health care system. Kitson (2009:217) concludes that only the purposeful integration of systems theory with knowledge, translation theories and models may enable the application of new research and new knowledge. The Management of Violence in the Workplace Training Programme therefore attempts to challenge this assumption.

The Framework guidelines on which the Management of Violence Programme is premised poses a systemic formulation, with a design based on people, systems, strategy, structure and process.

For purposes of this study, the literature focused on the following areas:

- Nurses as a group;
- Gender and patriarchy;
- Environmental factors;
- Organisational climate;

- Profile of the victim;
- Profile of the perpetrator;
- Victim-bully relationship;
- Victim-organisation relationship;
- Age of the victim;
- Health of the victim;
- Personality of the victim.

The empirical study included a few more areas, such as the person's position, the unit/ward in which they work, and policy and procedures.

1.3. Problem Formulation

The actual problem was first defined in context, while the extent of the problem and the impact thereof were also considered before embarking on the study.

1.3.1. Problem definition

"The first characteristic that makes a problem a problem is that we must know it is there. The second characteristic of a problem is that we must be able to do something about it" (Grinnell & Williams, 1990:59).

There is also usually more than one way of resolving a problem, but "which solution we choose will depend on why we wanted to solve the problem in the first place, that is, on our immediate and ultimate goals" (Grinnell & Williams, 1990:60).

1.3.2. Extent of the problem

The different definitions used in discussions of workplace violence make it difficult to estimate the exact extent of this problem. Magnavita (2014:369) reported the following statistics in a study on workplace violence and occupational stress, namely

That 24.6% of the cohort reported being a victim of at least one incidence of physical aggression in the 12-month period preceding the study. Non-physical violence was more prevalent than physical aggression, with 52.6% reporting non-physical

aggression in the preceding year notes that data from developing countries is virtually non-existent and undocumented. The researcher is of the opinion that this study can make an important contribution to address the identified gap in the field of knowledge.

In South Africa, relatively little was known about workplace violence before 2000. In 1997, the book titled *Corporate Hyenas at Work* was published by Marais and Herman, while in the same year a study focusing on work stress among a group of black nurses was completed by Ngwezi (1997). The first International Conference on Workplace Trauma was held in November 2000, which raised some public awareness of workplace violence. However, the first research on workplace violence per se was that from the Medical Research Council in 2001, titled *The impact of crime and violence on the delivery of state health care services in the Western Cape.* Their analysis revealed that 60% of all the respondents frequently had to deal with workplace crime and violence. Verbal abuse is commonplace, with 92.3% of respondents suffering verbal abuse in the two years preceding the study.

In 2001, the Ethics Institute of South Africa conducted an ethics audit at the Chris Hani Baragwanath Hospital, during which workplace violence emerged as one of the problems experienced by staff. Two-thirds of the staff agreed that the number of security staff was inadequate and 76% felt that they were poorly equipped to perform their jobs, while 57% believed that visitors were inadequately screened.

In South Africa, the work of Steinman (2003:8) was ground-breaking, as it focused on workplace violence per se and also compared the public and private sectors. The study also produced results that were very similar to those of the developed world, with 67.4 % of healthcare workers in the public sector reporting having been attacked, whilst 42.5% had witnessed physical violence in the workplace. She also compared this to the private sector where 42.5% had experienced a physical attack and 19.2% had witnessed an incident. Staff in the public sector were “more anxious than those in the private sector, where there were higher numbers of incidents“.

The problem identified is the total absence of evaluative data on the outcome of the Management of Violence Training in the Workplace Programme. This study is intended to make a contribution towards adding to the body of work on evaluating programmes related to workplace violence. The impact of this study is to contribute towards

understanding whether the designed workplace violence training programme had incorporated the correct and appropriate indicators of knowledge, attitude and skills.

1.3.3 Impact of the problem

Kennedy (2004:19) reports that the effects of violence could range from minor to serious physical injury, but there could also be psychological trauma resulting from fear and anxiety. In severe cases, victims may suffer from post-traumatic stress disorder. It is thus logical to conclude that the costs of violence and the resultant stress and anxiety to organisations must be enormous. Di Martino (2000:vii) has written extensively on the relationship between stress and workplace violence. He notes that stress and violence cause immediate and often long-term disruption to interpersonal relationships, the work organisation, and the overall working environment.

> Data from the European Union shows a significant correlation between violence and stress, with the cost of stress calculated at 20 billion euro per year. In the United States, the cost of stress has been calculated at US$350 billion per year and the cost of violence alone has been calculated at US$35.4 billion. Altogether, it is estimated that stress and violence account for approximately 30 per cent of the overall costs of ill-health and accidents. Based on the above figures it has been suggested that stress/violence may account for 0.5 to 3.5 per cent of GDP per year (Di Martino, 2003: vii).

The extent and impact of workplace violence has been documented but may not always be understood in its entirety. This is largely owing to varying definitions and lack of reporting, particularly in developing countries. The phenomenon of workplace violence is, however, receiving increasing attention as understanding and awareness increase, but implementation models are still limited. Very few models for the management of violence in the workplace and related training have been applied. In particular, the overall systems theory framework, which speaks to people, systems and structure, has largely been ignored when workplace violence is addressed.

The research problem, therefore, was the fact that the lack of evaluative knowledge on the management of workplace violence programmes results in uncertainty as to the effectiveness of interventions. The workplace violence training programme specifically is the component of the overall workplace violence programme that will be evaluated It is important to evaluate such a programme as the design was based on sound theoretical knowledge, covered in the sections above but it is vital to test whether the material as designed achieves the envisaged outcomes. The evaluation will lend value

in terms of assessing whether the indicators of knowledge, attitude and skill are appropriate in assessing the relevant outcome of the training programme. Without such rigorous scientific scrutiny the outcomes are at best anecdotal.

This study thus focused accordingly on evaluating the existing training programme known as Management of Violence in the Workplace Training Programme, developed to address both psychological and physical violence in the workplace.

1.4. Goal and Objectives of the Study

The terms “goals”, “purpose”, “objectives” and “aim“ are often used interchangeably, or as synonyms for each other (Fouché & De Vos, 2011:94). Fouché and De Vos do, however, assert that both “aim” and “purpose” are something which is planned and why something actually exists. A “goal” is stated as an aim, and often implies the broader and more abstract conception of what the researcher plans to achieve. An “objective” further refers to the more practical steps a researcher undertakes in order to achieve the goal. This study will therefore accordingly use the terms as denoted above, to describe its goals and objectives.

1.4.1. Goal of the study

The goal of this study was to evaluate the effectiveness of the Management of Violence in the Workplace Training Programme at the Dr Yusuf Dadoo Hospital. The goal of this study was thus evaluative in nature.

1.4.2 Objectives of the study

Objectives are the more concrete, measurable and realistic steps the researcher has to take within a specific time-span in order to achieve the dream (Fouché & De Vos, 2011:94). “Objectives transform research questions into behavioural aims by using action oriented words” (Kumar, 2005:46).

The Management of Violence in the workplace programme does not consist of the training part of the programme only, however, the unit of analysis for purposes of the empirical study specifically can be described as the training component of the mentioned programme.

The objectives of this study were thus

- To describe the management of violence from a theoretical perspective; in order to determine whether the contents of the Management of Violence in the Workplace programme, is sound.

- To explore and describe the phenomenon of workplace violence in the public healthcare sector from a theoretical perspective as this underpins the current Training Programme contents.

- To explore the role of the EAP in the management of violence in the workplace as recommendations for the expansion of EAP's role will be discussed.

- To explore the phenomenon of workplace violence in the Yusuf Dadoo Hospital, to justify the introduction of a Management of Violence in the Workplace programme – which entails more than the mere training part of the mentioned programme. The extent of existence of the phenomenon, through the survey would determine whether the actual empirical study would be necessary. If no workplace violence existed, no training and no evaluation could realistically be concluded.

- To evaluate the impact of the Management of Violence in the Workplace Training Programme on the Yusuf Dadoo Hospital by measuring the identified indicators:

    - Levels of knowledge on workplace violence

    - Attitudes and beliefs about workplace violence

    - Skills for implementing action plans for management of workplace violence

- To make recommendations for best practice in the public healthcare sector regarding the management of violence in the workplace;

- To develop and describe guidelines for the EAP in the management of violence in the workplace in general, and specifically for the health sector in South Africa.

1.5. Research Approach

1.5.1. Hypothesis

When a quantitative study is decided on, the researcher also decides on a formal problem formulation, which may include a hypothesis. Grinnell and Williams (1990:75) maintain that "A hypothesis is a statement. Not only is it a statement – it is a statement written in such a way that it can be proved or disproved by comparison with known facts". Bless and Higson-Smith (1995:37) note that "problems are questions about relations among variables, and hypotheses are tentative, concrete and testable answers to such problems".

In a hypothesis, one usually proposes a relationship between two variables, an independent variable and a dependent variable. The independent variable is "the variable we manipulate … the variable that is manipulated or treated in a study to see what effect differences in it will have on those variables proposed as being dependent on it … the researcher determines which values of the independent variable are received by the study's subjects" (Grinnell & Williams, 1990:82). "The dependent variable is the variable that we do not directly manipulate … this is the outcome variable … after the different levels of the independent variable have been administered, all subjects are measured, in the Same way, on the Same dependent variable … a variable in which the changes are results of the level or amount of the independent variable(s)" (Grinnell & Williams, 1990:82).

Kumar (2005:74) concludes that a hypothesis has certain characteristics:

- It is a tentative proposition;
- Its validity is unknown;
- In most cases, it specifies a relationship between two or more variables.

The **hypothesis** for this study was the following:

If the Management of the Violence in the Workplace Training Programme is effectively implemented in the Dr Yusuf Dadoo Hospital, the employees of this institution will be empowered through an increased level of knowledge about violence in the workplace,

with enhanced skills for the management of violence and a positive attitude about their own abilities when it comes to the management of such violence.

The **independent variable** was the intervention in the form of training provided according to the Management of Violence in the Workplace Programme.

The **dependent variables** were individual employees' knowledge of violence, skills in management of, and attitude to the management of violence in the workplace.

1.5.2. Selection of research approach

The researcher used both a **quantitative and qualitative** research approach. This mixed methods approach allows the quantitative and qualitative methods to complement each other and permits a more complete and in-depth analysis of the phenomenon of workplace violence and the actual research problem. Delport and Fouché (2011:435) have written on the scientific value of mixed method research, noting that it has the ability to produce stronger inferences and provide an opportunity for more divergent views, as well as allowing the researcher to simultaneously address a range of different questions. It could also eliminate all types of bias. The researcher in this study felt that all these points had merit when she was pursuing this study and decided on the basis of such strong scientific argument to pursue mixed methods research.

1.5.3. Theoretical back-up for research approaches

Mouton and Marais (1990:155-156) have identified the following characteristics of the **quantitative** approach:

- It is more highly formalised and more explicitly controlled than the qualitative approach;
- Its range is more exactly defined than that of the qualitative approach;
- It is relatively close to the physical sciences.

Neuman (2000:16) speaks of a **"quantitative style"** and isolates a few characteristics that are typical of this "style":

- Measurement of objective facts;

- Focus on variables;
- Reliability as the key criterion of scientific excellence;
- A value-free stance;
- Research conducted independently of context;
- Many cases or subjects involved;
- Statistical analysis is the method of choice;
- Researcher maintains detached attitude.

Cooper and Hoel (2001:76) maintain that: “To date, quantitative research methods have dominated the field of violence research”.

1.5.4. Motivation for choice of specific approach

For the purpose of this research, a **quantitative and qualitative research approach** was applied, as the researcher’s purpose was to evaluate the effectiveness of the Management of Violence in the Workplace Training Programme. This was achieved by obtaining the views of the majority of employees as respondents on the phenomenon of violence and on the impact of the training to be provided. This training was related to the increased knowledge, skills and change in attitude regarding their level of empowerment in managing violence in the workplace. The dominant model was a quantitative paradigm, while a small component was a qualitative paradigm. Phase 1 consisted of the survey. Phase 2, considered as such because it focused on the smaller sample of only forty participants, includes the pre-test post-test, the training and the qualitative component.

1.6. Type of Research

1.6.1. Theoretical back-up for the type of research

Basic research is driven by curiosity and has the main aim of expanding human knowledge rather than creating or inventing something, while applied research is designed to solve practical problems.

Fouché (2011:449) indicates that the “mainstream” of evaluation research in the caring professions consists of programme evaluation.

According to Fouché (2011:450), “What really distinguishes intervention research from programme evaluation is, to our minds, the fact that, when intervention research is attempted, something new is created and then evaluated”, while “programme evaluation assumes the prior existence of a programme or intervention designed and developed by someone else, perhaps long before the evaluator ever entered the field”, which is then evaluated. The training was an existing programme which had never been applied at the Dr Yusuf Dadoo hospital. The study under discussion amounts to evaluation research, as it clearly introduces a new intervention, and then evaluates it. The Management of Violence in the Workplace training programme was introduced and its impact evaluated. Fouché (2011:450) warns, there are overlaps between the first phases of intervention research and some types of formative evaluation research.

1.6.2. Motivation for choice of type of research

The researcher focused on the evaluation of an existing intervention (Management of Violence in the Workplace Programme), therefore the study can thus be described as evaluation research in the context of applied research. It is evaluation research, for the reasons discussed above. Schilling (1997:174) says that an intervention or an evaluation is an applied action taken by a social worker (the researcher in this case), usually in collaboration with the client, here the Dr Yusuf Dadoo Hospital employees, to enhance the well-being of employees at the particular site.

Fouché (2011:449) notes that Evaluation Research as a term can be quite misleading, but explains that there is no separate set of rules guiding this approach. The purpose of evaluation would be three-fold:

- Summative evaluation: Does the programme work or not?
- Formative evaluation: Investigating the use of social intervention programmes in ways adapted to organisational, political and social environments;
- Process evaluation: Programme monitoring, which assesses problems in implementation and performance.

For purposes of the current study, the impact or outcome of the training programme is assessed. It is summative, as it would allow the researcher to pronounce on the effectiveness and utility of the Management of Violence in the Workplace Training Programme. Rossi et al. (2004:234) iterate that the outcome or the impact of the programme would not have occurred had the programme been absent. Further, "The problem of establishing a program's impact is therefore identical to the problem of establishing that the program is a cause of some specified effect".

Because the study was confined to only one of the 60 hospitals in the Gauteng province, the impact assessment was also considered important, before it could be launched in the other hospitals. Fouché (2011:460) indicates that it is prudent to do this type of impact assessment when a programme is initiated in order to show that the programme has the desired effects before it is launched within a broader context.

1.7. Research Design and Methodology

The research consisted of two phases:

Phase 1 consisted of the exploration of the phenomenon of violence in the workplace, the Dr Yusuf Dadoo Hospital.

Phase 2 consisted of training and evaluation of the training as embedded in the Management of Violence in the Workplace. Such evaluation was completed with a measurement immediately before the training, then after, with a further post-measurement two months after the completion of the training programme.

A research design is crucial for guiding the research process.

1.7.1. Research Design

1.7.1.1. The nature of a Research Design

Bless and Higson-Smith (1995:63) define research design "as a specification of the most adequate operations to be performed in order to test specific hypotheses under given conditions". Kumar (2005:84) extends the definition by concluding that the research design has two functions, which include the logistical arrangements and the identification of procedures. He also emphasises the importance of quality regarding validity, accuracy and objectivity.

1.7.1.2. Choice of design

For the purposes of this study, a **quantitative design** was used for Phase 1 and a combination of **quantitative** and **qualitative** designs for Phase 2.

During **Phase 1**, specifically a quantitative-descriptive (survey) design was applied. Fouché et al. (2011:156) report that survey designs are most widely-used in-experimental designs in social sciences. They have the advantage of being able to describe a sample that shares certain characteristics and answers a series of questions, as carried out in this study. The demographics of those participants exposed to workplace violence are described and discussed along with their experience of workplace violence. Fouché (2005:137) notes that "survey designs are often more of a quantitative nature, requiring questionnaires as a data collection tool", and that respondents are "selected by means of randomised sampling methods". The randomised cross-sectional survey is thus the specific research design that was used in Phase 1 of this study (see Annexure 4).

During **Phase 2**, specifically the quasi-experimental design, called the one –group pre-test –post-test design (Babbie: 2005:215) was applied.

Fouché et al. (2011:143 -149) provide the following quantitative design classification, namely, experimental designs, which are pre-experimental, quasi-experimental and truly experimental.

Quasi-experimental designs seems to be the most appropriate design, since no random allocation of participants was made and no control group was composed. Quasi-experimental designs are subdivided into the randomised one-group post-test only design, the comparison group pre-test post-test design and the interrupted time series design.

The above will be addressed in the phases below.

Although no comparison group was applied, an intervention was introduced, followed by a repeated measurement of the dependent variable. The two different states, pre-test and then post-test were compared. (Fouché et al., 2011:149).

The pre-test post-test thus focused upon the following independent variables: knowledge, attitude and skills relating to the nature and extent of workplace violence, in order to evaluate whether these variables have shifted as a result of the training. It was postulated that, if this had happened, the Management of Violence in the Workplace Training Programme would be deemed an effective intervention programme to address workplace violence.

After the pre-test, the independent variable in the form of the training programme on the management of workplace violence was conducted. The post-test was conducted immediately after the training.

Two months later, the qualitative section of the study, interviews, was conducted. The latter was completed to test whether knowledge, attitude and skills were retained after a period of time had elapsed. A collective case study has been employed to gain knowledge about a particular social issue, this being workplace violence training and has been extended to a number of cases (De Vos et al, 2011:322).

1.7.2. Data Collection

Quantitative data-collection methods included questionnaires, indexes, scales and checklists. Delport (2005:166) maintains that “the basic objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue”.

Furthermore, there are different types of questionnaires:

- Mailed questionnaires;
- Telephonic questionnaires;
- Self-administered questionnaires;
- Hand-delivered questionnaires;
- Group-administered questionnaires.

It is often very difficult to persuade busy hospital staff to complete a questionnaire, but the wellness coordinator in the hospital assisted with the distribution and completion of the questionnaire for this survey

Phase 1: Data during Phase 1 was collected by means of a self-administered questionnaire.

Phase 2: Data collection for Phase 2 was done by means of a questionnaire developed by the researcher.

For the qualitative part of Phase 2, information was collected by conducting individual interviews.

1.7.3. Data Analysis

Data for **both phases** of the study were analysed by using the computer package SPSS version 19.0.

The researcher analysed the data, but the services of a bio-statistician were used for statistical purposes. The bio-statistician ensured that the contents of the survey and the pre-test post-test questionnaires were uploaded and analysed using the statistical package. Decisions on cross-tabulations and the parameters to report on were decided by the researcher when the questionnaires were being formulated.

1.8. Pilot Study

Mouton (2001:103) asserts that the pilot study is the researcher's way of orientating himself to the study, and it therefore forms an integral part of the study. It is thus the test for the feasibility of the study and will highlight any problems or shortcomings with the plan and actual investigation. Strydom (2011:236-240) further outlines the process of conducting a pilot study, noting that first, a literature study is important; second, the experts' experience should not be ignored; third, an overview or preliminary exploratory study should be conducted and, finally, a thorough study of a few units should be undertaken. The researcher piloted both the survey questionnaire and the pre-test and post-test questionnaires. Two employees from the high risk units were identified to participate in the pilot study. They were excluded from the actual study, and, as a result of the pilot study, a number of questions in all three questionnaires were either rephrased or completely reworded.

1.8.1. Feasibility of the study

De Vos (2005:209) says that, even if a researcher is very experienced and knowledgeable, he still needs to prepare himself for every possible situation, and a feasibility study is a valuable way of gaining practical knowledge and insight into the research area.

1.8.2. Permission from authorities

This study was conducted in the Gauteng Department of Health at one of their hospitals, the Dr Yusuf Dadoo Hospital. The Gauteng Department of Health had committed itself to the project and this was borne out by the fact that the researcher was assisted in its implementation by both the hospital management and the employee wellness co-ordinator at the hospital. This assistance in managing the logistics of the project was invaluable in completing the project within the planned timeframes. Permission had also been granted for this study by the research unit in the Department of Health. Access to respondents and authorisation were assured, and a letter of authorisation from the relevant authority was made available (see Annexure 2).

1.8.3. Availability of resources

The other facilitating factor was that this programme is located in the EAP Directorate, and commitment was demonstrated through budgetary and resource allocation. Resources required for the study, such as the files for training, were prepared by the Employee Wellness Directorate of the Gauteng Department of Health. Thus a good infrastructure supported this evaluation study. At the time of initiating the study, the researcher was the co-ordinator and facilitator of this process in the Gauteng Department of Health. The researcher was thus keenly aware of her position of authority in the Department of Health, however, as the research protocols of the Department are strict, they were respected. The researcher had left this employer by the time the data was gathered.

1.8.4. Testing of the data-collection instrument

In this study, the pilot testing of the data-collection instruments and the semi-structured interview schedule were conducted at the same hospital, the Dr Yusuf Dadoo, with a view to piloting the questionnaires. A decision was taken to pilot the questionnaire at

the same hospital, as different hospitals show subtle differences in terms of the organisational culture related to the demographic make-up of the hospital, its size and the community it serves. This decision was therefore taken to control for these variables during the piloting phase.

Phase 1:

Two respondents were selected for pilot testing the questionnaire: neither was included in the main study. These participants were asked to volunteer as they were from the high-risk units on which the study focused, for phase 2. The wellness co-ordinator asked for volunteers. Babbie (2001:250) maintains that "no matter how carefully a data-collection instrument is designed, there is always the certainty of possible error, and the surest protection against such error is pre-testing the instrument".

Phase 2:

Two respondents were selected for the pilot test of the semi-structured interview questionnaire. Neither was included in the main study. The questionnaires applied in Phase 2 were developed by the researcher. The same method of selecting participants applied for this phase of the study, as was done with the survey (see Annexure 4). The participants involved in the pilot test were requested not to discuss any of the instruments with any other hospital employees after the pilot test.

1.9. Description of the Research Population, Sample and Sampling Method

1.9.1. Research population

Sampling means "selecting observations" and then from making relatively few observations, generalizing them to the rest of the population (Babbie: 2005:164). One therefore makes inferences about the population based on findings from the Sample. Arkava and Lane (in De Vos, 2002:198) Say that the universe refers to "all potential subjects who possess the attributes in which the researcher is interested", and the population "is a term which sets boundaries on the study units".

The population/Sample

McBurney (in De Vos, 2005:194) refers to a population as the sampling frame, while Powers et al. (in De Vos, 2005:194) denote population as the set of entities in which the researcher is interested because they possess specific characteristics. The population for this study was the complete staff complement of the Dr Yusuf Dadoo Hospital.

The Sample

The Sample is thus a subset of the whole population that is actually included in the study and whose characteristics are generalised to the population (Bless & Higson Smith, 1995:86). No Sample was used for Phase 1 as the whole population of the Dr Yusuf Dadoo Hospital was included in the survey.

1.9.2. Sampling method

Strydom and Venter (2002:203) state that there are two major groups of sampling procedures: probability sampling and non-probability sampling. Probability Sampling is based on randomisation, while non-probability Sampling is done without randomisation.

Phase 1:

The whole population of the Dr Yusuf Dadoo Hospital was included in the survey, so sampling did not take place.

Phase 2:

With reference to Phase 2 of this project, **non-probability sampling**, specifically, **purposive Sampling**, was used. Babbie (2005:166) cites that sometimes it is appropriate to use your own judgement or knowledge of the population and this is purposive Sampling.

Purposive Sampling seemed appropriate, as it is based entirely on the researcher's judgement. The Sample for Phase 2 consisted of employees from the maternity unit, the admissions unit, the outpatients unit, security, and the casualty ward, identified for attendance at the training presented, according to the Management of Violence in the Workplace Programme, by Dr Susan Steinman.

The specific criteria the researcher used for selecting these units can be described as follows:

- Staff working in those units of the hospital where there is significant interface with the public.
- Where the risk of being exposed to workplace violence is more common owing to daily contact with the public (being the patients themselves, patients' escorts or their relatives or family members).
- Participants who had undergone training in Management of Violence in the workplace;
- Participants who had previously been victims of violence.

1.9.3. Size of the Sample

While Grinnell and Williams (1990:127) maintain that a 10% sample should be sufficient for controlling sampling errors, whilst Bless and Higson-Smith (1995:93) state that larger samples increase representativeness, allowing for the formulation of more accurate conclusions and predictions. Although the sample size for this study was small , findings were reported on in relation to previous studies and literature review findings and caution was exercised in the discussion of such findings, given the small sample. Strydom and Venter (2002:199) address sample size by indicating that the larger the population, the smaller the percentage of that population the Sample needs to be. The size of the sample was small as a result of the nature of intervention - training provided to respondents - where a smaller group was viewed as a more feasible group for effective training and preferred by the contracted trainer.

Phase 1:

In terms of Phase 1 of this survey, **no sampling** was done, as the whole population (staff component of the hospital) was included in the survey – a total of 400 employees.

Phase 2:

For Phase 2, the purposive sampling method was used and a sample of 40 participants was used for this phase of the study.

The 40 participants were selecting by utilizing the criteria of them having been exposed to workplace violence. This was the only criterion as those exposed to workplace violence would be able to engage around the workplace violence issues that were discussed in the training.

1.10. Ethical Issues

Babbie (2001:470) says that "Anyone involved in research needs to be aware of the general agreement of what is proper and improper in scientific research". Kumar (2005:210) states that "In research, any dilemma stemming from a moral quandary is a basis of ethical conduct".

Some of the ethical issues outlined by various authors are the following:

1.10.1. Informed consent and voluntary participation

Accurate and complete information on the possible advantages and disadvantages, as well as dangers to which respondents may be exposed, should be given to participants. Participants can then make an informed decision on their participation in the study.

Strydom (2005:59) states that

> obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures which will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives.

The cover page of all the questionnaires spelt out the ethical issues relating to the research and reassured participants of confidentiality as far as the study went.

1.10.2. Avoidance of harm

Strydom (2005:58) asserts that subjects may be physically or emotionally harmed. Emotional harm is often far more difficult to predict. It is therefore the researcher's responsibility to protect respondents, rather than repairing damage after the fact.

Best (2012:20) points out the researcher's responsibility to ensure that no harm is caused to research subjects and also to have that awareness that the research process may be harmful to participants…Training of this nature, such as the Management of Violence in the Workplace Programme, can often revive old emotional

wounds and scars. The researcher was available in the event of the participants requiring debriefing and needing referral for counselling, if ongoing services were required.

1.10.3. Cooperation with contributors

Because research is sometimes sponsored, ethical dilemmas may arise:

- Sponsors may exert pressure on the researcher to report according to their expectations;
- The real identity of the sponsor may not be disclosed or the real goal of the study may be hidden.

These are ethical dilemmas needing management. Ethical issues should be clarified before the process.

In addition, the extent to which acknowledgement of each participant's contribution deserves careful consideration (Strydom, 2005:65). Grinnell (1993a:88) says that co-authors should decide collectively on the acknowledgement that each one should receive.

As the study was carried out under the auspices of the Gauteng Department of Health, written permission was granted by the Gauteng Department of Health's research unit for this study to be conducted. The contribution from the Gauteng Department of Health was confined to the preparation of files for training. The researcher sponsored meals for the three-day training programme. Provision of food during training is common practice in the hospital and tangible proof of the appreciation of management to delegates to the training sessions. This information about the researcher being the sponsor for the meals during the three-day training programme was however never communicated to the respondents at any stage and as such could not have influenced their willingness to participate or even the contents of their responses. The researcher had no choice other than to sponsor – as the training was not part of the 'usual' training programme, administered by the hospital management. By not providing food during the first day of training, could have influenced the attendance by delegates of the remaining days of training.

1.10.4. Anonymity and confidentiality

Information given anonymously should ensure that the participants' privacy is respected. Confidentiality refers to the fact that information gathered is handled in a confidential manner. This is important, as it is the individual's right to decide when, to whom, where, and to what extent s/he will share personal beliefs and information, and this right should be safeguarded by the researcher (De Vos: 2005:62).

Babbie (2001:472) distinguishes between anonymity and confidentiality by asserting that confidentiality means that only the researcher and a few members of the staff would be aware of the respondents' identities, while anonymity implies that no one, not even the researcher, would be able to identify any respondent afterwards.

Phase 1:

The questionnaire used for data collection during the survey included a cover page containing information on the study and the assurance that confidentiality and anonymity would be maintained. Names would not be required in Phase 1 of the study, so respondents' privacy would be protected by the assurance of anonymity.

In an environment such as that of the Gauteng Department of Health, there were definite concerns about maintaining confidentiality, privacy and anonymity. It was necessary for the researcher to provide absolute reassurance in this regard. The researcher had a track record with potential participants in this process – a relationship of trust and integrity, which assisted in the completion of this study. However, at the time of the completion of the empirical phase of this study, the researcher had exited the Gauteng Department of Health and was in no position of authority over any of the participants during the various phases of this study.

Phase 2:

Because the delegates who participated in the training were the respondents, anonymity could not be guaranteed. Linking or associating specific questionnaires with specific respondents, however, was not possible, and all information given was handled in a confidential manner. Questionnaires were numbered in order to compare the pre-test and the post-test. This information was discussed with the respondents before the commencement of the training and the numbering was retained only by the

researcher on a manual spreadsheet, for purposes of the study only. The greatest confidentiality was adhered to in conducting interviews with participants in the final phase of this study, and names were not relevant at this stage. The pre-test questionnaire is annexure 5 and the post-test questionnaire is annexure 6. In addition, the cover letter is annexure 3.

1.10.5. Special populations and new inequalities

Strydom (2005:67) comments on the research across cultural boundaries currently being undertaken in South Africa, where in the past there was very little contact between cultural groups and often cultural customs and norms were not respected. The researcher is aware of these customs and norms, and respected them. Similarly, workplaces have a workplace culture, and in this case the public health sector has a particular type of culture. The workplace culture of the hospitals within the Gauteng Department of Health is one of respect for hierarchy and health care workers are seen as professionals. Because this is a public hospital, there is often a perception amongst health care workers that they are less privileged than health care workers in the private sector and that no one looks after their well-being. An intervention such as the training in Management in the Workplace would thus be viewed very favourably.

As an ex-employee in the workplace where the study took place, the researcher was keenly aware of the culture of the organisation and which strategies would or would not work, given the nature of the study within the context of the public health sector. As an ex-employee, the researcher understood that reassurance had to be given regarding the nature of the study, as well as reassurance around confidentiality. At the time of the empirical phase, the researcher had already exited the Department of Health, so did not feel contaminated by relationships but more enlightened about the sensitivities regarding confidentiality and reassurances about no harm.

1.10.6. Actions and competence of researcher

Researchers have to ensure that they are competent and adequately skilled to undertake the proposed research, particularly if the research is of a sensitive nature. The process must also be conducted ethically, with the results being correctly reported. This aspect also relates to the researcher's sensitivity to cultural customs as well as a responsible approach to the use of resources. The researcher had a keen

understanding of the subject being researched as well as the culture of the organisation and the study site, having been an employee.

Strydom (2005:63) notes that “researchers are ethically obligated to ensure that they are competent and adequately skilled to undertake the proposed investigation”. Training was conducted by a facilitator who is a respected expert in the area of workplace violence within South Africa and internationally. In addition, the researcher had completed research work before for a Master’s dissertation. In the organisation she had also facilitated the implementation of a number of research projects on HIV and Aids, as well as behavioural risk assessments.

1.10.7. Deception of respondents

Strydom (2005:60-61) asserts that this involves the process of deliberately deceiving respondents as to the nature or purpose of the study. Sometimes deception happens inadvertently, not deliberately, and should immediately be corrected. Information about the study was shared with participants; this was included in the introduction to the training and was also on the cover sheet to the questionnaire, outlining the purpose of the study (Strydom, 2005:61). The participants also all signed an attendance register as part of the informed consent process once they had read the cover letter. Thus no deceptive practices were undertaken as part of the research.

1.10.8. Release or publication of findings

It is important to communicate the findings of the study in the form of a report that should be accurate and objective. Shortcomings should be discussed clearly and openly and utilisation of the information should be encouraged. Respondents should also be informed about the outcomes of the study.

Strydom (2005:65) asserts that the findings of the study must be introduced to the public in written form. Huysamen (1993:191) also feels that it is desirable to present the findings to subjects as a form of recognition, and for good relationships.

The research report would be in the form of a doctoral thesis submitted to the University of Pretoria, and respondents were informed about this.

The implementation of this project produced a lot of interest among other public sector environments as well as the international bodies listed, and may be written up in scientific journals and other publications and presented at conferences.

1.10.9. Debriefing of respondents

One way in which researchers can minimise harm to respondents and assist them is by ensuring that debriefing occurs. According to De Vos (2005:66), this would entail working through their experiences in the study, as well as giving the researcher the opportunity to correct any misperceptions.

Judd et al. (1991:517) note that "debriefing sessions during which subjects get the opportunity, after the study, to work through the experience and its aftermath is one possible way in which a researcher can minimise harm".

Debriefing was available to all respondents at the site at which the study was conducted. Participants were alerted to this possibility. A counselling and advisory service was available and had been arranged with the Gauteng Department of Health for the debriefing period. It is to be noted that none of the participants made use of this service during the research period.

1.11. Definition of Key Concepts

Two definitions of workplace violence formulated by Steinman (2003) as part of her study are the following:

Workplace violence: "The intentional use of physical force, 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, death, psychological harm, mal-development, or deprivation" (WHO, 1995).

Workplace violence is an "Incident where staff is abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their Safety, well-being or health." (European Commission DG-V).

"Workplace violence is any action or incident which causes physical or psychological harm to another person" (Australia Capital Territory, Sa).

For the purpose of this study the researcher used the WHO definition. This maintains consistency with regard to definitions, as this definition was also used in the original research conducted by Steinman (2003:4) in the health sector in South Africa.

This definition is also favoured because it provides a broader frame of reference, recognises group interactions and explicitly recognises psychological harm.

In addition, other key words which need to be defined are used in the text:

Physical violence: "The use of physical force against another person or group that results in physical, sexual or psychological harm. It includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching" (WHO, 2002).

In a review of guidelines on workplace violence, Wiskow (2003:7-8) outlines terms used for physical as opposed to psychological violence.

Psychological violence: "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. It includes verbal abuse, bullying/mobbing, harassment and threats" (WHO, 2002).

Psychological harassment refers to "Destroying someone psychologically through lowering his or her confidence, self-respect, self-esteem and self-worth" (Luzio-Lockett, 1995:14).

1.11.1. Types of Violence

Wiskow (2003:8) has clearly outlined the different types of violence that are relevant to this study. They are also relevant under this section on definitions, as follows:

Type 1 (External violence)

Where the aggressor has no legitimate relationship to the workplace and the main objective would be to commit robbery or another crime. In the healthcare context this could be gang violence spilling into a hospital where injured gangsters are sometimes "finished off" if still alive.

Type 2 (Client-initiated violence)

The aggressor is a recipient of services provided by the workplace. This could also include client escorts or family of the recipient of services. In the healthcare sector this would be patient, or patient-escort on staff violence.

Type 3 (Internal violence)

The aggressor has an employment-related involvement in the workplace. Usually it is another employee, supervisor or co-worker. This is staff-on staff violence.

In a review of guidelines on workplace violence, Wiskow (2003:7-8) outlines terms used for physical as opposed to psychological violence.

Terms used for physical violence	Terms used for psychological violence
❖ Those incidents which cause major injury, require medical assistance, require first aid only ❖ Assault, assaultive incident ❖ Murder ❖ Fatalities ❖ Physical or sexual assault attack ❖ Abusive behaviour	❖ Threat (verbal and non-verbal), threat of assault, threat of sexual nature, threatening behaviour ❖ Verbal abuse, verbal attack ❖ Non-verbal abuse (stalking) ❖ Bullying ❖ "Ganging up" ❖ Harassment (includes threatening letters, phone calls) ❖ Health and Safety hazards, including inducing fear by way of intimidation

Table 1: Terms for the types of violence

Assault/ Attack: "Intentional behaviour that harms another person physically, including sexual assault" (WHO, 2002).

Attacks refer to interpersonal physical violence (Bowers et al., 2002:17). In this study, assault or attack will refer to an incident in which an individual has been physically harmed through an intentional or malicious act.

Abuse: "Behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual" (Alberta Association of Registered Nurses).

Abuse may refer to both physical and psychological abuse. These types of abuse may also be verbal. Physical abuse and aggression usually occur in interactions with the public.

This study holds abuse to be as far-reaching as the definition used for workplace violence and covers the range of behaviours from verbal to psychological to physical abuse.

Bullying/mobbing: "Repeated and protracted offensive behaviour through vindictive, cruel or malicious attempts to humiliate or undermine an individual or a group of employees" (WHO, 2002:4).

Bullying can take many different forms, from the act of deliberate lying, to focusing blame on the target, manipulating the context, undermining of work, disadvantaging the target, verbal abuse, isolating individuals, interfering in work practices, continual criticism, demeaning, destroying confidence, fabricating complaints and setting up to fail (Lewis, 2006:54).

Bullying is a type of workplace hostility in which there is hurtful, repeated treatment of an individual "target" by a bully (De Falco, 2001:193).

Once again, the WHO definition will be used, as it alludes to a pattern of unacceptable behaviour that has negative intentions and takes into account both groups and individuals.

Harassment: "Any conduct based on age, disability, HIV status, domestic circumstance, sex, sexual orientation, gender reassignment, race, colour, language, religion, political, trade union, or other opinion or belief, national or social origin, association with minority, property, birth, or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work" (Human Rights Act, UK).

Sexual Harassment: "Any unwanted, unreciprocated and unwelcome behaviour of a sexual nature that is offensive to the person involved, and causes that person to feel

threatened, humiliated or embarrassed (Irish Nurses Organisation). Sexual harassment can involve a range of unacceptable behaviours, including unwanted physical contact, offensive sexual comments and sexual propositions" (Kennedy, 2004:8).

Racial Harassment: "Any threatening conduct that is based on race, colour, language, national origin, religion, association with a minority, birth, or other status that is unreciprocated or unwanted and which affects the dignity of men and women at work" (Human Rights Act, UK).

Threat: "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" (WHO, 2002:5).

Victim: "Any person who is the object of act(s) of violence or violent behaviour(s) as described" (WHO, 2002). Victims are also "those who have been on the receiving end of aggressive behaviour and felt helpless" (Luzio-Lockett, 1995:15). In this study the victim is at the receiving end of behaviour that is either psychologically or physically damaging to him/her.

Perpetrator: "Any person who commits act(s) of violence or engages in violent behaviour(s) as described" (WHO, 2002:5).

The healthcare sector: For the purpose of this study, only healthcare workers registered with South Africa's Health Professional Council and Nursing Council are included in the study. In addition, allied professionals, such as social workers, physiotherapists and occupational therapists are also included. Administrative staff, working in the Gauteng Department of Health at the Dr Yusuf Dadoo Hospital was also included.

1.12. Limitations of the Study

- There is a plethora of international literature on the phenomenon of workplace violence, but far less on the actual management of workplace violence and even less on the evaluation of such programmes, in particular, training programmes. More recently, there have been a number of South African studies, which will add to the literature for future research into this phenomenon.

- The size of the sample for participation may prove to have limited the generalisation of the results, as only one group could be trained, given the circumstances at the institution. It is always difficult to conduct training over a number of days, owing to operational requirements. The inclusion of more participants in the training may have led to greater representivity and a greater ability to generalise the results.

- In the pre-test questionnaire and the post-test questionnaire, there was a difference in the way the question which enquired about the reasons why workplace violence was a serious phenomenon. As a result of this difference, the statistical significance could not be assessed. (See annexures 5 and 6)

- On certain items in the questionnaires, there was a high degree of non-response which posed a limitation (See annexures 5 and 6).Despite this limitation the findings mostly correlated well with the literature review and this has been taken into account with regards to the discussion.

- One of the limitations of the study was that the intended sample was to be drawn from the high-risk units, but on the day of the training a nation-wide taxi strike left the hospital severely short-staffed and many of the intended participants were unable to attend. The result was that those slots were filled by other hospital employees who were not necessarily from high-risk units.

- One of the limitations may also be that the study was conducted over a lengthy period of time. The empirical part of the study was however covered in a reasonable time, referring to the survey (Phase 1) and the consequential training, consisting of the pre-test and post-test and repetition of the post-test. The researcher also ensured that the literature review was updated. As such the protracted period of the study did not have an adverse effect on the outcome of the study.

The study was carried out under supervision of the Department of Social Work and Criminology at the University of Pretoria – being a tertiary institution known in South Africa for its track record on training of a variety of professionals in the field of Employee Assistance Programmes on different levels, i.e. continuous education through short courses, education and training on a masters and a doctoral level. However, despite the above leading role, the EAP is not the domain of Social Work, due to its multi-disciplinary nature and involvement of a variety of professionals. As

such the researcher and promoter did not enter in a debate as part of this study about whether the topic under investigation should be linked with Social Work or not. The focus of the study is all about the evaluation of the identified management of violence in the workplace training Programme.

CHAPTER 2

Workplace violence as a phenomenon

2.1. Introduction

This chapter will review the literature on the phenomenon of workplace violence. The literature has focused on the extent and prevalence of the phenomenon. This chapter will also focus on the literature on workplace violence in the health care sector, as the study centres specifically on this. All the factors contributing to workplace violence are unpacked, including the profiles of the bully and the victim. Finally, Chapter 2 deals with the consequences of workplace violence and its prevention. In the section on prevention, the actual training programme applied is contextualised within the Framework guidelines for workplace violence, which are the broader context informing the training programme.

The focus of this study will be on all types of workplace violence, towards consumers of services, towards providers and interpersonal conflict between employees. Therefore violence in the workplace in the broader sense will be covered within the literature study as well in the empirical study.

Before an evaluation of any kind of management of violence in the workplace programme can effectively be carried out, one would assume that absolute clarity of all relevant concepts are provided. For this reason, the phenomenon of violence in the workplace should be clearly discussed and the elements contributing to it are clearly understood. This was important in designing the pre-test and post-test questionnaires as well as the interview schedule.

2.2. Definitions of Workplace Violence

Definitions of workplace violence are either very focused and limited or very broad and all-encompassing. This contributes further to the fact that the information on this phenomenon is somewhat limited, as well as rather confusing.

Badzmierowski and Dufresne (2005:19) report that there are many names for workplace violence, including bullying, incivility, disrespect, psychological abuse, emotional harassment and even psycho-terror, but that, in essence, it is any negative behaviour that demonstrates a lack of regard for other workers.

The International Labour Organisation (ILO) uses the following definition when referring to workplace violence: Any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. These behaviours would originate from customers and co-workers at any level of the organisation.

A broad definition of workplace violence is favoured because it includes verbal abuse and threats which have serious psychological consequences, as well as effects on productivity. The World Health Organisation (WHO) definition is considered to be a broad definition, as it defines 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, death, psychological harm, mal-development, or deprivation. Leather (2003:9) believes that it is only by accepting a broader definition that a full range of circumstances in which a worker might be attacked can be accommodated.

The debate apropos of a broader or narrower definition is relevant, as it is often difficult to compare studies because of the variation in definitions. This variation also makes it difficult to have a true conception of the actual incidence of workplace violence. The narrower definitions are severely limited in that they often have a minimising effect. This is because only physical incidents are considered, so it is easy to overlook some of the psychological incidents.

2.3. Workplace violence as a phenomenon

Violence in the workplace is not a well-known phenomenon. It is often called by other names, such as “bullying” or “incivility”, which is one of the reasons for its relative obscurity. This euphemistic approach to this phenomenon is one of the factors that contribute to the relative ignorance surrounding the concept.

However, Hannabus (1998:304) concludes: “This is an issue that has come out of the closet in recent years”, and goes further by adding that “bullying is an issue that has been for far too long swept under the carpet”. Cooper (2003:v) concurs, Saying that workplace violence has become an issue of increasing concern, especially in Europe, Australia and North America. Leather (2003: 8) asserts that in different countries the meaning of workplace violence is embedded in different socio-political realities. These

different socio-political realities give rise both to different conceptions of the very nature and character of the problem itself, as well as acceptable ways of tackling it.

The example he uses is the fact that worker-on-worker violence is emphasised in the US, while client or customer-initiated violence receives more attention in the UK. This analysis is influenced by whether a broad or more restricted definition is favoured.

Emotional or psychological abuse may include verbal abuse, bullying, harassment and threats, and, as Kennedy (2004:15) noted, these actions may not leave scars but the emotional damage can be severe.

Another type of abuse is sexual harassment, which ranges from unacceptable behaviour, including unwanted physical contact, to offensive sexual comments and sexual propositions (Kennedy, 2004:15).

Psychological violence: This is the intentional use of power, including a threat of physical force against another person or group that could result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats (WHO, 2002).

Psychological harassment: refers to destroying someone psychologically by lowering his or her confidence, self-respect, self-esteem and self-worth (Luzio-Lockett, 1995:14). The psychological nature of bullying makes it difficult to document and almost impossible to prove, as the incidents that make up the abuse often seem innocuous, trivial and even pathetic.

Chechak and Csiernik (2014:1) propose a continuum of violence which recognises psycho-social acts as well. This continuum of violence prevents the researcher from being lulled into highlighting only issues related to bullying as a distinct phenomenon. The continuum provided by these authors is useful, as it offers a framework within which the phenomenon of workplace violence can be addressed.

The Continuum of Workplace violence was adapted from Chechak and Csiernik (2014: 14) and informed by Buss (1961); CCHS (2012); Crisis Prevention Institute (2012a, b); Mantell (1994); Neuman and Baron (1998).

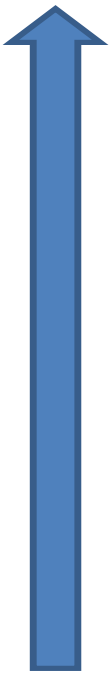
			Physical Actions	**Verbal Actions**
		Overt aggression	Physical assaults Weapons offences Theft Rape Arson Biting Murder	Inflicting psychological trauma. Hateful expressions of anger.
		Mobbing		Spreading rumours. Taunting.
		Bullying	Sabotage Stalking	Organizing actions against victim.
		Harrassment	Pranks Property damage Sexual	Insults. Sexual. Discrimination.
		Threatening behaviour	Throwing objects Destroying property	Statements that elicit alarm or threaten a person's welfare.
		Intimidation	Shaking fists or other gestures	Statements that instil fear or alarm.
	Escalating expressions of Violence	Disrespect	Eye rolling Laughing at a person	Swearing. Use condescending language.

Table 2: Continuum of workplace violence

(Adapted from Chechak and Csiernik: 2014:14)

The above model was particularly useful, as it helped the researcher formulate types of workplace violence that extend beyond the realm of “bullying”.

2.4. The Prevalence or Occurrence of Workplace Violence

The extent and actual exposure estimates vary largely because of the absence of a standard definition of workplace violence as well as the absence of a standardised measuring instrument.

Statistics on the phenomenon have shed some light on the issues but, once again, the fact that different definitions have been used in different studies leads one to believe that there is a complexity to the phenomenon which needs to be clearly understood. Recent research from the National Institute for Occupational Health and Safety in the USA (NIOSH) indicates that workplace bullying is increasing. A 2004 survey revealed the following findings: 24.5% of the companies approached in this survey reported that some degree of bullying had occurred there during the preceding year; 55.2% involved the employee as the target, 10.5% the customer, and 7% the supervisor (Badzmierowski & Dufresne, 2005:19).

Kowalenko et al. (2012:523), in their study on workplace violence in Emergency Medicine, have indicated that assaults are the leading cause of occupational injury-related deaths for all US workers. Emergency departments have been identified specifically as high-risk settings.

Leather (2003:9) reports on a number of studies, particularly that by van Londen, Hes and Ameling, who report on assault rates for nurses working in comparable hospitals in Amsterdam and Tel Aviv as being 15% and 45% respectively. Once again, the variation could be attributed to socio-economic and cultural conditions in Holland and Israel. Bjorkly has reported on the following rates of different inpatient aggression, namely, verbal threats (13.5 episodes per patient per year); physical threats (6.5 episodes per patient per year); physical assault (5.9 episodes per patient per year). The researchers collated the numbers per patient and numbers of patients over the years and then averaged them at the rates as outlined.

In a study of government workers (Hoobler, 2006:234), almost half of the workers had experienced some type of verbal harassment or abuse in the previous year, with 15% reporting being physically harassed or abused. Five percent of employees reported being victims of sexual harassment or abuse.

South Africa, as a developing country, is a society where “the awareness of workplace bullying is still in its infancy” and is not always recognised as an adult problem (Pietersen, 2007:59). Annual rates of physical aggression against health care workers reported on by Magnavita (2014:367) who references a number of studies, viz Estryn-

Behar et al (2008) where rates are between 11-25% and Chen et al (2008) between 35 and 80%.

Chechak and Csiernik (2014:9) further report that, according to Canadian data between 1988 and 1993, only two percent of fatal injuries were attributed to violent acts. Instead, over 50% of work-related deaths were related to a combination of exposure to harmful substances, transportation accidents or being struck by an object. They acknowledge that, while the Canadian statistics are lower than those of the US, it should be acknowledged that incidents of workplace violence still remain fourth in place, behind transportation accidents, falls and being struck by objects. The Canadian scenario has received further attention because of three highly-publicised cases involving the shooting of an administrator by her supervisor, a bus-driver killing four employees and a nurse who was stabbed to death by her former partner.

In Finland, a telephonic survey conducted by the Finnish Institute for Occupational Health found that 10.5% of healthcare and social sector service workers reported violent incidents in the twelve months before the survey. Sweden reported that, in a national sample of 2 600 registered nurses, 29% indicated that at some stage in their careers they had been victims of violence, and 35% had been victims of threat. In British Columbia, healthcare workers accounted for 55% of claims, and nurses had the same risk of workplace violence as police officers, who had a rate nearly four times the incidence of other professions (Jenkins, 2003:32).

Despite the vigorous debate on broad and narrow definitions, many developing countries have instituted reporting systems which provide a grim picture. Ongoing surveys have also allowed for some insight into the phenomenon of workplace violence and those most at risk, as well as the magnitude of the problem. These surveys and tracking systems have also allowed for a keen perception that, in the developing world, countries such as South Africa are probably under-reporting incidents, societal perception of normalised and institutionalised violence notwithstanding.

2.5. Violence in the Healthcare Sector

Workplaces are not all the same, and delving deeper into this phenomenon begs the question of whether there are certain workplaces which may be more susceptible to incidents of erupting violence. One could thus assume that there are certain

circumstances which may predispose one particular sector more than another, and it is in this context that one of the sectors in which workplace violence has indeed been studied and given some attention is the healthcare sector. There are probably a number of reasons why this sector in particular is vulnerable to more incidents of violence. Also take note of the statistics on workplace violence in the healthcare sector as were shared by Jenkins (2003:32) above.

Winstanley (2005:342) has quoted a number of studies suggesting some situational factors related to incidents erupting in the workplace. She quotes Whittington's (1996) study, which describes three categories of antecedent:

1) The patients' mental state;

2) Receiving care or treatment;

3) Refusal or delay in care or treatment.

2.5.1. Situational factors

Winstanley (2005:340) reports that few detailed explanations have been given for patient aggression from the patients' perspective, and she has proposed a cognitive model of patient aggression towards healthcare staff from the patients' perspective.

Cooper (2003:v) asserts that, in the service sector, health workers are at particular risk, estimating that they face a sixteen times higher risk of violence from patients/clients than that faced by other service workers. .Leather (2003:11-14) has expressed the view that the acknowledgement that nurses who are most exposed to workplace violence showed a shift in research to this sector, with many studies confirming that the majority of healthcare workers were at high risk of workplace violence, and disproportionately so. In an attempt to understand why the healthcare setting is a particularly dangerous workplace, he concluded that individual patient factors have been overemphasised at the expense of situational factors. Despite an individual propensity for violence, it still requires situational factors to trigger a reaction. Kitson (2008:217) postulates that there is a view that the healthcare sector operates like machine while general systems theorists have the opposite view and see the

healthcare system more as an organism. This may account for the somewhat limited focus on individual factors. Leather (2003:18) concludes:

> The majority of violent incidents across all healthcare settings result not simply from individual psychopathology, but from the interaction of a number of factors related to the environment, the staff member, the perpetrator, and the interaction between them.

South Africa is no different from the developing world, as the sector in which workplace violence has been put under the spotlight is the healthcare sector.

2.6. Factors Contributing to Workplace Violence

2.6.1. Nurses as a group

A number of studies have also explored the factors contributing to workplace violence. Lawoko, Soares and Nolan (2004:39) suggest that studies have indicated that nurses and women may be more abused at work than psychiatrists and men, but that there is also a lack of cross-cultural data on the topic. They refer to studies by Chappell and Di Martino (2000), in which 51% of workers who were exposed to workplace violence were women. Violence occurs in all occupational sectors, but psychiatric care increases the risk.

Lawoko et al. (2004:34) note that in a number of studies it has been suggested that nurses are more exposed to violence (Liss & Macaskill, 1994; Whittington & Wykes, 1992); Holden, 1985). Occupational risk factors for workplace violence which are inherent to the nursing profession have been spelled out by Anderson (2002:353) as being close contact with the public, life and death decisions, and the need for round the clock personnel, job stress due to poor staffing, long hours and poor staff-patient-ratio. She further postulated in this study that a past history of abuse may be considered a risk factor; as such a history may create a sense of vulnerability in some cases. Other characteristics are passivity or compliance and in other cases an aggressive “on guard” personality. The Anderson (2002:351) study concluded that over half of the nurses reported being victims of either childhood or adult abuse.

2.6.2. Gender and Patriarchy

Kennedy (2004:16) cites Chodoram, who believes that violence against nurses should be looked at from a gender perspective. The dynamics she outlines are that nurses

continue to accept abuse because they feel they do not have the power to change it. They have also, as a predominantly female profession, been conditioned to accept behaviour from those they consider powerful, as women have often been socialised to be passive and to relinquish power. Lastly, she asserts that nurses are easy targets for patients who bite, kick, hit and spit because they have the greatest exposure to these patients.

The issue of power in this sector is also highlighted, with nurses feeling that they are powerless, as the above studies suggest. It would thus be quite revealing if more studies focused on how issues of patriarchy and power are played out in these organisations, where the organisational climate is conducive to workplace violence and supportive of such behaviour. The discussions in the literature around gender and specific professions such as nursing being female-dominated and as such might be more vulnerable - may all be reflective of a patriarchal society and issues of power.

2.6.3. Environmental factors

Other unfavourable working conditions have also been suggested as risk factors, such as physical working conditions like poor lighting and ventilation, which may act as contextual stressors, according to Lawoko et al. (2004:52).

Cooper (2003:vi) has highlighted a number of environmental factors which contribute to workplace violence. He noted variables that included the gender of female workers, mental illness and alcohol or drug use among patients. In addition, he has also noted a number of organisational factors, such as poor lighting, poor security, accessibility to objects that can be used as a weapon, understaffing, low supervisory support, work overload, poor workgroup relationships or impending workplace changes, which correlate with Lawoko's views.

Healthcare settings are often in communities with high levels of crime or gangsterism and drug use. Cooper (2003:vi) also noted societal factors like changing societal norms around issues of aggression or violence.

Lastly, some workers are also deployed in dangerous environments like war zones, thereby exposing them to heightened physical and mental dangers.

There are not many conceptual models in the literature which clearly outline all the factors associated with workplace violence, but Curbow (2003:40) has proposed a conceptual model of general and healthcare-specific factors associated with workplace violence (see Table 3).

Factors from NIOSH (1996)	Healthcare settings	Factors from Bulatao & Van den Bos (1996)	Healthcare settings	Factors from Elliott (1995) specific to healthcare
Contact with the public.	High	Feeling aggrieved.	High	24-hour open door policies for patient access.
Exchange of money.	Low	Being forced to wait.	High	Decrease in available treatment for mentally ill and substance abuse patients.
Delivery of passengers, goods or services.	High	Perceived intrusions into private life.	High	Availability of money and drugs in hospitals.
Having a mobile workplace such as taxicab or police cruiser.	Low	Prejudice	High	Prevalence of weapons among patients.
Working with unstable or volatile persons in healthcare, social services, or criminal justice settings.	High	Staff attitudes.	High	Current cost-cutting focus and widespread downsizing.
Working alone or in small numbers.	High	Uncomfortable physical environment.	High	Working alone at night or in the early morning.
Working late at night or during early morning hours.	High	Alcohol	High	Traditional staffing patterns that may have low staff during high flow.
Working in high crime areas.	High	Mental instability.	High	Circumstantial factors; gang members, trauma patients, distraught family members, long wait, inability to get care.
Guarding valuable property or possessions.	Low			
Community-based setting.	High			

Table 3: Health Care specific factors related to workplace violence

2.6.4 Organisational climate

Kgosimore (2004:68) calls upon the employer fraternity to acknowledge their role in the perpetuation of workplace violence and notes one of the areas not receiving adequate attention is organisational climate. Luzio-Lockett (1995:12) believes that there has been no adequate recognition that conflicts may almost be forced upon people by the organisational climate, or at least have been allowed to perpetuate because they are not acknowledged. If this is so, what then can be done in organisations to avoid conflicts or to minimise violence being seen as “normal”? We thus have to look at how we can bring about an organisational culture in which interpersonal relationships are healthy. Luzio-Lockett (1995:17) proposes the following:

- **Awareness on the part of the organisation**. This means that organisations must recognise harassment and bullying and also understand that, if it occurs, it affects not only individuals, but also the organisation as a whole. Respect should be demonstrated in a number of different ways.

- **Clear policy.** This refers to an organisation’s ground rules and stands against harassment and bullying. This policy statement is building the ethos of the organisation, but also spells out systems for employees’ protection and security in the workplace.

- **Appraisal system.** An appraisal system has a role to play when it comes to employees receiving feedback on performance. Supervisors must therefore have the appropriate skills without using confrontation, subjectivity or judgemental behaviour. Problems which may hinder performance can thus be identified.

- **Interpersonal skills at work.** These types of courses should be given a high priority and supervisors should be equipped to understand the consequences of their verbal and non-verbal behaviour in determining a successful relationship and ultimately an improved work environment. Openness in communication is also stressed.

- **Assertiveness training**. Assertiveness means being able to state your case without infringing the rights of others, and is a technique that can be learned

In a study that considered organisational factors in the maintenance of a bullying culture, Lewis (2006:52) concluded that bullying is a "learned behaviour" in the workplace rather than any predominantly psychological deficit in individual perpetrators or targets. Hoobler et al. (2006:231-232) believe that organizational cultures are likely to play a role in workplace violence, as cultures serve to create a degree of order in social life. The writers indicate that "recurring patterns of behaviour form organizational cultures to which people become attached and these behaviours become norms to which determine appropriate organizational behaviours, yet these norms may not always be positive even if socially sanctioned". This systems approach is further enhanced by Kitson (2008:226) in an article on systems change where she posits that in order to change behaviour in a system, researchers need to change the way they think about the system itself, "the way new knowledge is created and how we become involved in the process of knowledge translation"

2.7. Profile of the Perpetrator

2.7.1. Lack of typical profile

This phenomenon of workplace violence prompts organisations to seek information on the perpetrator and on the victim. As the employer, we may assume that it is a particular type of person that falls into either category. "Over 80% of bullies are bosses and a bully is equally likely to be a man or a woman" (Watkins, 2005:7).

Watkins (2005:7) Says that bullies are "insecure people with poor or non-existent social skills and little empathy, who turn their insecurity outwards". They find the capability of their target a threat and therefore find satisfaction in attacking and diminishing the capable people around them.

Di Martino (2002:17) notes that the studies he conducted in countries like South Africa, Australia, Portugal, Thailand, Brazil, Bulgaria and the Lebanon confirmed the difficulty in establishing a profile of the perpetrator of workplace violence and that this may result in stereotyping and generalisation. However, it does suggest that in the countries under investigation a pattern seemed to emerge whereby patients were the main

perpetrators of physical violence, while staff were the main perpetrators of psychological violence. Hoobler (2006:235) explains that, in their study, the main perpetrator was the customer, and, to a lesser extent, the co-workers and superiors.

He further notes that, in South Africa, patients were the main perpetrators in 45% of the incidents of physical violence in the public sector and that staff appear to have been the perpetrators of more incidents of psychological violence in both the public and private sectors.

However, in his later work, Di Martino (2003:17) proposes the following factors as being particularly relevant for the perpetrator's profile:

- History of violent behaviour;
- Being male;
- Being a young adult;
- Experience of difficulties in childhood, including inadequate parenting, troubled relationships within the family and low levels of school achievement;
- Problems of psychotropic substance abuse, especially problematic alcohol use;
- Severe mental illness, where symptoms are not adequately identified or controlled through therapeutic regimes;
- Being in situations conducive to self-directed or interpersonal violence, including access to firearms.

2.7.2. Victim-bully relationship

Hannabus (1998:306) has written extensively on the profile of the bully. He notes that bullies look for victims, and refers to the bully-victim dyad of which sociologists speak. This means that the bully's and the victim's personalities are created and are the result of complex social processes. Bullies have learned that they can turn to aggression to solve their problems, while victims have learned to be submissive and to avoid confrontation and rejection.

Hannabus moots childhood explanations in this regard, as victims may have learned to respond to bullying by either a parent or sibling by being conciliatory or submissive, and think that this type of behaviour might mean that they will be liked. Bullies, on the other hand, discover that being aggressive can have specific pay-offs, which could be parental attention, a gift, or something which favours them. In this way they are then encouraged to continue behaving in this manner in adulthood, in order to get their own way.

Trying to typecast the bully may be controversial as one looks to individual defects to explain the emergence of the phenomenon, whereas in fact organisational or societal factors may play a leading role. Authors such as Hannabus, who has written extensively on the profile of the bully, may, however, argue that not all those who are employed under the same circumstances turn out to be bullies, which suggests that there must be an individual component in workplace violence.

In essence, the researcher concludes that the issue is complex, with layers of contributory factors emanating from society, organisations, and the individual. The process is a dynamic one with many interacting components.

2.8. Profile of the Victim

Watkins (2005: 7) challenges the myth that a target or the person being bullied is a weak person, saying that the chosen target will often be a “capable, dedicated staff member, well-liked by co-workers”. They are usually also people who have a cooperative, interpersonal style and are non-confrontational.

A non-confrontational style may predispose these individuals to being bullied, as they seek to avoid conflict and would then be considered by a bully as “ripe pickings”.

2.8.1. Victim-organisation dyad

In considering the profile of the victim, Hannabus (1998:307) suggests the following, which was elucidated in the “Bully in Sight” homepage:

- Victims are often good at their job;
- Are popular;

- Stand up for a colleague who is being bullied;
- Blow the whistle on incompetence;
- Unwittingly reveal incompetence by being competent;
- Are unwilling to compromise because of high moral standards;
- Are too old or too expensive.

The work by Hannabus, although once again focusing on individual behaviours, asks whether the bully is merely acting out organisationally congruent behaviours, suggesting that the organisational culture may be the real culprit. The individual employee bully is merely the "hand by which the blow is delivered". Would the blow be delivered if there was no confidence in "the weapon that organisational culture has provided"? The weapon is sometimes that incompetence is the norm and unethical behaviour is tolerated. For example, any deviation of individual behaviours from that norm would possibly give rise to workplace violence. These actions would not be tempered or managed if the organisational culture accepted the things that served as precipitators.

Bahg (1990:21) allows for a systems understanding of the fact that individual considerations are inadequate to explain the host of factors contributing to workplace violence erupting by articulating the following: "Society cannot act on its members but the members of a social group can act severally upon a single individual; the behaviour of each individual is determined not only by his genetic make-up but also by the role he plays in society. Interaction between two societies is an individual –individual affair, and social change is a change in the social structures of society-hence a change at both the societal and the individual level."

The relationship between the individual healthcare worker and the hospital is thus critical in addressing the underlying roots of workplace violence and more importantly interventions to address the problem.

2.8.2. Gender of the victim

Di Martino (2002:18) concludes that, difficult as it is to establish a profile of the perpetrator, it is even more difficult to establish a profile of the victim of workplace violence. Gender-based differences do appear, but most healthcare workers are female, which accounts for the bias in this direction.

The country studies produced other results as well. In Bulgaria and Portugal, women are more subject to verbal abuse than men are, while in Thailand men are more prone to be the victims of physical violence, bullying/mobbing and racial harassment. The report from the Lebanon indicated that women were more at risk of sexual harassment, while the Portuguese report revealed that men at the health centres were more at risk of sexual harassment. These reports, therefore, caution us to beware of stereotypes (Di Martino, 2002:18).

2.8.3. Age of the victim

Interestingly, age did not seem to play a significant role, except that seniority often mattered when it came to defusing situations. The personality and attitudes of workers were also considered, and it was found that certain staff members were better at handling difficult situations than others. In addition, nurses with low self-confidence and poor defence skills were more likely to be victimised.

2.8.4. Uniforms

Di Martino (2003:17) notes that there are “many attributes of a victim of workplace violence which could be associated with a degree of risk. These include appearance, health, age and experience, gender, personality and temperament, attitudes and expectations”.

He uses the example of uniforms, which usually denote respect and authority and are discouraging of workplace violence, but in certain cases, such as in the UK, an increasing number of cases of aggression towards ambulance staff occurred because of general public hostility. This definitely contradicts the popular assumption that uniforms may result in some form of respect for authority, and thereby lower the occurrence of violence.

2.8.5. Health of victims

Workers' health can also influence how they interact with the public, as stress brought about by heavy workloads can lead to more misunderstandings and consequently aggressive behaviour. Age is a relevant factor, as older workers have more experience in handling difficult situations, and the risk accordingly increases the younger the worker.

2.8.6. Personality of victim

The personality and attitude of the worker may also be relevant to the creation of a potential conflict situation, as some workers may be more tolerant than others when dealing with the public.

Kennedy (2004:58) found that patients who were perpetrators of abuse received compromised care, as 75% of nurses interviewed said that they then performed their duties under duress and were prepared to do only what was minimally expected of them. Abusive patients were often ignored or avoided. The debate on the profile of a victim may indeed be a difficult one as there may be no typical picture. The individual-organisational fit or incongruence may very well be the leading factor and is thus a more dynamic, complex interaction varying from one situation to the next.

2.9. Consequences of Bullying

There may be long, tedious and tangled discussions about the profiles of the bully and the profile of the bullied, but it goes without saying that the consequences of this behaviour can be devastating for individuals and counterproductive to the levels of morale and productivity in any workplace. Beech et al. (2006:31) Say that estimating the full cost of workplace violence may not be easy, as many of the costs are intangible. These could be, for instance, loss of morale, increased staff fear and post-traumatic stress disorder. Other costs, such as absenteeism, early retirement and ill health may be easier to calculate but it is a fact that the social and economic costs of workplace violence are substantial.

Watkins (2005:7) notes that between 10% and 52% of a bullied employee's time at work is wasted. Research shows that they spend time defending themselves, networking for support, thinking about the situation, feeling unmotivated and stressed,

or taking sick leave owing to stress. Peter Senge (1990) has written on systems thinking and effective organisations and has highlighted the concept of dynamic complexity which refers to the impact and the different effects an action can have over time or on different parts of the system. He also alludes to unintended and non-obvious consequences. The psychological consequences of bullying are often such non-obvious consequences, but may have a serious impact on the workplace and on the individual.

2.9.1. Incident not viewed seriously

Lewis (2006:55) maintains that in the healthcare setting, managers often attempt to contain the situation and, although this may be desirable, the victims often feel that their complaints are not taken seriously or that disciplinary and investigative procedures are not followed. The result may be that the bullying continues, as the root causes are not dealt with.

Lewis (2006:55) refers to the work by Nami at the American Bullying and Trauma Institute, who analysed 200 completed surveys of workplace bullying and found that 80% of this had been perpetrated by bosses, and that many victims who had tried to obtain redress had actually become more of a target.

2.9.2. Victims considered as trouble-makers

Interestingly, Nami (unknown) also concluded that the Human Resources Department in particular often failed to support victims. In only 7% of the cases were bullies transferred, punished, or had their employment terminated.

Victims face an uphill battle for redress, as they are often seen as troublemakers, have very little support from their colleagues, and fear that this will impede their career advancement and position.

2.9.3. Victim-bully relationship

An interesting position on this situation has been postulated by sociologists, according to Lewis (1999:306), who speaks of the bully-victim dyad as of one needing the other. They suggest that the bullying and victim personalities are created through complex social processes. The foregoing paragraphs have touched on the interactive and

dynamic nature of workplace violence and have painted a picture of a phenomenon driven by a complex web of different factors in society, the organisation and the individual. Lewis's work in this regard highlights the fact that it may not be helpful to label an employee a victim or a bully, but that the interaction between people in the workplace may be a more useful factor to explore.

2.9.4. The cost of workplace violence

Badzmierowski and Dufresne (2005:20) quote statistics of a study of 9 000 federal employees, 42% of females and 15% of male employees had been harassed over a two-year period and that the associated costs had been $180 million in lost time and productivity.

Janssen (2004:62) has examined the effects of conflict with superiors and postulates that it creates a barrier between employee empowerment and organisational commitment. It is suggested that "conflict with superiors is a psychologically strong and salient job stressor that has the deleterious potential to block the beneficial impact of empowerment on the development of positive attitudes towards the organization". One can reasonably assume that, if an employee finds the workplace a conflictual, unsafe space, one which does not add value to employee empowerment and development, organisational commitment and engagement will be difficult to achieve. Organisational engagement is very often achieved as part of the process of employees being made to feel part of the greater vision of the organisation, and conflict with a superior negatively affects this. Kitson (2008:220) firmly believes that when the deeper structural and process patterns are recognized, as just noted, only then can researchers know how to influence those patterns.

2.9.5. Post-traumatic reactions

Workplace violence can trigger a range of both physical and emotional reactions. Cooper (2003:vii) reports that emotional experiences can include anger, fear, shock, anxiety, depression and sleep disturbance. Physical injuries range from bruises to broken bones. One of the consequences of workplace violence is that those being bullied are more likely to report that they are planning to leave their jobs than those who were not victims.

Workplace violence has significant consequences for the retention of employees in an organisation. Employees who are bullied may believe that they have no choice other than to leave their organisation, especially if there is no recourse for the victim. The consequences are often the loss of skilled employees and additional cost implications, as a lost employee has to be replaced and the associated costs of recruitment apply.

2.9.6. Stress and workplace violence and bullying

Di Martino (2003:vii) has focused on the inter-relationship between stress and workplace violence, and holds the view that quantifying the cost of workplace violence is crucial to the shaping of anti-violence strategies. He refers to data from the European Union which shows a significant correlation between workplace violence and stress, with the cost of stress calculated at €20 billion per year. In the USA, the cost of stress has been calculated at US$350 billion per year. The cost of violence alone has been calculated at US$35.4 billion. In addition, he reports that it is calculated that the cost of stress and violence contributes to 30% of overall ill-health costs and that stress/violence accounts for 0.5% to 3.5% of the GDP per year.

Hannabus (1998:307) says that, unfortunately, power and influence often decide who stays and who wins when a complaint is filed and investigated, and usually it is the victim who leaves. He further notes the effects on victims, including psychological injury, stress, anxiety, insomnia, feelings of guilt and shame, irritability, low self-esteem, panic attacks, and poor concentration. Physical symptoms such as headaches, sweating, psychosomatic illness and skin irritations are also common.

2.10. Prevention of Workplace Violence

2.10.1. Training

Hannabus (1998:309) shows that training is often recommended to deal with bullying, one of the most common forms of workplace violence. This training may be direct training on aggression and violence in the workplace, assertiveness courses and conflict resolution, as well as instruction on harassment policies in the company. Training is also often integrated into programmes on team building, interpersonal skills and quality assurance. Despite this, Beech et al. (2006:33) are of the opinion that, despite the fact that training has received a clear and emphatic endorsement by

researchers, it is not offered universally, the issues being that there is a large variation in the amount of training, as well as variation in training for different staff groups. The numbers being trained often do not reach a critical mass and very little information has been collected on the length and content of training and the preparation of trainers.

2.10.2. An integrated approach

Cooper (2003:viii) highlights a number of violence prevention programmes which he notes can be divided into two, action for patient/client prevention and preventive action for co-worker violence. These usually overlap. Cooper has identified a number of key criteria for these prevention programmes:

- Strong commitment from healthcare administration;
- Clear written policy/programme for job safety and security, which is communicated to all employees;
- Targeting the physical environment (removing items which could be used as weapons, providing or installing proper lighting, security cameras, alarm buttons);
- Addressing administrative controls;
- Providing training/education programmes for staff;
- Job stressors, such as high workload demands or poor communication between staff may increase the risk of workplace violence, and job redesign may have to be considered;
- Putting in place a monitoring system which assesses the numbers, types and severity of violence and injuries, and which can be used to assess the effectiveness of preventive action.

2.10.3. Multi-dimensional approach

Wiskow (2003:14) has noted that, because workplace violence is multi-factoral, it is important to use a multi-dimensional approach. As already noted, workplace violence is determined by individual, situational, organisational, and interactional and even societal factors.

One of the key decisions when implementing any intervention programme is often the aspect of customisation to the organisation. A range of possible interventions seems expedient, as the phenomenon needs to be tackled at a number of different levels. However, even within that, a variation may be which weighting would be attached to which activity, and some parts of the multi-dimensional approach may be given more attention, time and concerted implementation. This process of customisation must be taken into account in any intervention process, as failure to do so may result in an overall lack of support for the intervention. Wiskow's formulation of the multi-dimensional approach brings us closest to systems theory, which is the framework underpinning this study.

2.10.4. Strategies

There are different ways of categorising the strategies recommended, the most common of which differentiate between the proactive and reactive interventions which consequently outline preventive and post-incident measures. Another category uses three separate categories, prevention, protection and treatment. This categorisation of proactive and reactive interventions is very useful, as it allows organisations to ensure that, within the range of interventions decided upon, those from both the proactive and the reactive categories are included. A phenomenon such as workplace violence, which has a multi-dimensional base, will best respond to a comprehensive, multi-dimensional model of implementation.

Wiskow (2003:14) further proposes strategies according to types of violence. In the health sector, strategies can be divided into two, strategies that are patient or outside-initiated and those resulting from co-worker violence. She found that guidelines focus mainly on violence initiated by clients and that the attention given to violence initiated by co-workers is relatively little.

The usefulness of this categorisation may best be felt in the area of managing interventions in an organised and clustered approach, that is, looking at the area of co-worker violence as needing a group of interventions. The model to be used would, for best results, still have to include both proactive and reactive interventions. Once again, this type of categorisation could be used in certain organisations.

2.10.5. Research

Cooper and Hoel (2003:76) have also highlighted the need for more scientific and rigorous studies, which should contribute to a better understanding of the effectiveness of individual preventive measures. They also noted that studies should take into account factors such as absenteeism and poor lifestyle habits, and that issues of rehabilitation have not been researched at all. It is thus proposed that the evaluation and comparison of different intervention studies would be useful and may produce a business case to recommend more workplace violence programmes.

Cooper and Hoel (2003:76) also recommend that future research projects should build on current research but that better research instruments must be developed. This places emphasis on the standardisation and validation of instruments. In addition, longitudinal studies are rare in this field, with the result that there is very little evidence to link the antecedents of workplace violence, long-term effects and effective prevention strategies.

Wassell (2009:1054) indicates that the area of workplace violence is an active one that is yielding new additions to the literature. The final conclusions as to which interventions have been proven to reduce workplace violence are also constantly evolving.

2.10.6. Evaluation of training programmes

Rallis and Bolland (2004:5) Says that: “Programme evaluation is like any other deliberate enquiry process about learning” and “explicates programme purposes, activities and outcomes……goes beyond describing; it generates knowledge about the programme.”

They further note that programme evaluation has three key concepts

- Systematic enquiry
- Judgement of worth, merit, value or significance
- Information for decision-making

Tyler's (1949) approach to programme evaluation was to propose an objectives – based model and programme evaluation was thus an approach to determine how effective a programme was in helping clients achieve behavioural objectives as is the case with the current empirical study.

Gard et al (2004:179) contends that in the health care sector programme evaluation is often used for the following activities, namely

- Maintaining quality
- Assessing curriculum and instruction
- Identifying areas of challenge
- Facilitating programme improvement
- Providing data for reports to state agencies , accrediting agencies and governing boards

This study clearly used programme evaluation then for the purposes of facilitating programme improvement.

2.10.7. Programme context

The local conditions or societal background is very important. A good example is the USA, which has very different gun laws and bullet-proof glass armed security guard requirements, which are reflected in the US legislation. These requirements are not to be found in the health sectors of other countries. Even within countries, organisational differences have to be accommodated, as noted by Wiskow (2003:24), who notes that organisational differences have to be taken into account. It is also vital that the customisation of solutions takes local conditions into account, as developing countries require strategies different from those of industrialised nations. The emphasis needs to shift to more often addressing basic healthcare infrastructure.

In evaluating the major known guidelines of different countries, Wiskow (2003:24) reports that the essential elements of an anti-violence programme most often named are:

- Management commitment;
- Employee involvement.

Thus there has to be commitment and cooperation on the part of these two groups if this programme is to be successful. There are a number of other critical issues that Wiskow (2003:24) believes should be addressed in the different country guidelines on workplace violence:

- timeframes are not clear;
- relevance (credibility of the measures, as it is sometimes difficult to measure the sustainability of strategies.

Despite the above it is clear from an overall review of guidelines that a multi-level response is the best. Both management and employee participation cannot be sufficiently underscored, and the interface between these two groups is of paramount importance to the overall success of such a programme.

2.11. Conclusion to the Chapter

This chapter has clearly outlined the issues which the literature has suggested could be linked to workplace violence, such as, inter alia, organisational factors, age and gender. In addition, it has explored the health care sector and the levels of workplace violence, as well as the factors that make this a vulnerable sector, such as the types of clients being managed, the location of hospitals, and environmental factors. This chapter is important in that it examines the factors related to workplace violence, which forms the backdrop to the training programme and on which all data collection tools have been premised.

In conclusion, Rallis and Bolland's (2004:5) pronouncements on the fact that evaluation theory based on the three key concepts of systematic enquiry, judgement of merit or significance and additional information for decision-making is indeed what underpins this study. The broader objective of the evaluation study would be to add knowledge to the phenomenon of workplace violence as it is currently understood and also to provide possible avenues for further research on the issue of workplace violence.

CHAPTER 3

Literature Review on the Management of Violence in the Workplace Programmes

3.1. Introduction

There has been limited research describing the phenomenon of workplace violence. Kgosimore (2007:61) notes that because the phenomenon of workplace violence remains largely under-researched, violence against employees cannot be properly controlled. Very little research has been conducted on programmes for mitigating and managing workplace violence and even less on measuring the impact of different interventions. Kgosimore (2007:77) had confirmed the role of criminologists as being useful in exploring the phenomenon of workplace violence, which may lead to better conclusions on workplace violence prevention strategies. This chapter thus focuses on reviewing the literature on different intervention programmes.

3.2. Research challenges

Given the above challenges noted, a number of questions remain, as outlined by a specific relevant government publication [sa]:

- What are the specific tasks and environments that place workers at greatest risk?
- What factors influence the lethality of violent incidents?
- What are the workplace assault victims' /offenders' relationships?
- Are there identifiable precipitating events?
- Are any safety measures in place?
- What were the victim's actions and did they influence the outcome of the attack?
- What are the most effective prevention strategies?

Due to the formulation of the hypothesis, earlier in this report, the above questions had not been acknowledged formally as 'research questions' – but a number of important

matters had been addressed by these questions – of which most of them have been answered through the empirical data specifically.

3.3. Reporting on Workplace Violence

Reporting incidences of workplace violence is critical to enhance the level of awareness, to assess the actual prevalence of workplace violence and lastly to ensure that incidents are noted for possible recourse management. Di Martino (2002:29), in his country studies of Bulgaria, Thailand, South Africa, Australia, Portugal, the Lebanon and Brazil, reported extensively on the effective responses by workplaces to the phenomenon of workplace violence. He notes that reporting is essential for an effective response and that in Bulgaria only 23% of respondents had indicated that there was some type of reporting procedure. In two thirds of physical violence incidents the victims did not tell anyone and over half of the respondents said that reporting was useless, while 14% did not report at all as they were afraid of negative consequences. Interestingly, in cases of verbal abuse and mobbing, about 15% did not report anything, as they thought the incident was not important. In Thailand, 38.5% of the victims pretended the incident had not happened and only 37% of all incidents of violence that were reported were investigated. However, in 63.4% of the latter cases they were not pursued to a conclusion and in 44.4% of the cases no action was taken against the perpetrators. Di Martino notes that a similar picture emerged from the South African and Portuguese studies, with the majority of cases, particularly those of psychological violence, being unreported in South Africa. In the majority of those cases, no action was taken, the perpetrator was not prosecuted and the victim felt dissatisfied with the way the incident was handled. In Portugal only 7% - 14 % of victims reported the incidents.

A different picture emerged in Australia, where 79% of health workers reported that there were procedures in place for formally reporting violent incidents. In contrast, however, only 8% to 12% of all incidents of violence were actually reported. In Brazil, the situation was similar, with 71% of respondents being aware of the reporting procedure and knowing how to access it, but with 72.4 % saying that they were not encouraged to do so.

The conclusion is that, although reporting forms an important component of an intervention response, a number of other factors render it an effective or non-effective strategy. One could postulate that reporting would be considered an effective strategy if, as a measure of recourse, it runs to a natural conclusion, is considered a measure which is fair to both the victim and the bully, and which also ensures that there are repercussions for the bully. Victims should also have confidence in the fact that, if they do report, they will not be negatively affected. One can also reasonably deduce that a greater awareness of reporting procedures would also increase the reporting rate. Gershon (2003:24) concludes that "It is important to have uniform categories and definitions for violence in the healthcare setting for a wide range of reasons." Such uniform categories would refine reporting and enhance awareness about the phenomenon of workplace violence.

3.4. Long-Term or Short-Term Measures on the management of violence in the workplace programmes

Di Martino (2002:30-31) also reports on the importance that different countries attach to strategic, long-term rather than short-term measures. The Bulgarian report emphasises the strategic, long-term solutions that address larger socioeconomic and social problems in all their complexity and variety. It also sees the reform of the healthcare system and interactions with their national health insurance as significant solutions to the issues of workplace violence. In South Africa, there was greater focus on training in skills, stress management, communication and conflict management. Better orientation, refresher courses, getting to know other staff members and team building were also offered as possible solutions. It was also mooted that staff members who had been attacked should be treated with more care and understanding, and the role of management in this process was highlighted.

3.5. Security Measures

The improvement of security measures was also suggested as a measure whereby management should be more active, according to Di Martino (2002:30-31). In Thailand, the use of security measures to deal with workplace violence was reported by 82%. Similarly, the most widespread intervention to combat workplace violence according to the Bulgarian report was the use of security measures reported by 70.8% of respondents. 66.2% of the South African sample also believed that security

measures would be the most effective measure. The Brazilian sample ranked human resource and training more frequently, as did Portugal, where respondents in a focus group discussion said they did not believe that security measures alone would solve the problem.

It is thus apparent that there is some merit in implementing measures to improve security as part of an overall approach, but how much weight this intervention strategy should be accorded is debatable. It is certain, however, that this measure should not be applied in isolation.

3.6. Policies

Luzio-Lockett (1995:17) maintains that the foundation on which to build a quality work environment in organisations is the vital necessity of a clear policy indicating, through ground rules, the ethos of the organisation and its stand against psychological harassment.

Howard and Wech (2012:112) have highlighted some of the gaps in the literature on workplace violence. They postulated that, while the effects of policies on organizational climate have been researched, the effects of the formalization of these activities and their influences on workplace violence have not really been studied. They further argue that understanding the effects of policies, procedures and practices is critical to understanding the conditions under which employees might exhibit workplace violence, offering the opinion that formalization could either reduce or cause conflict in organizations.

In the majority of cases in the country studies reported by Di Martino (2002:3233), no specific policy on workplace violence was in operation. In addition, where there was reference to policies, it was not to specific policies on workplace violence but general health and safety policies, which create conditions for preventing and reducing workplace violence. The focus group discussions during these country studies shed some light on the fact that the measures being taken were often within the context of disciplinary procedures.

In South Africa there were generally no policies, or else they had not been communicated to the healthcare workers. Only 25.1% of respondents in the public

sector, as opposed to 43.7% of respondents in the private sector, confirmed that their employers had policies against physical violence in place. The situation was reported to be worse in relation to psychological violence, where specific policies existed in as few as 12%, and no more than 36% of surveyed workplaces. In Australia, policies were being developed at the time. In Thailand, 42% of respondents reported that there were policies to address verbal abuse, 35.8% for physical violence, 25.7% for sexual harassment and 13.3% for racial harassment. Di Martino (2002:33) cautions that the introduction of workplace violence policies should not be seen as a panacea for all problems, as the introduction of policies often ironically sees an escalation in such incidents.

This would best be explained by the fact that workplaces that have a high incidence of workplace violence would put in place policies to reduce or minimise such incidents. Another explanation could be that putting policies in place creates awareness, and consequently reporting increases, creating the impression of increasing prevalence. Swanson et al. (2003:65) note that unless a policy is clearly communicated it may be ineffective. In addition, if a strategy is to be effective, the following conditions have to be met:

- Have a clear definition of workplace violence;
- Clearly state a zero tolerance stance;
- Management commitment to employee health and safety;
- Encouragement of prompt reporting of incidents;
- Ensure that employees who report do not face reprisals;
- Provide a plan for maintaining security in the workplace;
- Provide actions to be taken by employees when they experience workplace violence;
- Provide a contact list.

Policies are not very effective on their own as a strategy, as has been demonstrated in many other areas. The strategy to communicate and create awareness is pivotal to

the policy's success, and awareness programmes to promote their implementation are critical.

3.7. Country Studies' Recommendations

Basing his recommendations on impressions and research in the country studies, Di Martino (2002:34-37) collated a set of recommendations for the management of workplace violence. They are summarised as follows:

- Knowledge and awareness building;
- Legislation, policies, plans and reforms;
- Motivational approach to become actively involved in implementing programmes;
- Assessment and evaluation of the workplace in relation to risk of violence;
- Workplace planning in relation to workplace violence in a project management fashion;
- Organisational interventions;
- Environmental intervention;
- Individual-focused intervention;
- After the event intervention;
- Monitoring and evaluation.

Luzio-Lockett (1995:17) believes that awareness penetrates to a number of different levels, in the sense that the organisation has to recognise that environmental and psychological aggression occurs there. It also means recognising that, if it affects the individual employee, it ultimately affects the organisation in ethos, culture and well-being. She goes further by pronouncing that this awareness would also mean recognising that different people bring their individual opinions and that everyone's opinion has to be respected. The notion of respect, self-worth and self-respect for the individual, if encouraged, will lead to stronger, positive organisational culture.

Workplaces often implement programmes aimed at enhancing individual functioning, well-being and productivity, while completely ignoring the dynamic interaction between the individual and the organisational culture. This approach has proved ineffective as it often places blame on individual workers while ignoring important contributory organisational factors.

It is a somewhat “safer” approach, as exploring organisational factors may mean challenging the status quo for which many organisations are not prepared.

3.8. Effective Workplace Violence Programmes

The following sections should be read against the back-drop showing that literature on workplace violence is scant and that the terms bullying and workplace violence are often used interchangeably throughout the literature. The researcher has throughout the thesis provided literature sources which refer to both workplace bullying and workplace violence. Often bullying, because it is an earlier term, has produced more research. The researcher is thus aware that under the different literature sections there may be reference to only bullying or only to workplace violence, as the literature emerged. A third dimension which forms the backdrop to this more recent sources of literature have moved away from considering workplace violence as only bullying to embracing the more comprehensive continuum of workplace violence as proposed by Chechak and Csiernik (2014:14-15).

Kelley and Mullen (2006:498) have isolated a number of variables which they believe are key to the effective management of workplace violence:

1. Leadership;
2. Recruitment;
3. Selection;
4. Training;
5. Performance Appraisal;
6. Discipline;
7. Environmental Factors.

3.8.1. Leadership

Kelly and Mullen (2006: 498) set out the view that response strategies begin with the organisational leadership that is responsible for minimising the potential risks before the violence even occurs, ensuring a behavioural and emotional response so that healing can take place.

Einarsen and Cooper (2005:237) propose that, because workplace bullying happens "within a situation which is regulated by formal behavioural rules and responsibilities, it is always and by definition the responsibility of the organisation and its management". Leaders play a critical role in creating the culture in any organisation. Einarsen et al. (1994:237) found that dissatisfaction with leaders was one of the strongest predictors of bullying. Vartia (1996:237) noted that bullying has been associated with lack of involvement in all decision-making processes in work environments where employees are afraid of expressing their opinions and where an authoritarian style of conflict management is practised.

An interesting contrast is reported by Ashforth (1994:238) where, in some cases, bullying may be a reflection of a leader's weakness or perceived lack of power. In such situations, leaders resort to unacceptable treatment of their staff in order to stay in control.

3.8.2. Recruitment

Kelley and Mullen (2006:500) have noted that prospective employees will no longer consider taking a position in a company if it is their perception that a crisis response was inadequate and not well managed. If they have heard from employees about a violent event not receiving a satisfactory response, they will no longer consider this to be an employer of choice, which may have significant consequences in terms of attracting talent into an organisation.

Organisations are at pains in today's global economy to be seen as an employer of choice. Companies who do not manage workplace violence well may not be considered prime employers by potential recruits.

3.8.3. Selection

Selection is a rather controversial area, as labour legislation prohibits organisations from using variables of the dispositional and attitudinal types. In addition, demographic variables are sometimes the best predictors of workplace violence, according to O'Leary-Kelly et al. (Kelley & Mullen, 2006:501).

The interaction between the individual and the organisation is also not considered in this analysis. However, Neuman and Baron (Kelley & Mullen, 2006:502) suggest that personnel screening, pre-employment testing and carefully-structured job interviews may assist in identifying potential offenders before they enter an organisation. This view remains controversial in the South African context, with its strong labour legislation.

3.8.4. Performance appraisal

It has been noted that often aggressive reactions occur just prior to a performance appraisal. In many organisations, the process is always fraught with tension, disappointment and dissatisfaction. Kelly and Mullen (2006:504) argue that "Given the importance of managing perceptions of unfairness, the appropriate actions and attitudes of managers throughout the appraisal process can be tools in the prevention of workplace aggression". This suggests that, if employees perceive managers to have a negative or aggressive attitude during these appraisals, they will respond negatively, which may lead to aggressive incidents. Managers should be aware of this, as the conscious awareness of demonstrating a positive attitude defuses potentially explosive situations with the employee. It has been noted that relevant training for both managers and employees could be a useful strategy.

3.8.5. Discipline

Kelly and Mullen (2006:504) note that both the administration of discipline and the lack thereof may be a contributory factor. They also note that there has been little research into this area, but indicate that, as discipline itself gives rise to workplace aggression, organisations can work towards employees perceiving that this is part of the organisational culture.

3.8.6. Environmental factors

Kelly and Mullen (2006:506) focus on the effects of downsizing as a result of the economic crisis and its effects on the workplace. There are increased levels of frustration, depression, resentment and stress. Management of these conditions may include violence management.

3.9. Training as an Intervention Strategy

The literature search revealed that there were very few studies focusing on training, or in fact on any other strategies implemented to deal with workplace violence. Kelly and Mullen (2006:502) quote the writings of Braverman (2003), Klein and Waver (2000) and Schat and Kelloway (2003), which provide empirical evidence on training aimed at workplace violence. Training was not intended for those who were directly affected, but for employees who may experience violence vicariously. It was noted that training appeared to improve the emotional and somatic well-being of employees and therefore serves a "therapeutic role" for those suffering vicarious traumatisation. The training thus contributes to positive well-being.

Schat and Kelloway (2006:579) refer to their earlier work in 2002. This study indicated that there was preliminary evidence to suggest that training is an effective strategy for dealing with workplace violence. They also noted the context of this research, which was in the healthcare sector, so training has thus been specifically focused on healthcare workers, teaching them how to deal with aggressive patients.

Schat and Kelloway (2006) also indicate that there are few rigorous studies evaluating the effectiveness of these training programmes. Schat and Kelloway (2006:599) refer to the work of Pryor and Fitzgerald in 2003, when they studied a group of federal postal workers. Sixty-three per cent (63%) of the respondents had reported that the training provided by their agency reduced or prevented sexual harassment. In addition, in a 2000 study, the National Centre for Addiction and Substance Abuse at Columbia University found, in a focus group survey of postal workers, that participants indicated a greater awareness of potential warning signs and responses to workplace violence (Schat & Kelloway, 2006:599).

Kritek (2008:307) outlines a programme developed by the Nursing Leadership at the University of South Carolina. The programme is aimed at furthering the Centre's goal

of creating Safe, supportive work environments through relationship-focused leadership development programmes. This training programme allows participants to acquire valuable take-home tools essential in conflict resolution, consensus building and the creation of a violence-free workplace.

Similar to this workplace violence programme which is being evaluated, the nursing leadership programme also opens up dialogue about workplace violence, exploring its nature and causes and assisting participants in discovering personal behaviours that contribute to workplace violence. The difference with the latter programme, though, is that it is directed more at individual personal development by means of an introspection process. The workplace programme being evaluated is directed at institutional responsibilities as well as at having a comprehensive approach to mitigating workplace violence. It is not clear whether the nursing leadership programme has been evaluated, although it is pointed out that it has been refined over the 12-year span of its implementation. This paper proposes three key components of successful training:

1. Institutions must invest in both the process and the relationship competencies of conflict resolution;

2. Competencies like analysing conflict, recognising shadow projection, naming “the elephant in the room” and building consensus takes time to master, and there is no easy solution;

3. Multi-disciplinary partnerships among healthcare professionals in practice and academic and professional organisations result in more successful and comprehensive training programmes (Kritek, 2008:307).

Candela and Bowles (2008:321) have questioned nurses about verbal abuse in the USA with the aim of designing and evaluating learning modules aimed at developing skills to recognise and manage interpersonal skills. Another study, by Ditmer (2008:368), also explored nurses’ understanding of workplace violence, as this has implications for their perceptions of victimisation. The aim was to develop a violence prevention and workplace Safety programme. Both the above studies first surveyed the phenomenon and then tailored a programme to address the issues.

Duncan (2008:334) reports on a training programme followed in Australia. The programme focused on mandatory aggression training for staff working in the health service. The one-day mandatory programme included both theoretical and practical techniques to enable staff to recognise triggers, and to anticipate and de-escalate a situation. The programme was deemed to be quite successful, as incidents after the training decreased by more than 50%.

A three-year project was initiated by the International Council of Nurses, which included five SADC countries: Mauritius, Lesotho, Zanzibar, Swaziland and Botswana (Carmen Anazor, 2008:371). Each country has a trained national representative and Zanzibar underwent training in 2008. The training content was designed by the WHO, ICN, ILO and PSI, as was the content of the training programme which this researcher is evaluating.

The programme, as noted earlier, has, however, been adapted to South African circumstances by Dr Steinman.

The above workplace violence training programme contains the following modules:

1) Understanding types of workplace violence;

2) Risk assessment;

3) Interventions (individual, organisational and environmental);

4) After the event interventions.

There is no reference to an evaluation of this programme but recommendations centre on the fact that an enlarged community, such as the media, is needed for training, research and educational institutions, consumer groups, NGOs and criminal and justice professionals, among others.

3.10. The Role of EAPs in the management of Violence in the Workplace

Employee Assistance Programmes often, by default, ultimately seem to deal with the consequences of workplace violence, which include depression, long-term counselling and sometimes psychiatric care. Watkins (2005:7) proposes that EAPs should put preventive programmes in place by helping organisations to develop anti-bullying

policies, as well as identifying bullying as unacceptable in staff handbooks and establishing proper systems for recording and dealing with workplace violence. The role of the EAP is thus positioned as being broader than the case management role traditionally held by EAPs.

Systems theory as a purposeful integration with other theories and models, even the EAP model with its core technologies may enable the practice of new knowledge to be speeded up or result in new applications of practice.

Badzmierowski and Dufresne (2005:20-21) propose a comprehensive strategy for the involvement of EAPs. This strategy includes the following elements:

- Be respectful in the workplace;
- Listen to employee concerns;
- Support policies that call for respectful behaviour at all levels;
- Implement an ongoing training process that advocates infusing respectful attitudes and behaviour into the workplace;
- Provide skills-building training on respectful behaviour.

Ongoing training on the phenomenon of workplace violence is a vital part of building a culture that constantly places emphasis on valuing the importance of building a respectful workplace. Other competencies, such as conflict resolution, negotiation, coaching, listening and stress management, are also very important when it comes to managing the issues of workplace violence and indeed, mitigating the risk of this phenomenon occurring. EAPs often form the arena where the training interventions just mentioned are managed, and could thus be the relevant arena for conceptualising and including workplace violence as part of the overall training agenda.

De Falco (2001:202) emphasises the importance of the relationship between EAPs and the workplace security department. In her reference to this relationship, she discusses a software programme called Security and Workplace Violence, which was released by the Joint Commission on Accreditation of Healthcare Organisations. This

software programme teaches healthcare workers Safe practices for reducing the risk of security incidents, including workplace violence.

De Falco (2001:20) further notes that the EAP aims at the following in helping staff identify and understand:

- Staff participation in the organisation's security awareness plan;
- Security-sensitive areas in the facility and risk management strategies used in the area;
- Situations that increase the risk of workplace violence;
- Tactics for reducing the risk of workplace violence; and
- How to respond to security threatening incidents.

The technologies used by EAPs (see 3.11) make it conducive to inclusion as a key role player in the mitigation and prevention of workplace violence in the following ways:

A government publication [sa] has clearly spelt out the role of EAPs in addressing workplace

3.10.1. Role in early prevention efforts

- **Promotion of the EAP.** The effectiveness of a workplace violence programme is greatly enhanced in an organisation with an active, well-known EAP, where marketing of solutions is actively carried out at seminars, workshops and training with management, unions and employees.
- **Information dissemination.** EAPs often provide booklets, pamphlets and videos on relevant issues, and workplace violence could be included.
- **Early involvement in organisational change.** When companies are faced with re-structuring, EAPs can help prevent potential outbursts, keep information flowing, help keep feelings under control, provide constructive outlets for feelings of frustration and help employees plan for the future.

- **Employee and supervisory training.** EAP counsellors can help with training on topics such as conflict resolution, dealing with angry co-workers and customers, and communication skills.

3.10.2. Participation on an incident response team

- **Consultation with a supervisor when an incident is reported.**

  Depending on the type of incident reported, it is often important for the EAP counsellor to work with an employee relations specialist and a security officer, as part of a response team that consults with the manager. The nature of the incident will determine the role of the counsellor. It is important for the EAP counsellor to maintain neutrality under these circumstances.

- **Response intervention.**

  The EAP counsellor could also help with conflict resolution in cases that are reported early enough for such intervention. The counsellor could work with the victim by giving advice and guidance, or with the perpetrator by defusing angry feelings and hostility. Mediation is thus one of the roles an EAP counsellor could play.

3.10.3. Follow-up to a violent incident

- **Individual interventions**

  Prompt individual interventions for employees who have had stressful experiences can best be dealt with by an EAP counsellor. Strategies for longer-term interventions should be included as part of the planning.

- **Critical Incident Stress Debriefing.**

  EAP counsellors are best positioned to provide this service or coordinate related efforts.

3.10.4. Acting as consultants to management

The EAP counsellor assists managers with information on traumatic events and can assist them in analysing the situation and developing strategies for the organisation's recovery.

3.10.5. Guidelines for non-involvement

There are also guidelines as to where the EAP should not be involved:

- **Taking the incident report.**

  Confidentiality requirements prohibit EAP counsellors from disclosing information, putting them in a situation whereby informing other team members about the report could lead to serious misunderstandings among staff, and harm the credibility of the EAP.

  However, an EAP counsellor is often the first to hear about an incident involving threatening behaviour, and the planning group should decide ahead which type of report the EAP counsellor should handle alone and which should be reported to the team.

- **EAP as the first intervener**.

  This is not recommended because

  1) Issues of confidentiality cause numerous conflicts for the counsellors;

  2) It would lead to the perception that perpetrators of workplace violence are treated as victims needing counselling, rather than as perpetrators needing discipline.

- **EAP and psychological exams.**

  It is recommended that psychological or psychiatric examination is offered by an external contractor, as this process is time-consuming and highly specialised. The EAP should take on the role of teacher and facilitator, helping everyone to understand the report and putting its recommendations into practice.

Very little has been written directly on the potential and complete role that EAPs could play in addressing workplace violence. Van der Merwe (2007:22) discusses the role of EAPs in addressing abuse and violence in the workplace but is not very clear as to what this role could be.

In a study of registered nurses in the USA, which focused on strategies for transforming hostile workplaces to healthy ones, one of the key components explored was the channel used by employees following an incident or incidents of bullying (Vessey et al., 2009:303). Sixty one percent (61%) of the Sample had indicated that employee assistance programmes were available to them. Whether they accessed these services is unclear.

Chechak and Csiernik (2014:20) propose that stress management training for employees and access to counselling services should be a standard practice, incorporated into the EAP, given that there is an overlap between workplace violence and other psychosocial factors that may lead to ill health.

3.11. EAP Core Technologies

The comprehensive role that EAPs could play is best spelled out when one peruses the core technologies of EAP; those are the prescripts that guide all EAP practice (Standards Committee of EAPA-SA, 2010: page 1). The core technologies are:

1) Training and Development

Training and development of, and assistance to work organisations and stakeholders (managers, supervisors and unions) seeking to effectively manage the employee who is experiencing behavioural, emotional and wellness issues; enhancing the work environment; and improving employee job performance.

2) Marketing

Outreach and promotion of EAP services, their availability and guarantees of confidentiality to management, supervisors, unions, employees and their family members.

This core technology refers directly to the fact that services will be known only if they are marketed. The awareness sessions on workplace violence fall within this component.

3) Case Management

Confidential and timely risk identification, assessment, motivation, short-term intervention, referral, monitoring, follow-up, reintegration and aftercare services for employees with personal and work-related concerns that may affect job performance.

Case management and identification of risks is addressed well during the workplace violence programme under research. It is also well-addressed in the literature on workplace violence.

4) Consultation with the work organisation

There is consultation with the work organisations to proactively address inherent trends stemming from personal or organisational issues. EAPs often fail to consider this core technology, as they are more comfortable performing case management. Modern EAPs are more aware of this technology, so the phenomenon of workplace violence allows them to demonstrate their ability in this respect.

5) Networking

Networking to establish and maintain effective relations with external and internal role-players and service providers.

In relation to workplace violence, there is strong emphasis in the training programme on the stakeholders, such as, inter alia, the police, security and the community. This includes a combination of internal and external stakeholders. This core technology is relevant to the exploration, training and comprehensive strategy adopted in relation to workplace violence.

6) Monitoring and evaluation

Monitoring and evaluation of the value/success/impact of EAP services relating to the work organisation and individual job performance.

This core technology touches directly on what this research study is addressing, which is to evaluate the impact of a training programme.

3.12. Conclusion of Chapter 3

It is thus apparent from the literature that issues of the positioning of the Management of Violence in the Workplace Programme and training programmes are critical to its success. Employee assistance programmes seem ideally suited to provide a “strategic home” for such a programme.

Much has been written on the different types of intervention strategies and it would appear that a combined strategy is proposed. If one looks at the content of the training programme being proposed, the elements of an effective strategy are highlighted. A workplace would thus already be considering all the alternative strategies in the adoption of this Management of Violence in the Workplace Programme.

CHAPTER 4

The Management of Violence Workplace Training Programme

4.1. Introduction

The previous chapters have outlined the research methodology, the literature that was reviewed in order to determine the scope of the study and the possible role that the EAP can play in the management of workplace violence programmes. This chapter will crisply outline the workplace violence training programme, as this is the unit of analyses and will also discuss the logistics surrounding the Workplace Violence Training Programme.

4.2. Background

In 2003 Steinman conducted a research project on workplace violence in the health sector. Steinman had also been involved with the World Health Organisation, the International Labour Office, the Public Services International and the International Council of Nurses (2002) to develop the Framework Guidelines for addressing workplace violence in the health sector. She was allowed to conduct the study within the Gauteng Department of Health. Steinman's findings are discussed in Chapter 2 of this report but in summary she found that 61.9% of all health care workers experienced at least one incident of workplace violence in the year prior to the study.

In 2005, when Steinman again approached the Gauteng Department of Health for permission to conduct a pilot programme, she was permitted to do so. Steinman's obligation to the Gauteng Department of Health was to develop a programme to address workplace violence, which involved training employees/potential victims of violence in the workplace in the phenomenon of violence in the workplace, and strategies for empowerment to manage violence in the workplace. This process has been documented, but at that stage has never been evaluated to determine the effectiveness of the programme, Management of Violence in the Workplace, in order to make an informed decision as to whether or not it should be expanded to other workplaces.

The present study thus focused on evaluating the Management of Violence in the Workplace Training Programme. The training programme was but one element of the overall Workplace Violence Programme. More detail on the overall violence in the Workplace programme and more specifically the Workplace Violence training as this was the component which was evaluated, is discussed.

4.3. The Framework Guidelines for addressing WPV in the Healthcare Sector

The Workplace Violence Training programme was premised on a Framework Guidelines. This was in reaction to the international response to the problem of workplace violence which was initiated in 2002. The International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organisation (WHO) and Public Services International (PSI) jointly developed Framework Guidelines for addressing Workplace Violence in the Health Sector. A joint programme on workplace violence in the health sector by the ILO, WHO, ICN and PSI has produced Framework Guidelines for addressing Workplace Violence (2002:1-31). These guidelines form the background to the Management of the Workplace Violence Programme which is being evaluated in this study.

This study utilised an adapted version of the Framework Guidelines in the implementation of the training intervention. The training has thus been adapted to the cultural context of the country but also keeping in mind the organisational culture of the health care sector in South Africa. The contents of the Framework Guidelines, adapted, are as follows:

4.3.1. Background, scope and definition of workplace violence

This section explores what is meant by the phenomenon of workplace violence as definitions differ and may thus impact upon the findings of studies, in particular those measuring prevalence.

- Extent of workplace violence;
- Scope;
- Definition.

4.3.2. General Rights and Responsibilities of stakeholders/role-players?

This section outlines the various role-players that have a responsibility to manage workplace violence but also who have rights in relation to the phenomenon of workplace violence. These role-players are:

- Governments;
- Employers;
- Workers;
- Professional bodies;
- Enlarged community.

4.3.3. Approaches of managing workplace violence

This section explores the different approaches to workplace violence and whether they are largely preventive or reactive**.**

- Preventive;
- Participative;
- Culture/gender-sensitive and non-discriminatory;
- Systematic.

4.3.4. Violence Recognition

This section focusses on exploring the different concepts used when recognising violence and the role-players in these scenarios of workplace violence

- Organisations at risk;
- Potential perpetrators;
- Potential victim.

4.3.5. Violence Assessment

During the assessment of workplace violence there are certain factors that should be kept in mind and this section outlines those factors by analysing the available information and identifying risk factors.

- Analysing available information;
- Identifying situations at special risk.

4.3.6. Workplace interventions

Much has been said in the literature on multi-level interventions and this section highlights the different levels of interventions and different types of interventions

- Preconditions;
- Organisational Interventions;
- Environmental Interventions;
- Individual-focused interventions;
- After-the-event Interventions.

4.3.7. Evaluation

The programme implemented in this research was based on the Framework as outlined, but it has been customised according to the local conditions. Evaluation, refers to evaluating each group training and the evaluation of the incorporation of these learnings or future group trainings. This is thus a process of feedback. Senge (1990) speaks about reflection-on –action because in this way deeper patterns start emerging and a deeper understanding also then enhances the ability to assess how to influence those patterns.

4.4. Logistics related to the research project

4.4.1. Permission to conclude research project

Written permission was obtained from the Gauteng department of Health Ethics Committee for the researcher to launch the study. The researcher was then able to engage with all the stakeholders at the Dr Yusuf Dadoo hospital once permission had been granted. Dr. Steinman had for a time indicated the need for a formal evaluation of the VETO programme which had been implemented at some of the other hospitals within the Gauteng Department of health, but not Dr. Yusuf Dadoo.

4.4.2. Stakeholder engagement

Once permission had been granted, the researcher was allowed to engage the necessary stakeholders within the hospital, which included the CEO, the head of nursing and the wellness co-ordinator. All parties were very supportive of the study and assisted the researcher in getting access to the wards and employees for all phases of the study.

4.4.3. Entry to the hospital

The Wellness co-ordinator, Mr Moses Thulo, was instrumental in assisting the researcher by distributing questionnaires, setting up boxes to collect questionnaires, introducing the researcher to employees and key stakeholders such as the unions and also ensuring venues were available for piloting of the questionnaire interviews, the actual training and lastly for the qualitative interviews

4.5 Logistics regarding the presentation of the programme for purposes of this specific study

This section will focus more specifically on the logistics as it relates to the Workplace violence training programme as the training component as this could also be a problem when facilitating and implementing training in government. Venues are in short supply, people are often not available for lengthy periods of course attendance. Logistics are thus important.

The training part of the programme is three days long and the facilitation incorporates lectures based on power point presentations, supported through case studies, exercises which highlight certain learnings and the use of readings on best practice models and additional information.

4.5.1. The Management of Violence in the Workplace training Programme (VETO)

The previous section (4.3) outlined the Framework Guidelines on which the actual Programme for the Management of Violence is premised. This section focusses attention on the contents of the mentioned Workplace Violence training programme Programme. The Management of Violence Programme is called VETO, which is an acronym for “Against Violence at Work, an Educational, Training and Operational Toolkit” (Steinman, 2002).

4.5.2 About the programme

The training manual was commissioned by the Steering committee of the ILO, ICN, WHO and PSI Joint Group as a companion guide to help implement the Framework guidelines for addressing workplace violence in the health care sector. The programme was piloted in South Africa by Dr. Susan Steinman (2002) and adapted and changed for South African audiences. (Steinman, 2003)

4.5.3 Vision of the VETO Programme

The Vision of the VETO Programme is to raise awareness of the phenomenon of workplace violence but also to empower participants to combat workplace violence in the workplace.

4.5.4 Mission of the VETO Programme

VETO is targeted at workplace situations and is also suitable for a wide range of operations in the health care sector and seeks to:

- Raise awareness on the issue of workplace violence in the health care sector.

- Provide clarity and understanding of the main messages of the Workplace Violence Framework Guidelines and their practical implications.
- Introduce and orientate participants to concrete action to combat violence at the workplace.

4.5.5 Values of the VETO Programme

The values that the VETO Programme strives towards are:

- Participation: The Programme is based on the full interaction and involvement of all participants in the training course and aims to promote the ownership of the messages by such participants.
- Prevention: The Programme delivers an unequivocal message that workplace violence can be largely prevented and provides the means to develop preventive actions.
- Results-oriented: Success can only be measured by the results obtained. Strategic and immediate objectives are compatible and address the monitoring and evaluation of action plans.
- Adaptability: Situations are complex and solutions are multiple, therefore one single approach does not work in all environments and cultures. Several approaches and options are presented and discussed so that users can develop programmes and actions that meet their unique needs.
- Self-sustainability: Actions Plans are highlighted focussing on those that were developed at the workplace level and were cost-effective and showed positive results and could thus be appropriate actions plans for participants in each group.

4.5.6 Programme for the training programme

Dr Susan Steinman facilitated the training for the three days whilst the researcher only ensured that she participated in the research phases, that is ensuring that the pre-test questionnaire was completed as well as the post-test questionnaires. The researchers role thus when it came to the training was that of observer. See timetable for the three- day workshop below:

Time	Day One	Day Two	Day Three
08.00	**Coffee/Tea**		
08.30-08.45	**Opening** Opening roster	4.3.Holistic approach 4.4.Sibongile case study	**Intervention continued** Individual intervention before the incident
08.45-09.30	Getting to know each other		
09.30-09.40	Expectations	**5. Recognising and assessing**	Individual intervention after the incident
09.40-10.30	**1.Introducing the phenomenon of workplace violence** **1.2.Definition** and relationship between physical and psychological violence	Recognition of factors associated with Violence against health care workers. Warning signals and coping strategies	
10.30-10.50	**Refreshment Break**		
10.50-12.30	**2.Awareness and Understanding** 2.1.Identifying violence 2.2.Terminology 2.3 Bullying 2.4.WPV in the health care sector in SA 2.4.Costing of WPV	Risk assessment **6.Intervention** Preconditions for intervention OrganiSational intervention group discussion	Monitoring and Evaluation Action Plan Winning against Workplace violence
12.30-13.30	**Lunch Break**		
13.30-14.15	**3.Rights and responsibilities** Who is doing what?	Continued	**7.Conclusion** Rolling out the mini Workplace violence programme and getting everyone on board
14.15-15.00	**4.Combining the best approaches** 4.1. Best approach 4.2 Reading	Environmental intervention	Debriefing Explaining internet contact Evaluations Closure

The various study units of the Training programme are further outlined.

Study unit: Introduction of the phenomenon of workplace violence

Specific learning outcome: Definitions of different concepts

At the end of this module the student will be able to:

- Discuss the different definitions relevant to the field of Workplace violence in order to achieve an awareness of the phenomenon of workplace violence.

Assessment criteria:

The following definitions should be understood and commented on by participants:

- Bullying, mobbing, psychological violence, physical violence and sexual harassment.
- Awareness of the various definitions as key to understanding and defining the phenomenon.

Study unit: Awareness and understanding of the phenomenon of workplace violence

Specific learning outcomes: Identifying Violence

At the end of this module the student will be able to:

- Discuss different workplace violence terminology
- Developing and understanding of the correlation between workplace violence and various factors such as gender, age, profession, unit/ward worked in and seniority of position.
- Developing an understanding of workplace violence in the health care sector of South Africa.
- Understand the cost burden of workplace violence

Assessment criteria

The concepts of workplace violence and bullying will be well understood by participants and they will have insight and awareness into the extent of the phenomenon of workplace violence in the health care sector of South Africa, including the extent of the cost burden of workplace violence.

Study unit: Rights and Responsibilities

Specific Learning outcomes: Rights and responsibilities of different role-players.

At the end of this module students will be able to:

- Understand the different role-players in workplace violence and also the roles that they play or could play in alleviating the phenomenon of workplace violence.
- Understand students' beliefs and attitudes about who the key role players and their roles are in respect to workplace violence.

Assessment criteria:

The roles and the role-players who are key to addressing the scourge of workplace violence, within the context of rights and responsibilities will be understood by the students. Beliefs and attitudes about rights and responsibilities of role-players are understood by students.

Study unit: Choosing the best Approach

Specific learning outcomes: Combining the best approach/es

At the end of this module students will be able to understand:

- Various approaches to workplace violence and the importance of a holistic approach.
- Best practice and the effectiveness of measures to address workplace violence.

The role of EAP and the potential to enhance its role in managing workplace violence is key.

Assessment Criteria:

The multi-level, holistic approach will be appreciated and understood by the students in that often one intervention may not be successful but needs to be a component of an overall programme. This section touches on students' awareness of but also skill to start recognising and designing a multi-level intervention.

Study unit: Recognising and assessing workplace violence

Specific learning outcomes 5: Recognition of factors related to workplace violence.

At the end of this module the student will be able to:

- Recognise factors associated with workplace violence in the health care sector
- Recognise warning signals and coping strategies of workplace violence

Assessment criteria

Risk assessment as a concept is introduced to participants at this stage and they will get an appreciation of how occupational groups, units worked in, and shifts are all contributory factors to workplace violence. Students' belief and attitudes in relation to factors, warning signals and even coping strategies is key to this section.

Study unit: Interventions on Workplace violence

Specific learning outcomes: Understanding interventions aimed at workplace violence.

At the end of this module students will be able to:

- Identify Individual, organisational and environmental interventions of workplace violence.
- Appreciate a holistic view of workplace violence interventions.

Assessment criteria

Interventions before workplace violence incidents and after workplace violence incidents, a holistic view of interventions and different interventions should be commented on by the students**.** The focus on intervention introduces elements of awareness and skills when assessing case studies

Study unit: Monitoring and Evaluation of workplace Violence

Specific learning outcomes: Winning against workplace violence

At the end of this module students should be able to:

- Report and record incidents of workplace violence
- Design action plans to combat workplace violence, which is within their span of control.

Assessment criteria:

Action plans within their span of control are designed by the students and they are taught the plan-do-check-act cycle and continuous improvement principles to help them action their plans. This section is aimed at skills development as students design action plans and practise the plan-do-check-act-cycle. Reporting and recording is also aimed at skills development when reading through scenarios and case studies.

Study unit: Conclusion and debriefing

Specific learning outcomes: Rolling out a mini VETO training to the workplace

At the end of this module students are:

- Given some tools to roll out a mini VETO if their action plans include training to any groups inside the hospital.
- Debriefing is made available to students who may require it, as often the topic of workplace violence brings up feelings in relation to previous incidents of workplace they may have experienced.
- After training contacts and support is made available.

Assessment criteria:

Mini VETO tools are discussed with students who demonstrate an ability to incorporate this skill into their action plans. Debriefing is also made available to them where required.

4.6 Research phases, dates and sequence of events

The table below clearly outlines the dates of all activities and phases of the study

Study phase	Research Design	Activity	Date	Comment
Phase 1	Quantitative	Survey through a self-developed questionnaire as data collection instrument with 400 respondents	February 2010	The survey was intended to run for 2 weeks but after 2 weeks the return rate was not good, as such the deadline for submission was extended for another 1 week
Phase 2	Quantitative	Pre-test through a self-developed pre-test questionnaire as data collection instrument with 40 respondents	15 March 2010	The pre-test was completed by participants on day 1 of the training, before the training commenced. An extra half hour had been built into the programme.
	Quantitative	Training of 40 respondents/delegates	15-17 March 2010	The training was 3 days in duration
	Quantitative	Post-test through a self- developed post-test questionnaire as data collection instrument with 40 respondents	17 March 2010	The post-test was concluded on day 3 of the training, after conclusion of the training.
Phase 2	Qualitative	One-to-one personal interviews – with a self-developed semi-structured interview schedule as data collection instrument with 10 participants	25-26 May 2010	These interviews were video recorded

.

4.7. Conclusion to the Chapter

This chapter has outlined VETO which is the workplace training programme and also demonstrated how the training programme was but one component of an overall Workplace Violence Programme. The vision, mission and values clearly indicate the direction the researcher was taking when embarking upon this study. The phases of the study have been clearly detailed for ease of reference for the reader in this chapter. All of the study units, learning outcomes and assessment criteria have been detailed to dovetail with Chapter 6 which is the discussion and recommendations chapter.

CHAPTER 5

Empirical Study on Workplace Violence and Management of Violence in the Workplace Training

5.1. Introduction

The problem identified is the total absence of evaluative data on the outcome of the Management of Violence Training in the Workplace Programme. This study thus focused accordingly on evaluating the existing training programme known as Management of Violence in the Workplace Training Programme (VETO), developed to address both psychological and physical violence in the workplace.

The researcher thus applied two research designs, quantitative and qualitative in two different phases. Phase one included a survey. Phase two included a pre-test, training programme and then the post-test. Phase two also included interviews two months after the actual training.

Data for this study was analysed, using the Statistical Programme for Social Sciences, Version19.0.according to ibm [sa]. The analysis of this data will be discussed in this chapter. As there are two phases but three distinct data sets, the information will be presented according to the different data sets, compiled for ease of reading.

The results will thus be discussed under the phases of the study:

Phase 1: **Survey** on Workplace violence to assess the extent of the phenomena and employee's experience of such.

Phase 2: **Pre-test, training and post-test** on the phenomenon of workplace violence with specific focus on attitudes, behaviour and skills. The training focuses on addressing behaviour, attitude and skills as well. **Interviews** in this phase are conducted to add a qualitative element to the study, which focuses on addressing behaviour, attitude and skills. (See Table 4).

The phases were chosen so that Phase 1 focused on only the survey and the overall population, while Phase 2 dealt with the smaller Sample of 40 and all related matters, that is, the pre-test, the training and then the post-test as intervention and the

qualitative interviews (10 participants) as a follow-up post-test. This study thus had two distinct phases.

Study phase		Research Design	Tool	Sample/ population	Response numbers
Phase 1	Quantitative	Survey	Questionnaire	400 employees	173
Phase 2	Quantitative	Quasi-experimental pre-test	Questionnaire	40 employees	40
		Quasi-experimental post-test	Questionnaire	40 employees	40
	Qualitative	Follow-up post-test in the form of a Collective case study	Semi-structured interview schedule	10 employees	10

Table 4: Study Phases

5.2. The Survey

The survey was conducted in the Yusuf Dadoo Hospital and the complete staff complement (400) was included in this phase. Sampling was seen as unnecessary due to the fact that a figure of 400 respondents is seen as manageable and could ensure proper representation. Sampling, especially stratified sampling was not seen as a guarantee for proper participation. Data for the survey was collected via a **self-administered questionnaire.** The fieldworker for the survey was the Employee Wellness coordinator, Mr Moses Thulo, who hand-delivered the questionnaires and arranged to get them back. He also engaged with night shift staff as they were coming off duty in the mornings while it was easier to engage with the day staff during normal working hours.

The data collection tool used for the survey in Phase 1 was a questionnaire developed by the researcher and approved by the Ethics Committee of the Faculty of Humanities at the University of Pretoria. The survey focused on exploring the extent of workplace violence in the hospital. The level of awareness of workplace violence as a

phenomenon as well as the reactions and possible associated trauma symptoms, were also explored. Participation in the survey phase was voluntary.

5.3 Pre-Test and Post-Test Phase

The data collection tool used during Phase 2 was a questionnaire, which was developed by the researcher (See annexures 5 and 6). The pre-test questionnaire and post-test questionnaire included a combination of exactly the same questions. The focus of the post-test questionnaire was to determine whether the knowledge, attitude and skills shared in the pre-test had changed as a result of the workplace violence training programme.

Participation in the pre-test and post-test was voluntary. The pre-test and post-test was conducted by the researcher, while the training/intervention was conducted by Dr Susan Steinman, who, in 2009, was the Director of the Work Trauma Institute and is now (2015) works as a consultant. The researcher was not directly involved in or responsible for the intervention in the form of training, according to the Management of Violence in the Workplace Programme, but was merely an observer of this process (training). However, she was actively involved in the pre-test and post-test.

The post-test conducted after the training was done to assess whether the training had resulted in improved knowledge, skills and change in the attitude to workplace violence. Participants in Phase 2 were selected by using purposive sampling. The criteria for inclusion was whether they had been exposed to workplace violence. Forty participants from high risk units in the Dr Yusuf Dadoo Hospital were requested to participate, to which they agreed. Data collected from participants not being exposed to workplace violence would have made a lesser contribution. They were thus excluded. These participants volunteered to participate and were approached by the Wellness co-ordinator, who was not in any position of authority over any of the participants and as such could not be manipulated regarding their participation and contribution.

5.4 Qualitative Interviews

For the qualitative part of Phase 2, information was collected by conducting individual interviews with a Sample of ten (10) participants drawn from the participants who

attended the training. These interviews were semi-structured interviews, and were tape-recorded or video-recorded, depending on the participant's preference. Purposive sampling was used for the qualitative part of this study, as ten participants who completed the actual training were interviewed. The criteria followed for this phase were:

- Participants who were victims of violence previously;
- Participants who had undergone training on Management of Violence in the Workplace.

For the qualitative phase, ten participants were selected, using purposive sampling, as those who had been exposed to workplace violence volunteered to take part in this phase of the study. The greatest confidentiality was adhered to in conducting interviews with participants in the second part of Phase 2 of this study; names were not relevant to this section. The interviews were conducted by the researcher for the qualitative Phase 2 of this study. Participants were asked during the training whether they were willing to volunteer for interviews for the final phase of this study and a group of 11 offered. Ten participants were required and the first ten names on the list were included.

5.5 Data Analysis

Data for **both phases** of the study was analysed with the computer software package SPSS, Version 19.0. It was analysed by the researcher with the assistance of the Department of Statistics, University of Pretoria.

5.5.1 Phase 1

Data was analysed statistically and presented in frequency distributions and grouped frequency distributions. The data is presented graphically by means of bar graphs, pie charts and tables. Cross-tabulations were also performed between a number of different indicators and these are presented as bar graphs or p-values plotted in tables.

5.5.2 Phase 2: Pre-test post-test

Data analysis in the pre-test and post-test focused on assessing whether there were any differences between the pre-test and the post-test in attitudes, knowledge and skills relating to the phenomenon of workplace violence. Cross-tabulations between various variables were also carried out and are presented in tabular form with the p-values or in bar graphs where possible. Data analysis thus focused on the differences between attitudes and knowledge shown in the pre-test and the post-test.

De Vos (2002:340) refers to Creswell's process of qualitative data analysis, which is:

- collecting and recording data;
- managing data;
- reading, writing memos;
- describing, classifying, interpreting;
- representing, visualising.

5.5.3 Phase 2: Qualitative phase

The researcher planned for the data systematically by labelling audio tapes and video tapes. Data interpretation focused on themes that emerged during the qualitative phase. Data analysis focused on the knowledge and attitudes of the group involved in the qualitative interviews. These outcomes are presented thematically. Purposive sampling was used for the qualitative part of this study, as ten participants who completed the actual training were interviewed. The criteria followed in this phase were:

- Participants who had been victims of violence;
- Participants who had undergone training on Management of Violence in the Workplace.

5.6 Sampling

5.6.1 The population

Phase 1

The population for Phase 1 of this study consisted of the total staff component of the Dr Yusuf Dadoo Hospital. The site chosen for this study was the Dr Yusuf Dadoo Hospital, which is situated in Krugersdorp, South Africa. The total staff component consisted of 400 employees.

Phase 2

The population for Phase 2 of this study consisted of all the employees identified and nominated for training according to the Management of Violence in the Workplace Programme.

5.6.2 Sampling

Phase 1

For the purposes of the survey to be carried out, no sampling took place, as the total staff component was incorporated. Sampling was seen as unnecessary due to the fact that a figure of 400 respondents, is seen as manageable and could ensure proper representation. Sampling, especially stratified sampling was not seen as a guarantee for proper participation.

Phase 2

The Sample drawn for Phase 2: the pre-test-intervention and post-test phase consisted of all the staff identified and nominated to attend the training according to the Management of Violence in the Workplace Programme. This involved 40 employees, 10% of the hospital staff. The criteria utilised for sampling was thus

- Participants exposed to workplace violence
- Participants working in the high risk units

This group was used for the pre-test and the post-test immediately before and after the training.

The Sample for the qualitative phase was drawn from the participants who attended the training. For the qualitative phase, ten participants were selected. These participants were from the group who had participated in the training and who volunteered after the training to take part in the interviews conducted two months later. The criteria were thus:

- Experience of workplace violence
- Participated in the Management of Workplace violence Training Programme.

5.7 Analysis of the survey data

The survey was conducted in February 2010, and participants were given two weeks in which to respond to the questionnaire. Because of the low return rate after two weeks, the time was extended for another week, which significantly improved the return of the questionnaires. The Wellness co-ordinator engaged informally with staff in the different units and encouraged them to participate by completing the questionnaires.

5.7.1. Response rate to the survey

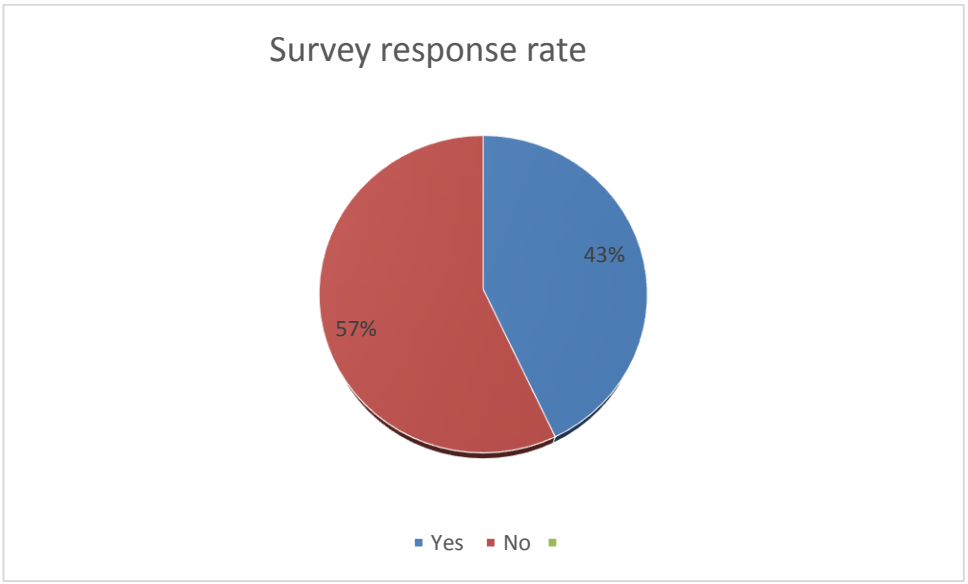


Figure 1: Survey response rate

n=400

5.7.2. Exposure to Workplace violence

Question 8 on the Survey questionnaire

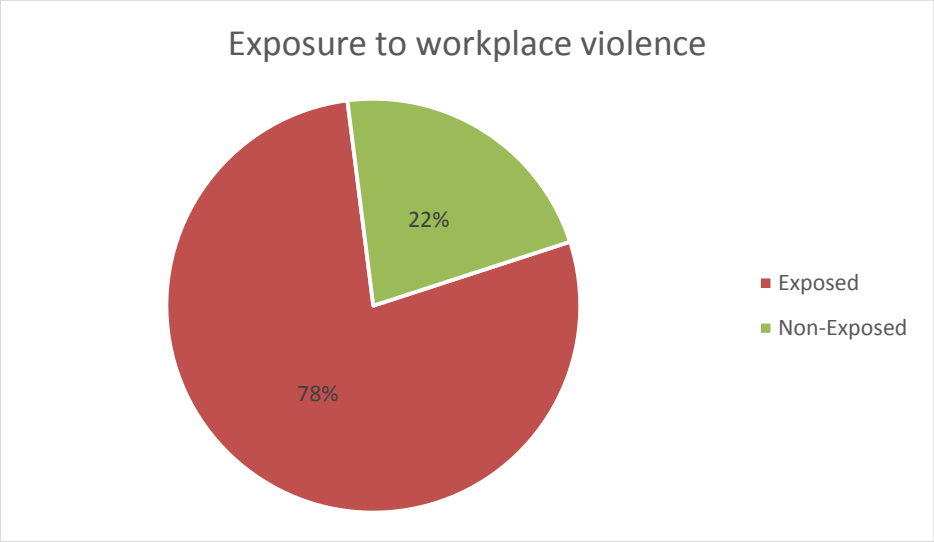


Figure 2: Exposure to workplace violence

*5 missing values

n=173

Discussion

Of the possible 400 respondents to whom the questionnaire had been delivered, 173 (43.25%) responded and 227 (56.75%) did not respond. This is a good response rate for a survey of this nature. Hospital employees are always very busy and hardly ever have the time to respond to surveys. The response rate was advanced by Mr Moses Thulo, the Employee Wellness co-ordinator, who gave verbal reminders a to all the employees about the survey and the closing date.

In addition, 131(75.7%) of the 173 respondents had been exposed to workplace violence, while 37(21.3%) had not. Five (5) respondents did not respond on this question –which is seen as missing values on this question. It is important to note that some questions applied only to the 131 who had been exposed to workplace violence. For the purposes of analysis for the rest of the section, these numbers are important.

The total number of 173 who responded is also important as some questions applied to all the respondents. In addition, there were a number of cross-tabulations done with different questions such as cross tabulation between exposure to workplace violence and gender, for example.

It should also be noted that missing values refer to a participant's lack of response to that question. When cross-tabulations are done between two questions, the missing values can be a fairly big value across the two questions. Below each graphical representation the missing values will be noted. "The McNemar test covers situations in which the dependant variable is nominal data, (i.e. frequencies for categories) .This test is literally looking for a significant change in the category of subjects" (Lewis-Beck et al, 2004:622).

"The McNemar test is also known as a test of correlated proportions, is a non-parametric test used with dichotomous nominal or ordinal data to determine whether two Sample proportions based on the same individuals are even. It is a test of symmetry between two related Samples , often used in before-after studies in which the Same individuals are measured at two times, a pre-test post-test for example" (Salkind,2010:779) . The study under discussion thus used this test, as the same group of individuals was being observed from pre-test to post-test.

Salkind (2010:491) further notes that the Fisher's least significant difference test refers to the fact that when an analysis of variance gives a significant result, it does not indicate which group differs but this test looks at specific comparisons (the so called pairwise comparisons.

In the context of this study the survey phase examines the phenomenon of workplace violence and cross-tabulates with indicators of gender, age, professional category and the Fisher's Exact Test thus indicates whether or not this relationship is one of significance.

5.7.3 a Gender vulnerability to workplace violence

Cross-tabulation between Questions 1 and 8 on the Survey questionnaire

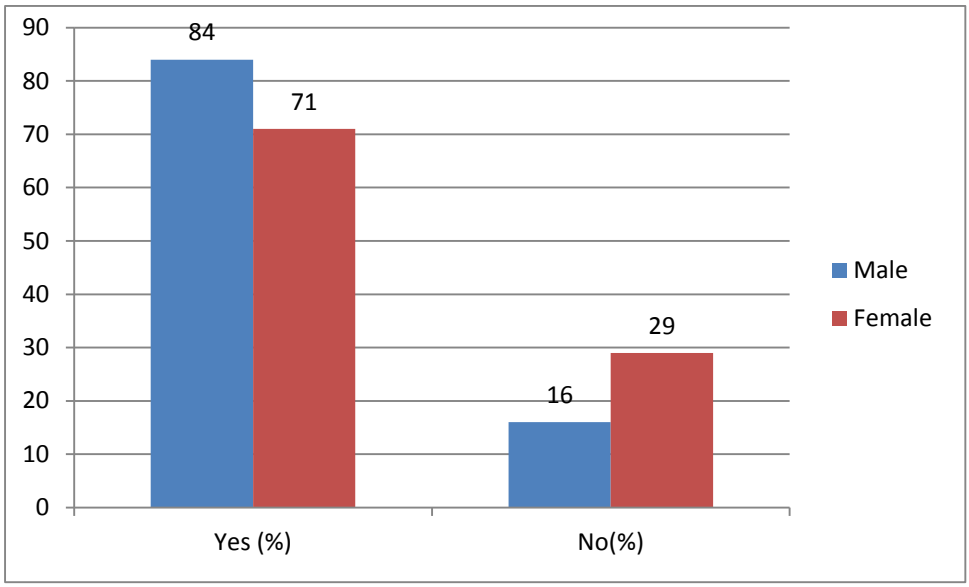


Figure 3: Victims of workplace violence as correlated with gender

*10 missing values

n=173

Data

The general demographics and gender profile at Dr.Yusuf Dadoo Hospital is a 70% to 30% female to male ratio.

Of the sample of 103 employees who indicated that they were indeed exposed to workplace violence, 59.5% were female, 37.6% were male and 2.9% did not report on their gender. Against this general demographic of respondents for the survey, a cross-tabulation was done to establish whether males or females were more likely to be victims of workplace violence, that is, to establish whether gender played a significant role.

This data is presented in Figure 3 above.

Discussion

More males than expected reported “yes” to experiencing workplace violence and fewer than expected reported “no”. On the other hand, fewer females than expected

reported “yes” to experiencing workplace violence and more females than expected reported “no”. The p value was 0.046 and the ø=0.156, thus there was a small effect size.

The finding of this study thus does not fully correlate with studies by Chappell and Di Martino (2000), in which 51% of workers who were exposed to workplace violence were found to be women and there was thus a significant association between gender and exposure to workplace violence.

The country studies (Di Martino, 2002) also indicated that in Bulgaria and Portugal women are more subject to verbal abuse than men are, while in Thailand men are more prone to being the victims of physical violence, bullying/mobbing and racial harassment. The Lebanese report indicated that women were more at risk of sexual harassment, while the Portuguese report revealed that men at the health centres were more at risk of sexual harassment. This cautions us to beware of stereotyping. The study under review did not attempt to cross-tabulate whether a particular type of violence was more endemic among males and whether other types were more endemic among females.

5.7.3.b Multiple incidents of workplace violence

Question 9 on the Survey questionnaire

Data

The majority of the respondents had had more than one incident of workplace violence (70%) which suggests that workplace violence is not a once-off event in the lives of healthcare workers, but is a phenomenon to which they may have become accustomed and desensitised.

Discussion

Only 30% reported one incident of workplace violence and perhaps further studies could explore single incidences and complete cross-tabulations with gender, age and units, an aspect which this study did not explore. Gender cross-tabulated with exposure to workplace violence was explored in this study, and will be presented in the next section.

5.7.4 Gender vulnerability to multiple incidents of workplace violence

Cross-tabulation between Questions 1 and 9 on the Survey Questionnaire

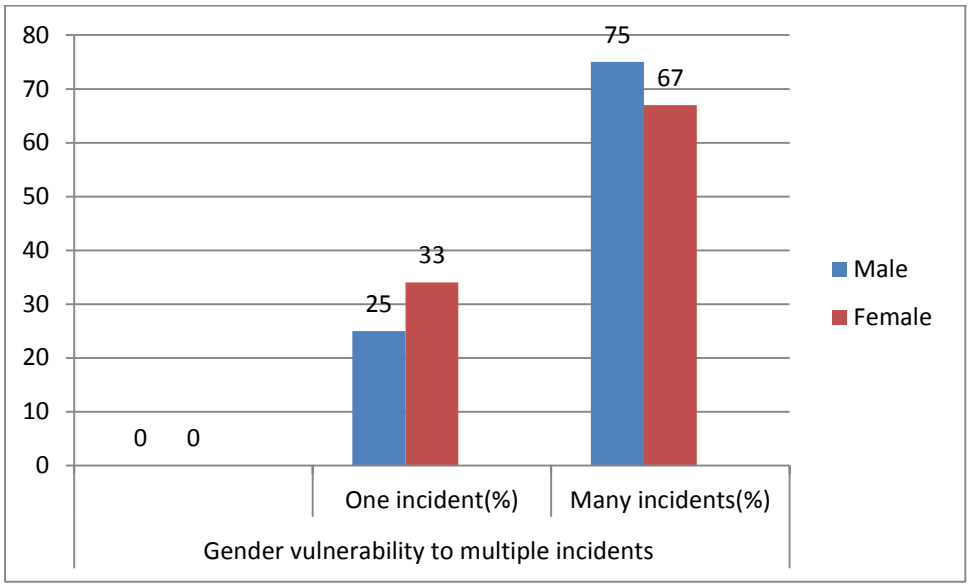


Figure 4: Gender and multiple incidents of WPV

*8 missing values

n = 173

Data

In addition to plotting how many participants had experienced one incident of workplace violence the study also explored whether females or males experienced multiple incidents. Of the 30% of respondents who had experienced one incident of workplace violence, 25% were males and 34 % were female.

When it came to multiple incidents, 75% were male and 67% were female. The Fishers Exact test showed a p value of 0.134 which is not a significant association between the two variables.

The Pearson ø=.287, indicated that there is no significant difference between gender and the number of incidents of workplace violence.

Discussion

Gender has been strongly associated with workplace violence in previous studies.

Cooper (2003:vi) focused on individual factors, including gender, while Kennedy (2004:16) quoting Chodoram highlights gender dynamics from a power perspective. The current study has not supported the view of previous studies that there is a significant correlation between gender and workplace violence as evidenced by the study by Cooper (2003:vi), and also did not find that females were more exposed, thus having multiple incidents. One could thus postulate that, after one incident or a first incident, females are more alert to circumstances that may trigger workplace violence.

South Africa may be seen as a society where violence has been normalised, and the gender divide around issues of workplace violence may not be as evident as it is in other countries. This is a surprising finding, as issues of patriarchy and power are all prevalent in young democracies like South Africa. Lewis (2006:52) reflects on female professions like nursing, and the powerlessness inherent in both society and organisations.

Repeat incidents have been strongly linked to incidents being viewed as occurring more often in certain units, so those staff members are more exposed to workplace violence. The study, as can be seen above, does not bear this out, as it does not show a significant relationship between the occurrence of workplace violence and the unit in which staff work. One of the units/wards often mentioned is psychiatry, where the risk increases (Lawoko et al., 2004:39).

5. 7.5. Age and multiple incidents of workplace violence

The age groups that responded to the survey are as follows: 20-30 years (19.2%); 31-40 years (21.6%); 41-50 years (15.3%); 51-60 years (9.8%); and older than 60 years (1.8%). It should be noted that there were a huge number of non-responses when it came to disclosing age. This made the cross-tabulation below quite difficult and may have had an impact on the outcome of the findings

Cross-tabulation between Questions 2 and 9 on the Survey questionnaire

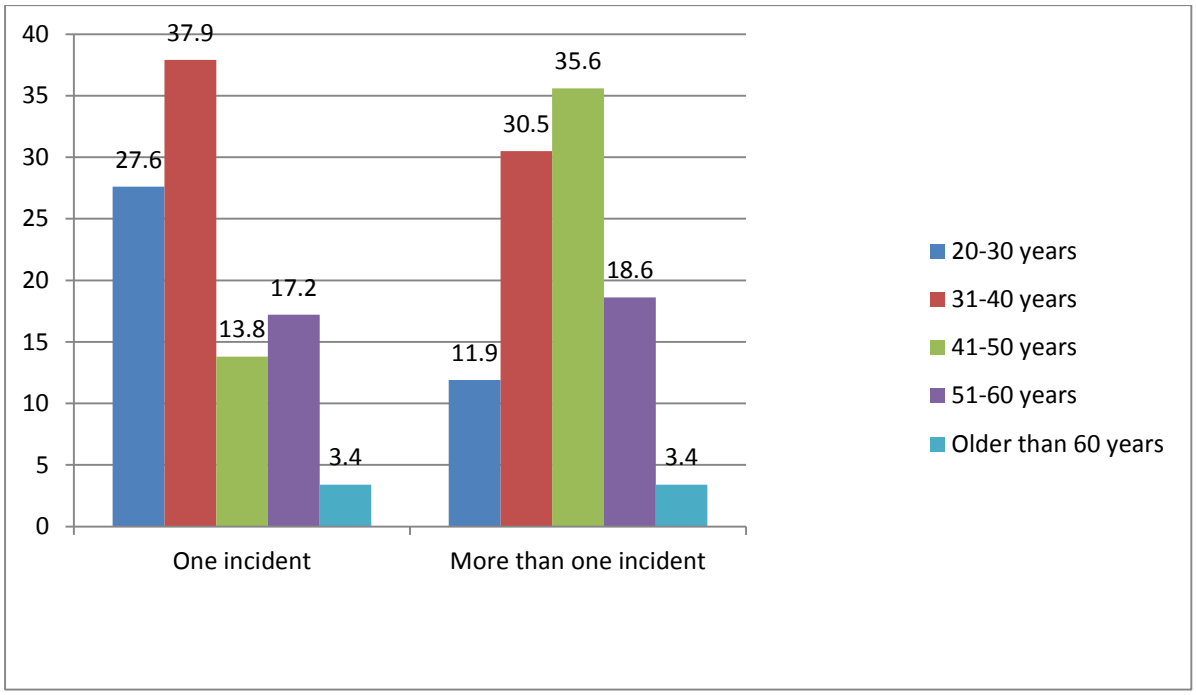


Figure 5: Age and multiple incidents of WPV

*43 missing values

n=173

Data

In this section, the researcher did a cross–tabulation between age and multiple incidents of workplace violence, of which data is presented above. The ages of the respondents for both one incident and multiple incidents are presented in the graph above. The researcher has graphically presented the age groups for both one incident and multiple incidents of workplace violence. A large number, that is, 32.3% did not volunteer their age on the questionnaires, which resulted in the large number of missing values. The p-value computed through the Fisher's Exact Test is 0.139, which is more than 0.05, therefore indicating no significant association between age and the number of incidents of workplace violence to which health workers were exposed.

Discussion

This finding does not correlate with other studies such as the Grubb et al. (2005:55) study, which found that bullying and incivility appear to coexist with a number of other indicators of a hostile work environment. Those indicators could include sexual harassment as well as formal complaints about violence as a result of race, age

and/or disability. The study under review correlates more with what was found in the country studies conducted by Di Martino (2002:18), in which age did not seem to play a significant role, even though seniority often did so when it came to defusing situations.

5.7.6. Professions most exposed to workplace violence

Of the respondents to the survey, 6.4% were doctors, 30.1% were nurses, 4.0% were pharmacists, 24.9% were admin/clerical staff, 19.1% were support staff, 6.9% were allied health workers and 6.9 represented other professions, while 1.7% did not respond to this question.

Cross-tabulation between Questions 3 and 8 on the Survey Questionnaire

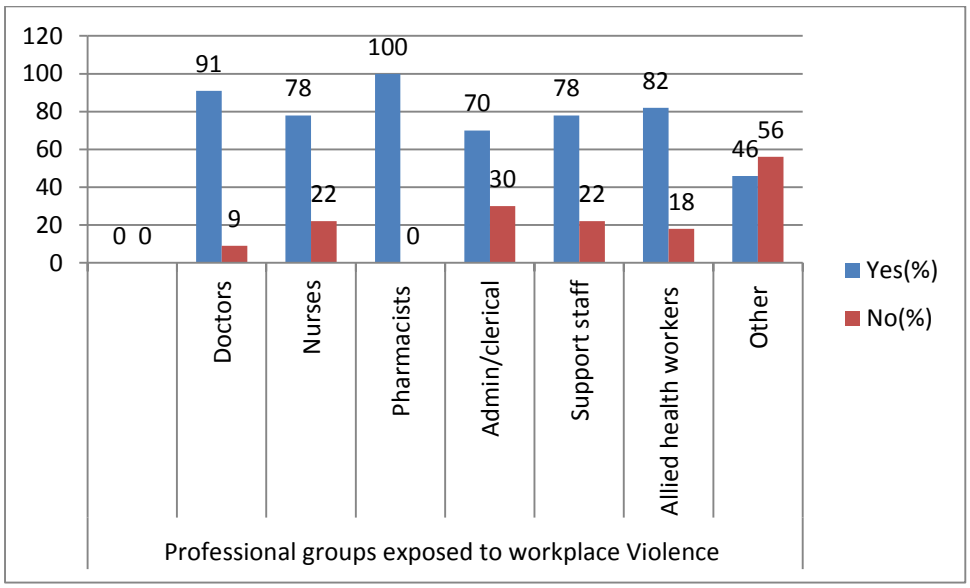


Figure 6: Professional category and exposure to workplace violence

*7 missing values

n = 173

Data

Against this demographic backdrop, the analysis of whether certain professional groups were more exposed to workplace violence was performed and presented in Figure 6. The information presented above is thus a cross-tabulation of exposure to workplace violence and professional category. The p-value from the Fisher's Exact Test was 0.147, so at the 5% confidence level there does not seem to be a statistically significant association between staff category and exposure to workplace violence.

Discussion

Pharmacists and doctors in this study seem to be more exposed to workplace violence than nurses. Equally high was the exposure of allied health workers which included social workers, physiotherapist and occupational therapists.

Kennedy (2004:16) cites Chodoram, who maintains that violence against nurses should be looked at from a gender perspective. The dynamics she outlines are that nurses continue to accept abuse because they feel they do not have the power to change it. As a predominantly female profession, they have been conditioned to accept behaviour from those they consider powerful, as women have often been socialised to be passive and to relinquish power. However, Chodoram also asserts that nurses are easy targets for patients who bite, kick, hit and spit, as the nurses are most exposed to patients. Generally, it was staff categories that were more exposed to workplace violence, followed by middle managers and then line managers. One could postulate that these categories are more exposed to patients and the general public than senior managers are.

5.7.7.a Seniority of position and exposure to workplace violence

Question 4 on the Survey Questionnaire

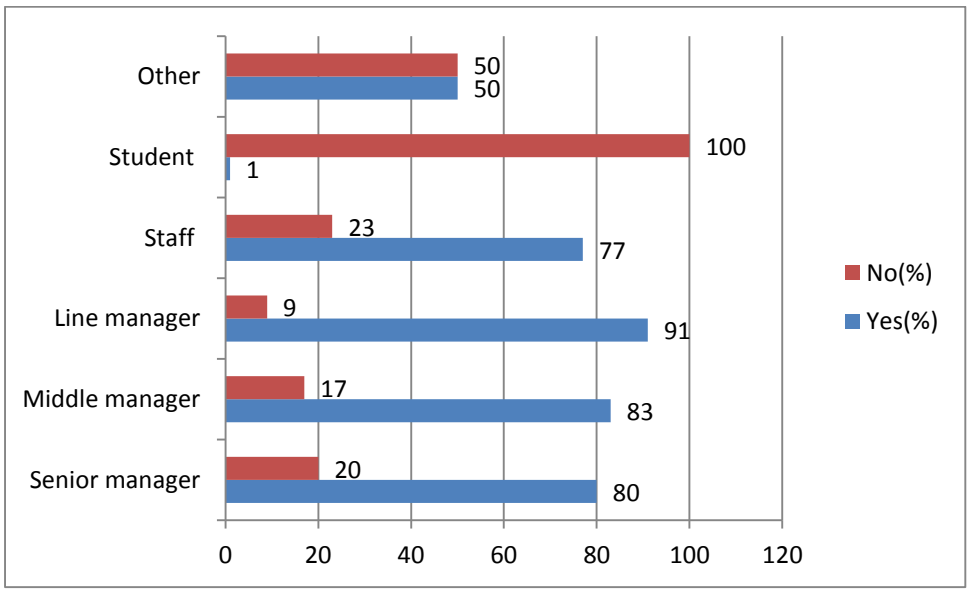


Figure 7: Seniority of position and exposure to WPV

*1 missing value

n=173

5.7.7 b Seniority of position and extent of workplace violence incidents

Cross-tabulation between Questions 4 and 9 on the Survey Questionnaire

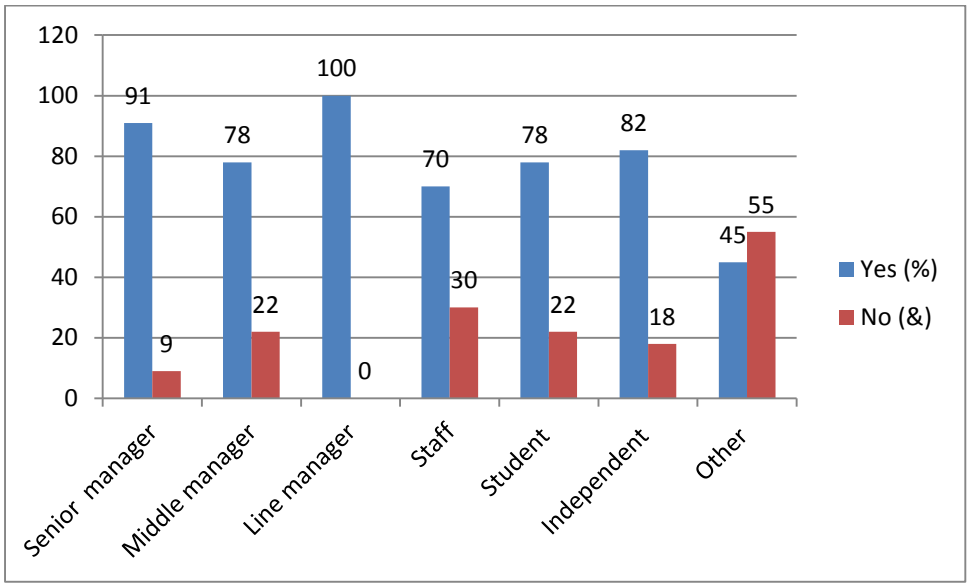


Figure 8: Seniority of position and multiple incidents of WPV

*45 employees did not respond to this question

n = 173

Data

The data discussed in this section are presented in the two graphs above.

Figure 7 is a representation of which general “staff” positions were exposed to workplace violence, and Figure 8 presents an analysis of whether certain staffing categories were more exposed to multiple incidents of workplace violence. This was because they reported having encountered more than one incident of workplace violence. It was therefore concluded that they were more vulnerable to multiple incidents of workplace violence.

The p-value was 0.000 and ø=0.37, thus a medium effect size was present in exposure to workplace violence and seniority of position. When one further explores the relationship between seniority of position and the extent of workplace violence the p value is 0.147 indicating that there is no association between seniority of position and the number of workplace violence incidents per se.

Discussion

The study revealed that all staffing categories reported more exposure to workplace violence than not and not one category seemed to be more exposed than another.

The literature strongly suggests most often students, are more exposed to workplace violence. In addition, students often lack the confidence to effectively deal with circumstances that could lead to workplace violence and are thus more prone to victimisation. The current study, however, did not support the view that students, who are usually young and inexperienced, are therefore more vulnerable to workplace violence.

5.7.8. a Unit/Ward the employee works in.

Question 6 in the Survey Questionnaire

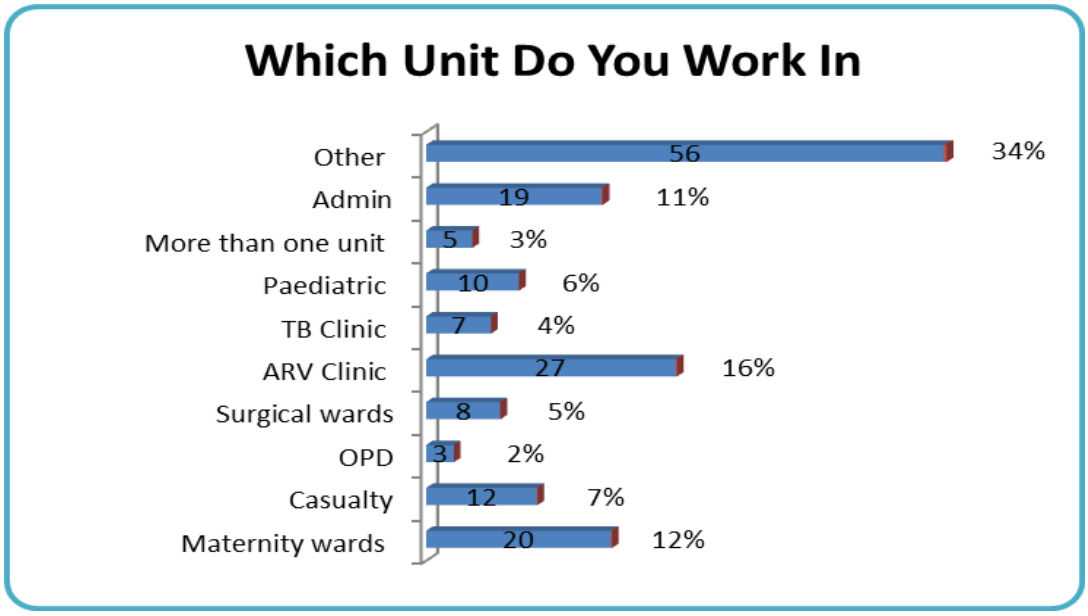


Figure 9: Which unit do you work in?

*6 missing values

n=173

5.7.8 b Unit/Ward and exposure to workplace violence

Cross-tabulation between Questions 6 and 8 on the Survey Questionnaire

	Yes		No	
Unit	**n**	**%**	**n**	**%**
Maternity wards	19	24%	1	3%
Casualty	12	15%	0	0%
OPD	2	3%	1	3%
Surgical wards	7	9%	1	3%
ARV Clinic	4	5%	21	64%
TB Clinic	3	4%	1	3%
Paediatric	6	8%	4	12%
More than one unit	5	6%	0	0%
Admin	19	24%	0	0%
Other	2	3%	4	12%
Total	**79**		**33**	

Table 5: Unit/Ward and exposure to workplace violence

* 61 missing values

n=173

Data

The data on the spread of units in which employees worked is represented in Figure 9 above. The largest group was from “other” category, namely (34%), whilst the second largest group was from the ARV clinic (16%) and thirdly from the Maternity wards (11%). Table 5 then represents the cross tabulation of the units/wards where violence occurred. The Fisher’s Exact Test revealed a p value of <0.0001, which is highly significant. The ø= 0.72, indicating a strong effect size.

In other words, the study showed a strong correlation between the type of unit/ward and the likelihood of workplace violence occurring.

Discussion

Wistanley, (2005:342) strongly suggests that more incidents of workplace violence occurred in certain units. This current study arrived at the same finding and conclusion. Administration showed a high number of incidents, which often occur in the cadre of staff dealing with money and payments and who are in the first line of

contact in a hospital. This may account for this trend and some studies have pointed to the exchange of money as being responsible for conflict with patients and families.

The second unit to show more conflict in comparison is the maternity unit. It may be that the perpetrators in these cases are not the patients themselves, but their partners or spouses, who are denied easy and all-day access to mother and baby. Interestingly, the ARV clinic showed a high number of incidents erupting. The units pinpointed in the literature (Wistanley, 2005:342) as being major contributors to workplace violence did not reveal a clear picture. These outpatients did not show high numbers of incidents but casualty, as pointed out in the Wistanley (2005:342) report, contributed to a high percentage of incidents.

Wistanley (2005:342) quoting Whittington's study highlights refusal or delay of treatment or care as one of three categories of antecedents to workplace violence. Outpatient units are often points of conflict owing to long waiting periods and the poor information given to patients and families. We can see this in the denoted casualty unit named in this study. These casualty units are often overcrowded and poorly ventilated, factors which cause the eruption of violence. Employees in all of the wards discussed above experienced more than one attack of violence.

The TB ward reflected a low incidence of workplace violence in this study. TB wards house patients who spend extended periods in hospital and who are often bored and frustrated but are kept there because of the fact that they are infectious, especially those with multi-drug resistant TB (MDR) or extreme drug resistant TB (XDR). In 2008 and 2009 in South Africa there were a number of incidents in which TB patients escaped from the hospital, causing large-scale alarm in communities and the healthcare sector in general (News 24, 2009).

These patients leaving the hospital without being discharged focused a great deal of attention on levels of frustration and boredom and the lack of hospital programmes in these units - which could possibly result in workplace violence.

5.7.9. Types of workplace violence

Question 10 on the Survey Questionnaire

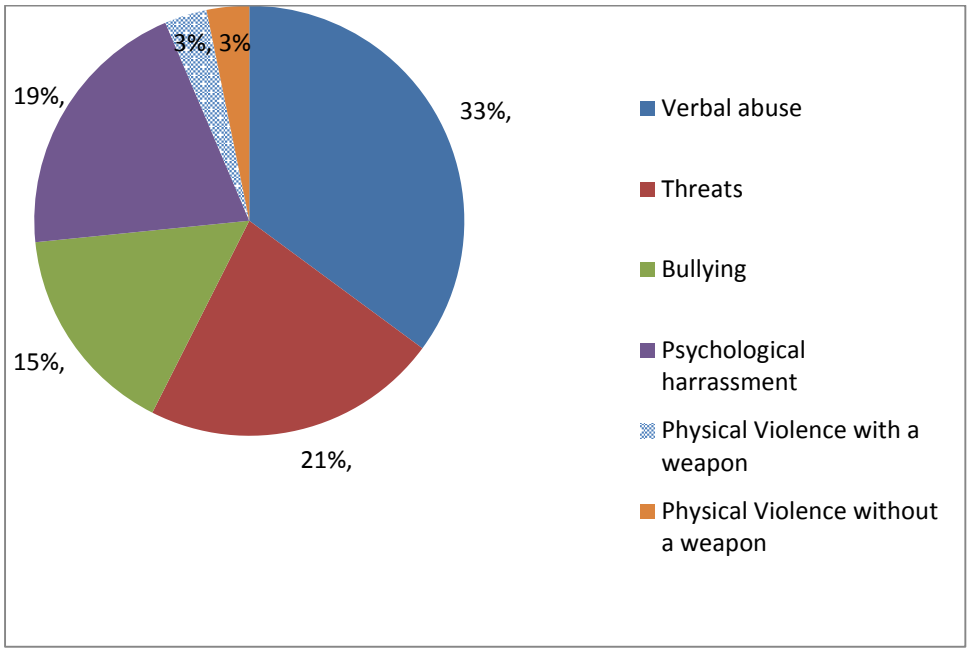


Figure 10: Types of workplace violence

*47 missing values

n = 173

Data

There were multiple responses to this question, as one respondent could have been exposed to more than one type of WPV. This drew 335 responses in total. The above data represents the range of responses to the types of workplace violence experienced by the respondents. Verbal abuse and threats were the most common forms of workplace violence experienced by this group of respondents. Figure 10 also suggests that physical violence with or without a weapon, does feature but it is not that common.

Discussion

This finding is in keeping with many of the previous research projects. A study in Turkey (0ztunc, 2008:118) found that 80.3% of the Sample had experienced verbal abuse. Similarly, a Nepal study reported on by Joshi et al. (2008:119) indicated that 67% of healthcare workers had encountered verbal abuse, while only 6% had experienced physical violence in the current study on Dr Yusuf Dadoo Hospital. Hoobler (2006:235), in a study of US government employees, found that 39% had experienced verbal abuse, 15% had experienced physical abuse and 5% had experienced sexual abuse. A most disturbing finding in the current study was that 3% of the sample had experienced sexual violence. Sexual abuse violence is different from sexual harassment in that it comprises more types of sexual violence than just sexual harassment. The researcher for the study reported on, had not considered adding this category at all, as it had not emerged as an issue for consideration during the piloting of the interview schedule and questionnaires.

5.7.10. The perpetrator of workplace violence

Question 11 on the Survey questionnaire

	Responses	
Offender	**n**	**%**
Patient/client	84	24.5
Staff member in institution	68	19.8
Colleague in same department	38	11.1
Immediate supervisor	49	14.3
Relative of a patient	64	18.7
Member of the public	28	8.2
Other	12	3.5

Table 6: Perpetrators of workplace violence

*45 missing values

n = 173

Data

The above data was elicited by the question on the perpetrator's identity.

For this question 343 responses were elicited as it was a multiple response-type option question. Respondents could thus tick as many responses as applied to them, as many had experienced more than one incident of workplace violence, with different perpetrators. Most often (24.5%) the offender was the patient or the client, while 19.8% of the time it was a colleague.

Discussion

In the study by Steinman (2002), which was conducted in South Africa, it was found that most of the incidents were perpetrated by patients' relatives. This finding was also reported by Oztunc (2008:118), who found that patients' relatives were the perpetrators in 57.2% of the incidents. The number of incidents perpetrated by an immediate supervisor was also rather high, viz. 4 (14%). This type of workplace violence perpetrated by a supervisor or manager has the most negative consequences for an employee.

Di Martino (2002:17) notes that the country studies he conducted in South Africa, Australia, Portugal, Thailand, Brazil, Bulgaria and the Lebanon confirmed the difficulty of establishing a profile of the perpetrator of workplace violence and that this could result in stereotyping and generalisation. He further states that in the countries under investigation a pattern seemed to emerge whereby patients were the main perpetrators of physical violence, while staff was the main perpetrators of psychological violence.

He further notes that, in South Africa, patients were the main perpetrators in 45% of incidents of physical violence in the public sector, but that the staff appeared to have been the perpetrators in more incidents of psychological violence in both the public and private sectors.

Hannabus (1998:306) has written extensively on the profile of the bully. He notes that bullies look for victims, and he refers to the bully-victim dyad of which sociologists speak. Work by Hannabus, although once again focusing on individual behaviours,

asks whether the bully is merely acting out organisationally-congruent behaviours and suggests that the organisational culture may be the real culprit.

It is thus quite difficult to conclude that the perpetrator is a typical stereotype, given strong evidence to the contrary. It is also clear that a number of individual factors interacting with organisational factors allow for a bullying culture, which overrides individual considerations.

5.7.11. The location of the incident/s

Question 12 on the Survey Questionnaire

	Responses	
Location of the incident/s	**n**	**%**
In the health facility	122	78.7
Outside the health facility	19	12.3
Patient's home	6	3.9
Other	8	5.2

Table 7: Location of the incident/s of WPV

*46 missing values

n=173

Data

The table above indicates the spread of the location of workplace violence. Sometimes staff members are doing home visits to certain identified patients, even the TB DOTS counsellors who ensure that medication is taken. One hundred and fifty five responses were elicited by this question. More often than not, 78% of the time the incident occurred inside the health facility.

Discussion

Most of the reported incidents occurred in the health facility, which highlights some of the environmental factors with which workplace violence has become associated in the literature, namely lighting and ventilation. Lawoko et al. (2004:52) have suggested that factors such as poor lighting and poor ventilation may act as contextual factors.

5.7.12. Post-incident action

Question 13 on the Survey Questionnaire

	Responses	
Post-incident action	**n**	**%**
Took no action	53	9.6
Told the person to stop	75	13.7
Told friends	62	11.2
Transferred to another unit	32	5.8
Told a colleague	74	13.4
Completed an incident form	25	4.5
Defended yourself physically	32	5.8
Sought counselling	42	7.6
Reported incident to a senior person	62	11.2
Sought help from the union	21	3.8
Pursued prosecution	19	3.4
Sought help from the Employee Wellness department	34	6.1
Reported incident to the Labour Relations department	12	2.2
Other	10	1.8

Table 8: Response to the incident/s of WPV

*46 missing responses

n=173

Data

The range of responses is represented above with a total of 555 responses received in answer to a multiple response-type question. The most common form of response was to tell the person to stop (13.7%) of the time, after which they would tell a colleague (13.4%).It is interesting to note that the union's support was sought in only (3.8%) of the incidents.

Discussion

The main system of support sought after an incident and after trying to defend oneself was to tell a colleague. Reporting the incident to a senior turned out to be only the third most popular response, leading to the conclusion that the internal workplace systems of support are not considered effective, accessible or trustworthy.

It is noted that seeking help from the unions is not common. This is interesting, given that South Africa has a strong history of unions who can be relied on to fight a member's case. In addition, the employee wellness or employee assistance programmes may not feature significantly as systems of support for employees. De Falco (2001:191) has noted that the focus by EAPs has been mostly on domestic violence and its spill-over into the workplace, with some focus on trauma management.

EAPs have been loath to address issues located at the level of organisational culture, given the strong focus on addressing individual needs. Di Martino (2002) has also concluded that, in particular, the Human Resources Department often failed to support victim and in only 7% of the cases were bullies transferred, punished, or had their employment terminated.

5.7.13. Deterrents to reporting workplace violence

Question 14 on the Survey Questionnaire

	Responses	
Deterrents to reporting	**n**	**%**
Reporting does not help	54	27
Not sure of reporting procedure	23	12
Not confident of being taken seriously	38	18
No confidence in management to follow through	39	19
Did not consider the incident to be serious	39	19
Other	9	5

Table 9: Reasons for not reporting WPV

*90 missing values

n = 173

Data

This question had the potential to draw multiple responses and 202 were elicited, as shown in Table 9.

Discussion

The majority of the respondents either did not report workplace violence because they believed reporting would not help or were not confident of being taken seriously. This phenomenon is something which Lewis (2006:550) comments on when he notes that care managers often try to contain the situation so that healthcare workers feel that their complaints are not taken seriously or that investigative procedures are not followed. It is thus not surprising that many of the victims did not consider the incident/s sufficiently serious to warrant reporting on them.

5.7.14. Emotional responses to incident/s of workplace violence

Question 15 in the Survey Questionnaire

	Responses	
Emotional response	**n**	**%**
Anger	103	30.6
Guilt	40	11.9
Shame	44	13.1
Fear	48	14.2
Stress	87	25.8
Other	15	4.5

Table 10: Emotional Responses to the incident

*46 missing values

n = 173

Data

The question of emotions experienced after an incident was a multiple response question and produced 345 responses, with the range of emotions graphically represented in Table 10.

Discussion

Workplace violence can trigger a range of both physical and emotional reactions. Cooper (2003:vii) reports that emotional experiences can include anger, fear, shock, anxiety, depression and sleep disturbance. Physical injuries range from bruises to broken bones. Reasons for leaving one's job vary from person to person and attrition rates in organisations can be high. One of the consequences of workplace violence is that those being bullied are more likely to report that they were planning to leave their jobs than those who were not victims.

Workplace violence has significant consequences for the retention of employees in an organisation. Employees who are being bullied may believe that they have no choice other than to leave their organisation, especially if there is no recourse for the victim. The consequences are often loss of skilled employees and additional cost implications,

as this employee now has to be replaced and the associated costs of recruitment would then apply.

5.7.15. Awareness of phenomenon of workplace violence

Question 16 on the Survey Questionnaire

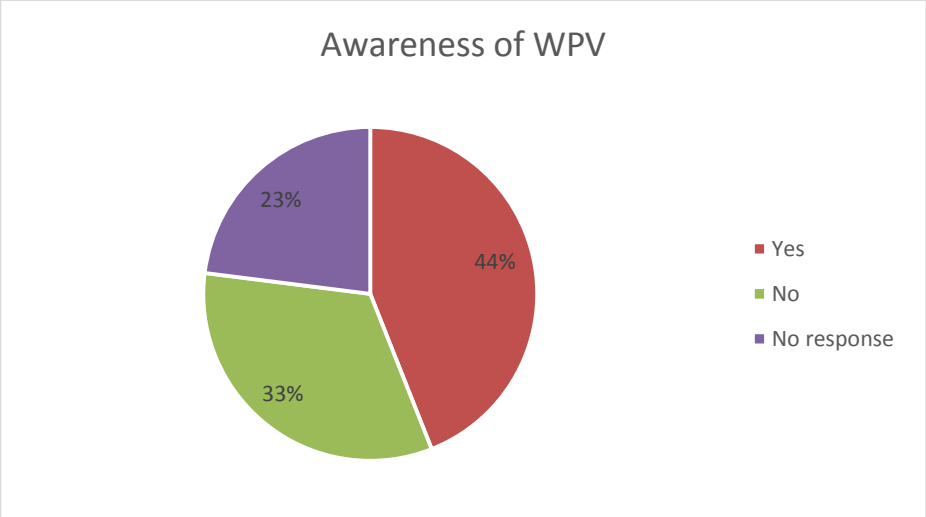


Figure 11: Awareness of workplace violence

n = 173

Data

A proportion of the respondents did not answer this question as indicated above, and this may have implications for the generalizability of this finding.

Discussion

Forty four percent (44%) of the respondents reported being aware of the fact that they were victims of workplace violence, yet many did not report the incident because they did not regard it as being serious enough to report. There is a distinct contradiction in this response.

Forty four percent (44%) is quite a large percentage of non-responses and the researcher is of the opinion that a certain amount of contamination had already occurred by respondents being aware that the study topic was workplace violence. Respondents may not have been aware at the time of the incident that they were

victims of workplace violence, but, given that the research topic suggested it, they opted out by choosing not to answer the question.

5.7.16. Post-traumatic symptoms following incidents of workplace violence

Question 17 on the Survey Questionnaire

	Responses	
Post-traumatic symptoms	**n**	**%**
Repeated disturbing thoughts	67	29.6
Avoided thinking about incident	44	19.5
Avoided talking about incident	34	15.0
Being super-alert/hyper vigilant or on guard	35	15.5
Feeling of everything is an effort	37	16.4
Other	9	4.0

Table 11: Symptoms after the WPV incident

*58 missing values

n = 173

Data

A range of symptoms as described graphically by the data above is experienced by victims of workplace violence. The number of responses elicited by this question totalled 226.

Discussion

Post-traumatic symptoms contribute significantly to the cost of workplace violence. Hannabus (1998:307) says that unfortunately power and influence often decide who stays and who wins. When a complaint is filed and investigated, it is usually the victim who leaves. He further noted the effects on victims, such as psychological injury, stress, anxiety, insomnia, feelings of guilt and shame, irritability, low self-esteem, panic attacks and poor concentration. Physical symptoms such as headaches, sweating, psychosomatic illnesses and skin irritations are also common.

Di Martino (2003:vii) is of the opinion that quantifying the cost of workplace violence is crucial to shaping anti-violence strategies. The researcher concurs, as organisations often have no idea of the cost of workplace violence, nor do they realise that a well-designed and implemented strategy will be effective in reducing the costs of workplace violence. This applies to both the direct cost level of recruiting and re-training new employees who have replaced those who have left, and the indirect productivity costs incurred by those who are traumatised and are absent.

5.7.17. Strategies to address workplace violence

Question 18 of the Survey Questionnaire

	Responses	
Strategies	**n**	**%**
Hospital policy	65	15.44
Supportive management	72	17.10
Proper security	65	15.44
Employee wellness programme	63	14.96
Clear reporting mechanisms	40	9.50
Union support	31	7.36
Family support	34	8.07
A transfer to another unit	18	4.27
A clear reporting procedure	22	5.22
Other	11	2.61
Total	421	100%

Table 12: Proposed strategies to address WPV

*59 missing values

n = 173

Data

The proposed strategies that respondents believed would help mitigate workplace violence are best presented in Table 12 above, with a total of 421 responses.

A supportive management (17.10%) and a workplace violence policy (15.44%) were mooted as the most important strategies for combating violence.

Discussion

The strategies which emerged from respondents centred on what they believed would have empowered them to behave differently. A supportive management topped this list, followed by a hospital policy and proper security. This order of preference is very much in keeping with what Cooper (2003:viii) proposed.

The employee wellness programme also takes a notable position in this study and may be an opportunity to position both policy development and training initiatives.

5.8. Analysis of the Pre-Test, Post-Test and Shift from Pre-Test to Post-Test.

5.8.1. Introduction

This section will present the findings from the pre-test and the post-test and the comparisons of attitude, belief and skills from pre-test to post-test. The McNemar-Bowker test of symmetry was used to determine whether the shifts in attitude, belief and skills were significant and this will be presented as a p-value. It tests for symmetry around the diagonal of the table. A statistically significant McNemar statistic indicates that the disagreement is not spread evenly across the cells of the table.

For purposes of the pre-test and post-test, data for the Sample and the respondents' experience of the phenomenon will be presented under 4.8.2. Thereafter all the findings from the pre-test, the post-test as well as the shifts in attitude, belief and skills will be presented in a separate section under 4.8.3. For all the sections, data will be presented either by means of bar graphs, tables or pie charts. With regards to changes to attitudes, beliefs and skills, the McNemar–Bowker test was used. This test is thus done to establish whether the workplace violence training had a significant impact on variables which have been pre-determined as being an attitude, a belief or a skill. For a shift to be significant, the p value must be smaller than 0.05. It should also be noted that the p value could not be computed for all the parameters as listed below, because of the structuring of certain questions. Lewis-Beck et al (2004: unknown) notes that the McNemar–Bowker test can only be performed on square tables where the number of rows and the columns are equal and represent the Same categories. Some of the questions were asked only in the pre-test questionnaire and were not matched by similar questions in the post-test questionnaire. In such cases the resulting tables were not square and McNemar-Bowker statistic could not be computed. There were also cases where the categories for a certain question in the pre-test included the "unsure" option, but in the post-test questionnaire this option was not selected. In such cases, the "unsure" category was excluded, and the McNemar-Bowker statistic was computed for the resulting square table.

In addition to the McNemar-Bowker test, the Pearson Chi-square test can also be used to see whether there's a relationship between two variables. (Field, 2009:688).The formula for the effect size is $w=\frac{\sqrt{x^2}}{n}$.

Lastly, the study also utilised the Wilcoxon signed-rank test. This test is based on the differences in the two conditions /variables but this test then goes on to rank those differences (Field, 2009:552).

This next section thus focuses on merely outlining the Sample group of 40 and their experience of and exposure to the phenomenon of workplace violence.

5.8.2. Exposure to workplace violence and experience

Of the 40 participants in the training, 57.5% had experienced workplace violence in the 12 months leading up to this study, and 42.5% had not**.** This section will thus present data on the following variables listed below, as this outlines their experience of and exposure to workplace violence prior to the pre-test being conducted. Only the pre-test data will be presented as the demographics of the group remains the same pre-test and post-test. It would thus be repetitive to present it twice.

Data will be presented on:

- Gender and workplace violence;
- Workplace violence according to professional group;
- Workplace violence and professional group;
- Workplace violence and staffing position;
- Workplace violence and type of unit/ward;
- Workplace violence and age;
- Workplace violence as related to public contact;
- Multiple incidents of workplace violence;

- Types of workplace violence;
- The perpetrator;
- Location of the incident/s;
- Response to the incident/s;
- Reason/s for not taking action;
- Emotions after the incident/s;
- Symptoms after the incident/s;
- Awareness of workplace violence.

5.8.2.1. Gender vulnerability to workplace violence

Questions 1 and 8 of the pre-test questionnaire

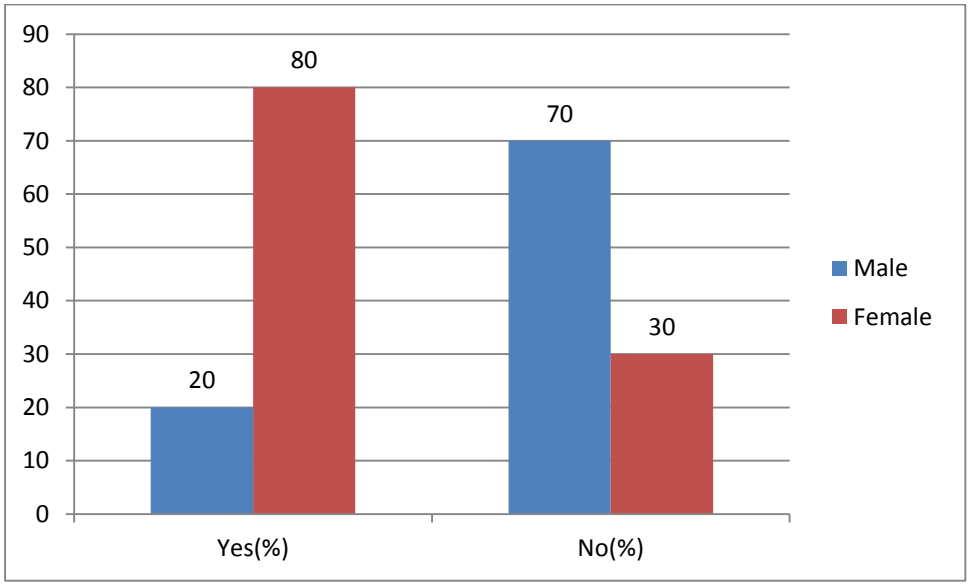


Figure 12: Gender and workplace violence

n = 40

Data

Although more women than men were exposed to workplace violence, this was statistically significant according to Fisher's Exact Test which revealed p value of 0.009. In addition the ø=0.4 also revealed a medium to strong effect size regarding victimisation between males and females.

Discussion

The work of Chappell and Di Martino (2002) clearly indicates that more women than men are exposed to workplace violence. Cooper (2003:vi) also notes gender as an individual factor contributing to the phenomenon. While the current study did support this viewpoint, the Sample for the actual training was quite small and males were under-represented in this sample. This may have accounted for the relatively small effect size.

5.8.2.2 Workplace violence and professional groups

Questions 3 and 8 on the pre-test questionnaire

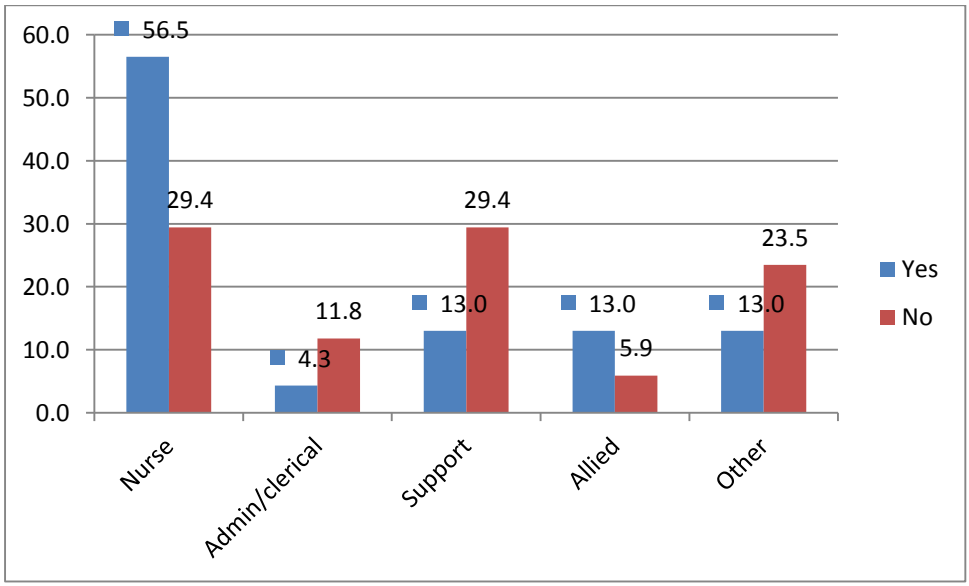


Figure 13: WPV according to professional group

n=40

Data

Nurses were well represented in the group that was included in the sample and they were the group that were the most exposed to workplace violence. The p value was

0.009 from the Fisher's Exact Test indicating that this was not a statistically significant finding. It showed that a medium to small effect size existed between male and female respondents.

Discussion

The above finding is in stark contrast to the British Crime survey in 1994, which indicated that the risk of assault for nurses was five times the national average. Jenkins (2003:32) noted that in British Columbia nurses ran the same risk as police officers, who had a rate of nearly four times the incidence of other professions.

Again, the sample for this study was a small one and the South African context, with its high crime statistics and subsequent desensitisation to violence, may have contributed to this finding. We thus find that, in this study, workplace violence was pervasive across all the different professional groups.

5.8.2.3. Workplace violence and seniority of position

Questions 4 and 8 on the pre-test questionnaire

Seniority of position	Yes		No	
	n	%	n	%
Middle manager	3	7	1	3
Line manager	1	3	0	0
Staff	18	45	12	30
Student	1	3	2	5
Other	0	0	2	5
Total	**23**	**58**	**17**	**43**

Table 13: Workplace violence and seniority of position

n=40

Data

The p value was 0.394 indicating no statistical significance between the level of seniority and workplace violence.

Discussion

According to the data from the current study, no confirmation was obtained that workplace violence is more commonly found amongst more senior staff members as the junior staff members often have more patient, patient-escort and general public exposure.

Middle managers are older and more mature, and are thus better able to defuse potential workplace incidents far more effectively. Di Martino (2002:18) noted that seniority often played a role when it came to effectively defusing a situation and consequently averting a possible incident of workplace violence.

5.8.2.4. Workplace violence and type of unit/ward the employee worked in

Questions 6 and 8 on the pre-test questionnaire

Unit/Ward	Yes		No	
	n	%	n	%
Maternity ward	2	5	0	0
Outpatients	1	3	0	0
Surgical ward	0	0	2	5
ARV Clinic	5	13	0	0
TB Clinic	1	3	1	3
Paediatric ward	1	3	1	3
More than one unit	2	5	1	3
Administration	1	3	1	3
Other	10	25	9	23
Total	**23**	**60**	**15**	**40**

Table 14: Workplace violence and types of ward/units

2 missing values

n=40

Data

The p value is 0.276 which is not a statistically significant association between the type of unit and exposure to workplace violence in this study.

Discussion

It is hypothesised that certain units are considered high-risk units, such as casualty, because of the high patient numbers and long waiting periods. The same is said of the outpatient unit. The mental state of the patient and psychiatric care have also been mooted as contributors; thus these hospitals or units are considered more prone to the eruption of workplace violence. Wistanley (2005:342) refers to the patient's mental state as one of the antecedents. This study did not concur with the literature and the under-representation of employees from high-risk units may account for this finding.

5.8.2.5. a Age and Workplace Violence

Question 2 on the pre-test questionnaire

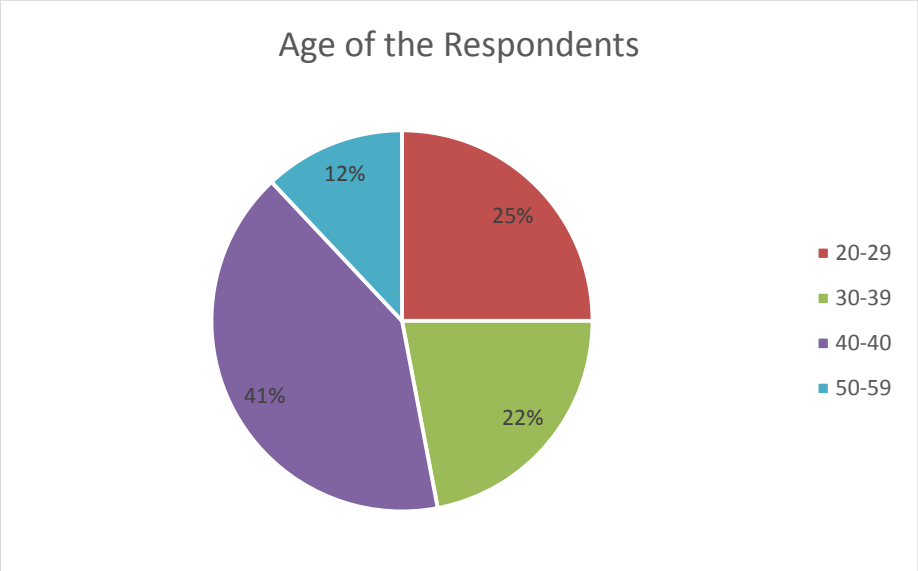


Figure 14: Age of the respondents

n=40

5.8. 2.5.b Age and exposure to workplace Violence

Questions 2 and 8 on the pre-test questionnaire.

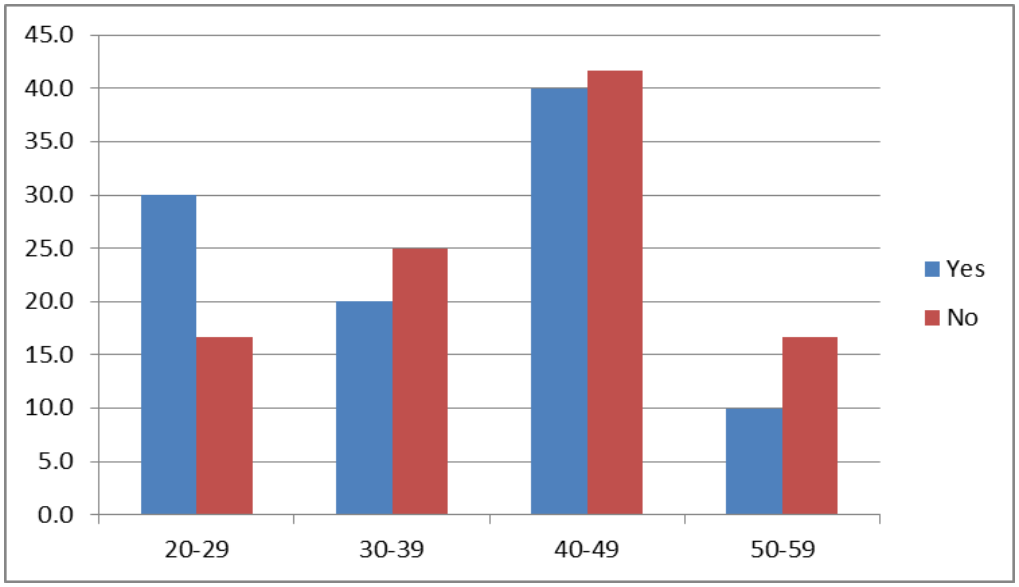


Figure 15: Age and exposure to workplace violence

n=40

Data

The average age of those who were exposed to workplace violence was 37.85 years, with a standard deviation of 10 years. The average age of those who reported “no” to workplace violence was 39.1 years, with a standard deviation of 9.7 years. The “yes” group was a little younger than the “no” group. However, the median age for both groups was 40 years. There was no significant association between age group and exposure to WPV with a p value of 0.847.

Discussion

Age has always been considered a significant factor in workplace violence, with younger people considered to be victims more often. The countries study by Di Martino (2002:18) seemed to refute this finding; he concluded that age did not seem to play a major role, but that seniority often did, when it came to defusing situations. The current study concurred with Di Martino’s 2002 findings.

5.8.2.6 Workplace violence as related to staff contact with the public

Questions 7 and 8 on the pre-test questionnaire

Place where violence occurred	Responses	
	n	%
Inside the health facility	122	78.7
Outside the health facility	19	12.2
Patient's home	6	3.9
Other	8	5.2
Total	**155**	**100**

Table 15: Workplace violence and contact with the public

n=40

Data

The study found that in 78% of the cases the workplace violence had occurred inside the health facility, with a minority of incidents occurring outside.

Discussion

This finding also correlates with the finding that most of the incidents of workplace violence occurred inside the health facility.

Data presented in a few sections below will not be graphically represented as was done with the more complex data section. The information presented in these sections are quite straight forward. This applies to sections 4.8.2.7, 4.8.2.10, 4.8.2.11, 4.8.2.13 and 4.8.2.15.

5.8.2.7 Multiple incidents of workplace violence

Questions 8 and 9 of the pre-test questionnaire

Forty seven percent (47%) of respondents had experienced one incident of workplace violence, while (52%) had experienced more than one incident, in a 12-month period.

Discussion

It has to be noted that the majority of respondents had been exposed to more than one incident of workplace violence.

5.8.2.8 Types of workplace violence

Question 10 of the pre-test questionnaire

Types of Violence	Responses	
	n	%
Verbal abuse	111	33
Bullying	50	15
Sexual Harassment	20	6
Threats	70	20
Psychological Harassment	64	19
Physical violence with a weapon	9	3
Physical violence without a weapon	11	4
Total	**335**	**100**

Table 16: Types of workplace violence

n=40

Data

In this group, the majority of respondents, viz. 33%, had experienced verbal abuse, followed by threats in 20% of the responses and 19% reported psychological harassment.

Discussion

Verbal abuse was the most commonly-experienced type of workplace violence, according to this study. Incidents involving physical violence were lower, at 5.9 episodes per patient per year, as also reported in studies such as that done by Bjorkly (Leather, 2003:9). This study was thus no different, with only 4% of respondents reportedly experiencing physical violence without a weapon and 3% experiencing physical violence with a weapon.

5.8.2.9 The perpetrator

Question 11 on the pre-test questionnaire

Perpetrator	Responses	
	n	%
Patient/Client	84	24
Staff member in the institution	68	20
Colleague in Same department	38	11
Immediate supervisor	49	14
Relative of a patient	64	19
Member of the general public	28	8
Other	12	4
Total	**343**	**100**

Table 17: The perpetrator

n=40

Data

In 24% of the responses the perpetrator was either the patient or the client, with 19% of responses indicating a relative of one of them. Equally high was the staff on staff violence which constituted 20% of the incidents.

Discussion

The findings in this regard conform to what has already been reported in the countries study by Di Martino (2002:17), who noted that 45% of incidents were perpetrated by patients. Psychological violence was more often perpetrated by staff members, an aspect of the workplace violence phenomenon which this study did not explore.

5.8.2.10 Location of the incident

Question 12 on the pre-test questionnaire

Data

Of the 40 respondents, 20 indicated that the incidents happened inside the health facility, while only one person reported that the incident took place outside the health facility.

Discussion

The role of the community in perpetrating incidents involving health care workers is not a significant finding of this study, as most incidents are perpetrated inside the facility.

5.8.2.11 Response to the incidents

Question 13 on the pre-test questionnaire

Data

The following represents the range of responses to incidents, viz. 27% of respondents told a friend or a family member, while 20% of respondents told a colleague, and 20% of respondents reported the incident to a senior person in the organisation. Only 17% represented those who told the person to stop. Reporting to the wellness department was the reaction in only 7% of incidents and similarly, only 2% reported to the unions.

Discussion

The role of the EAP or the employee wellness divisions has been explored in this study. The employee assistance programmes are often well-positioned to manage workplace violence by implementing a number of different strategies such as development of workplace violence policies and assisting in devising systems for recording and reporting workplace violence incidents. This view, expressed by Watkins (2005:7), highlights the potential for EAPs to implement preventive programmes as opposed to focusing primarily on reactive counselling services.

Badzmierowski and Dufresne (2005:20-21) have proposed a comprehensive model for the involvement of EAPs which includes, inter alia, training and policy development. Given that very few respondents from this study saw the employee wellness unit as a major role-player in the management of workplace violence, the researcher has concluded that positioning the EAP as a major stakeholder to address issues of workplace violence at a number of levels within organisations can be promoted.

5.8.2.12 Reasons for not taking action

Question 14 on the pre-test questionnaire

Reasons for not taking action	Responses	
	n	%
Did not consider the incident serious	38	19
Reporting does not help	54	27
Not sure of reporting procedure	22	11
Not confident of being taken seriously by organisation	37	18
Not confident that managers would pursue	39	20
Other	10	5
Total	**200**	**100**

Table 18: Reasons for not taking action

n=40

Data

This was a multiple response-type question. In the majority of cases (27%) the individual did not report as they thought that reporting would not help. Secondly, in 20% of cases, individuals did not take action because they had no confidence that management would pursue action. A third reason in 19% of cases was that individuals did not consider the incident to be serious.

Discussion

The action of reporting the incident/s was often not initiated because victims felt that reporting was useless, as shown in the Di Martino country study (2002:29). Other factors contributing to the lack of reporting were that victims often feared redress, and in other instances considered that the incident was not serious enough. The findings of this study are closely aligned with those in previous studies.

5.8.2.13 Emotions after the incident

Question 15 of the pre-test questionnaire

Data

In 50% of all the responses to the emotions listed as a multiple response question, respondents indicated that they experienced anger after the incident; in 30 % of all the responses the respondents indicated that the incidents were followed by feelings associated with stress, while in 3% and 11% of all the responses participants admitted to feelings of shame and fear.

Discussion

Cooper (2003:vii) has reported on the emotional and physical reactions to workplace violence, ranging from anger, fear, shock and anxiety to depression and sleep disturbance.

This study supports the previous research in terms of the gamut of emotions experienced after an incident. The cost of these on-going emotions, which can sometimes be debilitating and can impact on productivity, has been explored by Di Martino (2003: vii) and runs into hundreds of billions of euros and dollars per yea

5.8.2.14 Awareness of workplace violence

Question 16 of the pre-test questionnaire

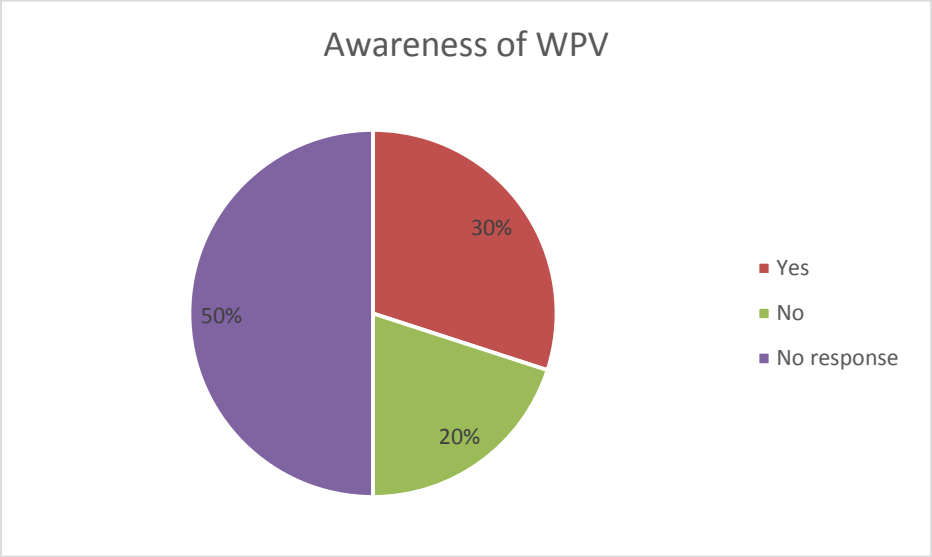


Figure 16: Awareness of workplace violence

n=40

Data

Thirty percent (30%) of the respondents indicated that at the time of the incident they were aware that they were victims of workplace violence, while 50% did not respond to this question

Discussion

Some respondents indicated that, at the time of the incident, they were aware that they were victims of workplace violence, but this was the minority of the respondents.

5.8.2.15 Symptoms after the incident/s

Question 17 of the pre-test questionnaire

Data

In 26% of all the responses to question 17, the respondents indicated that incidents were followed by respondents avoiding thinking about it, while in 21% of all the responses incidents were followed by victims feeling as if everything they did required

effort. In 15% of all the responses, the respondents indicated that incidents were followed by victims avoiding talking about it, while in another 15% of the responses incidents were followed by victims being super-alert and on guard.

Discussion

A significant percentage of respondents reported symptoms of post-traumatic stress, which was also reported on by Di Martino (2003:vii), who notes insomnia, irritability, panic attacks and poor concentration, as well as a number of somatic complaints. These effects on workplace functioning can be considered significant.

5.8.3 Shift in attitude, belief and skills from pre-test to post-test.

This section will present the findings from the pre-test and the post-test and will then investigate whether any shifts in attitude, belief and skills from pre-test to post-test occurred. The McNemar-Bowker test was used to determine whether the shifts in attitude, belief and skills were significant. This will be presented as a p value. For a shift to be significant, the p value has to be smaller than 0.05. It should also be noted that the p value could not be computed for all the parameters as listed below, because of the structure of certain questions.

The parameters which will be presented in this section are:

- Awareness of workplace violence;
- Policy as a driver of workplace violence;
- Belief that workplace violence is serious issue;
- Insight into the cost of workplace violence;
- Attitude as to whether verbal abuse constitutes workplace violence;
- Belief as to whether own behaviour can trigger workplace violence;
- Belief as to whether colleagues' behaviour can trigger workplace violence;
- Belief in authority to effectively combat workplace violence;
- Belief in the effectiveness of measures to deal with workplace violence;

- Belief in the effectiveness of individual contributions to combating workplace violence;
- Belief as to whose responsibility it is to manage workplace violence;
- Attitude towards health care sector vulnerability;
- Attitude to factors contributing to workplace violence.

5.8.3.1 The cost of workplace violence

Question 26 in the pre-test questionnaire and Question 29 in the post-test questionnaire

The hypotheses to be tested here are as follows:

The null hypothesis

H_0: The number of participants who changed their opinion about the costliness of WPV after the training is exactly the same for each of the possible symmetric opinion changes

Against the alternative hypothesis

H_1: The number of participants who changed their opinions after the training the costliness of WPV is different for at least one of the possible symmetric opinion changes

	Pretest		Post-test	
	n	**%**	**n**	**%**
Yes	17	42	33	82
No	5	13	1	3
Unsure	14	35	4	10
Missing	4	10	2	5
Total	**40**	**100**	**40**	**100**

Table 19: The Cost of Workplace violence

n=40

Data

42% of respondents in the pre-test indicated that they thought workplace violence was a significant cost driver and this had increased to 82% in the post-test. The number of "no" responses had decreased from 13% in the pre-test to 3% in the post-test and the number of unsure responses had declined to 10% from 35%.

The McNemar-Bowker test (p=0.002) confirmed a shift of respondents who had completed training and confirmed that knowledge that workplace violence was a major organisational cost driver.

Discussion

There thus appears to be a general uncertainty as to whether this phenomenon does present itself as a cost-driver for organisations. Ignorance of the phenomenon in general would present participants with a general dilemma as to whether to view this as a significant cost driver for organisations. Badzmierowski and Dufresne (2005:20) quoting Urbanki and Farrel place costs at $180m in lost time and productivity over a two-year period. Training resulted in an increased awareness that workplace violence is costing the workplace money. The costs associated with impaired functioning due to stress emanating from workplace violence incidents, as well as the costs of recruitment after victims have decided to exit, are all noted and reported on by Di Martino (2003:vii) as significant cost drivers.

5.8.3.2 Verbal abuse

Question 18 in the pre-test questionnaire and Question 20 in the post-test questionnaire

	Pre-test		Post-test	
	n	**%**	**n**	**%**
Yes	32	80	35	88
No	2	5	4	10
Unsure	4	10	0	0
Missing	2	5	1	2
Total	**40**	**100**	**40**	**100**

Table 20: Verbal abuse

n=40

Data

There seemed to be a shift in the number of participants who believed that verbal abuse was workplace violence from 80% in the pre-test to 88% in the post-test. Two respondents in the pre-test did not believe verbal abuse was workplace violence. The "unsure" responses reduced to 0 in the post-test.

In order to use the McNemar-Bowker test for statistical computing, there have to be equal numbers of rows and columns. Because there were no "unsure' responses on the post-test the McNemar-Bowker test could not be used to compute the statistical significance.

Discussion

Despite general ignorance of the phenomenon of workplace violence as indicated in the data above, when it comes to awareness levels, the pre-test data does however suggest that verbal abuse is generally considered to be a form of workplace violence.

This finding may suggest that verbal abuse is behaviour to which everyone can relate and is one of the most common forms of workplace violence. This may suggest that deciding whether verbal abuse was workplace violence or not may have been an easier decision than with some of the other types of workplace violence.

On the other hand, verbal abuse has become the norm in many contexts, including the health care sector, with the result that it is no longer regarded as generally unsuitable workplace conduct.

Although some shift in attitude was observed, it may not be regarded as significant. The McNemar-Bowker test could not be conducted, as the post-test results did not include the "unsure" category. The cross-tabulation tells a story, however, in that the two people, who in the pre-test said verbal abuse was not workplace violence, said in the post-test that it was. The training programme therefore had an effect in this regard.

5.8.3.3 Workplace violence as a serious phenomenon

Questions 21 and 22 on the pre-test questionnaire and Questions 16 and 17 on the post-test questionnaire

	Pre-test		Post-test	
	n	**%**	**n**	**%**
Yes	36	90	40	100
No	2	5	0	0
Missing	2	5	0	0
Total	**40**	**100**	**40**	100

Table 21: Workplace violence is a serious phenomenon

n=40

Data

The data for this section on the actual shift in attitude from the pre-test to the post-test was difficult to compute, as the post-test had only a “yes” variable. The McNemar–Bowker test could thus not be utilised for calculation. There were two people in the pre-test who believed that workplace violence was not a serious phenomenon who, after the training, believed that it was. Although the null hypothesis could not be tested here, it can be seen that these two respondents changed their opinion from negative to affirmative.

In addition, the follow-up question, which asked why workplace violence was not considered a serious phenomenon, was difficult to assess, because of the discrepancy in the formulation of the question in the pre-test and the post-test. As a result, the McNemar-Bowker test could not be applied to assess statistical significance.

Discussion

In general, participants did not underestimate the severity of the phenomenon of workplace violence. Numerous research projects have pointed to ignorance of the phenomenon and its severity in terms of cost, impact and reporting. There is a great deal of ignorance about the existence of this phenomenon of workplace violence, as is evidenced in numerous research studies. Often, it is not reported because it is not considered to be serious, or even a problem.

The two persons who had responded “no” on the follow-up question, in the pre-test indicated the following reasons:

- There are more serious organizational issues than workplace violence;
- Workplace violence does not occur very often.

5.8.3.4 Policy as a driver of reporting workplace violence

Question 19 on the pre-test questionnaire

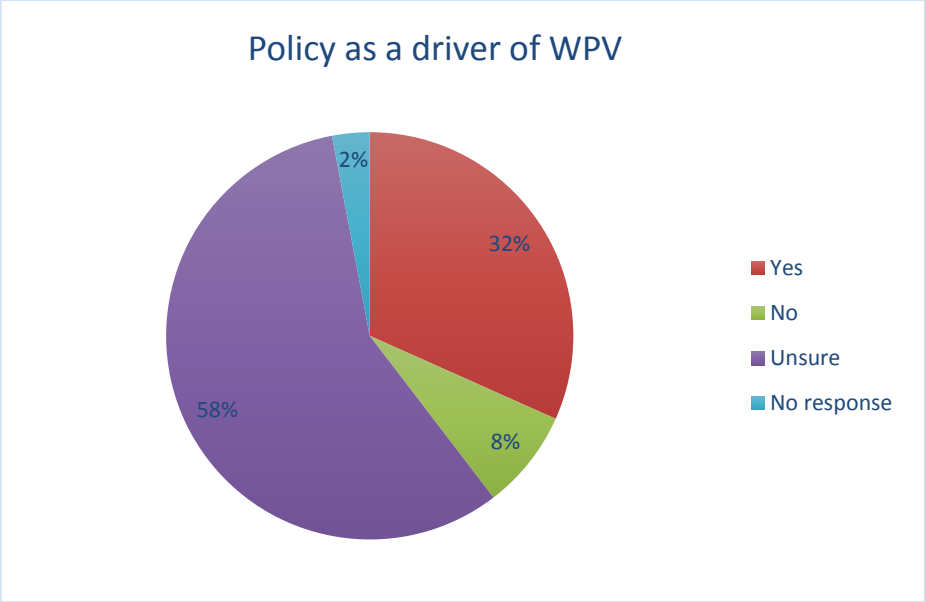


Figure 17: Policy is a driver of workplace violence

n=40

Data

Most respondents were unsure whether the hospital had a policy on workplace violence.

Discussion

This question was included only in the pre-test, as knowledge of the existence of a policy would not be different in the post-test. The pre-test data revealed that most

participants thought a policy could be a driver of increased reporting on incidents of workplace violence. Swanson et al. (2003:65) note that putting policies in place creates awareness, so reporting increases.

However, policies have to be well communicated if they are to be effective. Very often they are drafted and implemented, with the latter phase accompanied by training on the policy and procedures, such as reporting these procedures. In the researcher's experience, South African organisations consider this approach to be critical in terms of driving policies. This study certainly supports that approach. Post-apartheid South Africa has seen a plethora of policies and procedures designed and implemented. Much time has been spent by government on creating awareness of these policies and embedding them in a methodology of training, implementation and monitoring.

5.8.3.5 Own behaviour contributing to workplace violence

Question 28 in the pre-test questionnaire and Question 22 in the post-test questionnaire

	Pre-test		Post-test	
	n	%	n	%
Yes	25	63	25	63
No	10	25	9	22
Unsure	4	10	5	12
Missing	1	2	1	2
Total	**40**	**100**	**40**	**100**

Table 22: Own behaviour triggering workplace violence

n=40

Data

The data on whether participants believed that their own behaviour could trigger workplace violence revealed that there was no change in those who answered "yes" to this question in the pre-test, as this constituted 63% of the participants, and in the post-test 63% held this opinion. The number of "no" responses dropped slightly from 25% in the pre-test to 22% in the post-test and the "unsure" responses actually increased by 2% from 10% pre-test to 12% in the post-test.

There was no significant shift in the opinion that one's own behaviour contributed to workplace violence (p=.801).

Discussion

There was a strong response suggesting that most participants were aware that their own behaviour could contribute to the eruption of workplace violence.

Of concern, though, is the fact that a quarter of the participants did not believe that their own behaviour could contribute to the violence. The fact is that we are often more aware of others bringing about events with negative consequences than we are of our own contributions.

Perhaps it is just human to assign guilt elsewhere and fail to develop insight into our own contribution to negative events. This has already been discussed in the pre-test section and will be expanded further in the next section. The finding may be a reflection of this trend. It is often very difficult to admit to, or even develop insight into our own behaviour as contributing to negative events, as workplace violence is regarded. This supports the view that often the victim-perpetrator might have had the need to be considered, which could be the antecedent of workplace violence. It is the dynamic relationship between the two which should not be under-estimated, and workplace violence is thus not a static concept.

5.8.3.6 Colleagues' behaviour as a trigger of workplace violence

Question 29 in the pre-test questionnaire and Question 23 in the post-test questionnaire

	Pre-test		Post-test	
	n	**%**	**n**	**%**
Yes	38	95	40	100
No	0	2.5	0	0
Unsure	1	0	0	0
Missing	1	2.5	0	0
Total	**40**	**100**	**40**	**100**

Table 23: Colleagues' behaviour as a trigger of workplace violence

n=40

Data

The data on whether participants believed that their own behaviour could trigger workplace violence revealed that there was a slight change in those who had Said "yes" to this question in the pre-test, as this constituted (95%) of the participants, while in the post-test there were (100%) who held this opinion. The number of "unsure" responses decreased from 3% in the pre-test to none in the post-test. The p value could not be computed to assess shifts in opinion.

Discussion

Statistics could not be computed for this section. No conclusion could therefore be inferred.

5.8.3.7 Authority to combat workplace violence

Question 30 in the pre-test questionnaire and Question 24 on the post-test questionnaire

	Pre-test		Post-test	
	n	**%**	**n**	**%**
Yes	35	88	38	96
No	1	2	1	2
Unsure	0	5	0	0
Missing	5	5	1	2
Total	**40**	**100**	**40**	**100**

Table 24: Authority to combat workplace violence

n=40

Data

In the pre-test 88% of participants believed that they had the authority to combat workplace violence, while in the post-test this changed to 96% in the post-test. This can be ascribed to the two respondents who were unsure in the pre-test, but who changed their opinion to "yes" in the post-test. The McNemar-Bowker test could not be computed to assess shifts in opinion because the cross-table is not square.

Discussion

In the pre-test, the majority of the participants thought that they had some authority in their current positions to effect a change in workplace violence. One could postulate that this position may be an easy one to hold if you are not really aware of what constitutes workplace violence. The responsibility of managing and contributing to mitigating workplace violence may become more apparent as awareness on the phenomenon increases.

This attitude of disempowerment and helplessness is difficult to shift. Individuals often have difficulty in seeing the role they play in a situation and also do not believe they could effectively play a role in combating a phenomenon like workplace violence.

This is a learned helplessness view; it is easier to view others' contribution to the phenomenon and to believe that other people, such as managers, have more influence to change the behaviours and subsequently the phenomenon of workplace violence.

5.8.3.8 Belief in effectiveness of measures to combat workplace violence

Question 27 on pre-test questionnaire and Question 21 on the post-test questionnaire

Measure		Very	Moderate	Little	Not	Not applicable	No response	Total	p value
Improved surroundings	Pre-test	21	7	4	2	5	1	40	0.147
	Post-test	31	3	1	1	0	3	40	
Improved security measures	Pre-test	25	6	1	1	6	1	40	0.317.
	Post-test	34	0	1	2	0	3	40	
Restricting public access	Pre-test	17	7	2	1	12	1	40	0.072
	Post-test	26	5	3	2	2	2	40	
Patient screening	Pre-test	14	12	3	1	9	1	40	0.010
	Post-test	27	7	2	0	2	2	40	
Patient protocols	Pre-test	16	6	2	2	13	1	40	0.107
	Post-test	26	6	2	1	2	3	40	
Restrict exchange of money	Pre-test	9	4	5	6	15	1	40	0.216
	Post-test	13	10	4	4	5	4	40	
Increased numbers of staff	Pre-test	21	5	3	3	7	1	40	0.368
	Post-test	30	2	1	3	0	4	40	

Measure		Very	Moderate	Little	Not	Not applicable	No response	Total	p value
Check-in procedures for staff	Pre-test	18	6	3	2	10	1	40	0.247.
	Post-test	23	8	2	1	2	4	40	
Special equipment or uniform	Pre-test	11	7	4	5	12	1	40	0.038
	Post-test	24	6	3	2	3	2	40	
Changed shifts	Pre-test	10	7	4	4	14	1	40	0.173 .
	Post-test	20	9	3	3	2	3	40	
Training	Pre-test	28	2	0	3	6	1	40	0.149
	Post-test	32	2	1	1	1	3	40	
Human resource development	Pre-test	22	5	2	0	10	1	40	0.284
	Post-test	31	1	3	2	0	3	40	
Other measures	Pre-test	2	9	2	1	21	5	40	0.033
	Post-test	1	1	1	2	30	5	40	

Table 25: Effectiveness of measures to prevent workplace violence

n=40

Data

On examining which measures would prove to be effective in dealing with workplace violence, the following shifts in participants' attitudes were noted. A shift in attitude was noted on the following measures, viz. patient screening and special uniforms and equipment. After the training, participants thought that patient screening could play a significant role in reducing workplace violence. The second measure pertained to special uniforms or equipment in that, after the training, participants thought that this could be a deterrent to the eruption of incidents of violence. A third factor which seemed to undergo an attitudinal shift was that, after the training participants believed that restricting public access, could reduce incidents of workplace violence. The latter proved to be weakly significant with a p-value = 0.072.

Discussion

This section looked at the degrees of opinion on how participants rated the effectiveness of measures to prevent workplace violence. Training and human resource development is sometimes viewed as the panacea for all ills. Even in this context, training and human resource development was rated highly as a perceived effective measure to mitigate workplace violence.

This is ultimately what this research project attempts to measure and explore. The majority of opinions on the effectiveness of measures for reducing workplace violence shifted to the column on "very effective or moderately effective". Very few are represented in the columns for "not effective" or considered "a little effective ".

5.8.3.9 Belief in individual contributions making a difference

Question 32 in the pre-test questionnaire and 24 in the post-test questionnaire

Belief	Agree	Disagree	No responses	Total
My contribution will not make a difference.	4	5	31	40
No, because I have no position of authority.	3	6	31	40
Nothing will ever change the way things are in my workplace.	4	5	31	40
No, it is not my responsibility but management's	3	6	31	40
I really do not care all that much about these issues.	1	8	31	40
Other	3	6	31	40

Table 26: Belief in individual contributions making a difference

n = 40

Data

In the above section, the table represents degrees of belief. The pre-test data on this question is difficult to compute as there was such a high degree of non-responses to this question.

Discussion

It is quite puzzling that there were so many participants which selected "no" response to this question. It thus seems that individuals were really quite unsure about their own role; capacity or the possibility that they could make a difference. This may have resulted in the high degree of non-responses.

5.8.3.10 Responsibility to manage workplace violence

Question 33 in the pre-test questionnaire and Question 30 in the post-test questionnaire

Entity		Yes	No	No response	Total	p value
Government	Pre-test	24	15	1	40	0.267
	Post-test	29	11	0	40	
Employer	Pre-test	35	4	1	40	0.375
	Post-test	39	1	0	40	
Workers	Pre-test	32	7	1	40	0.070
	Post-test	39	1	0	40	
Trade unions	Pre-test	33	6	1	40	p value could not be computed.
	Post-test	39	1	0	40	
Professional association	Pre-test	26	13	1	40	0.146
	Post-test	33	7	0	40	
The community	Pre-test	22	17	1	40	0.002
	Post-test	34	6	0	40	
Others	Pre-test	8	30	2	40	1.000
	Post-test	9	30	1	40	

Table 27: Responsibility to manage workplace violence

n=40

Data

The McNemar-Bowker test indicated a weak significant shift in perception (p = 0.070), where more post-test participants now believed that workers should take some responsibility for violence at work.

In addition, there was also a shift in the belief that the community should take some responsibility for workplace violence, irrespective of its occurrence in the context of an institution or hospital. More respondents answered “yes” in the post-test than in the pre-test.

There was no significant shift in the beliefs related to other role-players such as the government, professional associations or trade unions, among others.

Discussion

In the pre-test, there was an even spread in terms of beliefs as to who should manage workplace violence.

Shared responsibility for managing violence in the workplace appears to be a good approach, as it suggests a multi-sectoral arrangement that could prove more effective than any single entity taking on the overall responsibility for managing this phenomenon. It is also in line with a more comprehensive multi-dimensional strategy advocated by many of the authors quoted in the current study such as Wiskow (2003:14).

The pre-test data already suggested that participants thought a multi-sectoral approach to workplace violence was a prudent one and was the responsibility of the different entities.

One would hope that the training had refined their knowledge and awareness of the roles or potential roles each entity could play in this regard.

5.8.3.11 Health Care Sector vulnerability

Questions 23 and 24 in the pre-test questionnaire and Questions 18 and 19 in the post-test questionnaire

Reason		Yes	No	No response	Total
Mostly females work in this environment.	Pre-test	16	15	9	40
	Post-test	29	9	2	40
Many patients are mentally unstable.	Pre-test	15	16	9	40
	Post-test	18	20	2	40
The hospital setting is a contributor.	Pre-test	9	22	9	40
	Post-test	26	12	2	40
Some staff members are just bullies.	Pre-test	23	8	9	40
	Post-test	33	5	2	40
Young workers get targeted.	Pre-test	15	16	9	40
	Post-test	28	10	2	40
We live in a violent society.	Pre-test	15	16	9	40
	Post-test	23	15	2	40
The hospital environment contributes e.g. poor lighting, ventilation.	Pre-test	6	25	9	40
	Post-test	26	12	2	40
Clothing or dress code.	Pre-test	5	26	9	40
	Post-test	14	24	2	40
Personality of the victim.	Pre-test	11	20	9	40
	Post-test	23	15	2	40
Interplay of dynamics between bully and victim.	Pre-test	12	19	9	40
	Post-test	21	17	2	40
Other	Pre-test	28	2	10	40
	Post-test	4	2	34	40

Table 28: Reasons for health sector health care sector vulnerability

n=40

Data

An even spread across all the different parameters of the question on why the health care sector presents as vulnerable, suggests a degree of uncertainty across the group in relation to this section. There is some strong agreement with the fact that some staff members are just bullies and some strong disagreement on the sentiments that the hospital setting or aspects of the hospital environment, such as poor lighting and ventilation, could play a role in triggering workplace violence. This even spread across all the categories as well as the “agree” and “disagree” categories suggests an element of uncertainty regarding this section.

In the pre-test, there was more uncertainty as to what made the health sector so vulnerable, one in which workplace violence was prevalent. There is a distinct decrease in the numbers of “no” responses to this question, leading one to conclude that some insight into factors which made the health care sector vulnerable had developed, as a result of the training programme.

Discussion

The training programme was aimed at assessing attitudes and beliefs about why there was workplace violence in the healthcare sector. There was a definite shift in attitude to understanding that certain factors, such as this sector being a female-dominated environment; the hospital setting contributing to the eruption of incidents; younger workers being targeted; the personality of the victim; and the hospital environment, including lighting and heating. This was linked to the learning outcomes for the study unit on “Awareness and understanding of the phenomenon of workplace violence”. There was some shift in the attitude to factors like; patients who may be mentally unstable; some staff members being considered bullies, living in a violent society, clothing or dress code, and the interplay of dynamics between bully and victim. These shifts were not as significant as the previous factors already mentioned and was linked to the learning outcomes in the study unit on “Recognising and assessing workplace violence”.

5.8.3.12 Factors contributing to workplace violence

Question 34 in the pre-test questionnaire and Question 31 in the post-test questionnaire

Factor		Yes	No	No response	Total	p value
Societal factors	Pre-test	22	17	1	40	0.039
	Post-test	30	10	0	40	
The perpetrator	Pre-test	23	16	1	40	0.013
	Post-test	34	6	0	40	
The victim	Pre-test	22	17	1	40	0.143
	Post-test	29	11	0	40	
The workplace	Pre-test	23	16	1	40	0.227
	Post-test	28	12	0	40	
The work organization	Pre-test	19	20	1	40	0.003
	Post-test	31	9	0	40	
Changing context	Pre-test	23	16	1	40	0.332
	Post-test	29	11	0	40	
Interpersonal factors	Pre-test	18	21	1	40	0.146
	Post-test	24	16	0	40	

Table 29: Factors contributing to workplace violence

n=40

Data

No strong trend was evident in the section exploring factors which may contribute to workplace violence. One could thus postulate that participants were of the opinion that a number of factors played a role in workplace violence, ranging from the individual to the organization to the societal realm. Once again, after the training, the post-test data suggests a less even spread between “yes” and “no” on this question. The “yes” column now showed an increase in the number of confirming responses. Statistical significance will be discussed in the next section.

Discussion

The training caused a significant shift in three of the attitudinal beliefs. These changes manifested as more “yes” answers in the post-test relative to the pre-test. These attitudes or beliefs were related to the role of societal factors in workplace violence,

the profile of the perpetrator and the work organisation. Perpetrators have often been blamed for workplace violence in a superficial analysis, but the literature review strongly suggests that there is no typical profile. The training changed this belief and enhanced understanding of the role of societal factors and the work organisation in driving the phenomenon of workplace violence.

5.8.3.13 Attitude towards individual contributions

Question 31 in the pre-test questionnaire and Question 25 in the post-test questionnaire

Factor		Agree	Disagree	No response	Total	p value
Increase colleagues awareness of WPV	Pre-test	28	5	7	40	0.219
	Post-test	36	2	2	40	
Listen carefully to patients and patient escorts	Pre-test	28	4	8	40	0.375
	Post-test	34	4	2	40	
Be more empathic to patients	Pre-test	26	5	9	40	0.219
	Post-test	33	5	2	40	
Be more empathic to colleagues	Pre-test	24	6	10	40	0.754
	Post-test	32	6	2	40	
Initiate or assist in policy development	Pre-test	24	6	10	40	0.344
	Post-test	33	5	2	40	
Training	Pre-test	24	7	9	40	0.063
	Post-test	33	5	2	40	
Other	Pre-test	29	5	6	40	0.063
	Post-test	4	34	2	40	

Table 30: Individual contributions to mitigating workplace violence

n=40

Data

Strong sentiments were expressed, indicating that participants really believed that their individual contributions could make a difference in combating workplace violence. The post-test data looks very different from the pre-test data, where many participants opted not to respond to this question. As already discussed, an “opt out” option could mean disagree or unsure, but this was not included in the Likert scale.

The McNemar-Bowker test revealed no significant shifts in attitude when it came to how individuals viewed their contributions to combating workplace violence.

Discussion

The McNemar-Bowker test showed weak evidence (p=0.063) of a change in “Other”, where the predominant response of “no idea” in the post-test still seemed to suggest a feeling of helplessness and an inability on the part of participants to view their role as significant in combating a phenomenon which may appear to be quite overwhelming in its guise and dimensions. In addition, the responses to this question may appear to be almost contradictory to what was reflected in section 5.8.3.7 where responses about individual contributions were more general. The responses measured in this question were more specific, indicating the types of possible responses and attitudes

5.8.3.14 Training on workplace violence was useful

Question 27 in the post-test questionnaire

Factor	Yes	No	No response	Total	p value
Helped participants to debrief and unburden	32	7	1	40	0.339
Helped raise awareness of WPV	38	1	1	40	0.053
Helped the organisation to be more aware f WPV	35	4	1	40	0.202
Helped participant to be more empowered to report an incident	34	5	1	40	0.202
Provided knowledge of policy, procedures and reporting processes	34	5	1	40	0.249
Helped participant and the hospital to gain an understanding of the phenomenon of WPV	35	4	1	40	0.202
Helped participants to “get over “ incident/s	30	9	1	40	0.422
Empowered participants to share knowledge with others	33	6	1	40	0.294
Increased knowledge of factors contributing to WPV	33	6	1	40	0.294
Other	6	33	1	40	0.294

Table 31: Usefulness of training

n = 40

Data

Most participants were of the opinion that the training had been helpful regarding the various components tabulated above. The training seemed to score highest on issues of raising awareness on the part of individuals and the organisation.

In direct questioning, the usefulness of the training was deemed useful only in that it helped participants to become more aware of the phenomenon of workplace violence, but there was weak evidence of this (p-value = 0.063). There was no shift in the other beliefs noted above.

Discussion

Training is often mooted as the solution and the findings suggested that training was useful in raising awareness and in shifting some of the beliefs, perceptions and skills.

These themes are further explored in Chapter 6.

5.8.3.15 Personal responsibility to manage workplace violence

Question 28 in the post-test questionnaire

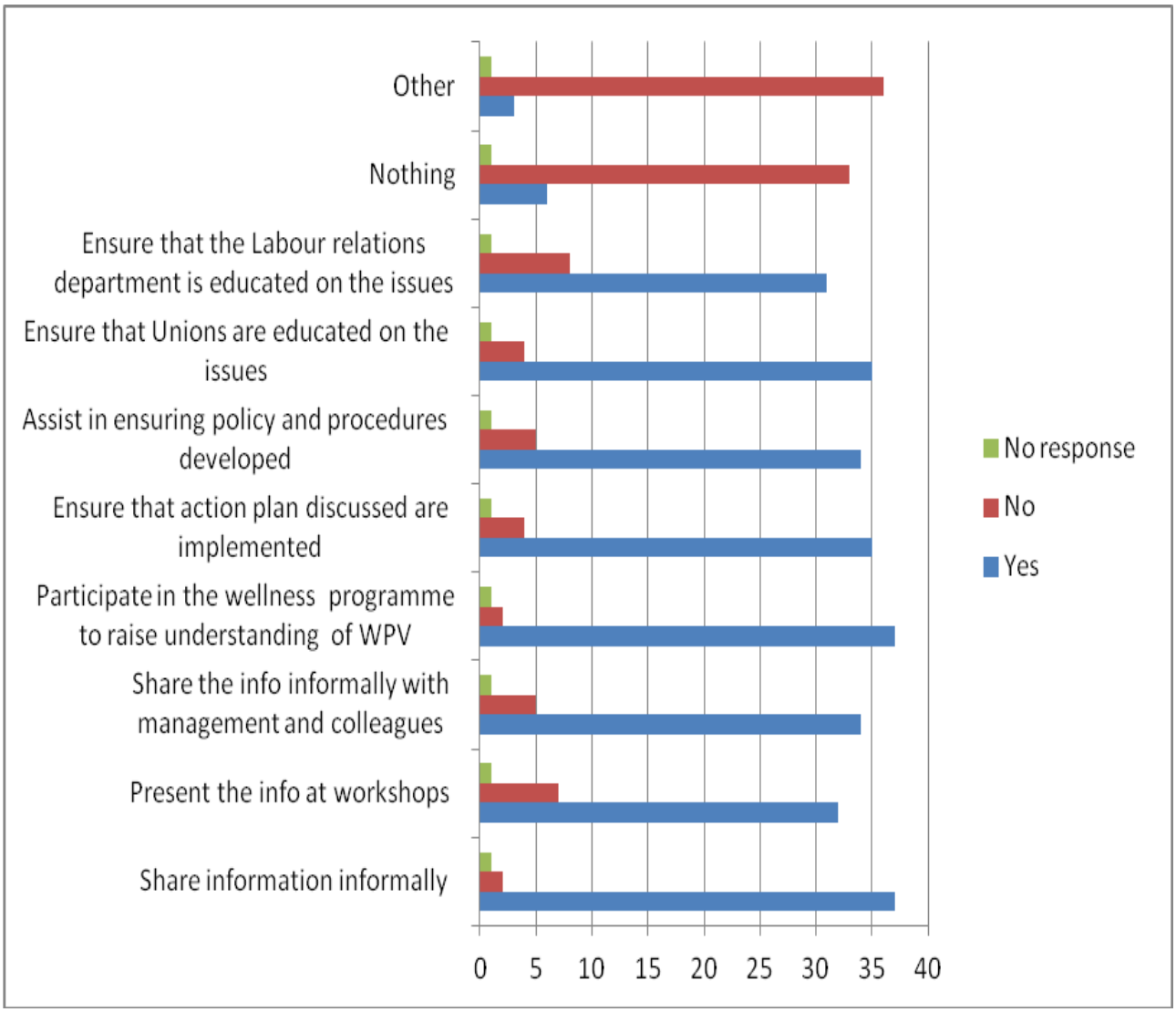


Figure 18: Personal responsibility to manage workplace violence

n=40

Data

The post-test suggested a strong commitment from all the participants to play a role in the different ways of mitigating workplace violence.

The strategies ranged from policy development, training and increased reporting to better integration into the wellness programme.

Discussion

There was a definite commitment from all the participants to engage in various activities to enhance awareness of workplace violence and to create conditions in their working environment that are conducive to health, well-being and better working conditions. These will be discussed in Chapter 6.

5.9 Qualitative phase

5.9.1. Introduction

The research design also included a qualitative section in the study, being a collective case study. Data was collected by means of a semi-structured interview schedule. The information gathered from the interviews via the semi-structured interview is presented thematically. The themes emanating from the qualitative phase of the study are presented in the following section. There were 10 interviews, of which five were voice-recorded and five were captured on a video recorder as agreed to by the participants. These interviews occurred two months after the training. Sampling was according to the purposive Sampling method.

5.9.2 Participant Profile

The following 10 participants agreed to be interviewed two months after the completion of the training. None of these participants can be identified, given the size of the hospital. The identity of these participants had been protected through the omission of details of the specific units in which they work - See Table 32 below.

A semi-structured interview schedule (see Annexure 7) was used for the individual interviews.

Participant number	Staff category	Position	Age	Gender
1	Professional nurse	Sister	46	F
2	Professional nurse	Professional nurse	34	F
3	Registered nurse	Employee Wellness manager	52	M
4	Professional nurse	Professional nurse	23	F
5	Physiotherapist	Physiotherapist	24	F
6	Counsellor	HIV/AIDS counsellor	44	F
7	Auxiliary nurse	Queue Marshal	52	F
8	Professional nurse	Unit manager	42	F
9	Security	Security	33	M
10	Professional nurse	Professional nurse	52	F

Table 32: Demographics for interviewees

The following information was derived from these interviews:

5.9.2.1. How has the training influenced your thinking on the phenomenon of workplace violence? (Question one)

Theme 1: Increased awareness

Participants (1-10) reported a general increase in their levels of awareness on issues of workplace violence.

Discussion

Much has been written on the fact that workplace violence is a relatively unfamiliar subject. The phenomenon is often given names other than workplace violence, which

is perhaps another of the factors leading to ignorance in this regard. However, Hannabus (1998:304) and Cooper (2003:v) indicate that there is growing concern about the phenomenon and that it is receiving far more attention.

From this study it would appear that training as a method of increasing awareness may prove effective.

Theme 2: Insight into "others'" behaviour

Participants 1, 2, 4, 6 and 10 spoke about their increased awareness of how others'

(patients, colleagues or general public) behaviour contributed to workplace violence.

Participant 10 specifically referred to the fact that colleagues' stress levels may lead to behaviour which causes this violence …….:

> *because I did identify some of the things somebody doing like misbehaving which is I think due to personal problems.*

Participant 6 related better insight into patients' behaviour and believes it can be dealt with before it escalates into violence. She Said:

> *firstly, I would like to Say that it helped me a lot to prevent that conflict in our working environment. More especially on the patients' side as I had to understand how to deal with those patients*.

Discussion

Very little has been written on how developing insight into "others'" behaviour (patient, colleague, general public) may assist in mitigating the risk of workplace violence by reacting differently to behaviour that is potentially threatening to lead to an incident.

Wistanley (2005:340) notes that few detailed explanations have been given for patients' aggression from the patients' perspective. This type of approach would assume a stance that is sympathetic to the aggressor and thus may not find general favour. It would mean developing the skill of reading people's behaviour, with which many may not be comfortable.

Theme 3: Insight into how own behaviour may contribute to workplace violence.

Participants 1 and 10 raised the theme of how the training had contributed to alerting them to their own behaviour and how this could, in fact, contribute to workplace violence.

Participant 1 also specifically commented on how this insight had changed her attitudes to patients by stating,

> *……nowadays I give more information to the patients, rather than letting them wait. And it really works, for they get information….I think I only got one complaint from that time.*

Discussion

Not many participants commented on whether the training had changed their view of their own behaviour as contributing to the eruption of incidents. This is a very natural human response, as it is often easier to find reasons outside ourselves to explain negative events, as opposed to developing insight into ourselves and how we have contributed to a situation.

Theme 4: Taking the training to others

Participants 5 and 10 specifically referred to the fact that, as a result of their increased awareness, they could go out and talk to other colleagues in the hospital about these issues.

Discussion

The concept of “train the trainer”, which refers to training a particular target group who are then equipped to cascade training initiatives further down in organisations, is a methodology which is favoured in many large-scale corporations and organisations as a strategy for reaching a critical mass of employees with training, or even to change management interventions. The reference by the above participants allows for consideration that this may prove to be a useful approach, with some customisation, e.g. including a module on general group facilitation.

Theme 5: Awareness of what constitutes violence

Awareness of what constitutes violence, identifying the types of violence, how to deal with issues related to workplace violence, as well as increased knowledge of reporting were mentioned by Participants 10 and 5 as being outcomes of the training. Participant 10 highlighted the fact,

> *that most of the people they are aware that there are some things which we contribute to the workplace violence, because we do mistake not knowing that I'm also wrong. It's not only that person that was wrong, I also contributed.*

Discussion

Training programmes are often mooted as an appropriate intervention strategy for creating awareness of a new phenomenon, or a new approach, or even as a marketing approach in employee assistance.

Some of the participants in this phase of the study agreed with this and specifically highlighted the aspects on which this training had impacted, namely:

- The nature of the phenomenon of workplace violence;
- The types of workplace violence;
- Measures for dealing with workplace violence.

Theme 6: Empowerment

Participants 3, 8 and 9 spoke about the fact that the training had empowered people to stand up for themselves and had highlighted issues that were often overlooked and which could well lead to violence, such as snide remarks and undertones. Participant 4 Said:

> *it is more at work with your colleagues where you experience snide remarks, those undertones. I think I pick up a lot more of that than what I used to. I used to shrug it off…*

In this regard Participant 8 mentioned that new people were often taken advantage of and that one had to stand up for oneself.

The increase in participants' knowledge and awareness is perhaps best encapsulated in a direct quote from Participant 5:

> *…there are so many things that I didn't think that they were violence; because I thought nursing, you know, when you train, they tell you things, and so you think that actually all these things you get – like abuse, emotional or physical – you think that is fine. It is a calling. You just have to take it.*

Discussion:

The fact that training proved to be a method of empowerment was an interesting finding of this study. It does appear to be a case of empowering people with knowledge, knowledge which sets them apart from their peers and which allows them to engage with their peers and even their seniors.

On another level, the knowledge gained becomes armour with which participants can defend themselves. They are able to do this because they are more aware of their rights as employees, such as the right to dignity and respect.

5.9.2.2. Do you think that the training has influenced the situation at the hospital?

(Question 2)

Participants 2, 3, 5, 7, 9 and 10 were certain that the training had made a difference in the hospital. Various themes emerged:

Theme: 1: Empowerment

This theme re-emerged, with Participant 8 indicating that she was now able to stand up for herself and Participant 9 suggesting that the information allowed them to protect themselves. Participants 8 and 9 also said they felt empowered and able to stand up for themselves as a result of the training. They knew their rights. Participant 9 was direct in her response:

> *If you have more knowledge on something, a lot of people won't take you for granted so you try to equip yourself with knowledge so that people won't try to ride on you or step on your head, such things.*

Discussion

Once again, this theme emerged as a response to the question on whether the training had influenced the hospital. The training had clearly added the element of employee self-empowerment and the ability to engage with peers and management as a result of having information on their rights.

Theme 2: Extended/long waiting periods

Participant 6 spoke about giving information on waiting times as one of the factors which could mitigate workplace violence. Dealing with the issue before it escalates into workplace violence is indicated. Patients and family who were given information on waiting times were less likely to react with irritation or violence.

Discussion

Wistanley (2005:342) quoting the work of Whittington refers to the refusal or delay of care or treatment as one of the most common precursors of hospital violence. She also highlights the fact that, in this context of delayed care or treatment, other factors, such as healthcare professionals' approach, their manner of speech, or their insistence on rules, could also have an explosive effect on situations.

Participant 6 gives the idea that if this approach is changed by giving information, it could potentially have a positive effect and prevent violence.

Theme 3: Improved security

Participant 9 indicated that security was still too sparsely spread and that there were staff shortages. She Said:

> *…so we need more staff to allocate and to keep Safety in this environment because it's not Safe when we are so small.*

Discussion

Security measures and the improvement thereof as a solution to workplace violence have been well documented. Di Martino (2002:30-31) has noted that, in Thailand, the use of security measures to deal with workplace violence was noted by 80% of respondents, in Bulgaria, 70.8% of respondents and in South Africa, 66.2% of respondents. Whether this intervention on its own would prove effective is probably the main issue for debate.

Theme 4: Overall benefit to the hospital

Although Participants 1, 3, 4 and 6 indicated that they, as individuals and as the units they represented, had benefited from the training, it was difficult to Say whether the

training was of general benefit to the hospital in the wider context. Participant 8, from the polyclinic, felt she was too isolated to comment on the overall effect on the hospital, as the polyclinic is located just outside boundaries of the hospital.

Participant 4 expressed her uncertainty about the general benefit to the hospital in the following way,

> *It is quite difficult to Say, because we are quite a small group compared to the numbers at the hospital….. I haven't really noticed anything specific; more in myself rather than in the hospital in general.*

Discussion

There was some uncertainty as to whether the training had an overall positive effect in reducing workplace violence or creating awareness of the phenomenon.

This was the sentiment among some participants, despite the fact that other participants felt quite empowered. Training a critical mass of employees may be the answer, to ensure that the information is adequately received by the hospital. Any doubt in this regard is largely related to the lack of participation by the management of the hospital.

Theme 5: Lack of managerial involvement in the training

The uncertainty as to whether the hospital benefited was largely attributed to the fact that none of the senior managers were on the course and the fact that managers were not supporting the employees. The concern about the lack of managerial involvement was expressed by Participants 5 and 7. Participant 7 said;

> *There's a positive outcome but we are still having a serious challenge. The challenge is that most of the people that attended the training, they were junior and middle managers, but the top structures those are the people who are still giving us the hiccups. But there are positive outcomes between the juniors and the middle managers. The conflict we use to have before, they are addressing those issues and they approach them that even now the top managers are aware.*

Discussion

This theme, combined with the previous theme of uncertainty as to whether the hospital at large benefited, centred on the fact that none of the senior managers had participated in the training programme. Interventions are deemed effective only if management participates, supports the initiative and is visibly driving the change.

Participants felt very strongly that, unless this happened, the effectiveness of the training intervention would always be limited.

Theme 6: Insight into own behaviour and others' behaviour

This theme re-emerged once again from Participants 1, 3 and 10, who focused on the fact that the training programme had equipped them with the knowledge to assess how their own behaviour or that of others contributed to the eruption of workplace violence. This knowledge allowed them to look at how they treated patients and how such treatment could mitigate workplace violence.

Discussion

The discussion on this theme applies, as discussed above. It is noteworthy that, given different semi-structured questions, the same themes often re-emerged**.**

5.9.2.3. Have the action plans decided upon been implemented? What has been your contribution to implementing these plans? (Questions 3 and 4)

Theme 1: Management involvement

Participants 1, 2, 3, and 4 initially indicated that they did not remember the action plans of the group. After some consideration, however, all but Participant 8 did recall the plans. The action plans were varied but these participants all believed that, if management was not involved in implementing or even endorsing the plans, they were more likely to be unsuccessful.

Discussion

Management involvement in endorsing the training programme through their attendance, interest and support of action plans once again emerged strongly as a theme in this section.

Participant 5 once again highlighted the theme of lack of managerial participation:

> *So we actually talk to management in our action plan, but, as I said, if it is not that collective, it is not going to work.*

Table 30 below, outlines the action plans and the themes emanating from them.

Action Plan	Theme/s	Progress with plan (Refer to Question 4)
Participant 1 Giving patients more information on, for example, waiting times has had a very positive effect. Patients provided with information are less likely to become irritated or aggressive.	• Behaviour of self, contributing to workplace violence erupting.	Implemented
Participant 3 The issue of significant noise levels in a certain section of the hospital was seen as a contributory factor to levels of violence. Information to management highlighting this issue and its contribution to workplace violence was actioned as well as putting up information in the corridors	• Theme of managerial participation. • Environmental factors contributing to violence in the workplace.	Implemented
Participant 4 One group had agreed to set up a support group, but this plan had not been implemented. The problem of staff getting together to implement action plans was highlighted in this case and was also mentioned by a few other participants.	• Staff behaviour contributing to workplace violence, such as their stress levels.	Implemented

Action Plan	Theme/s	Progress with plan (Refer to Question 4)
Participant 5 The issue of poor ventilation in Casualty, which is a small room with no windows, was seen as a significant contributor to violence in this area. This group undertook to provide management with information on these factors, and to influence management to urgently look at another site in the hospital, but were disappointed as they had no support from management.	• Contributory environmental factors • Influencing management to understand the factors relating to workplace violence.	Partially implemented
Participant 6 Another group planned to develop protocols which would be aimed at preventing workplace violence. Work on the protocols was done but this participant was unsure whether they had been escalated to management as agreed. Another group member was responsible for this. The participant had not followed up.	• Reporting protocols and procedures.	Partially implemented
Participant 7 Another group had intentions of forming a type of crisis, a type of crisis committee which would include the South African Police Services (SAPS). This had not happened but there had been some discussion with SAPS and they are now more supportive once the hospital calls them in to react to an incident within the hospital premises.	• Security and governance structures	Partially implemented

Action Plan	Theme/s	Progress with plan (Refer to Question 4)
Participant 10 Another group focussed on the environmental contributors to incidents of WPV, such as temperature. Some wards are very cold and uncomfortable to patients and this gives rise to temper tantrums and conflicts. This team also ensured that all the wards had heaters and were going to ensure that all the wall heaters were operating when the weather turned cold.	• Environmental factors contributing to WPV.	Implemented
Participant 10 The last action plan was on proactively identifying employees with stress, understanding had developed to do with the link between stressed employees and erupting violence. This empathic response was in marked contrast to the previous attitude of intolerance. .	Own behaviour contributing to WPV.	Implemented
Participant 9 This group had decided to focus on establishing a crisis-type committee which would ensure that incidents were reported and investigated.	Reporting and procedures.	Partially implemented

Table 30: Action Plans

Discussion

The above section summarises all the action plans decided on as part of the training and gives the reader an idea of the real effort made to effect the plans, given the constraints**.**

5.9.2.4. What has your contribution been to ensuring that these action plans are implemented? (Question 5)

Theme 1: Plans were not difficult to implement as it helps to work in a group Participants 2, 4, 7, 10 commented on this.

Participant 7 had even managed to get the police involved, and was actively involved (see Table 30 above).

Participant 10 was actively involved in getting heaters working (see Table above).

Discussion

Some participants felt that action plans were not difficult to implement and Saw themselves as empowered as advocates for the move to mitigate workplace violence and create awareness of the phenomenon.

Theme 2: Plans were difficult to implement as it was difficult to get together as a group

Participants 3 and 6 introduced this theme.

Participant 6 mentioned that follow-through was difficult, while Participant 3 indicated that it was difficult to get together as a group.

Discussion

Some participants felt it was difficult to implement the action plans decided on largely owing to logistical reasons and work commitments.

Theme 3: Re-looking at how best to take plans forward

Participant 5 indicated at the time of the interview that they were trying to look at how best to take plans forward.

…we are actually thinking what it is we have to do that is going to make an impact.

Discussion:

Groups often decide on very ambitious action plans. The facilitator of the training process should get groups to understand that the action plans have to be powerful in creating awareness and mitigating workplace violence, but that their choices ought to be based on doing something within the ambit of their control, something that is easy to accomplish as part of their daily routine. The decisions as to which action plans are decided on are thus critical to the success of the workplace violence programme. Often the simplest things, such as giving information to patients and patient escorts in high volume areas, can prove to be the most effective strategy and easy to accomplish as part of the daily routine.

5.9.2.5. Do you believe that the workplace training programme has contributed towards changing people's attitudes, knowledge and skills around these issues? (Question 6)

All ten participants were of the opinion that the training had contributed towards changing attitudes, knowledge and skills relating to the phenomenon of workplace violence.

Theme 1: Training other team members

The training has allowed those who are trained to go out and educate their team members, resulting in some staff requesting the training once they have been informed about the content of the course. Participants 2, 5, 7 and 9 confirmed this theme, as the training had allowed them to talk to their colleagues about the phenomenon.

Discussion

The "train the trainer" methodology has already been discussed, but participants believed that the training had allowed them to be effective in influencing team

members/peers, because they now had the knowledge, imparted through the training, to do this. Those who included it as a regular discussion at team meetings believed it was a very effective approach

Theme 2: Empowerment

Participants 4, 1 and 9 believed that the training programme had empowered them by raising their awareness of workplace violence. They responded that they felt empowered and confident that they could do something about this phenomenon. Even the lay counsellor, Participant number 6, who was not a professional, felt that s/he now knew where to start addressing workplace violence.

Discussion

The theme of empowerment emerged, with emphasis on having the confidence to tackle the phenomenon.

Theme 3: Correct behaviour to be modelled in the workplace

Participants 1 and 10 believed that giving information on the phenomenon allowed for problem-solving and also promoted an understanding of the underlying issues leading to workplace violence. This increase in knowledge would lead to a change in attitude.

Discussion

Training seems to provide for information on a misunderstood phenomenon, and also provides a framework within which this phenomenon can be addressed. This was seen as a problem-solving method because it would deal with the underlying issues leading to workplace violence. It would also change attitudes.

The general opinion was that changing attitudes would also lead to behavioural change and correct behaviours could be modelled by participants and management alike.

Theme 4: Lack of management participation

Participant 8 again brought up the theme of managers and the fact that they continued according to their own strategy. It was important that they knew about the phenomena as:

> *… it has given awareness that these things do happen and normally you associate bullying and violence at schools and stuff but never really think that it happens at a professional place ….*

Discussion

The notion of management involvement was again mooted, as already discussed. It is thus a strong theme which will be considered further in the next chapter.

Theme 5: The Employee Wellness Programme

Participant 5 believed that attitudes have changed quickly, as

> *their actions are not really changing that fast, but the attitudes are*.

By "they", she was once again referring ring to the managerial cadres. She went on to say that this programme had helped to market the Employee Wellness Programme and they had become aware of the support provided as well as the services in this component**.**

Discussion:

The role of Employee Wellness was introduced in this section. The literature suggests that employee assistance programmes often play a reactive role in dealing with workplace violence, and in fact help deal with depression, anxiety and stress-related reactions to workplace violence.

Badzmierowski and Dufresne (2005:20-21) propose a comprehensive strategy, which includes listening to employee concerns, supporting policies, and an ongoing training process which focuses on respectful attitudes and behaviour in the workplace.

5.9.2.6 Have the reporting mechanisms improved as a result of the training and is there more confidence in the process? (Question 7)

Theme 1: Improved reporting mechanism

Participants 1, 2, 3, 4, 5, 6, 7 and 8 agreed that the training programme had the effect of improving the reporting mechanism. Participant 5 noted:

> *Because now I think people realise that there are other people that's can help, and they didn't realise they can go to them. If you cannot get to the person immediately in charge, then you*

go to someone higher, because they can be very helpful. So it (reporting mechanisms) has really changed a lot.

Discussion

Reporting has been noted as one of the essential components of an effective workplace violence strategy. There are a number of reasons why employees do not report incidents, ranging from believing that they will not be taken seriously to not considering the incident serious themselves.

In addition, not all organisations have procedures in place for reporting workplace violence.

Di Martino (2002:29) has noted that, in Portugal, only 7% to 14% of victims reported incidents, whereas in Australia, 79% of health workers said there were procedures in place. However, only 8%-12% actually reported incidents of workplace violence. The statistics in Brazil were similar, with 71% being aware of the procedure and how to access the reporting procedure, but 72.4% indicating that they were not encouraged to use it.

It thus follows that the mere presence and knowledge of reporting and the procedure does not necessarily translate into incidents actually being reported.

Theme 2: Improved confidence in reporting process

Participants 2, 4, 5 and 8 mentioned that there was increased confidence, as employees are feeling more comfortable about reporting incidents to their immediate superiors. Participants 4 and 5 also mentioned that they had become aware of the fact that there was an extended support network and that if you cannot go to your immediate superior, you can go higher. Participant 8 said:

If I have a problem there is only one manager I can approach, because you assess people, its not just one manager in the department, there are a couple of people. I have actually found that particular person, she has a strong character and I can actually approach that person and tell her I'm having a problem, let's say for example a doctor, and that lady honestly, she would do something about it.

Discussion

The existence of a reporting procedure does not necessarily encourage reporting, but having confidence in the procedure in terms of the outcome of a report is the defining factor. Reporting for the sake of reporting is not enough, as employees need to believe they are being taken seriously, that an incident will be investigated and that there will be consequences.

They also do not like thinking they will be “scapegoated” or prejudiced as a result of a report.

Theme 3: Fear of reporting

Participant 9 felt that employees were still afraid of reporting incidents, particularly if the matter involved a manager, as there may be negative consequences.

This may lead to more anger or threats, but the training has helped employees to deal with this.

Discussion

Employees need to feel confident that they will not be prejudiced by the act of reporting an incident of workplace violence. Di Martino (2002:29), in his report on Bulgarian participants, noted that 14% of the group indicated that they feared negative consequences.

Theme 4: Increase in the levels of reporting

Participants 2, 4 and 7 indicated that after the training there was definitely an increase in the levels of reporting, with Participant 2 also mentioning that reporting was now accompanied by recording. She said:

> *…….because when you record, you have to write it, you write data….if you don’t write, nothing has happened.*

Participant 4 felt that after reporting there was still the question of whether there would be any follow-up.

Discussion

One could reasonably deduce that the training had increased awareness and accordingly reporting and recording also increased. Concern was expressed; however, as this did not necessarily imply that the process would run to its natural conclusion and that there would be repercussions for the bully.

Theme 5: Crisis committee

Participant 7 reported on a type of crisis committee in her unit where all incidents are investigated and referred to the committee, to whom reports are sent, so that by the time top management intervened, the incident had already been dealt with.

Participant 10 indicated that if the problem was severe it should be escalated, but minor problems were dealt with at the departmental level.

Discussion

One of the outflows from a proper reporting and recording procedure could be a system of governance set up to deal with the issues. The crisis committee is one such forum.

5.9.2.7. What would you recommend to strengthen the training programme and its implementation? (Question 8)

Theme 1: Views on the training programme

There were few inputs in this regard, as Participants 1, 2, 3, 4 were satisfied with the training programme as it stood, and did not give much additional input.

Participant 4 indicated that the programme was not boring and dealt with all the relevant definitions as well as strategies for dealing with workplace violence. Employees should attend the course, to judge for themselves.

Discussion

There were no significant contributions in this regard.

Theme 2: Training to a critical mass and shortening training

Participants 5, 6 and 9 were of the opinion that everybody should be trained; with one person expressing the view that three days was a long time to be out of the workplace but that, if the training was shortened, more employees could be available for training at any given time.

Discussion

The issue of the length of the training programme is very relevant, as it is a significant portion of an employee's working week. There are other ways to structure this, for example, one day per week for three weeks. There may be some difficulty with this as the impetus to the programme may be lost. The advantage is that it does allow for learning to be absorbed while working, which would lead to richer and deeper engagements in group discussions.

Theme 3: Training

Once again, this theme emerged, with Participant 10 mentioning that management should be included in the training, even as a group on its own. The theme of managerial involvement has been mentioned a number of times.

Theme 4: Multi-media format to training

The most valuable input prompted by this question was from Participant 8, who indicated the following:

> *I think there should actually be videos that people can actually see because sometimes verbalising things or putting them down on paper, for some people it doesn't have that much of an impact but then if a person sees the thing on video or a play or something like that, it actually gives a person a wake-up call like you know what, this is happening to me. So you can relate to things that a person can physically see, because sometimes you read but then don't actually make that picture in your head, so if you see a certain picture in your head you'll actually see that this is really happening.*

Discussion:

A multi-media format has certain advantages in that it caters for employees with different learning styles and it would be less boring, as it provides variety.

Training methodologies have incorporated variety, as this lends richness to the material, and should be considered for this programme as well.

5.9.2.8. Has the training programme assisted you in dealing with the incident you spoke about? Please discuss this. Theme: Value of training programme (Question 9)

Participants 7, 8, 9 and 10 responded affirmatively that the training had assisted them in getting over the incident/s they had discussed during the training programme.

Theme 1: Empowerment

Participant 8 felt empowered by the programme to speak up and not keep things to herself. Participant 9 agreed that talking about the problem definitely helped one to come to terms with a problem.

Discussion

Cooper (2003:vii) has reported on the range of emotions that employees face when they have been subjected to workplace violence. These reactions are anger, fear, shock, anxiety, depression and sleep disturbance, all very intense emotions. These emotions often keep to themselves, unless they are lucky enough to engage in a therapeutic process of some sort. Speaking in a group context appears to provide this relief, perhaps also the knowledge that one is not alone in dealing with the phenomenon.

Theme 2: Employee Wellness Programme

Support from the Employee Wellness programme was also mentioned in this context. Participant 8 indicated the supportive role of the EWP, with Participant 5 once again highlighting how the programme had assisted the hospital by example, ensuring more security and helping to find other ways of dealing with workplace violence.

Discussion

The role of the Employee Wellness Programme, or the EAP, has been proposed as an important one throughout the study and, more importantly, its potential role as a key

stake-holder in managing workplace violence was noted, a fact to be explored further in Chapter 5.

Theme 3: Racial harassment

The theme of racial tension was raised by Participant 6, who felt that race may be perceived as something that enables certain patients see the doctor sooner , but this was not so, and it seemed that she often dealt with these incidents harshly, because she becomes impatient with anyone who tries to make these allegations. Race definitely does not play a role in who is seen first by the doctors.

Discussion

Even though South Africa is 18 years past its apartheid history, as a democratic country race sometimes still rears its ugly head, either as an accusation from someone who is aggrieved, or in some other guise. The participant did not specifically mention "apartheid' but did allude to racial tension.

The hospital procedure of triage, which may not be clear to the layperson, may often create an impression of racial favouritism and cause racial tension.

Theme 4: Emotions after an incident

One of the most heartfelt comments came from Participant 6, who said the following:

> *Sometimes it's not so easy to overcome those problems because sometimes you feel you are also human, you can also retaliate back, and then sometimes the patient who insulted you vulgarly, sometimes you want to retaliate, but it's unprofessional, you feel like you can cry. You just leave the place and go back to the tea room and sit there for a while until you can work it out.*

Discussion:

The comment above is an indication of the kind of emotion that can be produced by workplace violence. These emotions can sometimes be at a terrible cost to the organisation in that employees become demoralised and depressed. If they believe they are alone with no support. Emotions are magnified, and sometimes the employee leaves the profession.

5.9.2.9 General comments or recommendations (Question 10)

For the purposes of this chapter, recommendations and comments from participants will be noted and discussed in depth in the next chapter, which focuses more specifically on recommendations**.**

Theme 1: More training of staff

Participants 1 and 3 referred to the fact that more staff should be trained, with Participant 1 saying;

> *I think you really should continue with this; it helps people to breathe and to better handle problems.*

Theme 2: Training of managers

Participant 8 again mentioned that management should be trained:

> *It needs to be verbalised more and the management needs to be involved as well, and they need to start taking action because some people actually leave or resign because of such things.*

Theme 3: Training of the broader community

There was also reference by Participants 5 and 7 to the fact that the broader community should be made aware of the phenomenon of workplace violence and the issues underpinning it. Participant 7 felt that other specific government departments should also be trained, such as the Education Department, as in this way the broader community would be empowered.

As Participant 5 noted:

> *… the importance of the community: because they don't know, they really don't know. Sometimes, when they see the hospital, they see the structure, but not the people in the place; they do not understand our problems. If they are more involved they will understand our problems.*

Participant 7 also added that

> *If other government departments can have the same training as such, I think it would benefit us a lot, like education, so we will be empowering the whole community because we will be forming a number in the community, a larger sector will be involved.*

The rest of the participants were appreciative of the training and indicated that they had learned a lot. The programme should be continued.

5.9.2.10 Conclusion

In conclusion, Participant number 9 was eloquent in her praise and need for more action.

> *… I really appreciate you guys coming here, like I Said, it's a serious problem and it needs to be verbalised more and the management needs to be involved as well and they need to start taking action because some people actually leave or resign because of such things.*
>
> *Like for us in the …… department there is so much shortage, because people are resigning almost every month and when you trace it back it's because of people's attitudes. Because some people you cannot work with, you cannot tolerate and I mean this is a professional place, we cannot be acting like we're in school.*

5.10 Conclusion of Chapter

A number of key themes emerged from the qualitative interview phase of the study.

The training made employees feel empowered and it contributed to their awareness of the phenomenon of workplace violence. Empowerment meant that many of them had implemented the action plans to which they committed in the training. If not fully implemented, they were at least partially implemented. It is more difficult to comment on whether skills were retained, as the interviews were held two months after the training.

CHAPTER 6

Key Findings, Conclusions and Recommendations

6.1 Introduction

The researcher wanted to evaluate the impact of a workplace violence training programme (VETO) designed by the ILO, WHO, PSI and ICN and customised to South African conditions by Dr Susan Steinman. In order to achieve the afore-mentioned, the researcher had to first assess the presence and extent of the phenomenon of workplace violence at a particular public-sector hospital. Should the survey have confirmed that violence in the workplace in the Dr. Yusuf Dadoo was not prevalent, the need for such a training programme as part of the Management of violence in the Workplace programme, might not have been considered. The findings of the survey, justified the decision to proceed with the actual training programme on the Management of Violence in the workplace as the prevalence of such violence allowed for the next phase to continue.

From both the literature study and the empirical research, it was evident that the phenomenon of workplace violence is one about which there is still a great deal of ignorance. Despite this apparent ignorance, more than 70% of the respondents to the survey indicated that they had been a victim of workplace violence on more than one occasion.

The literature study suggested that very few impact studies had been conducted to evaluate workplace violence training programmes as an effective intervention programme, either as an isolated intervention or as part of a comprehensive organisational strategy for addressing workplace violence. The objectives of the training programme on workplace violence were to:

- Increase awareness of the phenomenon
- Change attitudes and beliefs about workplace violence;
- Increase skills levels in terms of dealing with workplace violence.

The above learning outcomes aligned to the study units and assessment criteria have been outlined in Chapter 4: Section 4.5.6.

The findings of the empirical study concluded that the training on workplace violence was effective in creating awareness of workplace violence, but was less conclusive in terms of whether it actually changed attitudes or increased skills for dealing with incidents. The workplace violence training programme (VETO) thus was successful in achieving the learning outcomes related to study units which were on developing awareness and understanding and changing belief and attitudes. These study units were;

- Definitions and introduction to the phenomenon of workplace violence
- Awareness and understanding of the phenomenon of workplace violence
- Rights and responsibilities of different role-players

It was less successful in achieving learning outcomes of the study units linked to some of the attitudinal change and also linked to skills development. The study units thus were;

- Recognising and assessing workplace violence
- Interventions on workplace violence
- Monitoring and evaluation of workplace violence related to the following study units

The literature study seems to suggest that a more comprehensive strategy for workplace violence is favoured, of which training would form only one component. The comprehensive approach would create awareness, change attitudes, allow for reporting and recording and increase levels of accountability and avenues for recourse. Chapters 1 - 5 are summarised with conclusions and recommendations, with emphasis on the key themes emerging from the study.

Chapter 6, the final chapter of this study, consists of the conclusions and recommendations of the study, which have been formulated on the basis of the literature study as well as the empirical research. Chapter 6 also emphasises the comprehensive multi-level strategy by proposing recommendations according to the four sub-systems proposed by Parsons (1937) in terms of systems theory, namely the

social system, the cultural system, the personality of the individual and the behavioural organism.

6.2 Chapter 1: General orientation to the study

6.2.1 Summary

Chapter 1 provides the theoretical framework for the research and outlines the problem formulation, the extent of the problem and the impact of the problem. The goals and objectives of the study and the hypothesis are also clearly outlined.

The research approach and motivation for choice of the specific approach is outlined The pilot study section deals with the feasibility of the study and the testing of data-collection instruments, before exploring the research population, sample and sampling methods. Ethical issues are addressed in detail, followed by a section on definitions of key concepts, which concludes this chapter.

6.2.2 Conclusions

From the literature set out in Chapter 1, the following conclusions can be derived:

- The phenomenon of workplace violence is still relatively unknown, in particular the interventions addressing this phenomenon.
- The definitions of workplace violence are either very broad or rather limited, which has implications for research in terms of comparative studies.
- South Africa, because of its apartheid legacy and violent past, has a population that is essentially desensitised to violence and this may impact on their evaluation or assessment of what constitutes workplace violence;
- Workplace violence significantly impacts upon the physical and psychological well-being of employees, as well as productivity and work performance.

  Symptoms of post-traumatic stress disorder are sometimes evident five years after the bullying has ceased;

- The healthcare sector is one in which workplace violence prevails because there are a number of factors that predispose it to being considered a “vulnerable sector”, such as its female-dominated environment. Further, there is exposure to mentally-ill patients and alcohol or drug abuse, as well as the fact that hospitals are often located in environments like gang-infested neighbourhoods.

- There are a number of organisational factors which may predispose the hospital to workplace violence, such as, inter alia, being a larger company, unionised environments, and organisations with a micro-management leadership style;

- The role of the Employee Assistance Programme was explored, which produced the view that EAPs have made a limited contribution to addressing the scourge of workplace violence, preferring to take a reactive counselling approach rather than one of active advocacy of a more comprehensive intervention approach. The systems theory provides a framework which can be considered in this regard. Within the framework proposed by Parsons (1937), where the subsystem is made up of the social system, the cultural system, the personality and the behavioural organism, EAPs have usually been content to deal only with individuals and interventions which are thus usually aimed at the individual personality, while the social, cultural and behavioural organism is largely ignored;

- The researcher opted to follow a mixed-methods approach to evaluating a Management of Violence in the Workplace Programme. The dominant component of the research was a quantitative paradigm with a small component being a qualitative paradigm. This combination of paradigms allowed for the researcher to 1) assess the extent of the phenomenon (n=400 and 2) to evaluate the impact of the training from both a quantitative and a qualitative paradigm (n=40), the latter adding depth and richness to the data gathered;

- The quantitative component was done two months after the actual training programme had been implemented, so the skills for dealing with workplace violence were assessed. This approach worked well, as some time had elapsed and this allowed sufficient time for participants to implement the agreed-upon action plans and produce feedback on skills acquired, an aspect which would have been difficult to test immediately post-test;

- One of the limitations of the study was that the intended sample was to be drawn from the high-risk units, but on the day of the training a nation-wide taxi strike left the hospital severely short-staffed and many of the intended participants were unable to attend. The result was that those slots were filled by other hospital employees, not necessarily from high-risk units.

6.2.3. Recommendations

- That more studies surveying the extent of workplace violence be conducted, both within the healthcare sector and comparatively between the healthcare sector and others. This would provide insight into how the different sectors compare regarding the phenomenon of workplace violence.

- That the same study is replicated within another hospital, a tertiary hospital, and that those findings are compared with the findings of the current study, which was completed in a district hospital. There may be distinct differences in the experience and the extent of workplace violence in a district hospital and in a tertiary hospital.

- That an in-depth study of the role of Employee Assistance Programmes be explored to gain more insights into the potential for positioning comprehensive workplace violence programmes.

- The role of organisational factors from a uniquely South African perspective would also provide clarity on a number of predisposing factors. Very little work has been done in this regard and the South African work landscape is unique, as it provides some useful insights. These insights, if translated into practice, could contribute to the overall well-being of employees. Bridgeforth (2005), writing on systems theory, maintains that in the current age organisational discussions certainly centre on policies, programmes and governance.

- Systems theory, with its focus on people, policies, systems and structures, provides a sound framework when future studies are considered pertaining to workplace violence and, in particular, strategies for addressing workplace violence. Bridgeforth (2005) maintains that some systems theory authors have focused more on concepts like projects, management practices, leadership and the deployment of key people.

6.3 Chapter 2: Literature Review on the Phenomenon of Workplace Violence

The following insights were gained from a thorough literature review on the phenomenon of workplace violence.

6.3.1. Summary

- Sufficient knowledge and skill about Violence in the workplace is relatively limited, in particular interventions addressing the phenomenon, but where the phenomenon has been measured, definitions differ, giving rise to a situation in which conceptions of the reality and its nature are different, as are the interventions for tackling the problem. A broad or limited definition would be a determining factor, while socio-cultural influences should not be minimised.

- The extent or occurrence of workplace violence varies but this is also influenced by whether a broad or a limited definition has been used. There is, however, a growing body of evidence to suggest that workplace violence is prevalent in the healthcare sector around the world, and South Africa is no different. A number of research projects in recent years in South Africa have been noted in the literature review.

- In addition, studies have also isolated a number of situational factors; the female-dominated environment, environmental factors, gender dynamics and organisational climate which are contributory to workplace violence.

- The profile of the perpetrator has been reviewed in a number of studies. The findings seem to support the view that there is no profile of a typical perpetrator and the latter could be, inter alia, a manager, peer, patient, or a patient escort. The bully-victim dyad has also been proposed as the dynamic interaction of factors predisposing a situation to the eruption of workplace violence.

- The profile of the victim has been analysed, but it is even more difficult to establish a typical profile of a victim's age, gender, and health. Even the personalities of victims have been explored in a number of studies.

- It is generally accepted that the consequences of workplace violence can be devastating to individuals and counterproductive to organisations in terms of morale and productivity. It is also generally accepted that the costs of workplace violence can be very high. In addition, workplace violence may trigger a range of physical or emotional reactions in an individual, which may persist long after the bullying has stopped.

- Training is often recommended to deal with bullying, but the content of training programmes varies from directly dealing with issues on aggression and workplace violence, to assertiveness courses and conflict resolution. The training is sometimes also integrated into programmes on team-building and interpersonal skills.

- The importance of a multi-dimensional approach has been quite well addressed in the literature, as workplace violence is a multi-factor phenomenon. There thus needs to be a comprehensive strategy for addressing the problem.

6.3.2 Conclusions

From the literature review that was done and presented in Chapter 2, the following conclusions can be drawn:

- The extent of workplace violence as a phenomenon is impacted by sociocultural factors, while the related reporting is influenced by the choice of broad or narrow definition, as favoured by the researcher.

- There is growing awareness of workplace violence as a phenomenon. A few recent studies in the South African context on bullying has been noted.

- It is evident that violence as a phenomenon is indeed prevalent in the healthcare sector. A number of factors predispose this sector to workplace violence.

- There is no typical profile of a perpetrator of workplace violence. The continuum of violence then as proposed by Chechak and Csiernik (2014:14-15) would suggest a continuum of perpetrators.

- There is no typical profile of a victim of workplace violence.

- Workplace violence impacts on an individual's physical and psychological well-being.
- Workplace violence is costly to organisations.
- Training is often included as part of the strategy for dealing with workplace violence. Chechak and Csiernik (2014:19) emphasise training on various workplace violence topics. Educating workers would also empower them to refuse unsafe work.
- A multi-dimensional strategy for addressing workplace violence is strongly advocated by researchers.
- Training on workplace violence should be customised to local conditions.

6.3.3. Recommendations

The following recommendations emanate from the conclusions drawn from the literature review:

- More studies on workplace violence should be conducted to increase awareness of the phenomenon. Definitions of workplace violence should be carefully considered in the design of the studies.

Training may form one component of an overall strategy for addressing issues of workplace violence, but a more comprehensive, multi-dimensional approach is recommended. Customising training to local conditions is essential in achieving the objectives of the training programme.

- Future studies recommended are on:
  - Profiling perpetrators and victims of workplace violence;
  - Quantifying the exact cost of workplace violence.

These studies will provide insight into the phenomenon and add to the growing body of work which will shed further light on the management of the phenomenon and its consequences.

6.4. Chapter 3: The Management of Violence in Workplace Programmes

The following insights have been gained from completing a literature review on workplace violence programmes aimed at managing or mitigating the phenomenon.

6.4.1. Summary

- Workplace violence programmes have been slower to emerge than descriptive information;
- Much has been written on reporting. The difficulties with reporting have been noted, as well as the fact that reporting and recording are both important. Procedures and protocols used to report incidents have also been investigated in a series of research studies;
- The following measures for addressing workplace violence have been explored:
  - Long- or short-term measures;
  - Security measures;
  - Policies;
- Effective workplace violence programmes have been examined, with their focus on:
  - Leadership;
  - Recruitment;
  - Selection;
  - Training;
  - Performance appraisal;
  - Discipline;
  - Environmental factors.

- This chapter explores the role of the EAP, how it has been involved in various aspects of workplace violence and where its contribution can be enhanced.

- Finally, this chapter outlines the contents of the actual Management of Violence in the Workplace Training Programme, which will be implemented and analysed in this study.

6.4.2. Conclusions

- Much less work has been done on researching programmes dealing with workplace violence, while some studies have been conducted on describing the phenomenon. This may be because many studies have been large-scale country projects, in which it is easier to conduct descriptive studies. Organisations have been slower to recognise the phenomenon, measure it, implement a strategy and then measure the impact. It is this approach which will shed more light on programmes and their evaluation.

- Reporting, where done, involves a number of inherent difficulties:

  - Reporting does not include recording;

  - Reporting is considered futile, as there is no follow-up;

  - Reporting does not necessarily mean consequences for the perpetrator;

  - Victims fear repercussions after reporting;

  - Dissatisfaction with the way incident was managed.

- The conclusion is that although reporting forms an important component of an intervention strategy, a number of other factors make it an effective or a non-effective strategy.

- The debate on long-term or short-term measures for addressing workplace violence is country-specific, with South Africa focusing more on training in skills, stress management, team building and more effective management of incidents, while countries like Bulgaria focus at the macro-level in terms of health systems,

reform and workplace violence included. This is an indication of the maturity levels of managing workplace violence in a country, and South Africa will eventually reach the stage where it is addressed at the macro-level.

- The conclusion with both security measures and policies is that they are not very effective strategies on their own. They need to be integrated into an overall multi-dimensional strategy to address workplace violence. Again, a consideration of systems theory as a framework within which to address such studies is essential.

- The issue of leadership and leadership responsibility in terms of workplace violence is important, as leaders play a critical role in creating the culture within any organisation. They are responsible for mitigating the risk of workplace violence as well as ensuring that systems and structures are in place to manage the phenomenon of workplace violence. Kowalenko et al.(2012:528) have highlighted the issue of management commitment by stressing three important points:

  - The organization must promote the philosophy that says violence is unacceptable;

  - The organization must value their employees' well-being and safety;

  - The organization must convey to patients that violence will not be tolerated;

- Companies who want to be viewed as the employer of choice in a global economy would do well to ensure that they are perceived to be concerned about workplace violence and the overall well-being of their employees.

In South Africa, a country with a strong human rights culture and labour legislation, with regulatory practice between the employer and employee, the issue of screening before employment is highly contentious. Screening in this context would mean looking for signs of potentially bullying behaviour and potential for erupting workplace violence. Even in the current context, pre-employment psychometric tests are highly debated, as they are seen as Eurocentric and invalid for the South African population.

- Training is anecdotally noted to be an important component of a comprehensive workplace violence programme, but there is very little research that has rigorously evaluated the outcomes of such training.

- Incidents of workplace violence have been shown to decrease just prior to, or during periods of performance appraisal, and employers would do well to be aware of this and manage it appropriately.

- Very little work has been done in respect of discipline in the workplace, but there is an indication that both administration and lack of it may be contributory factors to workplace violence.

- Environmental factors such as downsizing appear to have an effect on workplace violence.

- EAPs should be major role-players in the management of violence in the workplace, but this is often not the case. EAPs' contributions have mostly been involvement at the level of reactive counselling after an incident. EAPs have sometimes been involved in facilitating training workshops on conflict resolution or assertiveness training and stress management. They have thus played a limited role and, if we benchmark this against the EAP core technologies, there is room for a greater degree of co-operation and involvement.

6.4.3. Recommendations

The following recommendations emerge directly from the conclusions above:

  - More organisations at the strategic level should take a decision to implement workplace programmes. A survey of the phenomenon would add to the body of knowledge on the subject and, in South Africa, would provide a basis for comparison against the healthcare sector, where some studies have been completed. This analysis would also provide organisations with the cost of workplace violence, a cost they would surely want to reduce.

- Organisations and companies who implement programmes should build in outcome and impact evaluations from the beginning, as it would be essential to evaluate these interventions.

- Evaluations of interventions are crucial in influencing macro-level policy and legislation, such as the National Health Care Act, in the case of healthcare workers.

- In the healthcare sector, where reporting processes are often in place, the issues of trusting the process, having the confidence that a process will run its course, having confidence that, as the victim, you will be taken seriously and will not be prejudiced, will have to be attended to if reporting is to serve its ultimate purpose.

- Strategically, organisations and companies need to understand that one intervention, in isolation, is not going to have the intended effect of mitigating workplace violence, but that an overall and comprehensive strategy is crucial. The components would include: leadership responsibility; training; policy; reporting; environmental factors; and security, to name a few. Again, systems theory has warned that, if we want to analyse a complex system, it is not enough to imagine a one-way flow of control, where the controller would decide what needed to be done, tell the system what to do and the system would do it (Arbib & Cornelis, 1981:375).

- EAPs have a pivotal role to play in terms of creating awareness, influencing processes, advocating for change and the management of the phenomenon of workplace violence, a role far beyond the one in which they have traditionally been involved. It is, however, a role which is clearly outlined by the EAP core technologies.

6.5. Chapter 4: The Management of Violence in the Workplace Training Programme (VETO)

6.5.1. Summary

Chapter 4 thoroughly outlines the actual Workplace Violence Training Programme (VETO), namely

- The background of VETO in relation to the Gauteng Department of Health and specifically Dr.Yusuf Dadoo Hospital is outlined.

- The Framework Guidelines for Workplace Violence is discussed in depth.

- Logistics related to the research and empirical component of the study is explained.

- The logistics for the Workplace Violence Training Programme (VETO) is clarified in this chapter.

- The vision, mission and values of the VETO programme are highlighted.

- The three day VETO programme, with the study units, learning outcomes and assessment criteria is explained in detail.

- Lastly, the research phases is summarised for ease of reference for the reader.

6.5.2. Conclusions

- The learning outcomes have all been aligned to the study objectives relating to workplace violence in terms of developing awareness, changing attitude and belief and developing skills.

- The vision, mission and values reflect a drive towards self-sustainability of the training programme but with ensuring empowerment of individual employees.

6.5.3. Recommendations

- On-going support to employees in terms of self-sustainability through a stronger mentoring and coaching framework should be considered.

- Evaluation of what empowerment may constitute for individual employees could also be built into the VETO Programme.

6.6. Chapter 5: Empirical Study on Violence in the Workplace and Management of Violence in the Workplace

6.6.1. Summary: Survey

The following themes emerged from the survey and will be presented thematically, as they were distinct and common themes which emerged during the survey and pre-test post-test phase.

- **Gender vulnerability:**

  From the survey data, gender as a predictor of vulnerability did not prove to be a significant predictor of exposure to workplace violence. In addition, the pre-test post-test phase did not find this to be a significant predictor. This study thus did not correlate with many of the previous studies, which found gender to be a significant factor, as more women than men were exposed to workplace violence (Di Martino, 2002; Chappel & Di Martino, 2000).

- **Gender and multiple incidents:**

  The empirical study specifically tested the extent of incidents; as about two thirds of the respondents exposed to workplace violence have been exposed more than once. This study did not show a significant correlation between gender and the number of incidents or multiple incidents. In other words, although gender was a predictor of workplace violence, females were not necessarily exposed to more incidents than males were.

- **Age and workplace violence:**

  There was no significant association between age and workplace violence, i.e. that younger employees more often become victims of workplace violence, as evidenced by this study. This finding from the empirical study did not correlate with the findings in the literature study

- **Workplace violence and professional group:**

  The empirical study showed up a statistically significant finding in this regard in the survey phase, but for the smaller Sample in the pre-test post-test phase there proved to be no correlation between workplace violence and professional groups. In the survey, nurses were found to be more exposed to workplace violence than any other professional category. This finding is in line with what emerged from the literature review (Kennedy, 2004:16).

- **Seniority of position and workplace violence:**

  The survey delivered the surprising finding that students, who are usually more often exposed to workplace violence, according to the literature study, reported less exposure to workplace violence in the empirical study. The literature study strongly suggests that younger staff members, most often students, are more vulnerable when it comes to workplace violence.

  This finding was once again not replicated with the smaller Sample in the pre-test post-test phase of the empirical study. This was thus not a significant predictor from the survey and the pre-test post-test phase.

- **Workplace violence and type of unit/ward:**

  The literature (Wistanley, 2005:342) has suggested a strong correlation between the type of unit or ward in which the victim works and the number of incidents of workplace violence. Both the survey and the pre-test post-test did not correlate with the literature review but the ARV Clinics and the maternity units appeared to be implicated in much of the workplace violence that was occurring at this hospital.

- **Types of workplace violence:**

  The survey indicated that verbal abuse was the most common form of workplace violence, followed by threats, while physical violence with a weapon was the least reported type of incident. In the pre-test post-test, psychological violence was the most common type of incident, followed by threats. The least reported, once again, was physical violence with a weapon. By and large, this

correlates well with the literature review (Oztunc, 2008:118; Joshi et al., 2008:119).

- **The perpetrator:**

  Both the survey and the pre-test post-test in this empirical study produced the finding that the patient was the main perpetrator, followed by a colleague. This finding is line with previous research findings (Di Martino, 2002:17).

- **Location of the incidents:**

  Both phases of this empirical study found that the majority of the incidents happened inside the health facility, which is in line with the literature. (Lawoko, 2004:52).

- **Response to the incidence of workplace violence**:

  There was a strong correlation between the survey and the pre-test post-test, on victims' actions after an incident. The most frequent response was to tell family members or friends, followed by telling a colleague and thirdly, to report the incident to a senior in the survey. In the pre-test it did not very much, with telling a colleague being the most popular choice.

- **Reasons for not taking action :**

  Reporting does not happen often for a number of reasons, but the empirical study revealed that, more often than not, this was owing to the belief that reporting does not help or that the incident was not serious enough to warrant its being reported. Lewis (2006:550) has noted that the trend for managers to try to contain or manage the situation creates the impression that a victim's complaints are not taken seriously.

- **Emotional responses to the incident/s:**

  Both the survey and the pre-test post-test revealed that anger was the emotion most often experienced after an incident. The second most reported emotion was that of feelings of "stress". In essence, however, this empirical study

revealed a range of emotions, which correlates closely with research in the literature review (Cooper, 2003: viii).

- **Awareness of workplace violence:**

  In the survey, more than 70% of the respondents reported realising at the time of the incident that they were a victim of workplace violence. It was significant that, with the smaller Sample in the pre-test post-test phase, 50% of respondents did not answer this question.

- **Post-traumatic symptoms:**

  All the victims reported post-traumatic symptoms ranging from, inter alia, repeated disturbing thoughts, avoiding thinking about the incident, feeling as if everything was an effort and being super-alert.

- **Strategies dealing with workplace violence:**

  A number of strategies for dealing with workplace violence were favoured by respondents during the empirical phase, in particular, supportive management, followed by hospital policy and proper security.

6.6.2. Conclusions

Gender has been revealed as a significant predictor of workplace violence in a number of studies and was supported by the empirical data gathered in this study. There was, however, no correlation between gender and the number of incidents, so being female does not necessarily increase the chances of more incidents, according to this study.

- This study revealed no significant correlation between age and workplace violence, which is in contrast to what the literature study revealed (Grubb et al., 2005:55).This finding aligned well with a further analysis of whether senior employees were more exposed than junior employees and no significant relationship was found between the two variables. Younger people are usually the less senior employees, so the two aspects were well aligned, according to this study.

- This study found a strong correlation between the type of unit/ward and the perpetration of workplace violence, a finding which is closely aligned with the literature (Wistanley, 2005:342).

- Physical violence with a weapon does not occur that often, but even incidents of verbal abuse and threats lead to significant emotional responses from the victims of workplace violence.

- The empirical study revealed that the patient was usually the perpetrator and that incidents happened mostly inside the health facility.

- Interventions should thus be tailored to a multi-dimensional approach, but with emphasis on the internal environment of the health facility.

Significant emotional reactions were experienced by all the respondents, along with post-traumatic symptoms, and the management of such emotions and reactions should be factored into a comprehensive workplace violence programme.

- Although over 60% of respondents in both the survey and the pre-test post-test phase believed they were victims of workplace violence at the time of the incident, they did not report it because they had no confidence in the reporting system.

- We can also conclude that the main source of support after an incident was the family or a friend, followed by peers and management or a senior, according to the empirical data, Management support was thus not visibly evident and was regarded as lacking. Hoobler et al. (2006:242) spell out the implications for managers and suggest that HR violence prevention programmes should focus on organizational insiders and organizational outsiders and be cognisant of customers as a major source of workplace violence. The interpersonal training of employees to de-escalate the eruption of incidents of potential workplace violence is also critical. They go even further, to propose a progressive system of ‘discipline’ for angry customers, and this may involve asking a customer to leave, or the employee to exit the scene. A next step may be to call in security or even the police.

6.6.3. Recommendations

- The phenomenon of workplace violence should be studied on a far wider scale than was intended in this study. Some of the correlations between exposure to workplace violence and indicators such as gender and types of ward or unit were largely supported here. The replication of this study within a larger, tertiary health facility such as the academic hospitals, either the Chris-Hani Baragwaneth or the Charlotte Maxeke Hospital would provide useful insights into the phenomenon of workplace violence in the healthcare sector. Such studies should thus examine the indicators of gender, age, the type of ward, the type of violence and the perpetrator.

- There are sufficient significant emotional reactions and post-traumatic symptoms evidenced by individuals to recommend that the employee wellness or Employee Assistance Programme should take a leading role in terms of shaping a comprehensive workplace violence programme for the organisation/healthcare sector employees. Their role in managing the trauma and emotional responses would remain, but their role as benchmarked against the core technologies of the EAP would dramatically increase, to include:

  - Training and development;
  - Consultation to the work organisation;
  - Case management;
  - Marketing;
  - Networking;
  - Monitoring and Evaluation.

- Reporting and reporting procedures form the basis of a well-structured training programme, which will ensure that reporting can be trusted, that it has procedures for follow-through and report-back built in, as well as recourse.

- Set up a response team which is trusted, is multi-disciplinary and will provide needed support after incidents of violence involving employees. This allows for the need to garner and receive support from many different sources. Management

support is critical, as it always indicates to employees that they are being acknowledged. Management should thus also be represented on the response team, as this would demonstrate a real interest, as opposed to merely posturing.

6.6.4. Summary: pre-test post-test

The following section will provide a summary of the findings of the pre-test post-test phase. The themes emanating from the description of the phenomenon have already been presented with the themes from the survey, as there are distinct areas of commonality. The focus of the pre-test post-test phase was, however, to test whether attitudes, knowledge and skills on the management of workplace violence changed as a result of the training programme.

Accordingly the learning outcomes clearly outlined in Chapter 4 is summarised here again as a reminder as all themes link to these learning outcomes. They are:

- Discussing different workplace violence terminology
- Correlation between workplace violence and various factors such as gender, age, profession, unit/ward and seniority of position
- Understanding the cost burden of workplace violence
- Developing an understanding of workplace violence in the health care sector
- Understanding the different role-players and the roles they could play
- Understanding the impact of individual behaviour on workplace violence
- Understanding various approaches to workplace violence
- Best practice and the effectiveness of measure to mitigate workplace violence
- Recognising warning signals and coping strategies after incidents.
- Appreciating a holistic and multi-level response.
- Ability to report and record incidences of workplace violence
- Designing action plans to manage workplace violence.
- Tools to implement a mini-VETO.

These findings, together with some cross-tabulations, will be presented in this section, with conclusions and recommendations.

- **Policy as a driver of reporting procedure:**

  The training programme brought about a shift from the pre-test attitude that policy was not a driver of knowledge on workplace violence to the belief post-test which held that policy was a driver of knowledge on workplace violence.

- **Belief that workplace violence is a serious issue:**

  Those few people who did not believe that workplace violence was a serious issue changed their response after the training to one of believing it was a serious phenomenon for organisations to deal with.

- **The cost of workplace violence:**

  There was a definite shift in knowledge from the pre-test to the post-test in this regard. In the post-test, respondents were of the opinion that workplace violence was a costly phenomenon. This was not the view in the pre-test. The training thus changed attitudes in this regard.

- **Belief that verbal abuse is workplace violence:**

  Those few respondents who were not sure that verbal abuse constituted a form of workplace violence changed their belief after the training and now believed verbal abuse to be a type of workplace violence.

- **My own behaviour as a trigger of workplace violence:**

  There was no significant change in attitude from the pre-test to the post-test as to whether the respondents' own behaviour could trigger workplace violence.

- **Colleagues' behaviour as a trigger of workplace violence:**

  It was difficult to draw a conclusion from the statistics, as the responses were constant in this instance.

- **Authority to effectively combat workplace violence:**

  There was no shift in the attitude that, as an employee, they could make a difference and command the authority to effectively combat workplace violence. The training did not impact on this belief.

- **The effectiveness of measures dealing with workplace violence:**

  The training programme on managing violence in the workplace did not lead to significant changes in knowledge about which measures would be effective in reducing workplace violence. There were only two indicators which showed a shift in knowledge, one on patient screening and the other on special uniforms or equipment. In addition, at the 1-% level of significance, there was also a shift in knowledge on restricting public access.

- **Individual contributions to combating workplace violence:**

  The empirical study revealed that the training programme had no statistically significant effect on changing individuals' attitudes about the contribution or value they could add by mitigating workplace violence.

- **Responsibility to manage workplace violence:**

  The training programme caused a definite shift in the knowledge about whose responsibility it was to manage workplace violence, with increasing awareness of the role of employees and the community in this regard. There was no observable shift in knowledge on the role of government, professional associations or that of the employer.

- **Healthcare sector vulnerability:**

  There were some significant shifts in attitude and belief as to the reasons for the health care sector being a vulnerable sector and these were in relation to understanding that the hospital setting may contribute to incidents erupting, the hospital environment as a contributor, younger workers being targeted and the fact that the victim's personality may play a role.

- **Factors contributing to workplace violence:**

  The training caused a shift in the belief and attitude as to which factors contributed to workplace violence, in particular, societal factors, the perpetrator and the organisation of work. There was no observable shift regarding other factors like the victim, the workplace, interpersonal factors and the changing context of work.

- **The usefulness of workplace violence training:**

  There was no shift in the attitude to or belief that workplace violence training is useful, except on the indicator of “awareness”. There was thus an increased belief that the training could provide more awareness of the phenomenon of workplace violence.

- **Individual contributions:**

  From the above findings, it appears that employees did not change their belief that the workplace violence programme could empower them to combat workplace violence, but they still noted a number of contributions they could make, predominantly, sharing information with their colleagues and participating in the wellness programme to effectively combat workplace violence.

- **Programme effectiveness:**

  Overall, it appears that the Management of Violence in the Workplace Programme created a significant shift in issues focusing on knowledge, and some shift in issues focusing on attitude, belief and skills.

6.6.5 Conclusions

The conclusions in this section emanate from the summary in Section 5.5.4, which centred on the shifts in attitude and belief, and knowledge and skills from the pre-test to the post-test.

The following conclusions have been drawn:

- The training programme on the Management of Violence In the Workplace definitely contributed to a shift in knowledge on the following factors:

- That policy can be a driver of reporting procedures;
- That there is a significant cost associated with workplace violence;
- That there are a number of identified role-players who are responsible for managing workplace violence.

Factors contributing to workplace violence

The training programme appeared to be less successful in increasing knowledge of measures that are effective in mitigating workplace violence. Kitson (2009:217) has concluded that only the purposeful integration of systems theory with knowledge translation theories and models may enable the application of new research and new knowledge. Future studies evaluating the training of the management of violence in the workplace may take this into account.

- The training programme on the management of workplace violence contributed to a shift in attitude and belief on the following factors relating to workplace violence:
  - That workplace violence is a serious issue;
  - That verbal abuse constitutes workplace violence;
  - The training programme is an effective measure to mitigate workplace violence;
  - The healthcare sector is vulnerable to workplace violence.

It was less effective in changing attitudes and beliefs:

- My own behaviour may contribute to workplace violence;
- I have some authority to contribute to mitigating workplace violence.

- The training programme on the Management of Workplace Violence seemed to contribute less to the development of skills, as respondents failed to view the potential individual contributions as key to managing the phenomenon.

6.6.6 Recommendations

- The workplace violence training programme, as outlined in this study, could prove to be an effective strategy, particularly in providing knowledge of the phenomenon. To a lesser degree, it affects shifting attitudes and beliefs. To an even lesser extent, it impacts on skills development. It is recommended that this training should not form a stand-alone component, but it is hoped that, where it is part of an overall strategy for addressing workplace violence, the outcomes of the training would be greatly enhanced. Kitson (2009:218), in his writings on systems theory, has concluded that the spread of knowledge into practice is a slow and unpredictable process.

- More time spent on the action plans may contribute to increased skill and this could be combined with the facilitator function in building in an element of mentoring. If this is combined with a different structuring of the programme, for example, across three weeks, it is hypothesised that this training programme could indeed contribute more effectively to skills development.

6.6.7 Summary: Interviews

The responses resulting from the qualitative interviews will be presented thematically. There were a number of themes which were repeated across the interview questions and which will be discussed in this next section.

- **Insight into how "others'" behaviour may contribute to workplace violence**
  There was some consensus that the training increased awareness of how "others'" behaviour contributed to workplace violence.

- **Insight into how my own behaviour may contribute to workplace violence**

  There was less insight into how the respondents' own behaviour contributed to workplace violence and how, understanding this, factors leading to workplace violence could be managed before they escalated. This allowed respondents to review how they were treating patients and how this could lead to incidents.

- **Increased awareness of the phenomenon of workplace violence**

There was an increased awareness of workplace violence, especially on the issue of what constitutes it, the types of workplace violence and measures for dealing with it.

- **Personal empowerment**

Participants felt more empowered to deal with workplace violence. The information also allowed them to stand up for themselves, armed with information.

- **Managerial involvement**

General managerial involvement was mentioned a number of times during the training. In order for the hospital to benefit, senior managers should be involved in the training to develop an understanding of the phenomenon of workplace violence. Managerial endorsement of the programme was considered critical to the success of the programme.

- **Security**

Security was considered important to the management of workplace violence.

- **Employee wellness programme**

There was a notion that the Workplace Violence Programme had marketed the employee Wellness Programme and that the latter could play a key role in mitigating workplace violence.

- **Increased and improved reporting mechanisms**

The training had improved the reporting mechanisms by creating awareness of the importance of this aspect.

- **Fear of reporting**

A belief that was not completely dispelled was the fear of reporting, lest there be negative consequences.

- **Increased confidence levels regarding reporting**

The training increased confidence levels in reporting and created awareness that there are a number of support networks within an organisation to which issues can be escalated. There was a definite increase in the levels of reporting after the training.

- **Modelling correct behaviour in the workplace**

An understanding of the phenomenon of workplace violence will lead to greater understanding, which will allow for a problem-solving approach as well as a model of behaviour that discourages workplace violence.

- **Training a critical mass of participants**

Training for a critical mass within the hospital was proposed, as this would reach greater numbers of employees and have a far wider reach in terms of the outcomes.

- **Training of the broader community**

Participants felt that the broader community needs training in awareness of the phenomenon of workplace violence and the factors underpinning it, as this could influence or change their behaviour.

- **Training of managers**

There was a strong belief that, unless managers are trained, the workplace violence programme would not achieve the necessary traction.

- **Train the trainer**

Some participants felt that they had been equipped to go out and deliver training themselves. They were also confident that they could do something about the phenomenon.

- **Multi-media format**

There was a proposal that the training could be improved by presenting it in a multi-media format and including videos or a play.

- **Racial harassment**

The theme of racial harassment was raised during the qualitative interviews.

6.6.8 Conclusions

All the conclusions emerged directly from the summary of interview findings and the themes which presented in this phase. The training created awareness among the participants both of others' behaviour and, to a lesser extent, their own behaviour as contributing to workplace violence.

- The training created increased levels of awareness of the phenomenon of workplace violence.
- Participants felt empowered by the workplace violence training programme and were confident enough to deal with incidents, report incidents and provide training or information to their colleagues.
- The role of managers is critical to driving a programme of this nature, as managers need to be seen as supporting the programme. Training for managers is thus essential.
- Training for a critical mass of employees is essential to create awareness. Training for the broader community is also recommended for effective behavioural change.
- The Employee Wellness Programme could play an effective role in the management of violence in the workplace and could implement relevant services.
- Anderson (2002:363) recommends that "from a tertiary level of prevention, an effective strategy for managing the recurrent risk of violence must include training. Staff often underestimate, or overestimate, the degree of risk they face; training enables them to identify the actual and potential risks of their workplace."

6.6.9. Recommendations

Recommendations based on the conclusions derived from the qualitative interviews are presented in this section.

- Future training programmes on workplace violence may consider a different structure, for example, one session per week, as this may create more awareness of own behaviour and that of others as contributing to the phenomenon. Time between training days allows for information to be embedded and participants to discuss issues. Behaviour may be influenced in this way.

- More senior managers should be encouraged to attend the training on workplace violence. Their responses to the issues of workplace violence may shed more light on the phenomenon. Replication of this study should be aimed at including senior managers in the research sample.

- Training should also be aimed at greater numbers to achieve the outcomes of the training. Employee wellness programmes should actively include workplace violence programmes and interventions as part of the programme design, with all the EAP core technologies taken into account.

6.7 Comparison between the Quantitative and Qualitative Empirical Results

As a mixed method approach was used, both quantitative and qualitative research approaches were followed in this study, of which the quantitative approach was the more dominant. Distinct common themes emerged from both the quantitative and the qualitative phases. The management of the Violence in the Workplace training programme was considered to have created awareness of the phenomenon of workplace violence, in key areas, such as:

- Policy can be a driver of reporting procedures;

- There is a significant cost associated with workplace violence;

- There are a number of identified role-players who are responsible for managing workplace violence;

- Factors contributing to workplace violence.

- The Management of Violence in the Workplace training programme was also key in shifting certain beliefs and attitudes, but was less successful in shifting attitudes related to the role of participants and others in contributing to workplace violence.

- The quantitative phase and the qualitative phase of the empirical study also highlighted the potential role that the Employee Wellness Programme could play in the mitigation of workplace violence.

- The important role of reporting workplace violence incidents emerged from both phases of the study, as well as the role that the training programme played in promoting reporting as a key component of a multi-faceted strategy for workplace violence.

- Personal empowerment emerged as a strong theme in the qualitative phase, but this appears to contradict the quantitative phase, where participants did not feel that they had sufficient authority to combat workplace violence.

- Lastly, a theme which emerged repeatedly in the qualitative phase was the importance of managerial involvement, buy-in and participation in the workplace violence programme.

6.8. Evaluation of the Goals and Objectives of the Study

6.8.1. Summary

The goal of this study was to evaluate the effectiveness of the Management of Violence in the Workplace Programme at the Dr Yusuf Dadoo Hospital.

The following objectives were formulated to achieve this goal:

1. To describe the management of violence in the workplace from a theoretical perspective.

2. To explore and describe the phenomenon of workplace violence in the public healthcare sector from a theoretical perspective.

3. To explore the role of EAPs in the management of violence in the workplace.

4. To explore the phenomenon of workplace violence in the Dr Yusuf Dadoo Hospital.

5. To identify indicators of a successful programme for the management of violence. These indicators would be levels of knowledge, attitude and skills for dealing with workplace violence.

6. To evaluate the impact of the Management of Violence in the Workplace Programme on the Dr Yusuf Dadoo Hospital by measuring the identified indicators.

7. To make recommendations for best practice in the public healthcare sector regarding the management of violence in the workplace.

8. To develop and describe a guideline for the EAP in the management of violence in the workplace in general and especially for the health sector in South Africa.

It is concluded that all the steps as outlined by the objectives of the study have been met.

6.8.2 Conclusions

The conclusion is that the goal was achieved, with a focus on the different objectives designed for this study. The objectives as achieved are outlined below:

- **Objective 1: To describe the management of violence in the workplace from a theoretical perspective.**

  This objective was achieved by completing a searching literature study on the phenomenon of workplace violence. Workplace violence is largely an unknown phenomenon in South Africa, but a plethora of international literature was consulted in this context. Chapters 1, 2 and 3 have provided the relevant references. With consultation with the experts on workplace violence in South Africa and with readings from current conferences on workplace violence, this objective was achieved.

- **Objective 2: To explore and describe the phenomenon of workplace violence in the public healthcare sector from a theoretical perspective.**

  One of the sectors in which workplace violence has been studied extensively is the healthcare sector. The relevant literature has been consulted and presented in Chapters 1, 2 and 3. The factors that contribute to the health sector being vulnerable to workplace violence are expounded on extensively in Chapter 2. The consequences and costs associated with workplace violence are also examined from the perspective of the literature survey.

- **Objective 3: To explore the role of the EAP in the management of violence in the workplace.**

  The current role of the EAP in managing workplace violence is explored extensively in Chapter 3. In addition, the EAP core technologies are presented as a benchmark against which EAP involvement in managing workplace violence can be measured. The potential for greater involvement of the EAP or the Employee Wellness Programme emerges from the empirical findings of both phases of this study. Recommendations for increased responsibility for the EAP are thus proposed.

- **Objective 4: To explore the phenomenon of workplace violence in the Dr Yusuf Dadoo Hospital.**

  This objective was met by analysing the data that emerged from the empirical phase of the study. Conclusions on the phenomenon of workplace violence were drawn from the survey conducted. The data was collected by means of a questionnaire. This allowed for insight into the prevalence and the factors associated with workplace violence to be examined. The researcher was thus able to expand the knowledge base, given the findings of the survey. The survey findings are presented in Chapter 5.

- **Objective 5: To identify indicators of a successful programme for the management of violence. These indicators would be levels of knowledge, attitude and skills for dealing with workplace violence.**

The indicators of a successful programme for managing workplace violence were adopted from the WHO, ILO, PSI and ICN designed framework guidelines for managing workplace violence. These guidelines underpinned the Management of Violence in the Workplace training programme (VETO). This programme was customised by Dr Susan Steinman for local South African conditions and was the training programme used for this study. The programme is intended to address knowledge, attitude and skills.

- **Objective 6: To evaluate the impact of the Management of Violence in the Workplace Programme on Dr Yusuf Dadoo Hospital, by measuring the identified indicators.**

  The impact of the Management of Violence in the Workplace Programme was measured by completing a quantitative pre-test post-test analysis and also by completing qualitative interviews two months after the pre-test post-test. The training programme was introduced as the intervention between the pre-test and the post-test. Indicators underpinning knowledge, attitude and skill were tested pre-test and post-test. Cross-tabulations between various indicators were also carried out and analysed.

  The qualitative phase provided data rich in theme and content. All the findings of these two phases are presented in Chapter 5. The sixth objective has thus been achieved.

- **Objective 7: To make recommendations for best practice within the public healthcare sector regarding the management of violence in the workplace.**

  Chapters 5 and 6 focus exclusively on formulating and presenting recommendations on research and best practice in terms of managing workplace violence. Much attention is given to a comprehensive, multidimensional approach, with training as a significant approach. Possible customisation of the current workplace violence training programme is also proposed. These recommendations emanate from a strong finding that the current workplace violence programme being evaluated impacted strongly on knowledge development, somewhat on attitude and belief, and less on skill.

- **Objective 8: To develop and describe a guideline for EAPs for the management of violence in the workplace in general, and especially for the health sector in South Africa.**

  The potential role of the EAP is discussed in Chapter 3, as benchmarked against the EAP core technologies, and also in Chapter 4, where the empirical findings are analysed and discussed.

  EAP guidelines could thus focus on the following:

  - Playing a role in early intervention efforts, with promotion of the EAP as a support system in managing incidents of workplace violence, disseminating information and creating awareness of workplace violence, ensuring early involvement in organisational change, which may spark incidents of workplace violence and providing training to supervisors and managers on workplace violence.

  - Participation in an incident response team by assisting with resolution of conflict cases, as well as consulting in a response team with the manager or supervisor and advising on the workplace violence incident.

  - Follow-up to a violent incident and prompt individual interventions for employees who have experienced workplace violent incidents, EAPs are best positioned to offer critical incident stress debriefing services.

  - Acting as consultants to management where the EAPs are also best positioned to offer management information on traumatic events and can help them analyse the situation and develop strategies for the organisation to recover.

  - There are also guidelines saying that EAPs should not be involved.in taking the incident report and EAP generally should not be the first intervener.

  One could thus conclude that all the objectives of the study have been met and recommendations based on the conclusions have been formulated and presented.

6.9. Evaluation of the Research Problem and the Hypothesis

6.9.1. Summary

The research problem for this study was the following:

- The fact that the lack of evaluative knowledge on the Management of Violence in the Workplace Programme results in uncertainty about the effectiveness of interventions such as training and counselling to address the phenomenon of workplace violence, which in turn may result in a negative impact on work performance and productivity.

The hypothesis chosen for the study was the following:

- If the Management of Violence in the Workplace Programme is effectively implemented in the Dr Yusuf Dadoo Hospital, employees of the mentioned institution will be empowered through an increased level of knowledge about violence in the workplace and enhanced skills in the management of workplace violence, with a positive attitude about their own ability regarding the management of workplace violence.

6.9.2. Conclusion

Both the research problem and the hypothesis emanating from this research problem have been dealt with in this empirical study in both the quantitative phase and the qualitative phase, as the analysis and discussion have clearly revealed. We can thus conclude that the study has meaningfully addressed the research question and tested the hypothesis as formulated.

6.10 Recommendations for Future Research

- That more research studies be undertaken on workplace violence in South Africa. A macro-level country study would provide insight into different industries and the prevalence of workplace violence therein.

- That this study is replicated in a tertiary training hospital in the public healthcare sector and the findings compared with those from this study, which was conducted in a district hospital.

- That a bigger Sample be used in the replication of this study, as it would then be possible to generalise.

- That the impact of training on workplace violence also be assessed, where it is positioned as but one of the interventions in a comprehensive, multi-dimensional strategy for addressing workplace violence. A study by Wassell (2009:1052), which examined workplace violence intervention effectiveness, included the aspect of training and concluded that this is useful for increasing awareness and staff confidence in dealing with aggressive patients. However, these studies did not necessarily address the issue of a decrease in workplace violence injury to staff.

6.11 Conclusion to Chapter

This research study will contribute meaningfully to the empirical knowledge on workplace violence. In particular, it will contribute to the knowledge of workplace violence in the South African context. Most importantly, it will contribute to knowledge of the impact of workplace violence programmes, specifically training programmes, and their ability to influence knowledge, attitudes and skills. It is hoped that these insights will prove of interest and will demystify a hitherto unknown phenomenon.

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