

## SPECIAL ARTICLE

# Violence at work

VIVIENNE SCHNIEDEN

*Department of Psychological Medicine, University College Hospital, London*

### INCIDENCE OF VIOLENCE

Violence appears to be increasing within our society along with a disregard for property as illustrated by the recent incidents on estates in Britain. The definition of violence varies and may include deliberate self-harm (DSH), damage to property, verbal abuse, threatening behaviour and physical attacks on persons or on staff (Shader *et al.*, 1977; Fottrell, 1980; Ruben *et al.*, 1980; Bouras *et al.*, 1982; Dietz & Rada, 1982; Tardiff, 1983; Aiken, 1984; Hodgkinson *et al.*, 1985; Werner & Bouras, 1988).

It has been recognized that Health Care Workers are at risk of violence in their working environment (Health Services Advisory Committee, 1987; DHSS Advisory Committee on violence to staff 1988; Harrington, 1990). A recent report by the National Union of Public Employees (1991) showed that 87% of those respondents to a questionnaire were worried about violence in their work, i.e. in a hospital setting. Few (43%) of the hospitals had a policy on violence, only 3% of hospitals offer special training to all staff and up to 50% give no training. Only 25% of the hospitals had advised staff on the procedure to report incidents. Much of the chronic under-reporting was of verbal abuse or threats. Under-reporting of assaults has been noted in previous studies (Lion *et al.*, 1981; Conn & Lion, 1983). A review by the author of incident forms in the Accident and Emergency Department of University College, London confirmed under-reporting of such events. Staff reported serious physical attacks or incidents relating to possible medical consequences — in this case exposure to blue asbestos; but not verbal abuse. Other studies also show serious incidents being reported (Wenk *et al.*, 1972; Infantino & Mustingo, 1985). Explanations that have been offered for under-reporting include the fact that the frequency is so high that it is not reported; that report filling is tiresome and staff see no change as a result of it and; staff fear serious accusations of negligence and inadequate performance (Conn & Lion, 1983; Lion *et al.*, 1983).

Doctors on call for psychiatry at University College Hospital Accident and Emergency Department had not filled in incident forms although there had been

several recent incidents known to the Department and to the author. There are reports that violence is relatively frequent amongst psychiatric trainees (Madden *et al.*, 1976; Tardiff & Maurice, 1977; Lehmann *et al.*, 1983; Kidd & Stark, 1992). Violence is commonly encountered with the mentally ill especially in hospitals (Solloff, 1983; Tardiff, 1984; Haller & Deluty, 1988). Solloff states 'violence is endemic in the mental health treatment setting and constitutes a real if unacknowledged occupational hazard'. In America assaults are most common firstly, in psychiatric hospitals secondly; in accident and emergency departments and thirdly in intensive care units (Drummond *et al.*, 1989). The United Kingdom has had different experience with the three areas most associated with violent events being accident and emergency departments, community health and psychiatric care (Health Services Advisory Committee, 1987). A recent survey of nurses at an Accident and Emergency Conference concurred that violence was a significant issue (Schnieden and Bell (1992)).

## TYPES OF VIOLENCE

Real incidents of physical violence are rare and are usually minor in hospitals (Lion *et al.*, 1981; Armond, 1982). Serious physical violence is rare in hospitals (Fottrell, 1980; Convey, 1986), but verbal violence is common and is usually in the form of obscenities or non-specific threats. Fottrell *et al.* (1978) found the majority of assaults were verbal. Violence often escalates from verbal to physical violence. Werner *et al.* (1983) found a 0.38 correlation between hostile verbalizations and physically assaultive behaviour but the target of assault varied.

## WARD STRUCTURE AND VIOLENCE

Studies on violent psychiatric inpatients (Tardiff & Sweillam, 1979) show that physical abuse appears to be associated with men aged 15–40 years (Shader *et al.*, 1977; Fottrell, 1980). There is a difference in opinion with relation to structure and violence. Edwards & Reid (1983) and Hodgkinson *et al.* (1985) found in in-patient psychiatric wards that the level of violence was related to the amount of activity on the ward. They found that more assaults occurred in a less structured environment, i.e. one with less activities planned for the patients. Ionno (1983) found that physical assaults were most common on visiting days and suggested that the increased activity level associated with these days may increase the likelihood of patients carrying out an assault. Pearson *et al.* (1986) found an increase in assaults in periods of activity. Staffing levels and the amount of pressure in the department may effect physical and verbal violence. An association has been shown between violence and agency staff levels in psychiatric hospitals (Fineberg *et al.*, 1988). Adequate provision of well-trained staff is thought to be important in the prevention of violence (Brailsford & Stevenson, 1973), James *et al.* (1990) showed a variety of factors effect violence including nursing provision.

## TRAINING

The lack of training in physical and verbal violence needs to be addressed (Brailsford & Stevenson 1973). Infantino & Musingo (1985) found training in aggression control techniques decreased the number of staff assaulted. Staff knowledge and performance in handling violent behaviour improve after training (Lehmann *et al.*, 1983). Violence usually escalates from verbal to physical and identification and intervention at an early stage could help in its prevention. The use of protocols should be encouraged (Green, 1989) and staging criteria of:

- (1) argumentative behaviour, threats perceived or implied;
- (2) verbally threatening behaviour to self, persons or property;
- (3) physically threatening behaviour to self, persons or property;
- (4) assaultive behaviour towards self, persons or property and;
- (5) out of control or violent behaviour to self, persons or property whereby high risk patients are identified and intervention occurs at Stage 3 with reporting to other members of staff at Stage 2.

## PREVENTION

A crisis plan to put into action once a violent incident has occurred should be part of the departmental policy (Kurlowicz, 1990). This would enable staff to deal with actual violence and identify potential for violence and to defuse that potential before it erupts (Dubin, 1981). The plan should consist of:

- (1) identifying potential violence, e.g. checking for history of violence, observing current behaviour, noting staff reaction to patients, patients diagnosis and demographics. The verbal and non-verbal signals that staff give to patients are important (Cardwell, 1984), e.g. tone of voice, stance and personal space and;
- (2) how to take action — talking and engaging the patient, using drug therapy after a physical examination and using common sense in ones approach to the patient.

Training in techniques of handling anger (Whittington & Wykes, 1989) may prevent a violent incident. Morton (1986) describes emotional intensity, states before and after the assault. The first two stages are mild and moderate and are functional states. Reasoning can be used in these stages. The remaining two stages are of severe intensity and eruption with loss of control over behaviour. The persons' capacity to process information is impaired and so effective problem solving is blocked. Ideally intervention should occur in the early stages. Braithwaite (1992) describes some of these defusion techniques and advises on predictive factors and the handling of acts of violence. The RCN Association of Nursing Practice Accident and Emergency Nursing Forum have produced Guidelines for Dealing with Aggression (1988) in the accident and emergency department.

An association between pre-admission threats and subsequent physical and

verbal violence has been found in psychiatric patients (McNeil & Binder, 1989). Training in aggression control techniques has evolved in Florida and three training phases recognized (Infantino & Musingo 1985) namely; Phase 1 — local policy and procedures, patient rights and verbal intervention procedures; Phase 2 — basic physical intervention techniques and; Phase 3 — specialized instruction in restraint control, transport of patients and incident reporting.

This technique utilizes a video in Phases 2 and 3. Training in Aggression Control was demonstrated to be inversely associated with the incidence of assaults. Training is often offered late in employment and staff with longer employment are assaulted the most (Lanza 1983). Some nurses with least experience were attacked most often (Hodgkinson *et al.*, 1985) and in another study least often (Fisher 1988). Thackerey & Bobbitt (1990) showed that underreporting of violence by clinical and nonclinical staff occurs and so all staff require training.

## CONSEQUENCES

Studies have shown the onset of post-traumatic stress disorder after assault (Conn & Lion, 1983; Lanza, 1983; Whittington & Wykes, 1989). The nursing staff assaulted showed an increase in symptoms e.g. anxiety, ruminations, intrusive thoughts about the incident, muscle tenseness and fatigue. They also increase their use of alcohol, nicotine and food in the hours and days after the incident. Sleep disturbances became increasingly common as time went on. Symptoms reported by some people were consistent with post-traumatic stress disorder. Many victims described few opportunities to talk about how they felt about the incident and what happened (Whittington & Wyke (1989)). The reactions of nursing staff to physical assault showed difficulties occurred in admitting fears and problems after physical assault (Lanza 1983). There appear to be few provisions made for victims of physical or verbal assault despite recommendations by the Royal College of Nursing and studies on peer and support program (Dawson *et al.*, 1988). Thompson recognized stress amongst nurses (Thompson, 1983) and found the coffee room was utilized to diminish this.

The Collegiate Trainees Committee Working Party (1991) expressed concern about the training of junior doctors with respect to violent incidents.

## FUTURE RESEARCH

The need for analysis after the event has been documented (Morton 1986). A standardized method of recording verbal violence needs to be developed similar to Fottrelles scale for physical violence or the Staff Observation Aggression Scale which includes a verbal measure (Palmistierna & Wistedt 1987).

Videotape recording (Brizer *et al.*, 1988) of psychiatric in-patient assaults showed that hostility was noted more on video than by accident and emergency departments other methods of recording. This could be a useful approach for accident

and emergency departments. The types of patients that carry out assaults in psychiatric hospitals and provide visible cues (i.e. verbal threats) differ from those who do not provide such cues (Tanke & Yesavage (1985)). A psychological profile of the victim and research into why staff in particular are assaulted is worthy of further study (Haller and Deluty (1988)). These issues need urgent consideration to improve safety at work and enhance training and hopefully morale.

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