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FOUR DIMENSIONS OF HEALTHY WORK: STRESS, WORK–FAMILY RELATIONS, VIOLENCE PREVENTION, AND RELATIONSHIPS AT WORK

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This chapter is a composite of four independent yet interrelated contributions related to the central issue of healthy work and a healthy world. Each of the authors brings a unique perspective and professional expertise to address a specific dimension of health at work. Although there is some overlap and some interdependence among the four sections of the chapter, each section stands largely as the contribution of the section author to the larger issue of how to build a healthy world at work and beyond. The resulting chapter is a composite of independent and interdependent perspectives that fit under the larger umbrella of healthy workplaces.

The first section provides an overview of stress and health in organizations. Paul Rosch (2001) of the American Institute of Stress calls job stress a health epidemic needing medical and psychological treatment. Since the early research on organizational stress, the public health notions have been applied to the stress process, with attendant concerns for workplace surveil-

lance and preventive interventions. This section considers related issues, such as unemployment, which have spillover effects on health at work. Occupational health psychology is a specialty in psychology aimed at enhancing healthy work. The section then recommends that psychology build healthier workplaces through chief psychological officers in organizations and by elaborating a framework for organizational therapy.

The second section brings our attention to the relationship between work and family life and discusses the limitations of current research in this field. It notes that families in the United States receive little government or institutional support to fulfill their important social responsibilities, so they struggle on their own to meet work and family obligations. It is further suggested that single parents in low-wage jobs have particular difficulty balancing work and family, but they have been largely invisible to work and family researchers. The section then calls attention to promoting the health of these vulnerable families through a new generation of research.

The third section addresses the low-frequency, high-impact health risk of violence in the workplace. It uses the public health notions of prevention, including workplace surveillance systems, to outline strategies for the prevention of workplace violence.

The fourth section addresses the unique occupational case of the professional athlete from the perspective of a professional sports consultant. The section focuses on the lifestyle issues and potential challenges to healthy work- and lifestyles with this select group. Areas for potential clinical investigation and intervention are also identified.

STRESS AND HEALTH AT WORK

Robert Kahn and his associates' seminal studies in role conflict and ambiguity placed psychology in the midst of understanding organizational and work stress (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). Prior to the early 1960s, stress was primarily a medical concept based on classic research by physicians Walter B. Cannon (1935) and Hans Selye (1976). By the early 1980s, stress and psychological disorders in the workplace had become one of the top ten occupational health hazards in America (Millar, 1984; Sauter, Murphy, & Hurrell, 1990). By the end of the century, Rosch (2001) suggested that job stress had reached epidemic proportions, based on data from the National Institutes of Health on working hours, increases in working hours, job losses, absenteeism, and turnover data. What has and what can psychology do to address the job stress epidemic?

Stress at Work

Job and work stress with their associated health risks had their foundations in the early days of the Industrial Revolution, which sprang from the factories and mills of Manchester, England, in the mid-1800s. Over the next 100 years these factories and mills gave way to large, modern corporations in the industrialized world, which were the subject of concern for Kahn and colleagues (1964). Psychiatry had an early concern with industrial mental hygiene with the "preventive management" of Elkind (1931), who applied a national mental hygiene agenda to workplace issues of industrial relations, human nature in organizations, management, and leadership. The American Psychological Association (APA) formed a cooperative agreement with the National Institute for Occupational Safety and Health (NIOSH) to address job stress and psychological disorders in the workplace (Murphy, Hurrell, Sauter, & Keita, 1995; Sauter & Hurrell, 1999). This three-pronged initiative aimed to design strategies for healthy workplace design, health promotion at work, and surveillance of health risks (Landy, Quick, & Kasl, 1994).

Healthy Workplace Design

Although Abraham Maslow (1965/1998) called for healthy work environments as early as the 1960s, Murphy and Cooper (2000) presented the most recent definition and evidence concerning healthy and productive work. Much happened in the intervening 40 years. An international tradition aimed at defining and encouraging the healthy workplace design through the identification of physical and psychosocial health risk factors coupled with redesign interventions to enhance mental health and psychological well-being grew up in the intervening years (Hurrell & Murphy, 1992; Quick, Murphy, & Hurrell, 1992; Sauter, Murphy, & Hurrell, 1990). The healthy workplace design tradition places priority on the characteristics of the work environment.

Individual Health

Individuals come to work with their own characteristics, not all of which are healthy. Von Dusch (1868) was the first to call attention to excessive involvement in work as a health risk factor for cardiovascular problems. His observations suggest that the work environment does not cause all stress. This view is broadly consistent with Lazarus' (1995) psychological theory of work stress and with Levinson's (1985) psychoanalytic theory of executive stress. These theories of stress look to the individual and the individual's responses to explain stress at work. Whereas these theories serve as bases for psychotherapeutic interventions for job stress, health promotion

activities and other more behavioral interventions are alternatives to enhance individual health at work (Ilgen, 1990).

Person–Environment Fit

Edwards (1996) examined the competing versions of person–environment fit theory, which aim to explain stress at work by considering both factors in the environment and in the individual. This view holds that stress cannot be fully explained by either environmental factors or individual factors.

Surveillance of Health Risks at Work

Assessment and surveillance activities are important for the measurement of workplace stress and to the enhancement of organizational health (Adkins, 1999). Many measures of stress are available for the workplace, including one developed by NIOSH. In her pioneering work, Adkins used the Occupational Stress Inventory to measure organizational demands and stressors, individual strains, and personal coping resources in a variety of organizations (Osipow & Spokane, 1992). Her results show marked organizational variance among these various measures, yet broadly show a clear link between stress and strain. The Job Stress Survey is a second and emerging assessment measure that consistently identifies two factors across work contexts (Vagg & Spielberger, 1998). These are job pressure and lack of organizational support.

Stress Factors Beyond the Workplace

Stress factors beyond the workplace are important to a more complete understanding of stress and health at work. Specifically, the interface between work and family, with the potential spillover effects that may occur, is a subject of increasing significance. In addition, unemployment, or the lack of work, is a major source of distress for an important minority in many industrialized nations.

The Work–Family Interface

One of the more important arenas in a person's non-work life is the family, and the work–family interface has been found important in understanding a person's health at work as well as at home (Piotrkowski, 1979). Although some individuals may be able to partition the various elements of their lives into different roles, such as work roles and family roles, spillover effects do occur.

Unemployment

Work may be stressful, but we have known for decades that the distressful effects of unemployment may even be more devastating from a psychological point of view (Levi et al., 1984). The Michigan Prevention Research Center's JOBS (Job-Search Workshop) program aims to help reemploy and enhance the mental health of those who fall into this sector of the potential work population (Vinokur, Schul, Vuori, & Price, 2000).

Preventive Stress Management

Prevention is always the best public health strategy for any disease epidemic. Quick, Quick, Nelson, and Hurrell (1997) have translated and applied the public health notions of prevention to organizational stress, framing the theory of preventive stress management. This theory is one of ten major theories of organizational stress (Cooper, 1998). If job stress has become an epidemic in America and other industrialized nations, then prevention holds the best hope for addressing this epidemic (Elkin & Rosch, 1990). Using the public health and preventive medicine model, Quick and colleagues (1997) classified prevention strategies into primary, secondary, and tertiary. Primary prevention aims to modify and manage the demands of the work environment. Secondary prevention aims to modify and manage the individual's response to these demands. Tertiary prevention aims to help and provide aid to those in frank distress.

Occupational Health Psychology

Occupational health psychology (OHP) is consistent with these public health notions and has a primary focus on the prevention of injuries and illnesses, and the enhancement of health (in contrast to the treatment of injuries and illnesses) by creating safe and healthy working environments (Sauter & Hurrell, 1999). OHP continues to use the three-stage strategy of primary, secondary, and tertiary prevention for the management of stress and the enhancement of psychological health at work (Quick & Tetrick, 2003).

Psychology Builds a Healthier World at Work

In addition to managing organizational stress, preventing psychological disorders in the workplace, and enhancing mental health at work through OHP, how can psychology help build a healthier world at work in our new organizational reality (Gowing, Kraft, & Quick, 1998)? First, psychologists can become chief psychological officers in organizations. Second, psychologists can develop the professional practice of organizational therapy.

Psychologists as CPOs

Organizations often have many chiefs: chief executive officer (CEO), chief operational officer (COO), chief financial officer (CFO), chief information officer (CIO), and so on. These "chief" officers are responsible for the critical resources and processes that influence the health of the organization. People may be the most important resource in any organization, especially in the information age. Yet responsibility for their support and development is often dispersed to functions such as personnel and human resources, the medical department, employee assistance programs for counseling and psychotherapy, and possibly an industrial chaplainry for their spiritual needs. Psychologists can become CPOs (chief psychological officers, or alternatively chief people officers). A key role for a CPO in an organization is to integrate the specialties on the human side of the enterprise. These specialties include human resource professionals, physicians and medical personnel, clinical psychologists and counselors, safety professionals, security forces, industrial–organizational psychologists, and chaplains and spiritual advisors. These professionals offer employees and executives a range of expertise. They are most effective when organized into functional role interrelatedness so as to complement and supplement each other as they serve individuals' health and safety needs at work. Psychology has a strategic opportunity to build on the pioneering work of U.S. Air Force Lieutenant Colonels Joyce Adkins and Charles Klunder, who were the CPOs for their respective commanding generals during the largest industrial restructuring activity in the history of the Department of Defense from 1994 through 2001 (Quick, Tetrick, Adkins, & Klunder, 2003).

Organizational Therapy

Frost and Robinson (1999) are concerned with the toxins and emotional pain that are all too often endemic to organizational life. Although their focus is on the health risks for those organizational heroes who absorb much of this emotionally toxic material at work, what also comes through their work is the fact that these organizational heroes do not have formal organizational roles for engaging in their therapeutic and curative activities. Edgar Schein (Quick & Gavin, 2000), in wrestling with essentially the same problem, suggested that what is needed is an evolving practice of organizational therapy to help heal organizations. Although healthy organizational systems may have natural homeopathic agents and immune systems that metabolize these psychological toxins and emotional pain, psychology can take the lead in crafting mechanisms, systems, and roles that help to metabolize the unhealthy energies that inevitably yet unintentionally emerge in many work organizations.

CURRENT RESEARCH NEEDS AND LIMITATIONS IN THE FIELD OF WORK AND FAMILY RELATIONS

Work and family are two critical spheres of human activity. Theory on the relationship between these two domains has been shaped by important social and economic changes. With industrialization, work and family came to be viewed as separate domains and workers were treated as if they had no families. In the 20th century, theories in sociology and psychology provided theoretical justifications for the male breadwinner family and the separation of work and family. In sociology, structural-functionalism held that the total separation of work and family realms was functionally necessary to avoid occupational competition between husbands and wives that would threaten marital stability. In psychology, attachment theory warned of dire consequences to children's development if the mother–infant bond were disrupted by separation. Therefore, when researchers did examine links between work and family, they focused on problems caused by male unemployment and by female employment: Depression-era research examined the effects of unemployment on family roles and relationships, whereas the influx of mothers into the labor force during the 1960s and 1970s spurred research on the supposed negative effects of women's employment on children and on marriage, as well as studies of the new dual-earner family (for reviews of these early research literatures, see Kanter, 1977; Piotrkowski & Gornick, 1987; Piotrkowski & Hughes, 1993; Piotrkowski, Rapoport, & Rapoport, 1987).

Over the past 20 years, there has been yet another significant shift in the way we think about the relationship between work and family life. As the employment of mothers and wives has become normative and economically necessary, we have come to recognize that all employees face complex challenges in negotiating paid work and family roles, to an understanding that work and family systems may affect each other, and to public discourse on how best to help employees balance obligations to their jobs and to their families.

With these changing views of work and family has come a literal explosion of work–family research within the social and behavioral sciences, as well as schools of nursing, social work, and management (Westman & Piotrkowski, 1999). In psychology alone, work–family research is conducted by clinical, social, developmental, family, organizational, and occupational health psychologists. Most research has focused on (a) the effects of work on family life rather than the effects of family life on work outcomes, and (b) on negative outcomes rather than positive ones. Despite numerous criticisms of this imbalance, this research emphasis is consistent with the relative powerlessness of families vis-à-vis the workplace, the lack of public

work and family policy, and an emphasis on promoting health and well-being in families.

In the United States, families receive little support from government and other institutions to assist their enormously important functions: the socialization of the young, the care and nurturing of all family members—including older people—and the economic support of the household through paid work. In the delicate and challenging endeavor of meeting obligations to families and employers, workers and their families are at a distinct disadvantage. Economically dependent on their jobs, most employees have little say in the policies and organization of work that affect them and their families, and the use of individual coping strategies are relatively ineffective in managing workplace stressors (Pearlin & Schooler, 1978). Family members have even less input in how work is organized. Therefore, it is not surprising that studies consistently find that employees report greater interference from work to family than vice versa (e.g., Burke & Greenglass, 1999; Frone, Russell, & Cooper, 1992b; Gutek, Searle, & Klepa, 1991; Netemeyer, Boles, & McMurrian, 1996). The Family and Medical Leave Act of 1993 (FMLA) partly redressed this imbalance of power by protecting some workers' jobs while they care for new or ill family members, but not all workers are covered by this legislation. Corporate work–family life initiatives and the emergence of a work–family consulting industry represent the acknowledgment by corporations that employees' families must be taken into account. However, these initiatives generally have been aimed at minimizing the family's intrusion into the workplace, maintaining productivity, and retaining skilled employees (Parasuraman & Greenhaus, 1997). Research evidence indicates these programs and policies are only marginally effective in reducing work–family conflict (Gottlieb, Kelloway, & Barham, 1998; Kossek & Ozeki, 1999b).

Given the lack of public and institutional support for families, employees and their families are left on their own to find child care, juggle demanding work schedules, protect themselves from stressful workplace conditions, and so forth. Although we can acknowledge that relations between work and family are bidirectional and that certain working conditions and policies may have beneficial effects on families, our first priority must be to identify those workplace conditions and organizational policies that interfere with family well-being so they can be addressed. As yet, however, work–family research has limited usefulness for policymakers, employers, practitioners, and families. This section describes these limitations and provides suggestions for how to address them.

Limited Theory

Because work–family research spans many disciplines and specialization areas within disciplines, theory-building has been limited. Terminology is

inconsistent and there are no agreed-upon central questions, no overarching generally recognized theories, and no systematic knowledge-building across disciplines (Allen, Herst, Bruck, & Sutton, 2000; Barnett, 1998; Lambert, 1990; Westman & Piotrkowski, 1999). For example, constructs such as "spillover," "carryover," and "crossover" are used interchangeably and inconsistently. Thus, knowledge remains fragmented and rudimentary.

In the past two decades, work–family research in psychology has focused on employees' experience of conflict between work and family roles (Greenhaus & Beutell, 1985) as the central mediator between work life and family life (Frone, Russell, & Cooper, 1992a). Work-to-family conflict and family-to-work conflict have been distinguished theoretically and empirically, and both their antecedents and consequences have been widely studied. For example, we have learned that work-to-family conflict is related to job dissatisfaction and burnout and to mental and physical strain (see reviews by Allen et al., 2000, and Kossek & Ozeki, 1999a). We also have learned that the antecedents of work-to-family conflict include classic job stressors such as excessive work demands and lack of autonomy (e.g., Frone et al., 1992a).

Yet this conceptual framework is too narrow. The almost singular focus on work–family conflict as a favored research variable means that other important direct and indirect processes linking work and family life have been neglected (Lambert, 1990; Piotrkowski, 1998). For example, few studies have examined if and how children learn about managing work–family dilemmas or the impact of adverse parental working conditions on their views, development, and behavior (e.g., Barling, 1986; Galinsky, 1999). Similarly, most Americans do not work the standard 9-to-5 work week (Presser, 1995), but we know very little about how these schedules affect family relationships and other family members. Other neglected topics include the effects of work-related injury and illness on families and the costs and benefits of the various coping strategies families use to manage difficult work situations and work–family conflict. An interesting example is provided by Presser and Cain (1983) who found that young, dual-earner families manage child care through "split-shift" arrangements, with mothers and fathers working different shifts. Although young couples are able to manage their child care this way, one wonders if this arrangement also may have some adverse consequences for marital satisfaction, problem solving, and intimacy. Absent systematic empirical research on such multiple processes and their outcomes, we are left with limited theory and inadequate knowledge to guide practitioners working with families.

Weak Methodology

Typical research designs still involve the collection of cross-sectional data, limiting causal conclusions. Moreover, data usually are collected only

from the employee, which may artificially inflate associations between predictors and outcomes because of common method variance. A further problem is that "the family" has all but disappeared from current work–family research. With some exceptions, the individual employee remains the unit of analysis (Barnett, 1998; Westman & Piotrkowski, 1999), even when organizational outcomes (e.g., turnover) or family outcomes (e.g., family satisfaction or distress) are studied. The collection of data from and about other family members remains the exception.

Measures of work–family conflict suffer from the additional problem of requiring respondents to make causal attributions, an approach long-abandoned in research on occupational stress. As an example, a typical item from a work–family conflict scale states, "Because my work is so demanding, I am often irritable at home" (Stephens & Sommer, 1996; also see Netemeyer et al., 1996). In their longitudinal study of work–family conflict, Kelloway, Gottlieb, and Barham (1999) concluded that reports of work-to-family conflict may result from an attribution process "whereby employees who experience stress 'scapegoat' their work." They found that work-to-family conflict did not predict psychological strain measured 6 months later; instead, strain 6 months earlier predicted work-to-family conflict 6 months later.

Limited Populations

A final significant limitation of current work–family research is the strong middle-class bias that has rendered the low-wage, low-skilled worker and his or her family all but invisible. Work–family research continues to focus on married, White, middle-class professionals and managers, a problem sometimes noted but rarely redressed. These latter populations are easy to study because they provide adequate response rates to mailed surveys, they speak English, and they are relatively easy to access. When low-wage workers are included in rare representative community samples, education and income are treated as nuisance variables to be controlled.

Yet, low-wage workers represent an important segment of our population; they are disproportionately represented among women, people of color, immigrants, and single parents. In 1995, 7.5 million workers were living in poverty (Hale, 1997), and millions of others were living in near poverty. One particularly vulnerable group of such workers is mother-only families. In 2000, over 75% of unmarried mothers were in the labor force (Current Population Survey, 2001). Even when they worked full-time, year round, in 1993 11% of mother-only families did not earn enough to lift their families out of poverty (Rodgers, 1996). Often financially strapped and with little household support, these women are subject to working conditions—such as limited autonomy—that are known to increase work–family conflict.

They also are more likely to work nonstandard shifts and weekends, making it especially difficult to locate child care (Presser & Cox, 1997). Family supports such as the FMLA have limited usefulness to these women (Hyde, Essex, Clark, Klein, & Byrd, 1996), particularly if they lack paid sick leave and vacations. They also lack a second income that would assist them in taking unpaid leave, and the FMLA provision requiring an employee to have worked at least 1,250 hours for a year with his or her current employer falls heavily on poor women who are especially likely to be new hires, to move in and out of the labor force, and to work part-time for small employers, who are exempt from the FMLA (Piotrkowski & Kessler-Sklar, 1996). Yet we know very little of the unique challenges these women face in combining work and parental roles, how well they manage, or how best to assist them (Oliker, 1995). The problems they face are not unique to poor women, but also plague other low-wage workers and their families.

There are several reasons why we cannot assume that findings from White professionals and managers generalize to low-skill and low-wage workers. Some working conditions are especially problematic for this latter population. They are more likely to face unique workplace stressors that include physical hazards and discomfort, nonstandard shifts, and limited or no sick leave. Non-White workers also must confront racial harassment and nonmarried women are more likely to face sexual harassment (Swanson, Piotrkowski, Keita, & Becker, 1997), with unknown consequences for family well-being and family role functioning. It also is likely that processes linking work to family life, as well as outcomes, differ by race and ethnicity. Economic resources also shape the strategies families have available to manage work–family conflicts and problems. Thus, an affluent family may hire a live-in nanny to care for their children, while low-income families rely on a patchwork of help from neighbors and relatives and low-quality day care.

This middle-class bias also seriously limits the application of our findings, because work–family research is not addressing the problems and needs of our most vulnerable workers and their families. As a result, work–family research has little relevance to the important policy debates about how to support vulnerable families, a problem noted by Kelly (1988) that still persists. Private sector work–family initiatives also favor professional and management employees and have been limited to large, corporate employers who can afford them. But most people are not managers or professionals, and half of all workers in the private sector work in establishments with fewer than 100 employees (Wiatrowski, 1994). As Googins (1997) has noted, "the working poor do not generally work in family-friendly corporations and are not well represented in work-and-family initiatives" (p. 228).

The Next Generation of Work–Family Research

It is time for a new generation of work–family research that aims to build theory and systematic knowledge that can be used to guide clinicians working with couples and families, to inform supportive work–family public policy, and to help unions and employers—large and small—develop cost-effective workplace strategies to ameliorate conflicts between work and home and negative effects of work on families.

This agenda points to new research directions. Work–family research needs to be truly interdisciplinary, so that integrated theory is developed that incorporates complex conceptualizations of the family, the workplace, and individual development (Piotrkowksi, 1998). Within psychology, cross-specialization research teams could integrate theoretical perspectives from organizational, family, developmental, occupational health, and clinical psychology. One benefit of this approach is that it would move work–family research beyond the individual as the sole unit of analysis to include family-level outcomes, such as the parent–child relationship, marital stability, and family "cohesion" (Piotrkowski & Staines, 1991) and to the inclusion of data from and about other family members. It is possible, for example, that the same working conditions affect family members differently. This approach would allow for a better and broader understanding of the costs and benefits of different working arrangements for all family members. Gathering data from more than one family member also can minimize the problems associated with relying solely on the self-report of the employee. Examples of this broader approach already exist within the work–family field (e.g., MacEwen, Barling, & Kelloway, 1992; Piotrkowski & Katz, 1982; Repetti, 1989; Repetti & Wood, 1997; Westman & Etzion, 1995).

In addition to incorporating family outcomes in work–family research, a cross-disciplinary approach would be useful in identifying a wider array of working conditions for study and a wider array of processes linking work life to family life, beyond work–family conflict. Such processes include socialization processes, the moderating effects of spousal undermining or support, family coping strategies, and so forth. Measures of work–family conflict that do not require respondents to make causal attributions also would represent a methodological improvement, as would longitudinal designs that allow stronger causal inferences to be made.

To meet our obligations to the well-being of our most vulnerable workers and their families, it also is essential that work–family researchers focus attention on ethnic minorities, low-wage workers, and single parents. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform) gives new urgency to this problem, as the safety net of public assistance has disappeared for most poor women with dependent children. These women will enter low-quality, low-wage jobs lacking even

the most basic family supportive benefits. Kelly (1988) also has encouraged the examination of work–family relations among the urban "underclass," who work in the informal underground economy. This shift toward the study of low-wage families will require a commitment to more cumbersome data collection strategies that go beyond the mailed survey, and to the development of culturally appropriate measures in other languages (e.g., Marin & Marin, 1991). It also may require less conventional methods of sampling, because of the difficulties inherent in studying work in the informal, underground economy. Such research will need to pay particular attention to cultural differences in how families manage work and family obligations, and to the processes linking work to home.

Finally, we need to anticipate how changing demographics and changes in the workplace affect relations between people's work and families' lives. For example, we need to learn more about work–family relations among contingent workers and the "sandwich generation" of workers—typically women—who are caring for dependent children and elderly parents (e.g., Lee, 1997), about the impact of the new job insecurity on families (Lewis & Cooper, 1999) and about "telework," which blurs the boundaries between work and home (e.g., Standen, Daniels, & Lamond, 1999). In all these ways, work–family research can inform public policy and organizational and clinical practice to support the development of healthy families.

WORKPLACE VIOLENCE: RESEARCH, RISK FACTORS, AND PREVENTION STRATEGIES

In recent years, violence in the workplace has received considerable attention in the popular press and among safety and health professionals. From 1994–1998, there were an average of 921 workplace homicides each year. These homicides included an average of 147 supervisors or proprietors in retail sales, 84 cashiers, 65 taxicab drivers, 51 managers in restaurants or hotels, 65 police officers or detectives, and 52 security guards annually (Bureau of Labor Statistics [BLS], 2000). An additional 2 million workers were assaulted each year (Bureau of Justice Statistics [BJS], 1998). Death or injury should not be an inevitable result of one's chosen occupation, nor should these staggering figures be accepted as a cost of doing business in our society.

Purpose and Scope

The purpose of this section is to review what is known about fatal and nonfatal violence in the workplace to determine the focus needed for prevention and research efforts. This document also summarizes issues to

be addressed when dealing with workplace violence in various settings such as offices, factories, warehouses, hospitals, convenience stores, and taxicabs.

Although no definitive strategy will ever be appropriate for all workplaces, we must begin to change the way work is done in certain settings to minimize or remove the risk of workplace violence. We must also change the way we think about workplace violence by shifting the emphasis from reactionary approaches to prevention, and by embracing workplace violence as an occupational safety and health issue.

Defining workplace violence has generated considerable discussion. Some would include in the definition any language or actions that make one person uncomfortable in the workplace; others would include threats and harassment; and all would include any bodily injury inflicted by one person on another. Thus the spectrum of workplace violence ranges from offensive language to homicide, and a reasonable working definition of workplace violence is as follows: violent acts, including physical assaults and threats of assault, directed toward people at work or on duty. Most studies to date have focused primarily on physical injuries, because they are clearly defined and easily measured. But this section examines data from multiple sources and acknowledges differences in definitions and coverage to learn as much as possible from these varied efforts.

The circumstances of workplace violence also vary and may include robbery-associated violence; violence by disgruntled clients, customers, patients, inmates, and so forth; violence by coworkers, employees, or employers; and domestic violence that finds its way into the workplace. These circumstances all appear to be related to the level of violence in communities and in society in general. Thus the question arises: Why study workplace violence separately from the larger universe of all violence? Several reasons exist for focusing specifically on workplace violence:

- *Violence is a substantial contributor to death and injury on the job.* NIOSH data indicate that homicide has become the second leading cause of occupational injury death, exceeded only by motor-vehicle-related deaths (Jenkins, 1996). Estimates of nonfatal workplace assaults vary dramatically, but a reasonable estimate from the National Crime Victimization Survey is that approximately 2 million people are assaulted while at work or on duty each year (BJS, 1998).
- *The circumstances of workplace violence differ significantly from those of all homicides.* For example, 75% of all workplace homicides in 1993 were robbery-related; but in the general population, only 9% of homicides were robbery-related, and only 19% were committed in conjunction with any kind of felony (robbery, rape, arson, etc.; Federal Bureau of Investigation [FBI],

1994). Furthermore, 47% of all murder victims in 1993 were related to or acquainted with their assailants (FBI, 1994), whereas the majority of workplace homicides (because they are robbery-related) are believed to occur among people not known to one another. Only 17% of female victims of workplace homicides were killed by a spouse or former spouse (Windau & Toscano, 1994), whereas 29% of the female homicide victims in the general population were killed by a husband, ex-husband, boyfriend, or ex-boyfriend (FBI, 1994).

- *Workplace violence is not distributed randomly across all workplaces but is clustered in particular occupational settings*. More than half (56%) of workplace homicides occurred in retail trade and service industries. Homicide is the leading cause of death in these industries as well as in finance, insurance, and real estate. Eighty-five percent of nonfatal assaults in the workplace occur in service and retail trade industries (BLS, 1994). As the United States economy continues to shift toward the service sectors, fatal and nonfatal workplace violence will be an increasingly important occupational safety and health issue.
- *The risk of workplace violence is associated with specific workplace factors such as dealing with the public, the exchange of money, and the delivery of services or goods*. Consequently, great potential exists for workplace-specific prevention efforts such as bullet-resistant barriers and enclosures in taxicabs, convenience stores, gas stations, emergency departments, and other areas where workers come in direct contact with the public; locked drop safes and other cash-handling procedures in retail establishments; and threat assessment policies in all types of workplaces.

Homicide in the Workplace

NIOSH Data

Data from the National Traumatic Occupational Fatalities (NTOF) Surveillance System indicate that 12,863 workplace homicides occurred during the 16-year period from 1980 through 1995, with an average workplace homicide rate of 0.70 per 100,000 workers (NIOSH, 2001). NTOF is an ongoing, death-certificate-based census of traumatic occupational fatalities in the United States, with data from all 50 states and the District of Columbia. NTOF includes information for all workers ages 16 or older who died from an injury or poisoning and for whom the certifier noted a positive response to the "injury at work" item on the death certificate. For additional discussion of the NTOF system and the limitations of death certificates for the study of workplace homicide, see Castillo and Jenkins (1994).

Sex

The majority (80%) of workplace homicides between 1980 and 1995 occurred among male workers. The leading cause of occupational injury death varied by sex, with homicides accounting for 12% of all occupational injury deaths among male workers and 42% among female workers (NIOSH, 2001). Although homicide is the leading cause of occupational injury death among female workers, male workers have more than three times the risk of work-related homicide (1.0 per 100,000 workers for males versus .3 per 100,000 workers for females).

Age

The largest number of workplace homicides occurred among workers ages 25–34 years, whereas the rate (per 100,000 workers) of workplace homicide increased with increasing age. The highest rates of workplace homicide occurred among workers ages 65 years and older; the rates for these workers were more than twice those for workers ages 55–64 years. This pattern held true for both male and female workers (NIOSH, 2001).

Race

Although the majority of workplace homicide victims were White (71%), Black workers (1.4/100,000) and workers of other races (2.0/100,000) had the highest rates of work-related homicide.

Industry and Occupation

During the 16-year period 1980–1995, the greatest number of deaths occurred in the retail trade (4,917) and service (2,329) industries, whereas the highest rates per 100,000 workers occurred in retail trades (1.7); public administration (1.4); and transportation, communication, and public utilities (1.0). At the more detailed levels of industry, the largest number of deaths occurred in grocery stores, eating and drinking places, taxicab services, and justice and public order establishments. Taxicab services had the highest rate of work-related homicide.

Bureau of Labor Statistics Data

Information from the Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries (CFOI) Program identifies the same high-risk demographic and occupational groups as NIOSH NTOF data and allows description of the circumstances of workplace homicides beginning in 1992. According to the BLS data for 1999, 77% of the homicides occurred during a robbery or other crime and 10% were attributed specifically to coworkers

or former employees (BLS, 2000). The CFOI system uses multiple sources, including administrative documents from federal and state agencies (e.g., death certificates, medical examiner records, workers' compensation reports, and regulatory agency reports) as well as news reports and follow-up questionnaires to business establishments (Windau & Toscano, 1994).

Discussion

Despite differences in data collection and the resulting total number of homicides reported by the NTOF and CFOI fatality surveillance systems, the ranking of high-risk industries and occupations is consistent, with taxicab drivers and chauffeurs, law enforcement and security personnel, and retail trade workers experiencing the greatest risks and the largest numbers of workplace homicides. Findings about the distributions by demographic characteristics are also remarkably similar (Castillo & Jenkins, 1994; NIOSH, 1996; Toscano & Weber, 1995; Windau & Toscano, 1994).

Differences in leading causes of occupational injury death by sex can be attributed at least in part to variations in employment patterns (Jenkins, 1994). For example, homicide is the leading cause of occupational injury death for female workers because they are exposed less frequently than male workers to hazards such as heavy machinery and work at elevations. The same is also true for differences among industries in leading causes of death. Workers in retail trade, services, finance, insurance, and real estate are not exposed to the same kinds of hazards as workers in construction, agriculture, forestry, fishing, mining, or transportation, communication, and public utilities. These factors are extremely important to the future direction of occupational safety and health as employment patterns shift from traditional heavy industry to retail trade and service sectors. Workplace homicide must be addressed to continue the trends of decreasing numbers and rates of occupational injury deaths (Jenkins et al., 1993; Stout, Jenkins, & Pizatella, 1996).

Elevated rates of workplace homicide among workers ages 65 and older may be attributable to a number of factors, including a decreased ability to survive injury or the perception that such workers are softer targets (Jenkins, Layne, & Kisner, 1992).

Nonfatal Assaults in the Workplace

Victimization Studies

Limited information is available in the criminal justice and public health literature regarding the nature and magnitude of nonfatal workplace violence. The criminology literature contains a few victimization studies that include designation of victimizations that occurred at work. Using the 1982 Victim Risk Supplement to the National Crime Victimization Survey, Lynch (1987) used log linear modeling to examine workplace victimizations

with regard to demographic variables as well as features of the workplace. Features of the workplace included exposure to and public access to the workplace, local travel, overnight trips, perceived dangerousness of the neighborhood and the workplace, and the frequency with which money was handled on the job. These analyses indicated that the risk of workplace victimization was related more to the task performed than to the demographic characteristics of the person performing the job. Factors related to an increased risk for workplace victimization included routine face-to-face contact with large numbers of people, the handling of money, and jobs that required routine travel or that did not have a single worksite. Using a 1983 crime survey in the metropolitan Washington, DC, area, Collins and Cox (1987) found results similar to those of Lynch: The delivery of passengers or goods and dealing with the public were the factors associated with an increased risk for workplace assault. State-specific studies of workplace assaults using workers' compensation data have also been conducted, as have industry- and occupation-specific studies; a summary of these appears in Castillo (1995).

Estimated Magnitude of the Problem

There are varying estimates of the magnitude of nonfatal assaults in U.S. workplaces. The first comes from the BLS Annual Survey of Occupational Injuries and Illnesses (ASOII). The ASOII is an annual survey of approximately 174,000 private establishments. This survey excludes the self-employed, small farmers, and government workers. These data indicate that 16,600 workplace assaults occurred in 1999; these represented 1% of all cases involving days away from work (BLS, 2001).

Another estimate of assaults in the workplace comes from the National Crime Victimization Survey (NCVS), an annual, national, household-based survey of more than 100,000 individuals ages 12 or older. NCVS data for 1992–1996 indicate that each year, nearly 2 million people were assaulted while at work or on duty (BJS, 1998). Twelve percent of workplace victimizations resulted in injuries.

When workplace victimizations were analyzed by type of work setting, these data indicate that 56% occurred in private companies, 37% occurred among government employees, and 7% of the victims were self-employed (BJS, 1998). BJS points out in its report that government workers make up only 16% of the workforce and thus appear to be suffering a disproportionate share of the attacks; it should also be noted that risk factors such as dealing with the public and delivery of services are common among government employees. In addition, all local, state, and federal law enforcement are included in this category.

When individuals in the NCVS were asked whether the workplace victimization was reported to the police, 56% indicated that it was not. For 30% of respondents, the reason cited for not reporting to the police was

that the incident was reported to another official such as a company security guard; another 21% believed the incident to be a private or personal matter (BJS, 1998).

Discussion

Nonfatal assaults in the workplace clearly affect many workers and employers. Although groups at high risk for workplace homicide and nonfatal workplace assaults share similar characteristics such as interaction with the public and the handling of money, there are also clear differences. For example, groups such as health care workers are not at elevated risk of workplace homicide, but they are at greatly increased risk of nonfatal assaults. Castillo (1995) suggested that some of the distinctions between fatal and nonfatal workplace assaults can be attributed to differences between robbery-related violence and violence resulting from the anger or frustration of customers, clients, or coworkers, with robbery-related violence being more likely to result in a fatal outcome. The premeditated use of firearms to facilitate robberies is also likely to influence the lethality of assaults in the workplace.

Risk Factors and Prevention Strategies

Risk Factors

A number of factors may increase a worker's risk for workplace assault, and they have been described in previous research (Castillo & Jenkins, 1994; Collins & Cox, 1987; Davis, 1987; Davis, Honchar, & Suarez, 1987; Kraus, 1987; Lynch, 1987; NIOSH, 1993; NIOSH 1996). These factors include

- contact with the public;
- exchange of money;
- delivery of passengers, goods, or services;
- having a mobile workplace such as a taxicab or police cruiser;
- working with unstable or volatile people in health care, social service, or criminal justice settings;
- working alone or in small numbers;
- working late at night or during early morning hours;
- working in high-crime areas;
- guarding valuable property or possessions; and
- working in community-based settings.

Prevention Strategies

Environmental designs. Commonly implemented cash-handling policies in retail settings include procedures such as using locked drop safes,

carrying small amounts of cash, and posting signs and printing notices that limited cash is available. It may also be useful to explore the feasibility of cashless transactions in taxicabs and retail settings through the use of machines that accommodate automatic teller account cards or debit cards. These approaches could be used in any setting where cash is currently exchanged between workers and customers.

Physical separation of workers from customers, clients, and the general public through the use of bullet-resistant barriers or enclosures has been proposed for retail settings such as gas stations and convenience stores, hospital emergency departments, and social service agency claims areas. The height and depth of counters (with or without bullet-resistant barriers) are also important considerations in protecting workers because they introduce physical distance between workers and potential attackers. Consideration must nonetheless be given to the continued ease of conducting business; a safety device that increases frustration for workers or for customers, clients, or patients may be self-defeating.

Visibility and lighting are also important environmental design considerations. Making high-risk areas visible to more people and installing good external lighting should decrease the risk of workplace assaults (NIOSH, 1993).

Access to and egress from the workplace are also important areas to assess. The number of entrances and exits, the ease with which nonemployees can gain access to work areas because doors are unlocked, and the number of areas where potential attackers can hide are issues that should be addressed. This issue has implications for the design of buildings and parking areas, landscaping, and the placement of garbage areas, outdoor refrigeration areas, and other storage facilities that workers must use during a work shift.

Numerous security devices may reduce the risk for assaults against workers and facilitate the identification and apprehension of perpetrators. These include closed-circuit cameras, alarms, two-way mirrors, card-key access systems, panic-bar doors locked from the outside only, and trouble lights or geographic locating devices in taxicabs and other mobile workplaces.

Personal protective equipment such as body armor has been used effectively by public safety personnel to mitigate the effects of workplace violence.

Administrative controls. Staffing plans and work practices (such as escorting patients and prohibiting unsupervised movement within and between clinic areas) are included in the California Occupational Safety and Health Administration Guidelines for the Security and Safety of Health Care and Community Service Workers (State of California, 1993). Increasing the number of staff on duty may also be appropriate in any number of service and retail settings. The use of security guards or receptionists to screen people entering the workplace and controlling access to actual work areas has also been suggested by security experts.

Work practices and staffing patterns during the opening and closing of establishments and during money drops and pickups should be carefully reviewed for the increased risk of assault they pose to workers. These practices include having workers take out garbage, dispose of grease, store food or other items in external storage areas, and transport or store money.

Policies and procedures for assessing and reporting threats allow employers to track and assess threats and violent incidents in the workplace. Such policies clearly indicate a zero tolerance of workplace violence and provide mechanisms by which incidents can be reported and handled. In addition, such information allows employers to assess whether prevention strategies are appropriate and effective. These policies should also include guidance on recognizing the potential for violence, methods for defusing or de-escalating potentially violent situations, and instruction about the use of security devices and protective equipment. Procedures for obtaining medical care and psychological support following violent incidents should also be addressed. Training and education efforts are clearly needed to accompany such policies.

Behavioral strategies. Training employees in nonviolent response and conflict resolution has been suggested to reduce the risk that volatile situations will escalate to physical violence. Also critical is training that addresses hazards associated with specific tasks or worksites and relevant prevention strategies. Training should not be regarded as the sole prevention strategy but as a component in a comprehensive approach to reducing workplace violence. To increase vigilance and compliance with stated violence prevention policies, training should emphasize the appropriate use and maintenance of protective equipment, adherence to administrative controls, and increased knowledge and awareness of the risk of workplace violence.

Developing and Implementing a Workplace Violence Prevention Program and Policy

The first priority in developing a workplace violence prevention policy is to establish a system for documenting violent incidents in the workplace. Such data are essential for assessing the nature and magnitude of workplace violence in a given workplace and quantifying risk. These data can be used to assess the need for action to reduce or mitigate the risks for workplace violence and implement a reasonable intervention strategy. An existing intervention strategy may be identified within an industry or in similar industries, or new and unique strategies may be needed to address the risks in a given workplace or setting. Implementation of the reporting system, a workplace violence prevention policy, and specific prevention strategies should be publicized company-wide, and appropriate training sessions should be scheduled. The demonstrated commitment of management is crucial to

the success of the program. The success and appropriateness of intervention strategies can be monitored and adjusted with continued data collection.

A written workplace violence policy should clearly indicate a zero tolerance of violence at work, whether the violence originates inside or outside the workplace. Just as workplaces have developed mechanisms for reporting and dealing with sexual harassment, they must also develop threat assessment teams to which threats and violent incidents can be reported. These teams should include representatives from human resources, security, employee assistance, unions, workers, management, and perhaps legal and public relations departments. The charge to this team is to assess threats of violence (e.g., to determine how specific a threat is, whether the person threatening the worker has the means for carrying out the threat, and so forth) and to determine what steps are necessary to prevent the threat from being carried out. This team should also be charged with periodic reviews of violent incidents to identify ways in which similar incidents can be prevented in the future. Note that when violence or the threat of violence occurs among coworkers, firing the perpetrator may or may not be the most appropriate way to reduce the risk for additional or future violence. The employer may want to retain some control over the perpetrator and require or provide counseling or other care, if appropriate. The violence prevention policy should explicitly state the consequences of making threats or committing acts of violence in the workplace.

A comprehensive workplace violence prevention policy and program should also include procedures and responsibilities to be taken in the event of a violent incident in the workplace. This policy should explicitly state how the response team is to be assembled and who is responsible for immediate care of the victims, reestablishing work areas and processes, and organizing and carrying out stress debriefing sessions with victims, their coworkers, and perhaps the families of victims and coworkers. Employee assistance programs, human resource professionals, and local mental health and emergency service personnel can offer assistance in developing these strategies.

Responding to an Immediate Threat of Workplace Violence

For a situation that poses an immediate threat of workplace violence, all legal, human resource, employee assistance, community mental health, and law enforcement resources should be used to develop a response. The risk of injury to all workers should be minimized: If a threat has been made that refers to particular times and places, or if the potential offender is knowledgeable about workplace procedures and time frames, patterns may need to be shifted. For example, a person who has leveled a threat against a worker may indicate, "I know where you park and what time you get off work!" In such a case, it

may be advisable to change or even stagger departure times and implement a buddy system or an escort by security guard for leaving the building and getting to parking areas. The threat should not be ignored in the hope that it will resolve itself or out of fear of triggering an outburst from the person who has lodged the threat. If someone poses a danger to himself or others, the employer should notify appropriate authorities and take action.

Dealing With the Consequences of Workplace Violence

Much discussion has also centered around the role of stress in workplace violence. The most important thing to remember is that stress can be both a cause and an effect of workplace violence. That is, high levels of stress may lead to violence in the workplace, but a violent incident in the workplace will most certainly lead to stress, perhaps even to posttraumatic stress disorder. The data from the National Crime Victimization Survey (BJS, 1998) show compelling evidence for the need to be aware of the impact of workplace violence. Employers should therefore be sensitive to the effects of workplace violence and provide an environment that promotes open communication; they should also have in place an established procedure for reporting and responding to violence. Appropriate referrals to employee assistance programs or other local mental health services may be appropriate for stress debriefing sessions after critical incidents.

Current Efforts and Future Directions: Research and Prevention

Although researchers have begun collecting descriptive information about workplace violence, a number of research questions remain:

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

These questions should also be addressed in developing violence prevention strategies for specific workplaces.

A number of these questions were raised in 1990 at a workshop convened by NIOSH. They continue to require attention through the collaborative research and prevention efforts of public health, human resource, and criminal justice professionals. A number of other recommendations were

made by a panel of experts in interpersonal violence on directions for NIOSH in this area (NIOSH, 1992). These recommendations have been implemented or initiated and include efforts to

- improve the quality of death certificate data,
- compare findings from NTOF, the National Center for Health Statistics, and the Federal Bureau of Investigation,
- conduct evaluation research to determine the effectiveness of various prevention strategies,
- disseminate information on workplace homicide risk,
- examine possibilities for collection and analysis of data on nonfatal workplace violence, and
- increase collaboration between public health and criminal justice agencies.

In the fall of 1993, NIOSH released an alert on preventing homicide in the workplace (NIOSH, 1993) and encouraged employers, workers, unions, and others with a vested interest to look at their workplaces and take immediate action to reduce the risk for workplace homicide. In related efforts, NIOSH responded to numerous requests from the media, resulting in print, radio, and television coverage of the data and the NIOSH prevention message: Although no single intervention strategy is appropriate for all workplaces and no definitive strategies can be recommended at this time, immediate action should be taken to reduce the toll of workplace homicide on our nation's workforce. This message still holds true and applies not only to workplace homicide but to all workplace violence. Clearly, violence is pervasive in U.S. workplaces, accounting for 1,071 homicides in 1994 and approximately 2 million nonfatal assaults each year (BJS, 1998). NIOSH continues to pursue research and prevention efforts to reduce the risk of workplace violence for the nation's workers. The murder of an average of 20 workers each week is unacceptable and should not be considered the cost of doing business in our society.

BUILDING A HEALTHY WORK–LIFESTYLE BALANCE FOR PROFESSIONAL ATHLETES AND THEIR FAMILIES

Lifestyle Issues in Professional Sports

Imagine being called into the office for your performance evaluation. Upon entering the office, you discover not only your boss, but hundreds of others are present to contribute to the analysis. Every detail of your perfor-

mance has been recorded on videotape, each action has been statistically analyzed, and a MANOVA (multivariate analysis of variance) computed to compare this week's performance with that of previous weeks. In addition, individuals who are totally unrelated to your workplace, many of whom you have never met, are continually evaluating your performance and broadcasting their assessments via print media, radio, television, and the Internet. This process occurs week after week, month after month, over the entire course of your career. How many of us would subject ourselves to this degree of scrutiny?

Many in our society perceive professional athletes as "having it all"—money, big houses, expensive cars, and fame and adulation—all based on their endeavors on the field of play. But the challenges associated with performing one's daily work in a high visibility workplace (i.e., the football field or the hockey arena) often go unrecognized. There are inherent drawbacks to sports fame. Fans are notoriously fickle. Athletes find that they may be worshipped one moment as the hero, while in the next be condemned as villain (a situation referred to as "going from the penthouse to the outhouse").

The public is often oblivious to the high (many say unrealistic) expectations for these modern-day gladiators. Many professional athletes decry their unwanted role model status, the intense public scrutiny, and lack of privacy. However, these cries fall on deaf ears. Fans often behave as if they are entitled to know everything about their heroes and heroines, leading many elite athletes to feel that they are "living their life in a fishbowl."

The sacrifices made in pursuit of athletic glory are also overlooked or ignored by the public. Athletic success often requires a single-minded devotion to one's sport, leaving little time or energy for elements of life that most people take for granted. To achieve and maintain dominance on the court or the playing field, athletes often neglect family, friends, and hobbies. For high-level athletes, their sport often becomes a "job" long before they cash a paycheck. Studies have estimated that collegiate student athletes devote 30 to 60 hours per week to their sport (Miller, 1999). In many environments, any interest or activity that is not directly related to one's sport is viewed as a distraction.

Many individuals who reach the professional ranks have been singled out at an early age due to their athletic prowess. They have been groomed for a sports career and toward this end they have led lives that have been highly structured for them (summer camps, workouts, practices, and so forth). At the same time, they have been sheltered from other responsibilities and experiences, and in many ways protected from everyday problems and concerns. In addition, because of the fame and adoration that is frequently heaped on athletes in our society, many grow up being

constantly catered to and deferred to, leading to a sense of privilege and entitlement.

This combination of an all-consuming "work" environment and sheltered upbringing can result in an individual who is markedly underdeveloped in other areas of his or her life. This development pattern has been termed *identity foreclosure*: that is, the individual "forecloses" on a convenient or comfortable role and fails to explore alternative identities (Marcia, 1966). In the sports environment, such foreclosure can contribute to an "exclusive athletic identity" (Brewer, Van Raalte, & Linder, 1993). This condition is characterized by an inability to identify and describe self-worth outside of athletic descriptions. This type of identity may also pose an impediment to important personal growth and development that is "unmasked" when the player's athletic career comes to an end (Murphy, Petitpas, & Brewer, 1996; Werthner & Orlick, 1990).

The odds against any individual becoming a professional athlete are astronomical. According to data compiled by the National Collegiate Athletic Association, in any given year there are more than 1,450,000 high school athletes playing football and basketball in the United States. However, there are fewer than 400 new professional positions available in these sports each year: less than one professional rookie position for every 3,600 aspirants (Hagwell, 1998). On the basis of these numbers it should be clear that once he or she overcomes all of the hurdles faced by the aspiring professional athlete, the rookie has then joined a very small, select, and basically closed society. The rookie also finds that initiation into this group comes at a considerable cost.

With lightning speed, the newly turned professional athlete is consumed by a myriad of activities, issues, obligations, and expectations—before ever stepping foot on the professional field or court. The game they have played, to this point for enjoyment and competition, is now not only their livelihood, but has become *the* foundation of self-identity and social support. No longer can they simply "play" the game; they must integrate new business and social factors as well. In addition, many rookie professionals must now learn for the first time to deal with life outside of a highly sheltered and supportive environment.

Family members of exceptional athletes (particularly parents, partners and significant others) also face challenges with the transition to the professional realm. They often feel that friends and members of their extended family do not understand the issues faced by their famous offspring or spouse, or how this newfound fame affects them as a family. Indeed, wives and mothers of players in the National Football League and the National Basketball Association have formed their own organizations to provide support and information to one another (Broussard, 1998).

Challenges to a Healthy Work Life in Professional Sports

Professional athletes are confronted with the same types of psychological issues that are experienced by those in the general society. Elements of the professional athletic lifestyle can comprise barriers to establishing and maintaining an effective therapeutic relationship with clinicians. If not appreciated by the provider, these aspects can give an impression of disinterest and a lack of commitment or disengagement on the part of the athlete.

The sports environment in the United States creates a climate that discourages athletes from seeking or accepting care for physical and psychological ailments. A "sport ethic" has been described (Hughes & Coakley, 1991) that dictates that one must "play with pain." Seeking treatment is implicitly (or explicitly) viewed as a sign of weakness (Linder, Brewer, Van Raalte, & DeLange, 1991). In this intensely competitive environment, perception can determine the degree of success in sustaining the professional athlete status. If a player is perceived to have problems that could impede his or her athletic performance, the exposure of such problems can be the "kiss of death" to a professional sports career.

An additional potential impediment to careseeking by athletes relates to the "star power" that is bequeathed upon celebrities in our society. As a result of this perceived power, elite athletes frequently find themselves besieged with requests and demands from every quarter. It often seems as if even casual acquaintances expect something from them (money, time, the enhanced status that accompanies being associated with them). The response to such constant demands may be a deep-seated suspicion and distrust of anyone outside of "their world." The athlete shares him or herself only with other players, family, and possibly a small circle of friends (Begel & Baum, 2000). This can eventually result in significant social isolation. Although many individuals in our society are reluctant to seek psychological help, the self-protective isolation adopted by many professional athletes can exacerbate this avoidance.

If these barriers to seeking care are overcome, a variety of non-clinical factors and influences can impinge on the provision of care to this group. Dr. Joseph Pursch is a substance abuse specialist whose practice includes a number of professional athletes. He describes the impact of celebrity on the clinical encounter:

> When I have a sports star in my office for the first time, I can expect all of the buttons on my telephone to be lit up. . . . His agent is on one line to tell me he has a beer commercial lined up for his client that can't be shot if it is known he is an alcoholic. . . . The coach wants to know how soon he can play; the hospital administrator wants to make a public announcement; and the star's lawyer wants it quiet. A TV network demands

a full report. Agents for the Players Association and the team have their interests, and his wife and ex-wife (and maybe a girlfriend) want to be assured his income will continue, and all of this is before I have even taken his blood pressure. (Cowart, 1986, p. 2646)

Role of the Therapist in Attaining and Maintaining a Healthy Work and Life Balance

Although there are unique or magnified elements of mental health care for professional athletes, in the majority of cases their assessment and treatment is identical to treatment of others seeking care for psychological issues. Basic principles of problem identification, differential diagnosis, investigation of stressors and contributing factors, and assessment of coping skills and support network must be applied. This diagnostic and therapeutic approach must be applied within the context of the professional sports arena.

The primary psychological problems seen in athletes in therapy are stress related, specifically: anxiety and stress, depression, eating disorders, and substance abuse (Brewer & Petrie, 1995; Petrie & Diehl, 1995; Petrie, Diehl, & Watkins, 1995). The life of the professional athlete is, more than most, one of constant instability and transition. These transitions may be related directly to the athlete (i.e., being traded or released from the team, injury, retirement) or to the work environment (coaches fired, entire teams moved from one city to another, etc.). Transitions, uncertainty, and the constant pressure to perform at a high level result in a significant degree of stress. A variety of psychological interventions have been proposed to assist athletes in stress management, recovering from injury and in some cases, preventing injuries. These include relaxation, goal setting, positive self-talk, and imagery (Ieleva & Orlick, 1991; Wiese-Bjornstal & Smith, 1993; Yukelson & Murphy, 1993).

In counseling professional athletes, as with all counseling, trust building and empathetic understanding are essential. Trying to understand the athlete's point of view, and communicating that understanding to the individual can establish the foundation for a trusting therapeutic relationship. Explicit acknowledgement of the unique aspects of the professional athlete's work life and lifestyle may also aid in nurturing this relationship and establishing a foundation of trust.

Therapeutic techniques and approaches that may prove useful in treating professional athletes include

- acknowledging the variety of emotions that the athlete is experiencing, normalizing their emotions and concerns, predicting their responses, and reframing their issues;
- assessing coping skills and assisting the athlete in developing and using healthy coping mechanisms; and

- providing assistance in expanding identity beyond athletics. Encourage non-sports related activities, active planning for life beyond sports. Help them recognize transferable skills (Murphy, 1995; Petitpas, Champagne, Chartrand, Danish, & Murphy, 1997). Assessment tools like Myers-Briggs or stress inventories (i.e., Moos) may be helpful.

As with most individuals, the social support system of athletes is frequently a key contributor to their psychological health and well-being (Brewer, Jeffers, Petitpas, & Van Raalte, 1994). Assessing these support networks and advising the athlete on ways to effectively use them can be of tremendous benefit. As in other settings, the support system of professional athletes usually consists of family and a few close friends. Coworkers (in this instance, coaches and teammates) may also be important components of the support network for professional athletes (Wiese, Weise, & Yukelson, 1991). A therapeutic approach based on family systems theory can often be useful in treating athletes (Zimmerman, 1999). With the athlete's permission, discussion with family, friends, and coaches can provide an opportunity to reinforce the important role that these individuals play in the treatment process. Reinforcing appropriate interventions on their part and educating them regarding useful therapeutic techniques can also be of benefit.

Clinicians in a sports environment must recognize that, in addition to providing support to the athlete, this network may often be the cause of or a significant contributor to the psychological issues that bring the athlete into therapy. In many cases, as a result of the financial windfall that often accompanies a professional contract, the athlete may find that their role in the family system has, almost overnight, gone from one of child or sibling to head of household. At times players will create businesses or opportunities to put family members and friends on their "payroll," resulting in additional role confusion (player as "boss" to Mom or Dad). The attendant responsibilities and obligations may prove overwhelming for a young adult who is still struggling to develop a sense of independence and a mature self-identity.

In other instances, the family support system may have been only minimally effective prior to the athlete entering the professional realm. The increased stress and intense public scrutiny may erode this tenuous foundation of support. The athlete then redefines his support network, often leading to further conflict.

Unique Clinical Aspects of Professional Athletes

As previously acknowledged, most of the problems leading to mental health care in professional athletes are common to many workplace

environments (stress and anxiety, depression, marital or relationship issues, lack of balance between personal and professional life). However, there are some conditions that are unique to, or experienced differently by athletes.

Substance Abuse

The athlete with drug addiction is a case in point. As exemplified by Dr. Pursch's description in the previous section, the assessment and treatment process are infringed on from many directions. In addition to these multiple distracters, the lifestyle of the athlete and the culture of professional sports make it extremely difficult for sustained treatment and follow-up (Cowart, 1986). If a player is suspended from competition due to substance abuse, he or she is not allowed to participate in team practices, meetings, or other activities. Because most athletes do not live in the same cities as their families of origin, suspension essentially removes and isolates the player from his only major source of support (the team). He or she is not able to work and may then become vulnerable to increased abuse of the substances. At the same time the athlete is without access to those relationships that may stabilize and minimize his or her abusive tendencies. Additionally, the athlete's struggles with sobriety are often played out on a highly public stage.

Retirement

Another example of a unique athletic psychological experience relates to retirement and end of career. According to statistics compiled by the National Football League Office of Player Development, the average player spends 3.5 years in the NFL. This "professional lifespan" is similar for other professional sports. Consequently, the career of most pro athletes "peaks" at a very early age (typically in their mid- to late 20s). As already discussed, many of these individuals have devoted the majority of their waking hours to athletic accomplishments. This transition to former athlete is often traumatic:

> The pampered treatment he has long received may have left him without basic skills for coping with life. Now he suddenly confronts a mystifying world that is normal to most. The countless people who have long stroked his ego may have left him with an unrealistic appraisal of himself and his value to the world, and now he suddenly confronts a society that is indifferent to his physical skills and is asking if he has any others . . . . He has long felt himself invincible . . . but now he must confront his own wretched mortality. (Myslenski, 1986, p. 20)

With retirement comes a host of losses: the loss of income; loss of identity and status; the loss of the routines, rituals, and the adrenaline rush of competition; and loss of the camaraderie of team. There may be feelings of helplessness and shame. These losses often trigger a grief reaction in

retired players. The period following retirement is an extremely vulnerable phase. According to National Football League surveys, during the first 4 years after retirement players are at increased risk of marital separation and divorce, and are more susceptible to developing or worsening problems with substance abuse (G. Troupe, NFL Senior Director of Player and Employee Development, personal communication, April 2001).

Schedules and Continuity

Scheduling and appointment issues frequently arise when treating professional athletes. Professional athletes work year round. The off-season is devoted to strength and conditioning—a vital part of their success once the season begins. They have very full schedules and may have very little time off during traditional business hours. It is expected that practitioners working with professional athletes will maintain a high level of flexibility. Players expect clinicians to work around *their* schedules.

Many pro athletes find it challenging to keep scheduled appointments because they are not accustomed to making such appointments, and they have been conditioned to expect that others will work with them at whatever point they decide to make themselves available. At the high school and collegiate levels, the athlete is typically not responsible for designing his or her schedule. Such details are usually handled by coaches or by advisors within the department of athletics. Most of the athlete's time evolves around their sport's schedule. There is little if any time for the athlete to be involved in other extracurricular activities. Once the athlete reaches the professional level, his or her time is even more consumed by sports-related activities. Free time is diminished, with the possible exception of the off-season. So much is "handled" for elite athletes (by team and coaches, agents, or personal assistants) that the need or the opportunity to develop personal time management skills is often eliminated. In addition, responsibilities to team and to sport are expected to override all other obligations. For example, a player may schedule (or have scheduled for them) an appointment "outside" of the sports system. This could be to explore a business opportunity or a clinical encounter. The team makes a last minute change in the schedule—a common occurrence—resulting in a conflict with keeping the appointment. The athlete then exacerbates the problem by failing to call to cancel or change the appointment. Such behaviors are reinforced by the general acceptance of this lack of courtesy and consideration by many who are accustomed to working with elite athletes.

In anticipation of such events, a discussion of expectations around time and scheduling issues early in the treatment process is warranted. Clarifying what will and will not be viewed as acceptable behavior, and consequences of deviation from this agreed-upon norm may prevent problems down the line.

Additional complications can arise as a result of the "revolving door" nature of professional sports (trades, injury, salary cap, etc.). Players have limited job stability and are literally "here today, gone tomorrow." A player may be traded without notice and report to work in another city within 24 hours. This can pose significant challenges to continuity in the treatment process.

Confidentiality Issues

The issues related to confidentiality in the professional sports arena are as critical as they are controversial. The practitioner may at times have difficulty identifying exactly *who* is the client, and be challenged by how information is disseminated and used within this setting. If clinicians are hired by a team or a sports league, there are usually expectations on the part of the hiring party that sensitive information about individuals will be shared. This can place the mental health practitioner in an unfamiliar and uncomfortable position.

Information such as the psychological history and family dynamics would typically be considered private and confidential by a clinician. However, intimate details are commonly included in the scouting reports used by coaches and teams in their "hiring" process for players. The dilemma the practitioner may encounter is determining to whom the information will be provided and how it will be used.

Professional sports organizations are typically unaccustomed to the appropriate management of highly confidential clinical information. Most athletes do not appreciate the sensitive nature of information revealed through the psychological and psychiatric evaluations that are often performed at the behest of interested teams. Therefore, sensitive and revealing information about that athlete's state of psychological functioning could be revealed indiscriminately to those within and outside of the sports organization.

Dual relationships abound within the professional sports arena. This has historically been a controversial area in the practice of psychology. It is imperative that the clinician understands the culture of professional sports, and clearly defines his or her role and establishes appropriate boundaries. One key is to always keep in mind exactly who the "client" is (league, team, or athlete) and how the needs of that client can be most effectively and confidentially addressed.

It is also incumbent upon the clinician to educate key individuals within the organization regarding the importance of client privacy and the need to severely limit access to sensitive information. Educating the player about such issues serves to empower the player, and may aid in building a bond of trust with the psychologist.

Final Thoughts

A recent front-page article in *USA Today* discusses the increasing interest in young athletes turning professional. The article discusses lucrative professional contracts offered to today's young stars. The athletes featured in this article were 12 years old (Brady & Rosewater, 2001).

The difficulties experienced by professional athletes as a result of underdeveloped life skills have been well documented. Many of these problems have been described in players who have entered the professional sports arena from college. What will be the long-term effects on those athletes who bypass college altogether?

Increasingly, the need for psychological consultation and intervention is being recognized in the world of professional sports. The need for more research providing empirical evidence, insight, and understanding into the coping and adjustment aspects of the professional athlete is clear. Other areas requiring exploration include effective methods of developing life skills, and studies of family issues in professional sports.

The issues have been presented before us. Psychologists, like elite athletes, must train and prepare for the challenge.

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This book is an extraordinarily exciting glimpse into the 21st century. It highlights the numerous contributions professional psychology is making, and shall continue to make, in successively addressing an impressive range of societal problems—particularly the crisis facing our nation's ever-evolving health care system. The authors are world-class, and their genuine enthusiasm for the future is inspiring.

—*Pat DeLeon, PhD, MPH, JD, Past President, American Psychological Association*

Psychology Builds a Healthy World is a groundbreaking volume that applies an integrative biopsychological model to the effective functioning of individuals, families, communities, and the workplace. The clearly conceived and comprehensive chapters offer a tantalizing menu of innovative theory and research, leading to strategies for the prevention of health risks and the promotion of psychological strength and well-being. I recommend this outstanding book as a must-read for every professional involved in the health-maintenance community as well as educators, public policy advocates, and the consumers of health information.

—*Judith Worell, PhD, Professor Emerita, Educational and Counseling Psychology, University of Kentucky, Lexington*

This book asks us to remove the arbitrary division between health and mental health. It takes a new approach to psychology: valuing diversity and strength as it integrates mind and body and recognizing the interaction of culture, class, and gender on the health of the people. Unlike the black plague of disease carried by rodents at the beginning of the 20th century, the current plague of disease in the 21st century is transmitted by humans. In today's global environment, we are asked to change our views of how human behavior influences our health, hence, how psychology can help to build a healthy world. It is a book well worth reading.

—*Jean Lau Chin, EdD, ABPP, Systemwide Dean, California School of Professional Psychology, Alliant International University, Alameda*

This is a must-read for psychologists looking beyond our traditional mental health boundaries to a healthy home, workplace, community, and world. This very readable book provides us with new insights. I heartily recommend it.

—*Robert J. Resnick, PhD, ABPP, Past President, American Psychological Association; Department of Psychology, Randolph Macon College, Ashland, VA*

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Psychology Builds a Healthy World

OPPORTUNITIES FOR RESEARCH AND PRACTICE

Edited by
Ronald H. Rozensky
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Carol D. Goodheart
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