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Nurses' Reactions to Physical Assault by Their Patients

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À l'aide du questionnaire sur les réactions par rapport à l'agression (Lanza, 1988a), on a étudié les réactions des points de vue social, affectif et biophysiologique de trente cinq infirmières non psychiatriques agressées par leurs malades. On a également demandé aux infirmières de décrire leur agression, de noter les causes et les stratégies qu'elles ont adoptées pour y faire face, et ce qui les a empêchées de rapporter l'agression. Les conclusions ont montré qu'étant donné que les infirmières font davantage face à des agressions au cours de leur carrière, leurs réactions sont plus intenses des points de vue affectif, biophysiologique et social. Les infirmières s'adaptent en apprenant; elles changent leur comportement, et le plus souvent, énumérèrent comme causes de l'agression des variables provenant du malade, contrairement au blâme qu'elles portaient sur elles-mêmes dans des recherches précédentes.

Using the Assault Response Questionnaire (Lanza, 1988a), the emotional, biophysiological, and social reactions of 35 female non-psychiatric nurses who had been assaulted by their patients were investigated. These nurses were also asked to describe their assault experience, and to identify causes, their coping strategies, and the barriers preventing them from reporting assault. Results showed that as nurses reported more assaults, they experienced more intense emotional, biophysiological, and social reactions. They coped by learning to change their behaviours and they most often cited patient variables as causes for the assault — a finding that runs contrary to the pattern of self-blame reported in earlier studies.

Violence against nurses by patients is a topic that is discreetly kept from the public and consumers of health services. It is not a new phenomenon, however. The assault of nurses by patients has always occurred, and nurses have tended to adopt the attitude that assault is part of their job (Ryan & Poster, 1989). Concern about this tolerance has focused recent attention on the study of nurse assault.

The impetus for this study lies in the lack of knowledge about the reaction of female nurses to assault by their patients. If more is known about how female nurses react, broader, more comprehensive intervention strategies may be formulated and implemented. Most of the reviews concerning staff assault have focused on the area of psychiatry.

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The present study has attempted to fill this gap in the research by focusing on assault of medical and surgical nurses in a hospital setting.

Literature Review

The perspective of nurses' reactions following an assault has been studied in only a small number of cases (Lanza, 1985; Ryan & Poster, 1989; Roberts, 1989). When patients physically assault nurses, there is a strong tendency for nurses to deny or minimize the experience (Lanza, 1983; Murray & Snyder, 1991; Roberts, 1989). Rationalization occurs in many forms. Nurses report feeling blamed and ostracized for provoking the assault (Lanza, 1985; Ryan & Poster, 1989). Under-reporting of assault episodes is a cause of some concern for nurse researchers, who have been unable to collect accurate statistics.

A number of factors may have contributed to these reactions. Much of the literature on nurse assault has highlighted intervention and management strategies in dealing with a violent patient (Cahill, Stuart, Laraia, & Arana, 1991; Carmel & Hunter, 1990; Stevenson, 1991; Thackrey & Bobbitt, 1990; Wright, 1989). Management support of assaulted nurses, mainly to the extent of sanctioning education in how to deal with aggressive behaviour, is not comprehensive enough. This approach may be seen as an implicit form of victim blaming, because it places responsibility for patient assault with the nurse, suggesting that improvement in nurses' behaviour, attitude, and skills will prevent assault (Kinross, 1992). The system or the hospital, thus helps to perpetuate violence against nurses as an accepted part of the job; the nurse, in turn, may not feel supported.

One of the first descriptive studies to explore nurses' reactions to physical assault, conducted by Lanza (1983), evaluated their social, cognitive, behavioural, and emotional reactions. Surprisingly, 50% of the nurses indicated "no response" to a majority of the questions on emotional, social, and behavioral response. Those who indicated reactions to the assault reported that the effects lasted up to one year.

In a followup study, Lanza (1985) compared the responses of the same nurses to a simulated assault situation and to an actual assault. Over 70% of the nurses who watched the simulation of a nurse being hit by a patient felt that the nurse would suffer fairly severe to very severe emotional and physical effects. These same nurses rated the effects of their own assault as either slight or non-existent. The author speculated that the nurses may have suppressed their reactions or

rationalized them, as their way of dealing with the anxiety and helplessness caused by the assault. The tendency to minimize and deny the effects of an assaultive experience has been documented elsewhere in the nurse assault literature (Lanza, 1983; Murray & Snyder, 1991; Roberts, 1989, 1991). This tendency to minimize and deny can also be found in the family violence literature (Gage, 1991; Moss & Taylor, 1991).

Lanza (1988b) reported various emotional and behavioural reactions to an assault, including shock, anger (at the patient and others), fear, depression, loss of trust, compulsive behaviour, returning to work too soon, concentration difficulties, strained family relations, and denial. The nurses' reactions included needing to keep control, absenteeism, fear, disbelief, and wanting to avoid the paperwork involved in reporting the incident. Only 50% of nurses reported the assault. Reasons for failing to report included the belief that only severe assaults should be reported — that assaults are too common to be reported each time, the opinion that patients are not responsible for their behaviour, the feeling that aggression against nurses is part of the job, there was not enough time, and peer pressure not to report.

Prior to the 1980's, studies concerning the assault of nurses were conducted and reported on by non-nurses. More recently, nurse generated research has added important descriptive information, primarily in psychiatry and geriatrics. Very little is known about general medical and surgical areas of the hospital, where assault is anticipated to a lesser extent.

The first goal of the present study was to extend the descriptive research done on assault in psychiatric settings to assault in general surgical, medical and specialty units of a hospital. More specifically, this study addressed the following question: What is the relationship between demographic variables (e.g., age, education, experience, number of times assaulted) and nurses' reactions to assault (emotional, biophysiological, social)?

The second goal of the study was to enrich the quantitative data with qualitative data, to gain a better understanding of various factors involved in nurse abuse. Four areas were investigated using a self-report survey: causes, nurses' opinions of why the assault occurred, coping strategies, and barriers to reporting assault. While there are limitations to using retrospective self-reports, they have the potential to provide helpful information about nurses' experiences that cannot be obtained through purely quantitative measures.

Method

Study Population

Questionnaires were sent to female nursing staff in all non-psychiatric units of a rural general hospital in Central Ontario. Of the 515 questionnaires sent, 160 were returned to the first author (a nurse consultant in the hospital), representing a return rate of 31%. (A one-third return rate is normal for mail survey research. In a meta-analysis of mail survey research, Yammarino, Skinner, and Childers [1991] found a consistent response rate of 20-40%.) Of the 160 returned questionnaires, 35 nurses — or 22% (24 registered nurses and 11 registered nursing assistants) reported being assaulted.

The age of the participants ranged from 26 to 61 years (M = 39 years). The number of years of experience in nursing ranged from four to 38 years (M = 17 years), the length of employment ranging from two months to 26 years. The registered nurses and assistants were employed as staff nurses on all units throughout the hospital except psychiatry. Participants were contacted through the hospital mail system. Each participant received a letter explaining the purpose of the study, and was asked to complete the Assault Response Questionnaire and the Personal Assault Experience Questionnaire on a voluntary basis. The letter of information sent to all participants defined assault as "occurring when any patient has knowingly physically touched you with the intent to harm (e.g., a punch, pinch, strike, kick)." All responses were anonymous.

Instruments

Assault Response Questionnaire — ARQ (Lanza, 1988a). The ARQ was developed to measure or quantify the intensity, for the nurse, of patient assault. It is composed of basic demographic data about the victim and the patient. The instrument contains three scales: emotional, biophysiological, and social. The emotional scale has 19 items, which measure the intensity of feeling after an assault (e.g., "shame," "withdrawal"). The biophysiological scale contains 15 items, which measure the intensity of physical reactions after an assault (e.g., "headaches," "nausea"). The social scale contains ten items, which measure changes in behaviour and/or relationships with others after an assault (e.g., "fear of other patients," "difficulty returning to work"). The individual is asked to rate each item on a Likert scale ranging from 1 to 5, with 1 indicating no reaction and 5 indicating severe reaction.

Lanza (1988a) obtained split-half reliability of .95 for the emotional scale, .89 for the biophysiological scale, and .93 for the social scale. Cronbach's alpha for these three scales in our study were .91, .84, and .91, respectively. Item analysis correlations among scales ranged from .84 to .86 (Lanza, 1988a). The ARQ has been used in other research studies (Lanza, 1983; Mahoney, 1991).

Personal Assault Experience Questionnaire — PAEQ. The questions in this portion of the written survey were developed by the first author and were intended to tap the nurses' experiences of assault in a qualitative manner. The questionnaire contained eight questions, but for the purposes of this study only the following four questions were used: (a) Describe an incident of assault that happened to you. (b) How have you explained to yourself why this incident happened? (c) How have you dealt with it since it happened? (d) Did you report the assault? If yes, what was the response you received? If no, what prevented you from reporting the assault?

Results

Thirty-five non-psychiatric nurses had been physically assaulted by patients in the past five years. The number of assaults during their careers ranged from one to many. Fifty-one percent of the nurses indicated the number of assaults as "many," "daily," "frequently," or "numerous". When asked whether they reported the assaults to the hospital administration, 34% responded "no," and 66% responded "yes." Sixty-nine percent of the patients who assaulted nurses were males.

In order to determine the relationships among the demographic data of all the nurses and their scores on the ARQ, Pearson product-moment correlations were calculated among all of the independent variables (age, height, weight, education, years of experience, patient's age, patient's sex, number of assaults, severity of assault, and coping behaviours) and the dependent variables (emotional reaction, biophysiological reaction, social reaction, and whether the assault was reported). These correlations are provided in Table 1. The number of previous assaults correlated significantly with emotional reaction, biophysiological reaction, and social reaction. As nurses experienced more assaults, their emotional, biophysiological, and social reactions intensified. The sex of the patient correlated significantly with the intensity of biophysiological reactions: more intense physical reactions were associated with assault by female patients.

Table I

Correlations Between Demographic Data and Assault Response Questionnaire Scales

	Experience	Patient Age	Patient Sex	Number of Assaults	Emotional Reaction	Biophysiological Reaction	Social Reaction
Patient Age	.07						
Patient Sex	-.18	.15					
Number of Assaults	.12	-.02	.24				
Emotional Reaction	-.09	-.02	.28	.48**			
Biophysiological	-.06	.07	.32*	.49**	.92**		
Social Reaction	-.12	.02	.13	.34*	.90**	.88**	
Reported	-.31	.13	.16	.17	-.11	-.06	-.03

$N = 35$ ** $p < .01$ * $p < .05$

All answers to the PAEQ were analyzed and categorized separately. The first item asked nurses to describe their assault experience. The requested information included the activity in which the nurse was engaged at the time of the assault, type of assault, and possible reason for assault. All of the reported assaults were preceded by close patient-nurse contact. Positioning and turning patients or assisting patients in returning to their rooms resulted in the most assaults (29%). Other tasks included bathing (20%), close-contact nursing treatment such as checking intravenous lines, dressings, monitors (17%), restraining (14%), toileting (11%), and unmentioned (9%). In 37% of the cases, the assault occurred after the patient had refused treatment, and ingestion of alcohol was involved in 14% of additional cases. Twenty-three percent of the nurses reported having received injury severe enough to require treatment.

The nurses' perceptions of why the assault occurred was divided into "patient reasons," "nurse reasons," and "other reasons." (Table 2). Patient reasons included confusion related to post-operative effects of anaesthesia, disease-related effects, medication-induced behaviour, alcohol-induced behaviour, or dementia, fear, anger, or manipulative behaviour. Nurse reasons included self-blame. Other reasons included anger at doctors and the administration.

Table 2
Causes Given by Nurses to Explain Patient Assault

Variable	Frequency	Percent
Patient Reasons		
Confusion	14	33
Fear	7	17
Anger	6	14
Alcohol	6	14
Manipulating	2	5
Nurse Reasons		
Self-Blame	2	5
Other Reasons		
Doctor	2	5
Administration	3	7
Total	42	

Note: Some incidents fit into more than one category.

Nurses dealt with assault in a variety of ways, such as learning from the experience and changing their nursing practice so that the incident would not occur again. Some nurses coped by forgetting about it or accepting it as a job risk, seeking support, becoming generally wary, becoming angry, or quitting the job (Table 3).

Table 3
How Nurses Dealt with Assault by Their Patients

Variable	Frequency	Percent
Learn and change	14	31
Forget	7	16
Responded affirmatively	7	16
Accepted job risk	5	11
Perceived support	4	9
Generalized wariness	4	9
Anger	3	6
Left job	1	2
Total	45	

Note: Some responses occurred in more than one category.

Of the nurses who had been assaulted, 66% reported the incidents and 34% did not. Of those who reported, 38% received support from the administration and their coworkers, 25% felt they had effected change as a consequence of their reporting, 29% reported no response, and 8% felt blamed. Fifty percent of the nurses who did not report the assault believed they would not be justified in reporting it because they perceived it was part of the job and no injury was sustained. The other 50% of the nurses who did not report tended to deny and minimize the assault, and fear blame from administration and their peers.

Discussion

The first goal of the study was to extend the descriptive research on assault in psychiatric settings to surgical and medical units of a hospital. In this study, 22% of the participants who returned the questionnaires indicated that they had been physically assaulted by their patients within the preceding five years. This low rate of reporting assault is consistent with the assault research of the past 12 years, which suggests that nurses tend to deny, rationalize, and minimize assault

by their patients (Brooks, 1967; Kalogerakis, 1971; Lanza, 1983; Lion, Snyder, & Merrill, 1981). The data differ, however, from a recent survey. The Registered Nurses Association of Ontario (1991) provincial survey found that 59% of 808 nurses reported being physically assaulted by patients during their careers. Although that study was carried out earlier than ours, these statistics clearly reflect a higher incidence of assault reporting.

Anecdotally, many nurses wrote that they did not feel they had been *assaulted* by a patient, even though they admitted that they had been hit, pushed, or punched. They did not consider these actions assaultive, for a variety of reasons. Some nurses felt that because patients were confused or unfamiliar with their surroundings, their behaviour was understandable, excusable, and not assaultive. Others thought that only severe events of hitting or punching should be considered assaultive.

This pattern of minimizing or excusing patient behaviours could be one of the reasons for the low response rate in the current study. Our definition of assault required a perceptual interpretation because it included the phrase "with intent to harm." Because nurses tend to believe that patients do not mean harm, they may not consider an incident assaultive when it happens.

In addition, hospital downsizing strategies taking place at the time the study was carried out could have affected the mood of the nurses.

Another reason for the low rate of reporting assault may be placement of blame on the nurse. Lanza (1987) found that women were blamed more than men for an assault. Perhaps the fear that they would be blamed for precipitating or provoking the assault caused the nurses to disclaim their assault experience.

We found that the more assaults experienced during a nurse's career, the more intense her emotional, biophysiological, and social reactions. It appears that, for these nurses, repeated assaults had a cumulative effect. This finding suggests that hospital administrations should provide support for nurses who are at high risk for repeated assaults, rather than deny or minimize the problem of assault within institutions.

A surprising correlation was that the nurses had more intense biophysiological reactions to being assaulted by female patients than by

male patients, perhaps because of the cognitive dissonance that may have resulted. In our society, it is much more stereotypically common for men to assault women (Freedman, 1985; Gage, 1991; Sinclair, 1985). Women have been socialized to be nurturers and caretakers, so when this internalized concept has been violated, the reaction may be more intense. It is interesting to note that only biophysiological reactions are intensified. Perhaps the nurses found it appropriate to react in a manner that was *least* threatening to others, and *most* internally self-focused. No previous research has correlated these variables; thus, it is not clear the degree to which this finding could be generalized to apply to other hospital settings.

The second goal of the study was to better understand nurses' view of the assault, coping strategies, and barriers to reporting the assault experience. It is interesting to note that 91% of the assaults occurred when it was necessary for the nurse to touch the patient's body. In 64% of the cases, the nurses' perception of why the assault occurred involved patient confusion, fear, and anger. It is possible that those who were confused, afraid, or angry struck out at the nurse when she was touching the patient for therapeutic reasons. These patients may have felt their personal body space was being violated. Few other professions are responsible for such intimate physical contact. Nurses approach patients with treatments that they perceive as harmless and routine; however, patients who are confused for a variety of reasons might not perceive the intervention as innocent and routine. Nurses need to be cognizant of the importance of explaining each procedure carefully before touching the patient.

The nurses' most frequent method of coping with assault was to learn from the experience and change their nursing practice by telling patients what to expect before proceeding with a treatment, maintaining a distance from angry patients, and communicating with other nurses by preparing a care plan. Seeking support from colleagues and the hospital administration was another strategy used by nurses in our study. These positive coping strategies may signify that the nurse is gradually taking more responsibility for her environment and refusing to accept working conditions as they have always been. Negative coping patterns such as accepting assault as part of the job, forgetting the incident, becoming angry or wary, and quitting the job were also evident in the present study. By failing to resolve the assault situation, these nurses may develop problems in the future. Negative coping styles are evident in other nursing studies (Lanza, 1988b; Ryan & Poster,

1989). These varied reactions to assault suggest that effective intervention for assaulted nurses could be multifaceted.

Underreporting of assault has been a serious problem in the past, because denial, rationalization, and minimization have been used as coping strategies (Casseem, 1984; Jones, 1985; Lion et al., 1981). Two thirds of the participants in our study reported the assault to the hospital administration. These nurses reported that they felt supported by the administration and their coworkers and felt that their actions had created a positive change in management's view of the abusive situation. Previous studies (Lanza, 1987, 1988b) have indicated that only a small percentage of nurses report assault, because of fear of reprisal from their peers, doctors, and the administration. The higher percentage of reporting found in our study may represent a shift away from an attitude of blaming, on the part of hospital personnel, toward one of openness in dealing with assault when it occurs.

A survey by the Registered Nurses Association of Ontario (1991) suggested numerous strategies for placing the onus on the institution to support the staff member and also for placing responsibility with the patient. Ways of empowering nurses include police protection for nurses, ensuring more input by nurses in decision-making treatment of patients who are violent, and charging patients through the legal system.

Intervention has been developed to help nurses deal with their reactions to an assault. Newer modalities of treatment available to the nurse include nursing support groups (Roberts, 1989) and nursing consultation support services (Murray & Snyder, 1991), which provide counselling and debriefing following assault. Hospital administrations could initiate, sponsor, and sanction programmes to deal effectively with the increasing problem of nurse assault (Kinross, 1992).

Certainly, a number of limitations to the current study affected the generalizability of the results. The PAEQ was used for the first time in research. As a self-report questionnaire, it may have been limited by difficulties common to such instruments (e.g., biased questions, answering in a socially desirable way, and inconsistency of responses). Interviews might have elicited richer, clearer, and more detailed data. The small sample size also makes generalizing the findings difficult. Finally, its definition of assault may not have fit some nurses' perceptions of their experiences.

Given these caveats, however, this study enhances the reliability of the ARQ (Lanza, 1988a). It also shows that the more assaults experienced, the more intense the nurses' emotional, biophysiological, and social reactions. Nurses who are at high risk will likely need specific supportive interventions so that their reactions are dealt with, and their trauma is resolved, at the time of the assault. Future research in the area of nurse assault is of paramount importance. Understanding the experiences of nurses prior to and following an assault is key to ensuring that comprehensive institutional policies will be developed. Research that focuses on testing and implementing various hospital support programs to identify which would be most beneficial for nurses is particularly needed.

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