Developing sustainable strategies for assisting assaulted mental health nurses

Paper

Charles Harmon
University of Newcastle, Callaghan, Australia

Keywords: Assault, violence, nurses, responses, qualitative research, grounded theory

Introduction

Patient violence has become a major issue in mental health facilities in Australia.[1-3] In the state of New South Wales health department policy requires all staff who have contact with patients to engage in mandatory training in the management of aggression. Staff who experience violence are strongly encouraged to report the incident; and it is the responsibility of line managers to enquire about the staff member's recovery and to inform them of the availability of the employee assistance program (EAP) which is an independent counselling service funded by NSW Health.[4]

International researchers have reported on mental health nurses' experiences of being assaulted by patients[5-9] but there are gaps in the literature about how mental health nurses respond following assault by their patients. In particular the present researcher was interested in the source of the anger and distress reported by assaulted nurses as well as the relevance of the victims' work environment in shaping their responses post-assault. The extent to which the employment of post-assault coping strategies such as avoidance and denial diminishes the capacity of nurses to engage therapeutically with patients[6, 7] was another issue of concern.

Methodology

This prospective study examined the responses of mental health nurses to the experience of patient-initiated assault using mixed methods but primarily employing the grounded theory method described by Glaser. [10-12] The study was designed to address two research questions:

1. What is the process of response of mental health nurses to assaults by patients?
2. What is the effect of a recent (patient-initiated) assault upon the ability of the mental health nurse to engage therapeutically with her/his patients?

For this study patient assault was defined as:

1. Any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (e.g. where the nurse is verbally threatened) OR
2. Any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (e.g. where the nurse is spat upon).[8]

The study was conducted in two phases within the inpatient units of a public mental health service located in regional New South Wales, Australia. Phase one of the study involved close observations of nurses in acute inpatient settings and will be published separately. During phase two of the project (July 2003 to August 2004), sixteen volunteer nurses were interviewed within three weeks of being assaulted by a patient using: the Assault Response Questionnaire (ARQ)[8], a 61-item questionnaire which measures a range of responses (such as anger and anxiety) on a five-point scale from 'none' to 'slight' through to 'severe'; and a demographic data form. Two follow-up semi-structured interviews were also conducted with this sample of nurses at three months and six months post-assault. The second and third interviews were broadly scripted to explore the following dimensions: working conditions; the nurse's ongoing responses to assault; changes in response over time; moderating factors which might affect coping; individual coping strategies; and relationships with patients and colleagues. Questions were posed broadly: "Tell me, how you have been coping since your assault?" and "Have you experienced any difficulties in the way in which you relate to patients since the assault?" Interviews progressed until it became clear that there was data saturation.

Data were analysed as they were collected using the grounded theory approach outlined by Glaser[10-12] in which the raw data were 'broken up' via a process known as open coding and then placed into interim

categories on the basis of shared characteristics. The data were then analysed with the aim of constructing categories with greater levels of abstraction and, hence, greater capacity to explain variation within the data. These activities were facilitated by the basic processes of memo writing, questioning the data and making theoretical comparisons; with the dual aims of facilitating categorisation of the data and verification of the procedures.

Results

Of the sixteen nurses interviewed for phase two of the project, eleven were males. Ages ranged from 26 to 55 years of age. Nursing experience ranged from one year to 25 years. Ten of the nurses reported 50 or more previous assaults during their careers. The most common form of assault reported for this study was a single punch. Five of the nurses reported experiencing a severe level of threat during their assault and six reported experiencing a moderate level of threat and five reported experiencing a mild or negligible level of threat.

Overall, responses on the ARQ tended to be reported mostly at 'mild' and 'moderate' levels with most participants recording at least one response in the 'fairly intense' or 'severe' categories. Responses typically included feelings of anger, anxiety and disbelief that the assault had occurred. The main purpose of using the initial questionnaires was to provide baseline data and to establish a 'language' that might facilitate the description of feelings during subsequent interviews.

During the second interview five of the inpatient mental health nurses reported experiencing only mild discomfort for several hours after they had been assaulted by a patient, and two participants reported mild responses for up to four days. In contrast nine participants reported strong reactions to their experience of assault and commenced a process of recovery, lasting from several weeks to months, marked by two distinct phases which were subsequently labelled *churning anxiety* and *reintegration* (see figure 1).

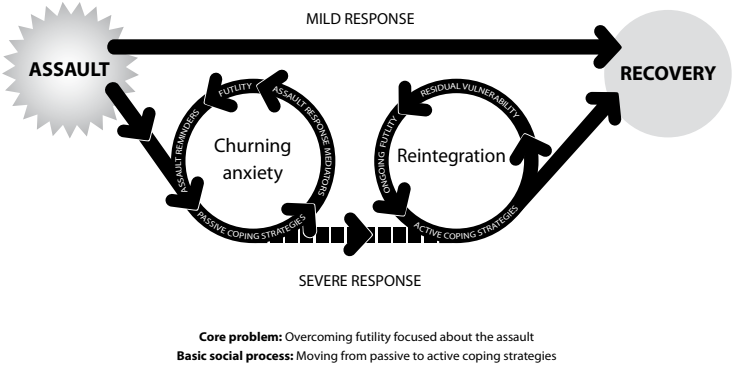

Figure 1: Depiction of the recovery trajectory for Phase Two participants as they moved from passive to active coping strategies.

Features of the churning anxiety phase were:

- Assault reminders: including ongoing distress related to fear of the assaultive patient and intrusive thoughts about the assault.
- Passive coping behaviours: including passive management strategies for personal emotions (such as minimising the importance of the assault or not thinking about it) and passive patient management strategies (such as keeping a distance from patients and not engaging with them).
- Assault response mediators. Participants who reported the perception that they had received 'adequate' support from colleagues during the post-assault period said that this experience helped to alleviate their distress. Those who reported the perception that colleagues (especially nurse managers) were not supportive, reported an exacerbation of their distress.
- Futility: related to the participants' continued expectation of being assaulted as well as the perception that their nurse managers had not acknowledged their distress.

It was hypothesised that PTSD theory is a useful vehicle for analysing the coping behaviours reported by participants such as the minimisation and suppression of psychological reactions. An example of the

suppression of post-assault responses in the present study was identified in the four participants who reported that they were 'over' the effects of their assault at interview two before realising that they had underestimated the duration of their reactions to their assault by several weeks at interview three.

The reintegration phase marked a departure from the passive coping strategies which were a feature of the churning anxiety phase of recovery. Participants engaged in the reintegration phase of recovery reported adopting:

- Active strategies in the management of their professional lives including: active patient management strategies (such as being more assertive with their patients); and actively managing safety concerns (such as participating in work safety programs and considering a new, and safer, job).
- Residual vulnerability: particularly in relation to the presence of aggressive patients.
- Ongoing futility: related to the perception that nurse managers were ignoring the requirement for improvements to workplace safety.

Whilst support from peers was valued there was an overall perception that a lack of support from nurse managers made recovery more difficult. Participant 'John', for example, reported that his line manager had ignored him after his assault which made him feel *"unsupported"* declaring *"... that's one of my major gripes* [regarding my assault] *... I don't feel supported here by administration"*. Similarly 'George' reported his continued frustration that "*... it seems to me that* [the nurse manager] *should have had someone approach me or say, you know, do you want to talk about this ... but it didn't happen"*. 'Louise' described the lack of support that she received as "stressful". Indeed nine of the participants reported either dissatisfaction with the level of support received from their nurse manager or that they had received no contact at all. Moreover only seven of the sixteen participants in this study were informed, by their nurse manager staff, of their right to access EAP to assist with the alleviation of their distress.

Discussion

Some nurse managers may have experienced difficulty recognising the distress of the participants in the post assault period and consequently did not offer support to the satisfaction of the participants. This lack of recognition may be influenced by the assaulted nurses' minimisation and/or suppression of the psychological impacts due to their assault. However, in most cases, the relevant nurse manager either did not enquire about the participant's level of distress or only enquired about their distress during the 24 hours following the assault. This behaviour may be due a lack of awareness about the possible psychological effects of patient assault or to the perception that patient initiated violence is just part of the job.[13]

According to Lazarus and Folkman[14] the ability of people to access and use social support is a key factor in alleviating stress. Further, the primacy of social support as a mitigating factor against the severity of post trauma responses is emphasised in a meta analysis by Brewin and Holmes.[15] However there appears to be a special expectation attributed to nurse managers by the participants in this study. One explanation may be that the nurses working for the particular health service, whether they have been assaulted or not, have come to expect low levels of support in their workplace.

If this is so nurse managers require education about the benefits of being more supportive toward assaulted staff. One venue for the dissemination of information on the potential effects of patient violence upon nursing staff is the mandatory aggression management program. These programs have proliferated in Australia and abroad since the mid-1990s and into the current decade. However Farrell and Cubit,[16] in their audit of 28 management of aggression programs in eight countries including Australia, Canada, Ireland, Japan, New Zealand, Switzerland, the UK, and the USA, reported that the content of these programs varied widely with several omissions. In the discussion of their findings Farrell and Cubit[16, (p. 51)] stated:

"Most programs appear not to address the psychological and organizational (sic) effects associated with aggression. This is surprising since the literature suggests that the effects of aggression are wide and varied, including increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, worker's compensation, reduced job satisfaction together with recruitment and retention issues".

There is a clear case for better preparation of mental health staff in respect of the potential effects of patient assaults (including information on strategies for the recognition of post-assault distress in colleagues and the subsequent potential for professional disengagement by victims of assault). Specific training for nurse managers is also indicated regarding: the importance of their role in the recovery of assaulted staff and also the requirement for them to engage in: pastoral care in enquiring on a more regular basis about the welfare of assaulted nurses; and the initial counselling of assaulted nurses followed by subsequent referral to more specialised support services such as EAP.

The potential benefits of nurse managers providing support for assaulted nurses are outlined by Kanaisky and Norris[17] who described the effects of increased levels of perceived support which, they found in their research with victims of violent crime, promoted well-being regardless of the distress experienced by victims. Kanaisky and Norris[17, p. 220] described the elements of *perceived support* as: *perceived appraisal support* (the perceived availability of both emotional support and guidance); *perceived tangible support* (such as providing time off from duties); and *perceived self- esteem support* (the availability of reassurance of self-worth). There also appears to be benefits in respect of increased competency of assaulted staff and improved workplace morale. Deans,[18] in his study, revealed that among assaulted nurses who reported experiencing relatively high levels of occupational violence, there was a significant relationship between perceived higher levels of organisational support and higher levels of perceived professional competence.

Historically critical incident stress debriefing (CISD) was provided to assaulted nurses on a routine basis. This practice was discontinued in NSW Health facilities due to controversies about whether the process of CISD may effectively 'pathologise' normal responses to the experience of traumatic such as denial and forgetting[19] and doubts as to the effectiveness of CISD in reducing distress and longer-term psychological sequelae.[20] Although a return to the practice of CISD is not being advocated in this paper it might be argued that the end of this practice has created a vacuum in the provision of effective organisational support. Practical measures which serve to fill this vacuum might be explored in future research including: the appointment of specific occupational health staff who might assist in the ongoing monitoring and support of assaulted nurse; the creation of support groups for assaulted nurses and the option of clinical supervision for all assaulted nurses who experience distress. There is limited research into the effectiveness of support groups[21] and clinical supervision[22] as means of reducing the stress experienced by individuals in relation to patient assaults. However there may be benefits associated with these strategies as their provision may increase the degree of *perceived support*.

Conclusion

A number of recommendations may be made on the basis of the study findings. New policy directions may include: the incorporation of information on the psychological effects of patient violence (regardless of the presence of physical injury) in aggression management programs; and specific contributions of nursing administration staff in the ongoing support of victims of violence. Strategies which improve the degree of perceived support by nursing staff should also be considered. One possible area for future research might be to study nurse managers' responses to staff who have been assaulted by patients, to investigate what managers think they ought to be doing and what they are actually doing. Future research might also focus on evaluating the impact of multiple support strategies, including clinical supervision and the introduction of support groups. These are achievable strategies which may facilitate a sustainable future in the provision of support for assaulted nurses.

Acknowledgements

I would like to acknowledge the 16 nurses who volunteered to be participants in this research project as well as the many health professionals who allowed me to observe their practice. I also acknowledge the valuable advice offered by my supervisors, and co-authors of this paper, Professor Michael Hazelton and Doctor Ashley Kable, in the conduct of my studies.

References:

1. Carr VJ, Lewin TJ, Sly KA, Conrad AM, Tirupati S, Cohen M, Ward PB, Coombs T. Adverse incidents in acute psychiatric inpatient units: Rates, correlates and pressures. Aust. N. Z. j. psychiat. 2008; 42 (4): 267-82.
2. Barlow K, Greyner B, Ilkiw-Lavelle O. Prevalence and precipitants of aggression in psychiatric inpatient units. Aust. N. Z. j. psychiat. 2000; 35 (6): 967-74.
3. Owen C, Tarantello C, Jones M, Tennant, C. Violence and aggression in psychiatric units. Psychiatr. serv. 1998; 49 (11): 1452-7.
4. Employee Relations Branch, NSW Department of Health. Zero tolerance response to violence in the NSW health workforce. North Sydney: NSW Department of Health; 2005. Document number: PD2005_315.
5. Needham I, Abderhalden C, Halfens R J G, Fischer J E, Dassen T. Non-somatic effects of patient aggression on nurses: A systematic review. J. adv. nurs. 2005;49 (3): 283-96.
6. Collins C J. The experience of patient assault and its impact on psychiatric nursing practice [PhD Thesis]. Chicago, Illinois: Graduate College of the University of Inninois; 1996.
7. Wykes T, Whittington R. Coping strategies used by staff following assault by a patient: An exploratory study. Work stress. 1991; 5 (1): 37-48.
8. Ryan JA, Poster EC. The assaulted nurse: Short-term and long-term responses. Arch. psychiatr. nurs. 1989; 3 (6): 323-31.
9. Lanza ML. The reactions of nursing staff to physical assault by a patient. Hosp. community psychiatr. 1983; 34 (1): 44-7.

10. Glaser BG. Grounded theory 1984 - 1994. Mill Valley (Ca.): Sociology Press; 1995.
11. Glaser BG. Emergence vs forcing: Basics of grounded theory analysis. Mill Valley (Ca.): Sociology Press; 1992.
12. Glaser BG. Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley (Ca.): Sociology Press; 1978.
13. Whittington R. Violence in psychiatric hospitals. In: Wykes T, editor. Violence and health care professionals. London: Chapman & Hall; 1994.
14. Lazarus RS, Folkman S. Stress, appraisal, and coping. New York: Springer Publishing; 1984.
15. Brewin CR, Holmes, EA. Psychological theories of posttraumatic stress disorder. Clin. psychol. rev. 2003; 23 (3): 339-76.
16. Farrell G, Cubit K. Nurses under threat: A comparison of content of 28 aggression management programs. Int. j. ment. health nurs. 2005; 14 (1): 44-53.
17. Kanaisky K, Norris, FH. Social support and victims of crime: Matching event, support, and outcome. Am. j. community psychol. 1992; 20 (2): 211-41.
18. Deans, C. Nurses and occupational violence: The role of organisational support in moderating professional competence. Aust. j. adv. nurs. 2004; 22 (2): 14-8.
19. Antai-Otong D. Critical incident stress debriefing: A health promotion model for workplace violence. Perspect. psychiatr. care. 2001; 37 (4): 125-39.
20. Adler AB, Litz BT, Castro CA, Suvak M, Thomas JL, Burrell L, McGurk D, Wright KM,. Bliese PD. A group randomised trial of critical incident stress debriefing provided to U.S. peacekeepers. J. trauma. stress. 2008; 21 (3): 253-63.
21. Lanza ML, Demaio J. Benedict MA. Patient assault support group: Achieving educational objectives. Issues ment. health nurs. 2005; 26 (6): 643-60.
22. Teasdale K, Brockelhurst N, Thom N. Clinical supervision and support for nurses: An evaluation study. J. adv. nurs. 2001; 33 (2): 216-24.

Correspondence

Mr Charles Harmon
University of Newcastle
University Drive
2308
Callaghan
Australia
+61 249 216 324
charles.harmon@newcastle.edu.au