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Gender, sexual harassment, workplace violence, and risk assessment: Convergence around psychiatric staff's perceptions of personal safety

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Abstract

This paper reviews literature in sexual harassment, workplace violence, and risk assessment as it relates to staff in psychiatric and forensic work environments. These three areas of research overlap in their applicability to psychiatric staff in that each addresses the understanding and management of types of violence to which many staff, particularly women, are likely to be exposed while working. Employee well-being, encompassing mental and physical health, job satisfaction, and morale, has been shown to be closely tied to organizational productivity and cost. In addition, gender has been shown to be an important factor in perceptions and decision-making, and prior work has suggested that female staff often have qualitatively different experiences in traditional male workplaces such as inpatient and forensic settings. Despite these findings, research to date on psychiatric staff has typically focused only on number of assaults by patients. It has not addressed how staff's gender may impact their perceptions of personal safety and judgments of risk from patients, nor have any empirical studies been performed in naturalistic settings to investigate this issue. Given the high correlation between organizational productivity and employee well-being, it is mutually beneficial to both employers and staff to examine current understanding of how certain staff variables such as gender may influence their feelings of safety and judgments of risk from patients.

Keywords: Workplace violence; Risk assessment; Gender; Sexual harassment; Safety

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1. Introduction

Workplace violence, sexual harassment, and risk assessment are currently three large and active areas of research in the law and psychology fields. Each of these areas addresses the understanding and management of violence in a particular context. Workplace violence typically encompasses attacks or attempted attacks that are precipitated by an employment organization's actions (as opposed to simply being directed at the organization) and that involve current or past employees (Neuman & Baron, 1998). Sexual harassment, defined in 1980 by the U.S. Equal Employment Opportunity Commission (EEOC) as either *quid pro quo* harassment (eliciting sexual cooperation using threats of job consequences) or as a *hostile environment* (sexually related physical or verbal actions that are offensive and unsolicited), is typically conceptualized as a type of sexual violence consisting of unwanted sexualized actions of employees toward their peers or subordinates. Risk assessment refers to attempts by clinicians to predict future violence, recidivism, treatment amenability, and appropriate disposition in the context of civil commitment or criminal offenders. These three areas of research overlap in their applicability to staff in forensic settings, yet little empirical work has recognized this connection. Consequently, employers and employees alike are potentially missing out on valuable information generated by researchers and policy-makers as to enhanced perceptions of safety, job satisfaction, and worker health.

A large number of staff work in forensic mental health settings and they face an inherent risk of personal safety from patients and offenders on a daily basis. Arguably, their positions place them at risk for violence from patients and require them to engage in ongoing risk assessments on a daily basis. Female staff in particular are at added risk for sexual harassment from both patients and peers. Because of the risk of either intentional assault/threat on staff or unintentional injury due to a patient or offender's violent outburst, forensic settings should be considered in studies of workplace violence. Because of the disproportionately high concentration of antisocial, sex offending, and psychopathic individuals in such environments, unwelcome sexualized attention is a frequent possibility and may elicit the same negative psychological and physical reactions in staff that the sexual harassment literature has identified in other work settings. Finally, because the risk for patient or offender violence is present daily, staff must engage in constant appraisals of their own safety — a type of risk assessment that differs from traditional definitions — but a risk assessment nonetheless. However, staff perceptions of risk to themselves from patients and offenders has yet to be considered in the workplace violence, sexual harassment, or risk assessment literature. In particular, the question of whether staff gender influences their perceptions of personal risk is worth considering, given the obvious physical size differential often present between men and women and the increased likelihood of women encountering sexualized communications and/or negative reactions in male-dominated settings.

This article reviews some key areas of research regarding staff safety, workplace violence, sexual harassment, and risk assessment as they apply to psychiatric and forensic settings, as well as the work done to date on how clinician gender impacts their decision-making. The aim of the paper is to call attention to the similarities between psychiatric and forensic staff's experiences and the issues addressed in studies of workplace violence, risk assessment, and sexual harassment in hopes of encouraging future research to elucidate workers' perceptions

regarding their own safety and whether it is influenced by gender. Added clarity on this issue could invoke empirically driven policy improvements that would benefit employers and their staff.

2. Are female staff actually at higher risk?

A basic question in risk assessment is whether the risk is perceived or actual. With regard to female staff in settings with potentially unstable psychiatric patients or mentally disordered offenders, it is important to determine whether or not they are actually at increased risk for assaults and threats from patients. Many studies have attempted to address this issue, both in terms of direct threats and assaults toward female staff as well as their increased vulnerability due to pregnancy.

2.1. Assault frequency: are women at higher risk?

Several studies have examined whether female staff in health care settings are actually at greater risk for patient violence than men. Intuition would suggest that they are, based on smaller physical size and strength, and on vulnerability to harassment and what is often minority status within the workplace. Some studies suggest that women are at higher risk (Binder, 1991; Ednie, 1996; Lanza, 1992; Wykes & Whittington, 1998). However, other results provide a different story: in general, a review of available articles on the topic suggests that women are in fact at lower risk than men. For example, Levy and Hartocollis (1976) compared incidents of violence against nurses over a 1-year period on two psychiatric units, one with a traditional staff configuration of both male and female nurses and technicians, and one with an all-female nursing and technician staff. The patient population consisted of both male and female patients who had an average hospital stay of 6 months and presented a variety of diagnoses. After one year, the number of violent incidents on the experimental all-female unit was zero, while the traditionally staffed unit had experienced 13 instances of assault conducted by five patients. The investigators hypothesized that patients who were agitated and prone to assault might find female nurses and staff to be less provoking than male staff, who project a masculine authority that may work to escalate aggression and conflict. Female staff might also use nonaggressive strategies to de-escalate tension and aggression rather than the traditionally male, "police-like" techniques that could generate a power struggle instead of diffuse anger.

Bernstein (1981) surveyed 422 licensed psychologists and psychiatrists as to frequency of their encounters with assaultive and threatening patients. Consistent with Levy and Hartocollis' (1976) findings, male therapists seemed to be at higher risk of assaults and threats from patients: of the 187 reported instances of violence or threats, 77.2% were against male therapists while 22.8% were against women. Interestingly, the issue of fear appeared to loom large for both male and female clinicians. Despite only 14.2% of the overall sample reporting they actually had been a victim, 60% of the sample reported fearing that it would happen. Thus, fear of patient assault was disproportionately higher than the true number of assaults. Paradoxically, respondents described the assaults as being frightening but when

asked to rate the degree to which the assault impacted them afterward, clinicians for the most part denied any impact (i.e., did not seek treatment for themselves or the patient). For example, Bernstein describes one respondent who had been attacked by a patient bearing a knife. Afterward the clinician committed the patient and purchased a gun. When asked how the incident had affected him personally, however, he indicated that it had had "no effect." This phenomenon suggests a denial of the impact that patient attack can have on one's psychological functioning. One reason for denial may be that mental health care providers overestimate their ability to (a) remain objective toward their patients in the face of personally disturbing incidences, and (b) deal with their assault at a cognitive rather than emotional level.

In a study of attacks against psychiatrists, Carmel and Hunter (1991) examined patient assaults in a forensic hospital over a 5-year period. They found that six of the seven injured psychiatrists were male, consisting of 14.3% of the male psychiatrist population at the hospital. Only 8.3% of the female psychiatrist population was injured by patient attack. Male psychiatrists were therefore nearly 50% more likely to be assaulted by patients. Rather than gender, age and experience appeared to place one at higher risk: younger clinicians who had less experience were at significantly greater risk for patient assault than older, more experienced psychiatrists. Similar findings were reported by Arnetz, Arnetz, and Petterson (1996), who investigated incidents of violence toward nurses. Nurses in Sweden were surveyed about their health and work environments, including whether they had been threatened or attacked at their workplace. A substantial number of nurses had experienced violence (29%), been threatened (35%), had seen at least one violent act (30%), and considered violence to be a problem in their workplace (27%). Overall, more male nurses than female nurses had been victims of patient violence (44% vs. 26%), and the victims of threats from patients (49% vs. 32%). Like Carmel and Hunter, Arnetz et al. found that younger and less experienced nurses were at higher risk for suffering assaults from patients. This particular finding is relevant to many psychiatric and forensic hospital settings that employ technicians to manage daily ward functioning along with nurses. Due to the nature of their position, the technician staff may be more likely to be younger as a whole and turn over at a greater rate than the "professional" staff such as nurses and clinicians. Consequently, findings such as these may be especially relevant for employers of inpatient psychiatric settings who are seeking to minimize staff injury by comprehensive training and understanding of patient–staff dynamics.

Binder and McNiel (1994) further assessed the issue of patient assault on psychiatric inpatient staff. They noted that the distribution of gender often coincides with mental health discipline (e.g., nurses are typically female, psychiatrists are often male, etc.), and therefore any study of interactions between staff and patient gender must also include professional discipline as a variable. The popular notion that female staff get assaulted more often than males might be in fact due to more women being nurses and nurses having the highest degree of exposure to patients, rather than to their gender. Instances of assault and characteristics of staff were thus analyzed for all medical and nursing staff who worked on an inpatient unit over the course of 2.5 years. The bulk of the assaults was directed at physicians and nurses (rather than psychologists, social workers, or other staff) so analyses focused on these two groups. Results showed that women were more often targets of patient assaults than men

(65% vs. 35%). However, the majority of the staff was female, and once professional discipline was accounted for, gender was no longer significantly associated with risk of assault. Instead, nurses were at significantly greater risk than were physicians. The authors proposed that inconsistent findings in other studies of who is at the highest risk of attack by patients may in part have been due to having assessed staff gender alone rather than in conjunction with professional discipline.

In conclusion, the answer to the question of whether women are targeted more frequently for assault than men seems to be no, but with one caveat: studies focused primarily on physical attack and tended to exclude the veiled threats and intimidation, particularly of a sexual nature, that women may be exposed to and that are likely to have a higher base rate than actual assaults. In addition, no study has examined threats versus actual assaults by patients on staff. Inclusion of threats and intimidation in future studies may therefore paint a different picture of the risks women face at work.

2.2. Pregnancy

Female staff safety in mental health settings has also been thought to be threatened by pregnancy and its impact on one's professional role. The work in this area is largely qualitative, has focused only on clinicians (psychologists and psychiatrists), and much of it appears to have been published several decades ago (Benedek, 1973; Berman, 1975; Lax, 1969; Nadelson, Notman, Arons, & Feldman, 1974; Paluszny & Poznanski, 1971). More recently, Binder (1991) reviewed this literature and concluded that pregnancy remains a significant issue for female clinicians. Pregnancy may place a woman in an emotionally and physically vulnerable position, in that it is a public reminder of one's sexuality, personal life, and multiple roles (mother, wife, and professional). Because of this, transference issues for patients can emerge more readily than they might at other times or with male nurses and clinicians. The literature repeatedly reports instances of patients experiencing envy, abandonment, rejection, maternal transference, and aggression toward the therapist, including fantasies of hurting or killing both the therapist and the infant (Binder, 1991).

Pregnant staff are at risk for overworking themselves or placing themselves in undesirable situations because they want to avoid what may be interpreted as an admission of weakness (Nadelson et al., 1974). By feeling forced to ask colleagues for flexibility with workload, hours, activity, availability, and types of clients (particularly in forensic or emergency room settings where the risk of physical and sexual violence is greater), women, especially young professionals attempting to establish their careers and credibility, may experience considerable stress. Overall the literature in this area points to pregnancy as a significant risk factor for women, particularly in violence-prone environments such as acute-care wards, emergency rooms, and forensic settings. Binder (1991) makes several recommendations to inoculate against attacks on female staff, including a call for more research on the nature of such assaults (e.g., psychological effects, risk factors, and incidence) to ensure that research and knowledge keeps pace with the changing demographics of current workplaces as compared to those in the 1960s and 1970s.

The consensus appears to be that women in mental health care settings are not at increased risk for patient assault. However, the question of perception of danger is qualitatively dif-

ferent from actual danger, and this notion has not been addressed by these studies. As some have found (Smith & Torstensson, 1997), actual risk of danger does not necessarily correspond directly to level of perceived risk. This discovery would explain the inconsistency between empirical studies finding that female nurses (Arnetz et al., 1996; Levy & Hartocollis, 1976; McNiel & Binder, 1995) and female clinicians (Bernstein, 1981; Carmel & Hunter, 1991) are at lower risk of patient assault than male nurses and clinicians, and descriptive reports of female staff's subjective feelings of emotional and physical vulnerability and experiences of patient assault (Binder, 1991; Nadelson et al., 1974). One question remaining, therefore, is whether women perceive danger to themselves differently than men do.

3. Sexual harassment

The question of whether men and women differ in their perceptions of certain social behaviors has been one of the central issues addressed in the sexual harassment literature (Fitzgerald & Ormerod, 1991). For example, Baker, Terpstra and Larntz (1990) presented a series of vignettes to students enrolled in a management course at a university and asked them to indicate whether they viewed the scenarios to be sexually harassing and what action they would take were they in that situation. The results showed that in 6 out of the original 18 scenarios, a disproportionately higher percentage of women indicated that they would react to the perceived harassment by reporting the incident, physically or verbally react to the incident, or leave the field. The authors concluded that harassment in the form of physical fondling, catcalls, propositioning of job enhancement, sexual propositioning without strings attached, or rape would elicit a more active response from women than it would from men.

In a similar study, Fitzgerald and Ormerod (1991) presented faculty and graduate student participants with a set of vignettes describing several different types of sexual harassment (e.g., seductive behavior, gender harassment, sexual coercion, and sexual assault) and asked them to rate each scenario on a Likert scale from *definitely is not sexual harassment* to *definitely is sexual harassment*. The investigators found that compared to men, women tended to rate all scenarios as more sexually harassing; the effect was particularly strong for the more ambiguous situations or those involving sexual activity without any coercion.

Although the majority of studies have found that women are more likely to view certain behaviors as harassing (e.g., Baker et al., 1990; Collins & Blodgett, 1981; Fitzgerald & Ormerod, 1991; Gutek, 1985; Kenig & Ryan, 1986; Padgitt & Padgitt, 1986), more recent studies have claimed that the differences in perception are attributable to other constructs. Terpstra and Baker (1987) found that the perceptual differences on 18 vignettes depicting varying levels of social–sexual behavior were between the working participants and student participants, not between the male and female participants.

Similarly, Baker, Terpstra, and Cutler (1989) expanded upon their 1987 data to test the hypothesis that the perceptual differences found originally were due to participants' personal and organizational backgrounds and to the types of scenarios presented, rather than to their gender. Their results showed that, overall, workers were more likely to perceive scenarios as sexually harassing compared to students. Male and female workers and male and female students did not differ significantly in their rankings of how severe the harassment in each

scenario was, nor did they differ in whether or not they considered the scenario to be sexual harassment. Baker et al. speculated that the perceptual differences identified were due to different values held by workers as compared to students. Maturity, employee policies on social–sexual behavior, and degree of experience with the opposite sex are areas in which workers would differ from students, leading to increased sensitivity to unwanted or inappropriate social–sexual behavior from others.

Other studies have also challenged the alleged gender difference in perceptions of harassing behavior. Blakely, Blakely, and Moorman (1995) found that after taking into account whether an individual had previously been sexually harassed, the gender difference in perception of what constituted harassment disappeared. In other words, history of harassment rather than gender was related to an increase in sensitivity to social–sexual situations. Gender differences in perception were also addressed recently by Wiener and Hurt (2000) in a study on workers' ability to understand and apply the "reasonable woman" versus "reasonable person" standards in cases of alleged sexual harassment. The investigators hypothesized that people tend to use themselves as barometers for evaluating the appropriateness of ambiguous social sexual conduct (e.g., situations in which sexual misconduct was debatable). That is, in situations where there is clearly either (a) no sexual misconduct, or (b) definite sexual misconduct, people are able to apply an objective standard for whether the harassment occurred because they can easily observe whether or not it occurred. In more ambiguous situations, however, observers tend to put themselves in the victim's shoes and evaluate based on their own internal standards, which in turn are based on the observers' gender. The authors' hypothesis was supported by results showing that in ambiguous situations, subjects used their own internal threshold to determine whether the sexual conduct was offensive or not. Most interestingly, it was the gender differences in these subjective internal standards (assessed by a sex role identification measure) rather than participant gender itself that produced gender effects in perceptions of sexual harassment. In general, therefore, research to date has shown that whether men and women perceive social–sexual behavior in the workplace differently depends on more than biological sex. Variables such as past history of harassment, gender role identity, and degree of situational ambiguity all impact whether a scenario is interpreted as harassing.

Although sexual harassment typically refers to behavior initiated by a colleague or supervisor in the workplace or academic setting, staff who work with antisocial or psychiatric populations are at increased risk for sexualized communications from their patients. History of assault/harassment and situational ambiguity, both implicated in influencing how one perceives social–sexual situations, are very relevant in psychiatric or correctional workplaces. In addition, certain attributes of these workplaces can potentially highlight issues of self-esteem, credibility, and professional identity for female staff that, combined with the threat of sexual harassment from patients, might create a qualitatively different work experience compared to that of men in similar positions. For example, because forensic facilities are traditionally male-dominated workplaces, group dynamics may negatively impact women. Moss-Kanter (1977) describes one of these dynamics, the "skewed group," in which there are only a few members, or "tokens," of the minority group. These tokens have a very different experience than the majority group in the workplace because they are viewed in terms of stereotypes and are put in uncomfortable positions of either requesting the

dominant group to change when it is behaving offensively or else feeling that one is not free to voice opinions (Lenhart, 1993). A token woman may be viewed as an "iron maiden" or a "femi-nazi," more tough and militant than she actually is, simply for insisting on equitable treatment. She may also be seen as "too sensitive" if she requests changes in the majority group's behavior.

Ednie (1996) also discusses ways in which women in the forensic psychiatry field may receive subtle messages that they are not as competent or as valued as their male counterparts. According to Ednie, female clinicians often experience decreased empowerment due to their communication style, interaction style, and style of confronting possible danger. In terms of communication style, women are perceived as delivering information in a less powerful way than men do, particularly in settings such as courtrooms where credibility is carefully evaluated at all times. This difference in delivery style stems not from a lack of knowledge or preparedness on women's part, but from an often less direct and less confrontational way of communicating (Tannen, 1994). With regard to interaction style, research on interactions between physicians and patients has revealed that in a number of ways, female physicians are accorded less respect than male physicians. Patients have been found to call women doctors more frequently by their first names and to interrupt them more often when compared to male doctors (West, 1984), and female clinicians have been described as feeling vulnerable to attack from male patients due to the physical size and strength differential (Binder, 1991). Ednie (1996) reasons that if women clinicians are viewed by colleagues as less credible and less authoritative, they will also be more vulnerable to intimidation and sexual harassment by these colleagues. This is likely true for intimidation and harassment from patients as well.

Women are also thought to be at a disadvantage compared to men when confronting possible danger in forensic facilities. Ednie (1996) notes that in forensic settings violence and victimization are common themes that pervade the workplace mentality because patients' criminal histories play such a salient role in the daily functions of staff and patients. In addition to the difference in size and physical strength, male patients and inmates may intimidate female clinicians based on their confrontational communication style and imply that physically or sexually based violence is possible. Binder (1991) described information that had been relayed by female clinicians to the American Psychiatric Association Task Force on Clinician Safety, which had been gathering data on assaults suffered by clinicians. She pointed out that female clinicians may be blatantly sexually assaulted by male patients while at work, experience threats of sexual assault (e.g., being threatened with rape unless she signs discharge papers), or be the object of rape fantasies or maternal transference which may also lead to assault.

Overall, it appears that aspects of the forensic work environment can pose substantial psychological and physical threat and intimidation toward female health care workers, which then likely impacts their attributions regarding patient dangerousness, level of perceived threat, and personal safety. The evidence suggests, therefore, that women's experiences in medical and psychiatric workplaces are qualitatively different than men's and that concerns of vulnerability and safety are heightened for many female staff.

Several important reasons exist for addressing these concerns related to job satisfaction and possible gender-based differences in experiences. First, numerous studies have shown that

sexual harassment negatively impacts psychological and physical health via low self-esteem, anger, self-doubt, demoralization, anxiety, depression, damaged interpersonal relationships at work, and disrupted job performance (e.g., Fitzgerald, 1993; Gutek, 1985; Lanza, 1992; Lenhart, 1993; Stewart & Robinson, 1995). Second, such negative consequences are critical to job satisfaction, which has been shown to be inversely related to absenteeism (Scott & Taylor, 1985) and positively related to prosocial behavior in the context of work (Organ & Konovsky, 1989). Others have found that job satisfaction is associated with higher reported levels of satisfaction with life in general (Liou, Sylvia, & Brunk, 1990). Third, the degree to which an organization is seen to be committed to workers has been shown to positively impact employee morale, involvement, loyalty, and job performance (as reviewed in Morrow, McElroy, & Phillips, 1994). It is clear that to minimize costs associated with poor morale, turnover, absenteeism, and loss of productivity, an organization must invest in their employees' physical and psychological health. One way of achieving this goal is to attend to issues of perceived worker safety and risk from sexual harassment.

4. Workplace violence

Studies examining patient dangerousness and its effects on staff in inpatient settings typically do not refer to it as workplace violence. Instead, workplace violence is often thought to refer mainly to "random" attacks on workers either by strangers or by disgruntled coworkers, rather than to assaults and threats from mentally ill or incarcerated individuals who are disorganized, impulsive, angry, and/or attempting to intimidate staff. This difference in perspective is likely due to the orientations of the two literatures. Studies on staff assaults are often found in the nursing or risk assessment literatures pertaining to custodial care of patients and inmates, whereas workplace violence studies are found in literatures focusing on a broader scope of occupations and on staff-on-staff (or "coworker") assault. However, threats or assaults in a hospital or prison (i.e., the workplace) constitute a type of workplace violence that should be understood, such that risk to staff—part of an employers' responsibility to uphold the Occupational Safety and Health Administration standards—(OSHA; P.L. 101-552, Section 3101, 1990), is minimized.

4.1. Incidence

We now have a more detailed understanding of the epidemiology, as well as the impact of and perceptions regarding, workplace violence. The U.S. Department of Justice's Bureau of Justice Statistics (BJS) recently released a report on workplace violence occurring between 1992 and 1996 (BJS, 1998) that provided an overview of its impact on employees. According to BJS, the most common type of workplace crime was the simple assault, defined as "attack [or attempted attack] without a weapon resulting either in no injury, minor injury, or in underdetermined injury requiring less than two days of hospitalization" (BJS, 1998, p. 7). Approximately 1.5 million simple assaults are estimated to occur yearly, followed by 396,000 aggravated assaults ("attack or attempted attack with a weapon, regardless of whether or not an injury occurred and attack without a weapon when serious injury occurs," BJS, 1998, p. 7).

Victims of simple and aggravated assaults tended to be men (66% and 74%, respectively). Rapes and sexual assaults were estimated to have been committed on 51,000 individuals, 83% of whom were females. After law enforcement, taxi drivers, and convenience store workers, mental health employees (both professional and custodial) experience the most occurrences of nonfatal workplace violence; 79.5 out of 1000 mental health professionals and 63.3 out of 1000 custodial care staff were victims. BJS also reported that 82.9% of workplace violence offenders were male (58% of whom were Caucasian), compared to 14.1% female and 2.9% unknown. With regard to reporting, only 40% of all violence was reported to the police, with robbery and aggravated assault being the most likely to get reported (72.8% and 60.8%, respectively) and rape the least likely (25.3%). Males were more likely than females to report (47% vs. 38%). In summary, the BJS report revealed that Caucasian males are the typical workplace violence offender, and that the majority of their offenses, provided they did not rob or significantly injure their victims, would not often be reported to law enforcement. In addition, mental health facilities represent a substantial risk for workers in terms of violence risk, and women are at particular risk for sex-related victimization but are unlikely to report it officially.

Other epidemiological studies have confirmed that health care professionals' safety is threatened by patients. For example, Guy, Brown, and Polestra (1990) surveyed 340 psychologists and found that 39.9% reported having been assaulted by a client at least one time, and 57% of 554 nurses surveyed by Ryan and Poster (1993) reported having been assaulted between one and nine times in their careers.

4.2. Cost

As in the sexual harassment literature, the workplace violence literature notes that regardless of who perpetrates the aggression and what the underlying motives are, the issue of cost to the organization remains of paramount concern. Cost is typically conceptualized in terms of the individual worker (physical/physiological and mental/emotional issues) and the organization (Barrett, Riggar, & Flowers, 1997; Hunter & Carmel, 1992). At the individual level, physical costs refer to consequences of workplace violence such as disrupted sleep, cardiopulmonary problems, fatigue, hypertension, and susceptibility to illness, while emotional costs encompass issues such as depression, loss of self-esteem, family conflict, cynicism, anger, and impaired coping. At the organizational level, costs are associated with decreased worker productivity and morale, lost work days, legal liability costs, employee turnover, and resources allocated to rehiring and retraining (Barrett et al., 1997).

4.3. Perceptions of safety

Although one study has addressed forensic staff's perceptions of safety and risk to themselves, it did not examine gender or perceptions of risk from patients. Shazer (1996) surveyed 85 employees (clinical, security, clerical/administrative, and other staff) of a forensic evaluation center with regard to workplace violence (staff-on-staff) in the facility. Employees were asked to estimate numerically the number of times staff at the facility had been assaulted or threatened by coworkers within a recent time period. Employees were also

asked to rate how safe they felt at work (ranging from *very safe* to *not safe*), and to indicate whether they themselves had experienced an assault or threat from a coworker at work. The survey results showed that a significant portion of workers (about one in four) would have been threatened during the time period in question, but in general employees still felt "very safe." Interestingly, workers were considerably more accurate in their estimates of the number of assaults suffered by other workers, suggesting that the level of awareness regarding threats (compared to assaults) is considerably lower and less accurate.

4.4. Workplace violence and its impact on the victim

As with sexual harassment, patient assault on staff of both genders has been found to have negative psychological effects. For example, Wykes and Whittington (1998) found that of the psychiatric intensive care unit nurses who had reported being recently assaulted, 25% reported feeling jumpier, overly alert, and bothered by recurrent thoughts about the incident. One third of the assaulted nurses also indicated that they experienced significant psychological distress and anger following the incident. The authors speculated on the extent to which underreporting was an issue in this study, and suggested that nurses may be reluctant to express strong negative emotions and reactions to encounters with patients due to their self-image as caregivers.

Lanza (1992) also noted that nurses underreport rates of assault for several reasons, one of which is a fear of blame (Lion, Snyder, & Merrill, 1981). Assault victims see themselves as weak and having been "singled out" in some way and often continue to fear the patient after the assault. Psychologically, it can be very difficult to carry out one's care-taking responsibilities within minutes or hours of a threat or assault (Wykes & Whittington, 1998). Lanza and Carifio (1991) found that female staff victims received more blame than male staff victims in the study's extreme assault conditions. Feelings of vulnerability were also noted by Poster and Ryan (1989), who found a positive significant relationship between prior assault and the belief that one should expect to be assaulted: 85% of assaulted staff endorsed this belief, compared to only 50% of unassaulted staff. Thus, personal experience in the workplace appears to play a primary role in determining feelings of vulnerability (Poster & Ryan, 1994). This finding is highlighted by research on assault victims reporting that after assault, one's sense of personal invulnerability is significantly damaged and fear of reoccurrence is high (Janoff-Bulman and Frieze, 1983, as cited in Lanza, 1992). Overall, these studies suggest that under-reporting, fear of blame, prior assault history, and feelings of vulnerability are important issues for psychiatric staff at risk for patient violence.

4.5. Workplace violence and patient gender

Although it has not been called workplace violence, there is a considerable body of research that has addressed patient assaults toward staff in psychiatric settings. These studies have examined the issue of gender, but only in the context of the patient; staff gender and its impact on perceptions of the patient has generally been overlooked. Rather than questioning how a staff member's gender filters his or her perceptions of the patient's level of

dangerousness, the focus has been on the patient's gender and how it affects staff's perceptions of the patient. Several reviews have been written on the issue of patient gender (Davis, 1991; Garb, 1998; Haller & Deluty, 1988) and have concluded that existing studies have produced inconsistent results about whether patient gender influences clinical care. Intuition would suggest that male patients are more assaultive and fear-inducing than female patients and some have found this to be the case (Bornstein, 1985; Lewis, Croft-Jeffreys, & David, 1990; Rossi et al., 1986). Others have found no differences between men and women in rates of assaultive behavior (Craig, 1982; Miller, Zadolinnyj, & Hafner, 1993; Tardiff & Sweillam, 1982), or have found that women actually assault more (Fottrell, 1980). Still others have determined that "it depends": Binder and McNiel (1990) found that while men engaged in more attacks and fear-inducing behaviors while in the community, women engaged in more physical attacks in the hospital. They concluded that gender, setting, and violence were interrelated. Bettencourt and Kernahan (1997) performed a meta-analysis of studies in which men and women were exposed to violent cues. They found that men are more aggressive in situations involving violent cues and no provocation, whereas no gender differences exist in situations involving violent cues and the presence of provocation. Finally, some researchers have found that violence is overestimated for men and underestimated for women (Lidz, Mulvey, & Gardner, 1993; McNiel & Binder, 1995). For example, in the Lidz et al. (1993) study, 6 months after discharge from the psychiatric emergency room, female patients were more likely to have become violent compared to male patients (49% vs. 42%).

Several reasons for these inconsistent findings have been proposed. Haller and Deluty (1988) argue that first and foremost, the definition of assault has been inconsistent across studies. For example, targets (other patients, staff, self, or visitors), type of violence (physical attack, verbal threat, self-injury, and property damage), and setting (general inpatient, forensic inpatient, and emergency room) all vary dramatically among studies of patient violence. Partially in reference to this issue, Flannery, Hanson, and Penk (1995) examined a range of patient violence against staff, deliberately defining assault broadly as "unwanted physical contact, unwanted sexual acts, threats that included specific statements of intent to harm specific staff, and specific nonverbal, noninterpersonal acts meant to frighten specific staff" (Flannery et al., 1995, p. 451). They found that threats were as likely to cause psychological distress and disruption of service delivery in staff as were physical or sexual assaults, suggesting that the definition of assault in future studies should include threats.

One well-known study that acknowledged that both patient and staff gender were worth examining in relation to patient violence was conducted by Coontz, Lidz, and Mulvey (1994). The researchers investigated whether patient gender affected professionals' assessments of how dangerous patients were, and relatedly, whether it affected their decisions to commit them. Earlier work by Lidz et al. (1993) had suggested that in their study's inpatient setting, staff appeared to underestimate the likelihood of female patients becoming violent upon release, presumably because of gender stereotypes that portray women as less violent than men. Coontz et al. proposed that clinicians are more aware of possible violence in men and thus make concerted efforts to predict it, and that male patients may be less self-conscious than female patients about verbalizing their violent acts. A sample of 417 patients

was interviewed upon entry to the emergency room, and 62 of those patients had committed a violent act within the past 3 days. Focusing only on the subsample of patients who had recently been violent, the authors hypothesized that clinicians (defined as "nurse clinicians" or psychiatrists) would broach the topic of violence earlier and more often with male patients than female patients in psychiatric emergency room interviews. Initial analysis of the 417 interviews showed that violence was discussed in significantly fewer cases with female patients compared to male patients (14.8% vs. 22.4%, respectively). Follow-up analyses on the subsample of recently violent patients supported the predictions: interviews with male patients contained nearly double the number of references to violence as did interviews with female patients, and these references tended to be initiated by the clinician rather than the patient. The investigators also explored whether the clinician's own gender affected judgments of how much to discuss violence with the patient. Findings showed that a female clinician was just as likely as a male clinician to broach and discuss the topic of violence to a patient.

Coontz et al. (1994) argued that the study's key finding was that patient gender has a significant effect on the interactions between clinical staff and patients in terms of judgments about potential dangerousness. Rather than being a simple dichotomous variable, the authors believe that gender is a framework for organizing and processing information such as judgments of dangerousness. Gender norms shape what information should be pursued and discussed. Clinicians subscribe to the gender norm belief that men tend to be more violent than women, and thus pursue the topic more frequently and in greater depth with male patients. This study is particularly interesting in its effort to capture the gender influences on the interaction process between staff and patients. The study clearly demonstrated that patient gender impacts how therapeutic staff views his/her potential for dangerousness.

The Coontz et al. (1994) study also attempted to ask whether the staff member's gender was important in this process. While the findings suggested that male and female clinicians did not differ in the number of times they broached and pursued the topic of violence during interviews, other questions were left unanswered. First, the influence of staff variables, such as prior experience with patient violence and experience working in these settings, was not examined. Second, the generalizability of the current findings to other mental health workers is questionable. The pace of a psychiatric emergency room is undoubtedly fast and demanding, and staff in such work environments may represent a particularly selective group of individuals. Thus the violence-related schema of mental health nurses, technicians, and clinicians in forensic settings may differ from those in the Coontz et al. study. Third, while staff assessments of the patient's likelihood of violence toward others were examined, personal safety was not considered. The literature suggests, however, that personal experiences and attributions are intimately connected to one's objective judgments.

It is clear that while the term workplace violence has not been used, researchers have recognized the threat of violence toward staff in psychiatric settings as well as the need to understand it. Although exploration of victim factors and perceptions is a necessary component to fully understanding violence, it has been largely absent from prior research on patient violence.

5. Risk assessment

As with the sexual harassment and workplace violence fields, risk assessment is another area that should include staff's perceptions of risk to themselves from patients. The state of the current literature in the area of risk assessment has come some distance since 1981, when Monahan published his landmark monograph on the topic, concluding that a paltry one in three of clinicians' predictions of violence was accurate (Monahan, 1981). Since then a flurry of studies, often referred to as the "second generation" of risk assessment research, has been conducted in an effort to reevaluate the notion that clinicians' rates of accurately predicting patient or inmate dangerousness are worse than chance alone. Despite advances in knowledge attained by research activity, however, some researchers have noted that there remains a considerable gap in communication between those who conduct studies on risk assessment (researchers) and those who actually assess patients for risk (clinicians). Researchers criticize practitioners for not keeping up with the latest empirical findings (implying that their treatment of patients will suffer), while practitioners criticize researchers for losing sight of what is clinically meaningful and useful rather than statistically significant.

One way in which risk assessment research could be practically useful to those involved in direct patient contact is in the of training of staff. Currently, the perspective of risk assessment work has been focused on violence toward third parties. Much of the work has examined how clinicians and other evaluators (e.g., social workers, psychiatric nurses, etc.) assess patients for dangerousness to others, either within the facility or within the community after release (e.g., Cooper & Werner, 1990; McNiel & Binder, 1995; Segal, Watson, Goldfinger, & Averbuck, 1988; Slovic & Monahan, 1995; Werner & Meloy, 1992; Werner, Rose, & Yesavage, 1983, 1990). Several recent reviews of this topic have also been conducted (Borum, 1996; Douglas & Webster, 1999; Mossman, 1994; Otto, 1992). Omitted from the research question, however, has been the staff members' perceptions of potential danger to themselves. As with any employment that involves the possibility for volatile clientele, appropriate training for work in psychiatric or correctional facilities that includes recognition of escalation and danger cues is a necessity. As important as clinicians' custodial responsibilities are in terms of seeking to avoid inappropriate release of a patient into the community or inadequate supervision while hospitalized, employers' responsibilities to cultivate a safe work environment by understanding staff perceptions of danger is equally important.

Many studies have examined the types of risk cues clinicians use when assessing patient dangerousness, finding that perceptions of dangerousness are not absolute. For the most part, these studies have shown that clinicians do not always use the most accurate cues to make their evaluations. Werner et al. (1983) found that cues used by clinicians to make their predictions about patients' likelihood of imminent assault (hostility, excitement, suspiciousness, uncooperativeness, posturing and mannerisms, conceptual disorganization, tension and grandiosity, but not motor retardation, depressed mood, and blunted affect) were not those cues that in reality predicted imminent violence (hallucinatory behavior but not emotional withdrawal or motor slowing). Werner et al. (1990) found that although clinicians agreed that conceptual disorganization, mannerisms and posturing, hostility, and excitement differentiated violent from nonviolent acute psychiatric patients, clinicians' choice of risk cues was not supported by the data.

Focusing on correctional staff in a medium-security federal prison, Cooper and Werner (1990) assessed decision-making strategies used to predict future violence based on information gathered on inmates at intake. Staff overemphasized some variables and under-emphasized others such that overall accuracy of violence prediction was low for both psychologists and case workers. Psychologists tended to weight race, current offense and its severity, and history of violence heavily; case workers focused on current offense and its severity, history of escape attempts, history of violence, precommitment status, and number of prior arrests and convictions. In actuality, inmate violence was correlated with commitment age (younger inmates were more likely to demonstrate violence), place of residence (inmates from nonurban settings were more likely to be violent), and number of prior arrests and convictions. Other work has demonstrated that patient gender and race erroneously impact clinicians' predictions of imminent violence (McNiel & Binder, 1995) and that overconfidence reduces the likelihood of using helpful decision-rules that might otherwise improve clinical accuracy (Arkes, Dawes, & Christensen, 1986).

Risk assessment predictions are probabilistic tasks that ask clinicians and other professionals (e.g., nurses, social workers, and technicians) to make daily judgments about the likelihood of violence. Applying the Arkes et al. (1986) study's results to clinical settings suggests that staff may over-rely on their "expertise" rather than employing empirically determined decision-rules, resulting in a lower rate of correct judgments. Awareness of the possibility of such overconfidence would be a necessary aspect of any training program for professionals and paraprofessionals who are expected to make frequent probabilistic judgments.

These studies show that judgments of patient dangerousness are often complex combinations of clinical experience and personal schema. Research to date has focused on staff's assessments of patients' risk to others. The informal appraisals of personal safety that staff in forensic settings inevitably perform on an automatic and daily basis, and the possible individual factors such as gender that may influence these appraisals, have not yet been addressed empirically.

6. Clinician gender and case conceptualization/diagnosis

To date, some work has attempted to touch on how staff gender may impact their perceptions of patients but the focus has been on case conceptualization (Gomes & Abramowitz, 1976; Teri, 1982; Zygmond & Denton, 1988) and diagnosis (Adler, Drake, & Teague, 1990; Loring & Powell, 1988; Wright, Meadow, Abramowitz, & Davidson, 1980) rather than on personal safety. The results are inconsistent, with four studies finding that clinician gender mattered in a variety of ways (Loring & Powell, 1988; Teri, 1982; Wright et al., 1980; Zygmond & Denton, 1988) and two finding that it did not (Adler et al., 1990; Gomes & Abramowitz, 1976). The primary problem with these studies is that with the exception of one that gathered data in a naturalistic setting (Wright et al., 1980), the remainder's findings are based on analog methodologies involving case descriptions distributed to clinicians. Criticism has been launched against analog methods (Abramowitz & Dokecki, 1977; Wright et al., 1980), primarily because they are thought to be less "realistic."

Clinician's reactions to the stimulus may be more removed and objective than they would be in a naturalistic situation. Despite the increased difficulty of conducting research in field settings and the corresponding decrement in degree of experimental control, the inconsistency of past research in this area suggests that future studies of gender influences on clinical decision making should involve naturalistic stimuli rather than vignettes or analog methods.

One recent study has addressed this methodological weakness by conducting perhaps the most specific assessment of gender and its impact on clinical judgment to date (Elbogen, Williams, Kim, Tomkins, & Scalora, in press). Multidisciplinary teams of mental health care providers (psychologists, psychiatrists, nurses, social workers, and technicians) at three different settings (acute, chronic, and crisis care) were asked to rate patients either at admission or discharge on risk cues taken from the Psychopathy Checklist-Short Version (PCL-SV; Hart, Hare, & Forth, 1994). Staff evaluated patients on the degree to which they demonstrated the 12 PCL-SV risk markers (e.g., impulsivity, deceitfulness, juvenile delinquency, lack of empathy, etc.) and on an overall scale of risk (ranging from 1 = *not dangerous to others*, to 8 = *very dangerous to others*). The investigators found that, consistent with some past studies, male patients were rated as more likely than female patients to be dangerous to others across nearly all settings at admission and discharge. More interesting for the purpose of this review, however, was that the female staff appeared to perceive dangerousness differently than the male staff based on patient's gender. Specifically, while both genders rated male patients as the more dangerous, the difference between male staff's ratings of male and female patients was nominal compared to the difference between female staff's ratings. Thus, all clinicians agreed on the level of risk of female patients, but female clinicians saw male patients as more dangerous than did male clinicians. The authors concluded that male and female clinicians in their sample used different cues to assess dangerousness to others depending on the gender of the patient, with clinicians tending to use the greatest number of cues when assessing patients of the opposite sex. These results suggest that when making assessments of risk to others, gender does impact how one evaluates a patient.

Overall, the literature exploring gender in clinical settings has examined the issue in terms of how the patient's gender affects clinician decision-making and how the staff's gender affects their actual level of safety and their case conceptualization. The question remaining is whether gender impacts one's assessment of risk to oneself: are female staff likely to use different risk cues or weight cues differently than male staff when evaluating their own safety from patients? Numerous studies spanning several research areas, including workplace violence, nursing, patient assault, and clinician decision-making, have called for more work in the area of gender and decision-making as it relates to occupational risk (Binder, 1991; Wykes & Whittington, 1998; Zygmond & Denton, 1988). A staff member's ability to evaluate his/her own level of safety with patients is critical to their ability to work effectively, soundly, and efficiently.

7. Conclusions

This paper has reviewed extant literature in several areas as it relates to the issue of gender and its impact on perceptions of personal safety in forensic and psychiatric settings. Some-

what disparate literatures were presented for various reasons. Research on assault frequency showed that although female staff are at lower risk compared to male staff in psychiatric facilities, issues such as pregnancy often heighten subjective concerns of assault or threat. Challenges to females' credibility and professional competence as noted in the sexual harassment literature likely highlights the perceived risks for women in male-dominated workplaces. Studies on sexual harassment also emphasized the importance of understanding the victim's perceptions of situations in addition to documenting incidence rates, a notion that is equally relevant to patient dangerousness toward staff. The workplace violence research indicated that worker safety is a major issue that has received attention from the federal government as well as from the research community. Injuries and other such disruptions sustained by employees can have a significant impact on their physical and psychological well-being, which in turn impacts worker productivity. It is therefore to the mutual benefit of employers and staff to examine level of patient dangerousness to staff.

Studies on clinical judgment and decision-making were reviewed to demonstrate methodological problems with past investigation of gender effects. These studies have been criticized for being rife with inconsistency (Abramowitz & Dokecki, 1977; Wright et al., 1980) primarily due to over-reliance on analog stimuli. Collectively, this body of work suggests that gender effects in decision-making are relatively small, and that future efforts to investigate them must employ naturalistic settings rather than vignettes or other analog methods.

Finally, the risk assessment literature illustrated how studies to date have exclusively examined patients' risk to others and have not considered the type of informal and automatic appraisals of personal safety that psychiatric and forensic staff must engage in on a daily basis.

The literature to date has examined the issue of how gender of the clinician impacts his or her work as a mental health care provider from several directions, but the work is far from complete. Future directions for research should include naturalistic field study of whether male and female health care workers use and weight risk cues differently when assessing whether they feel threatened by a patient. Other questions that could be addressed are whether level of exposure to patients is related to use and weighting of certain risk cues (i.e., do technicians and nurses, who have the most exposure to patients, attend to different aspects of a patient than clinicians, who have less exposure), and whether past assault or threat victimization is associated with using a different set of risk cues compared to a history of no assaults or threats. Finally, an important question that has been neglected thus far is what aspect of gender drives differences in perceptions and decision-making. Specifically, it is unknown whether such differences between men and women are attributable to biology, or to attitudes toward men and women that are shaped by our society. It is also unknown whether one's sex role identity — the extent to which one identifies with "masculine," "feminine," or "androgynous" characteristics and behaviors as described by Bem (1974) — affects our judgments about personal safety.

The contextual factors involved in staff perceptions of risk from patients are similar to those identified for victims of sexual harassment and/or workplace violence: personal safety, job satisfaction, psychological and physical health, worker productivity, and quality of relationships with peers in the workplace. As studies have shown, these issues are

inextricably tied to the employment organization's financial costs and functioning and therefore provide compelling justification for future research pursuits in this area.

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