Witnessing violence to staff: a study of nurses' experiences

This article highlights a study into the effects of witnessing violence in a psychiatric hospital setting. The results show that the majority of respondents who had witnessed violence to a colleague experienced similar emotional distress as the victims. The authors suggest measures that may help staff in these and other clinical areas. They conclude that violence to staff should not be an accepted part of the working environment.

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The healthcare environment has become a more violent place to work. Staff are increasingly prone to physical and verbal attack by patients (Turnbull 1993) and the consequences of these attacks range from emotional trauma through physical injury to death. Although most reports concentrate on the victims and the circumstances surrounding an assault, there is one group of staff affected by violent incidents who seem to have been neglected; those who witness such attacks.

VIOLENCE TO HEALTH STAFF

Over the last ten years the literature demonstrating that violence at work is a threat to healthcare workers has grown (Thomas 1995), particularly in psychiatric hospitals (Whittington 1994). This may be because psychiatric nurses spend long periods of time in face-to-face contact with aggressive patients and may be called upon to encourage patients to do things which they do not really want to do (Whittington and Patterson 1996).

The actual extent of the problem is difficult to establish. National figures on violence towards staff are not routinely kept; most figures come from single studies in individual hospitals or secure units. One estimate on the average frequency of assaults on nursing staff in psychiatric hospitals is one assault every 11 days (Whittington 1994). This may be because psychiatric nurses spend long periods of time in face-to-face contact with aggressive patients and may be called upon to encourage patients to do things which they do not really want to do (Whittington and Patterson 1996).

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Consequences of assault

It has been suggested that the emotional impact of incidents can exceed that of physical injury, and can have much in common with post traumatic stress disorder (Whittington and Wykes 1994a). Victims can have repeated flashbacks, experience extreme anxiety, irritability and sleep problems, feel out of control, helpless, depressed, guilty and ashamed (Whittington and Wykes 1994b).

Buyssen (1996) called the emotional results of such incidents 'psychotrauma', which he compared with a stone being thrown into the still waters of a person's psyche setting it in turmoil. Such reactions, Buyssen suggested, are the result of our psychological, physical and emotional boundaries being exceeded to the point where we find it difficult to cope. The result is an intense emotional reaction. Merely witnessing aggressive or severely challenging behaviour can be very stressful and may lead to similar emotional problems (Kay 1995).

There is little evidence to substantiate this latter claim. Therefore, this study focused specifically on the witnesses to violence, defined as those at the scene of an aggressive incident who do not themselves receive direct physical or verbal abuse from a patient. The aim was to examine the consequences of being a witness to violence for the individual, and in particular to identify the responses of colleagues and managers to these individuals.

METHOD

This was a retrospective, descriptive study that examined the experiences of staff in one psychiatric hospital. Data were collected through semi-structured interviews, an emotionally sensitive method for collecting data regarding distressing memories (Oppenheim 1992). The interview schedule was piloted on the first five individuals in the study to ensure that the questions were meaningful and acceptable to the respondents. Permission for the study was obtained from management. Respondents were assured of...
Table 1. Respondents’ clinical area when assault took place

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
<th>Clinical area</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>54</td>
<td>Acute</td>
</tr>
<tr>
<td>18</td>
<td>36</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>Elderly</td>
</tr>
</tbody>
</table>

Table 2. Reaction of work colleagues

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>46</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>15</td>
<td>30</td>
<td>All the support I needed</td>
</tr>
<tr>
<td>12</td>
<td>24</td>
<td>Asked if ok, but didn’t feel it was genuine</td>
</tr>
</tbody>
</table>

RESULTS

In total, the 50 nurse respondents had witnessed 23 separate incidents, with some being involved in the same event. These incidents ranged from staff being kicked or punched, to more serious assaults that resulted in broken bones. Males comprised 68 per cent (n=34) of the respondents, and females 32 per cent (n=16).

The clinical areas in which respondents were working at the time of the assault are shown in Table 1. Clearly, assaults can happen throughout all areas of a psychiatric hospital, although the largest group of respondents in this study were those caring for older people. When asked whether this was their first exposure to violence, 76 per cent (n=38) said it was not.

Effect of witnessing violence on the individual

What effect does witnessing violence have on the individual? Forty seven respondents said the experience had changed them. Most (60 per cent) felt that they were now more aware of the feelings of those involved in such incidents. A further 17 male respondents (34 per cent) said that they still thought about the incident, although it had not made major changes to their work practice. Only three people (6 per cent) said it had not affected their work practice.

The interview also explored apportioning of blame for the incident. Twenty nine male respondents (58 per cent) felt that blame had been attached to staff. They felt that those on duty at the time were held in some way responsible for what had happened. One of the incidents referred to involved a female colleague and the respondents felt that they had failed their colleague in some way.

We included a further question on whether respondents felt they had failed those who had been assaulted. The responses again varied by sex. All 34 males (68 per cent) said they felt they had failed, while all 16 females (32 per cent) said they did not feel they had failed the victims.

Response of other staff

What was the response of other members of staff where a colleague had been exposed to violence? Most colleagues had not raised concern about the welfare of a witness, perhaps because of a lack of physical injury (Table 2). In this first category, that is, those who had not received queries from colleagues, all respondents were male. A more positive response is illustrated by the second category where 11 of the 15 respondents were female. In the final category, colleagues were seen to be ‘going through the motions’ of being concerned.

Although no respondents asked to see management or senior clinical managers, 40 per cent were seen by their ward manager, and a further 12 per cent were seen by a senior manager. The most frequent question they were asked was whether they wanted to move from the clinical area where the assault had taken place. This was interpreted by the respondents as an indication of blame for what had happened.

All asked to remain in their usual clinical area. The response to this by managers was that they should put the incident behind them. This left the respondents feeling that management did not really understand the effect the incident had had on them. Managers were seen to be on the defensive when discussing the incident. This may not have been how managers saw the interviews, but how they have been interpreted by the staff concerned.

Managers offered counselling to 17 of those respondents they interviewed. However, only 18 per cent (n=3) accepted. Respondents were asked, where counselling had been offered, why had it not been taken up? The invariable response was that the counsellors were staff from the same health authority and confidentiality might not be ensured.

DISCUSSION

These findings cannot be generalised, but they do raise a number of interesting concerns in this controversial area. First, why are staff reluctant to share the emotional impact of a violent incident?

Buysens (1996) suggested that talking about these emotional effects has almost been a taboo subject until fairly recently. Whittington and Wykes (1989) suggested that there is a ‘macho’ attitude in psychiatry which makes male staff reluctant to admit emotional problems. They argued that the response of male staff is to act as though everything is under
control. This was reflected by the male respondents in this survey.

This reluctance may be the symptom of a ward or hospital culture. Wykes and Mezey (1994), for instance, suggested that closely knit communities, such as those found in psychiatry, develop traditional rules of conduct which preclude counter-cultural admissions of emotional pain or upset. They also suggested that counselling has a strong negative connotation.

**Recommendations** How can the situation be improved? It is easy to concentrate on individual responses to this question. Greaves (1994) indicated that employees are frequently expected to cope alone with emotional burdens, despite violence to staff being an organisational issue. The charter introduced by the National Association for Staff Support (1992) has been one attempt to develop legislation aimed at providing a culture of staff concern within organisations. Thomas (1995), describing developments within one trust, pointed out the importance of managers seeing assaults on staff as a health and safety issue.

The influence of the prevailing organisational culture is important. Greaves (1994) suggested that violence at work should not be seen as part of the contract of employment, dismissed as just ‘bad luck’ or somehow the failings of the individual in their dealing with patients. Turnbull (1993) suggested that managers should actively promote the view that violence to staff is unacceptable and should help to eradicate the myth that nurses who have been assaulted are somehow to blame.

There is perhaps no simple solution to this problem, or a single source of responsibility. There have been a large number of suggestions made for improving the situation. These range from organisational actions, such as increased reporting of incidents (Thomas 1995), to the provision of educational programmes aimed at increasing staff’s ability to identify and deal with violence (Collins 1994, Lanciotti and Hopkins 1995).

Although systems such as control and restraint, more recently referred to as care and responsibility, have been a popular suggestion, Lehane (1995) has called for attention to return to why patients become violent and identify ways of reducing such behaviour. This is certainly the approach taken more recently by Whittington and Patterson (1996) who have tried to develop a checklist of signs that may suggest an attack is imminent. Although they have had some success in suggesting an association between an attack and signs such as verbal abuse, aggressive stance, high overall activity level, loud voice and fast speech, they warned that these can be missing in some attacks.

Other authors have also suggested that following an attack, access to counselling services should be provided, both inside and outside the organisation (Ryan and Poster 1993, Thomas 1995, Turnbull 1993, Wykes and Mezey 1994). Turnbull (1993) is one of the few authors to suggest that support services should be made available not only to the victims of assault but also to those who observe such an event.

Despite all the suggestions, McDonnell et al (1994) commented that there is a noticeable lack of research evidence on the effectiveness of the solutions suggested in the literature. Most of the advice, they warned, is too frequently based on anecdote.

Practical ways to safeguard staff’s emotional well-being following involvement in or witnessing an assault must therefore be sought. Recent work by Buyssen (1996) suggested that one of the most important elements is social support from work colleagues. From reports of such incidents, he noted that often colleagues will not raise the subject of the incident and the emotional reactions that follow it. He maintained that one of the most important strategies for gaining control of a shock event is to talk about it.

Although Buyssen provided no evidence for this, the approach is supported by a survey by Whittington and Wykes (1989). Staff in their survey replied that they wanted more time to talk about what had happened.

**CONCLUSION**

This study has demonstrated that those witnessing violence can experience similar emotional difficulties as the victims of violence. The study shows that female staff are treated with consideration by colleagues, and are less likely to suffer from feelings of guilt and responsibility than their male colleagues.

Male staff appear to have difficulty in accepting emotional support in the form of counselling. Although in this sample concerns about confidentiality were given as a reason, Wykes and Mezey (1994) suggested that receiving treatment may be thought to be incompatible with the image of professional competence. Managers, like staff colleagues, may also be projecting an image of not being concerned either for the issue of violence or for those involved.

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**Implications for practice**

1. Strategies currently in use to reduce the incidence of violent incidents must be evaluated systematically.
2. Individuals must be helped to cope with the aftermath of such incidents.
3. Co-ordination is required to provide a culture of care where violence to staff is not tolerated as an inevitable part of service provision.