Perilous Work: Nurses’ Experiences in Psychiatric Units with High Risks of Assault

Deborah Kindy, Salvatore Petersen, and David Parkhurst

Psychiatric facilities struggle to maintain therapeutic environments made increasingly difficult by severe nursing shortages. Related safety concerns prompted a phenomenological inquiry about nurses’ experiences working in environments with high risks of assault. Ten registered nurses participated in open-ended interviews. Analysis of interview transcripts generated four categories and 13 subcategories subsumed under the primary construct of “perilous work,” providing the frame for the exhaustive description and essential structure of participants’ lived experiences. Outcomes suggest that serious work-related hazards exist and provide insight into possible remedies and a springboard for follow-up studies.

© 2005 Elsevier Inc. All rights reserved.

In this time of severe nursing shortages, psychiatric facilities are struggling to maintain therapeutic environments, a feat in times of adequate staffing and an almost insurmountable challenge when vacant nursing positions abound. For hospitalized psychiatric clients, a crucial aspect of healing lies in the maintenance of a therapeutic environment. A logical outgrowth of a healing environment is a workplace with reduced risks of assault for employees. Despite nursing morbidity and mortality associated with minimal staffing and a client population at risk for assaultive behaviors caused by cognitive, developmental, and emotional problems, research investigating nurses’ experiences of assault in psychiatric settings is scant.

For years, the American Nurses Association has been advocating for federal standards requiring that health care agencies provide improved environmental safety for its staff following the death of nurse Aida Ellington at the hands of a patient being admitted to a psychiatric facility (Georgia Nurses Association, 2001). These standards have yet to be imposed. Research in the United Kingdom found absent enforcement of agencies’ policies providing for the safety of those working in psychiatric facilities, resulting similarly in a call for explicit national guidelines governing and enforcing such policies (Wright, Lee, Sayer, Parr, & Gournay, 2000). Following the murder of Ellington, the American Nurses Association surveyed 4,826 nurses regarding health and safety issues in the workplace and found that 17% of nurses had been physically assaulted and 57% had been threatened or verbally abused in the previous year alone. Furthermore, 88% of nurses claimed that health and safety concerns influenced their desire to leave the nursing profession or the kind of nursing that they chose to perform (ISNA Bulletin, 2002). An Australian study also found that 88% of nurses surveyed in psychiatric facilities had experienced verbal or physical assault (Delaney, Cleary, Jordan, & Horsfall, 2001).

The media is replete with reports of the patient care crisis resulting from a severe shortage of registered nurses. The remedy is often touted as simply graduating more nurses. This approach ignores not only factors that contribute to absenteeism but also those promoting recruitment and retention of nurses. There is relatively minimal information regarding one serious cause of the
failure of recruitment and retention of psychiatric nurses—patient violence against staff nurses (ISNA Bulletin, 2002). The Centers for Disease Control (2002) reported that 6% of total American workforce injuries resulting in days away from work in 2001 were attributable to assault on nurses. Sequelae are significant as well with 33% of assaulted nurses experiencing posttraumatic stress disorder (Birmes et al., 2001).

To date, the focus of most research in English-speaking countries centers on nurses’ identification and management of clients who are at high risk for assaultive behavior (Delaney et al., 2001; Duxbury, 1999; Morrison et al., 2002; Quintal, 2002; Trenoweth, 2003) and on methods of training or supervising nurses to reduce assault and resultant injuries (Forster, Cavness, & Phelps, 1999; Mental Health Practice, 2002; Southclott, Howard, & Collins, 2002). Chou, Lu, and Chang (2001) investigated numerous variables contributing to the predictability of assaults among psychiatric inpatients and found that environmental factors such as nurse/patient ratios and spatial density and staff factors such as experience and training in prevention and management of assaults were important for maintaining therapeutic environments.

Missing from the published research are nurses’ personal meanings of working in an assaultive environment. How nurses perceive the dangers, interventions, and causes of assault and how they perceive the consequences for their personal professional lives can provide insight into developing avenues of remediation for not only assault but also elements of the nursing shortage as well.

PURPOSE

Of all hospital-based health care personnel, nurses in psychiatric wards are at the highest risk of being victims of violence (Centers for Disease Control, 2002). Therefore, the purpose of this study was to give voice to registered nurses who work in environments where there is a high risk of assault. For the purposes of this research, the definition of workplace violence is “violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty” (Centers for Disease Control, 2002, p. 1), adapted from the National Institute for Occupational Safety and Health, a branch of the Department of Health and Human Services. A phenomenological approach was used to answer the research question “What is the lived experience of registered nurses working in an environment where assault is a continual threat?”

METHODS

This qualitative descriptive study was based on the descriptive and interpretive phenomenological theories of Heidegger (1962). Heidegger valued not only the description of a lived experience but also the hermeneutics or an individual’s interpretation of the experience. Spielberg (1975) (as cited in Streubert Speziale & Rinaldi Carpenter, 2003) noted six core elements central to the phenomenological process of gaining a rich understanding of a lived experience. These elements include (1) objective exploration, analysis, and description of the phenomenon of interest, (2) finding common themes or essences and their patterns of relationship, (3) ways in which the phenomenon appears, (4) how the phenomenon evolves from first impressions to a more global view, (5) preservation of objectivity through continual examination of personal biases, assumptions, and presuppositions, and (6) the hermeneutics or scientific interpretation of the phenomenon to expose concealed meanings. These steps were necessary in establishing the study findings.

The method of phenomenological analysis by Colaizzi (1978), exemplifying Spielberg’s Elements 1–4, was used to interpret the data and arrive at an essential structure of the lived experience of working in an assaultive environment. This method requires extracting phrases of meaning from transcribed interviews, reformulating meanings to more concise phrases, and inductively grouping similar phrases into common themes. Themes are then grouped into categories from which an exhaustive description of the phenomenon being investigated is inductively generated. From the exhaustive description, the essential structure of the lived experience is deduced.

Following human subjects review by a university internal review board, advertisements soliciting a purposive sample of registered nurses willing to be interviewed about working or having worked in psychiatric or psychiatric/forensic facilities were placed in newspapers of three towns in northern California. Calls of inquiry were received in one location and referred to the researcher living closest to the inquirers. In addition, two participants were referred by other participants.
Appointments for the interviews were arranged for a time and quiet place convenient for the participants and researchers. Before conducting the interviews, all three researchers met to establish a common pattern of behaviors most useful for eliciting thorough responses and minimizing researcher influence. In addition, the researchers documented their values, beliefs, and assumptions about nurses, work environments, and clients in a psychiatric setting for bracketing purposes. Arrangements were made for referrals to appropriate resources in the event a participant experienced emotional distress during the interview. Following signed consent, audiotaped uninterrupted interviews were conducted in the clients’ homes or in quiet coffee shops at a time convenient to all involved. Interviews lasted from 1 to 2 hours. Following collection of basic demographic data, two printed questions were provided to the participants: (1) “Please describe your experience working in an environment with a daily risk of verbal and/or physical assault, including your feelings, thoughts and emotions” and (2) “Describe an actual assault experience you have had, including what you think the causes were, events during it, how the event ended, resolution and your emotions, thoughts and feelings as this occurred and afterward.” Taped interviews were listened to multiple times to ensure verbatim transcription. Transcriptions were then divided among the researchers who individually analyzed the data. When individual theme analysis was complete, the researchers met. Themes were similar among the researchers, signifying a high degree of interrater reliability and saturation. The researchers collectively used the themes to generate categories and subcategories, providing the structure for an exhaustive description and an essential structure.

**FINDINGS**

The demographics of the relatively diverse purposive sample are summarized in Table 1.

Four categories of meaning with subcategories contained under the primary construct of “perilous work” were inductively generated from the transcribed interviews summarized in Table 2.

**Category 1: Safety Fortifications**

When working in potentially assaultive environments, participants created, received, and instituted safety fortifications through two primary elements: (1) personal preparation and (2) tangible devices. Personal preparation included specialized education and training in methods of prevention and intervention. These included therapeutic communication, body language, physical positioning, teamwork, methods of managing assaultive behavior, noting client histories, observing patterns of behavior, and use of medications. Furthermore, nurses expressed a more generic personal preparation exemplified by the following:

Every day when I go to work I would prepare myself mentally and physically, to be prepared for whatever.

**Table 1. Demographics**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (n)</td>
<td>Female 6 Male 4</td>
</tr>
<tr>
<td>Age (years)</td>
<td>Range 28–52 M 39</td>
</tr>
<tr>
<td>Country of birth (n)</td>
<td>United States 6 Philippines 3 Japan 1</td>
</tr>
<tr>
<td>Ethnicity (n)</td>
<td>Filipino 4 African American 3 Caucasian 3</td>
</tr>
<tr>
<td>Education (n)</td>
<td>ADN 5 BSN 4 MSN 1</td>
</tr>
<tr>
<td>Experience in psychiatric setting (years)</td>
<td>Range 2–17 M 7.4</td>
</tr>
</tbody>
</table>

**Table 2. Categories and Subcategories of Primary Construct Perilous Work**

<table>
<thead>
<tr>
<th>Categories Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety fortifications</td>
</tr>
<tr>
<td>Personal preparation</td>
</tr>
<tr>
<td>Tangible devices</td>
</tr>
<tr>
<td>Catalysts for violence</td>
</tr>
<tr>
<td>Facility design</td>
</tr>
<tr>
<td>Increased acuity and insufficient staff</td>
</tr>
<tr>
<td>Unpredictable and uncontrollable environment</td>
</tr>
<tr>
<td>Administrative and staff abandonment</td>
</tr>
<tr>
<td>Perplexing aftermath</td>
</tr>
<tr>
<td>Blame and punishment</td>
</tr>
<tr>
<td>Fear and poor morale</td>
</tr>
<tr>
<td>Vigilance and distrust</td>
</tr>
<tr>
<td>Pervasive invasive sequelae</td>
</tr>
<tr>
<td>Emotional burden</td>
</tr>
<tr>
<td>Personal life sequelae</td>
</tr>
<tr>
<td>Role conflict</td>
</tr>
<tr>
<td>Withdrawal</td>
</tr>
</tbody>
</table>
Safety fortifications also involved suppression of emotions and behaving in a manner antithetical to how nurses felt. For example:

If I’m feeling sad or sorry, I can’t let that patient know that cause then they’re gonna get in to you. You cannot let them see any type of feelings cause they’ll break you down quick.

Relying on intuition or gut feeling was an important safety tool for some participants. Tangible devices used for safety measures included walkie-talkies, cameras, seclusion rooms, restraints, mirrors, and medications. However, participants noted that these devices were only as good as the persons operating them.

Category 2: Catalysts for Violence

Factors perceived to increase the risk for violence generally involved multiple catalysts working together, often with synergistically negative effects. Participants noted a sense of administrative abandonment in the form of inept scheduling resulting in days with dangerously poor coverage, decreases in staffing, mandatory overtime, numerous unkempt promises to improve environmental safety, “looking the other way,” lack of presence in or avoidance of the units, a plethora of inappropriate policies, excessive paperwork, and lack of knowledge of client characteristics.

...just dealing with the upper management and them not understanding what is actually going on is actually, like a war zone to tell the truth out there.

Physicians and ancillary personnel such as social workers were perceived to contribute to the risk of assault by unwarranted decreases in medicines, not following the treatment plan, cooperation with staff splitting, slow responses to emergency situations, professional elitism, limited availability, and disrespect for ethnic, racial, and gender issues.

...and we have a lot of pettiness among the treatment team, a lot of egos...my degree is better than yours, or I have more experience, and I think they forget the common sense aspect of it.

Participants reported that neither physicians nor ancillary personnel listened to their concerns about client behaviors.

You know we’d have to tell the doctor look, why do you lower the meds when we’re getting hit? We’re in the trenches here...but until they’re on the floor with us, on ground zero, seeing what’s going on...the doctors didn’t listen, they did NOT listen.

An interesting perception of participants is that physicians were afraid of clients.

I’ve had doctors tell me that they’re pretty afraid of these patients. So I’m thinking, if you’re afraid of these patients how can you treat these patients? They’re not going to help us with a takedown. They’re not going to help us put them in restraints. They don’t want to deal with it. Most of the time they don’t even want to go talk to the patient.

Staff contributed to an unsafe environment through insufficient education/training, fatigue, burnout, divisiveness, racism, sexism, and fixed cultural beliefs. On the other hand, some participants noted that they remained on the job because of a feeling of commitment to their co-workers despite the unsafe conditions. Further compromising group safety outweighed personal concerns.

One of many examples of facility design that negatively influenced security in units was as follows:

The tension is very high and not having space, a big space, for them to, you know, move and have their privacy...it gets everybody so irritated...suffocated in a way.

Clients were perceived as contributing to the unpredictability and uncontrollability of the environment owing to characteristics of psychiatric and developmental disorders including impulsiveness, explosiveness, and feeling superior to and antagonistic toward staff. Some nurses noted an increase in people avoiding prison by legal maneuvering into the mental health system. Furthermore, participants worried about victimization of older clients with mental illness at the hands of younger clients with criminal backgrounds. Although certain characteristics of the client population imply risks for violence, nurses expressed more concern about lack of support from peers, physicians, and administrators.

Category 3: Perplexing Aftermath

Following incidents of violence, participants reported being hypervigilant, distrustful, and fearful, which resulted in poor morale. Participants also reported a lack of postincident debriefing and being blamed and punished by administration after an assault.

Just because a patient says something against us doesn’t mean it’s true. They should treat it accordingly...we weren’t the criminals in there and I felt like I was being treated like a criminal there.
After recovery from a physical assault, participants reported returning to units with the same risks and the same assaultive clients.

It was really tough, I mean even after the assault there wasn’t any real resolution. For me it was just sort of a constant threat. And I just watched him more closely if possible.

Several participants experienced a desire to leave after weighing the risks and benefits of the job and perceiving that there was minimal hope for change.

I’m looking for a new job. I’m finding that it’s just absolutely too much and I think it’s asking too much and it is not a safe environment. I’m worried about patient care. And that will in turn reflect on my license.

Following an assault, participants were burdened by fears of future injuries, affecting their ability to earn a living.

I’m not completely healed but I’m back at work, so I’m a little scared that just one, one little knock or something could permanently injure me, and then my livelihood would change. And I’m really seriously thinking, is it really worth it?

Category 4: Pervasive Invasive Sequelae

Participants experienced pervasive emotional burdens associated with working in an assaultive environment.

The first thought always is... stress, constant stress. When you’re there or not, because you worry about going back. And there is no real let up... you have days off, constantly think about going back and having to worry about it again.

Differences in participants’ assumptions about the gratifications and functions associated with nursing and their actual nursing work experience generated feelings of conflict about nursing roles.

When you’re at work and you get hit or punched, I don’t know... it just kind of takes, takes a little part of you. I didn’t feel like a nurse. I felt like uh, I felt like an underpaid correctional officer. I didn’t feel like this was nursing.

Personal life sequelae involved influences on participants’ behaviors away from work.

It kind of made me cranky, you know, like, I remember I was snappy with my family, with my friends... it really got to me where I became, I kind of started acting like them... I was like a bitter man...

Participants described a need to withdraw or shut down out of concern that clients would sense fear and take advantage of it or simply burning out from the overwhelming levels of stress.

There are a lot of nurses I’ve worked with they, they just kind of shut down.

EXHAUSTIVE DESCRIPTION

Nurses used safety fortifications against workplace violence including mental, physical, and interpersonal actions driven by threats to safety of staff and clients. This was accomplished through multiple tangible devices and professional training intended to prevent, intervene in, and protect staff and clients from injuries. Despite these safeguards, nurses, ancillary staff, clients, physicians, administrators, nursing shortages, and workplace design served individually or synergistically as catalysts for violence. Human catalysts of violence contradicted behaviors expected of those in positions of help and support or clients desirous of care. After a violent incident, nurses experienced the additional trauma of a demoralizing and perplexing aftermath in which they felt blamed and punished by colleagues and administrators. They also felt hypervigilant and distrustful of clients and colleagues. All of these contributed to poor morale. Certain behaviors conflicted with the core values of nurses as caring professionals, resulting in role conflict and eventual withdrawal or emotional disassociation. Furthermore, nurses experienced pervasive and invasive sequelae as unwelcome emotional and behavioral changes that negatively affected their personal and professional lives. The work itself then was ultimately viewed as personally and professionally perilous.

ESSENTIAL STRUCTURE

Tangible devices and training were used to prepare nurses for workplace violence. Despite these safety fortifications, multiple factors catalyzed violence, the most distressing catalysts being workplace personnel such as administrators, physicians, and colleagues. Following violence, nurses were further traumatized by perplexing aftermaths in which they felt blamed and punished and perceived affronts to the core nursing value of caring. Subsequently, they experienced negative pervasive and invasive sequelae in their personal and professional lives and viewed their work as perilous.
DISCUSSION AND IMPLICATIONS

Limitations of this study include a small sample size both of nurses interviewed and facilities represented, thereby limiting study transferability. However, saturation was reached and 10 participants is an acceptable sample size for a phenomenological study. Interrater reliability was supported through meeting and rehearsing interview techniques, comparing and synthesizing individual theme analyses, and collectively generating theoretical categories and subcategories. Credibility, confirmability, and dependability were established with extensive paper trails, journalizing and bracketing exercises, and participant and peer review.

The theory of nursing interpersonal relations by Peplau (1952) provided insights into and support of the outcomes of this particular study. Peplau’s theory indicates that the nurse/client relationship is crucial to the therapeutic process. If nurses cannot create conditions allowing them to promote movement through the phases of a nurse/client relationship owing to unmet safety issues or because of psychological dysfunction brought on by past trauma, then interactions with clients become a custodial routine rather than a therapeutic process, as clearly illustrated in participant comments. In addition, Peplau noted that an individual must feel secure before satisfaction and personal growth can be sought. This theory is congruent both with Maslow’s hierarchy of needs and with the philosophy of phenomenology that indicates our perceptions of reality are individually realized and through them we create meaning in our lives. It would follow then that because nursing is a helping profession, a sense of work satisfaction is fundamental to staying in the profession. In the current study, nurses described being thwarted at many levels in their attempts to help clients.

A survey of psychiatrists and nurses working in psychiatric settings found that nurses were exposed to violence significantly more than psychiatrists were; however, large numbers in both groups received no follow-up support (Nolan, Dallender, Scares, Thomsen, & Ametz, 1999). Interestingly, when police officers are violently harmed by individuals, those inflicting the harm are subject to judicial proceedings and often punishment. The event is widely publicized. When an officer is killed, there is great ceremony and public outcry. Yet nurses in psychiatric forensic facilities who are also exposed to high rates of assault, injury, and occasional death quietly continue to assume their role with minimal recognition, recourse, or dedicated attempts by those in power to remedy the situation.

In times of budget and personnel deficits, solutions to safety problems in health care facilities are more difficult to solve. Yet it is becoming increasingly apparent that ignoring the problem will have disastrous effects on the health of clients as well as those who care for them, ultimately at great societal expense. Factors believed to improve workplace safety for nurses at a relatively low cost are beginning to surface in the literature. Trenoweth (2002) noted the importance of working with a skilled team. Delaney et al. (2001) found that nurses in assaultive environments wanted improved preceptorships, support structures, and postincident support. Yet participants in this study reported that working conditions in psychiatric forensic facilities continue to be seriously unsafe and that not much is being done to improve the situation.

CONCLUSION

Further studies with larger populations are needed to verify the outcomes of this small study. Instruments can be developed from qualitative studies to investigate the incidence of perilous nursing environments in psychiatric forensic settings for testing on a larger scale. If indeed follow-up research indicates that many of these environments are as perilous as this study suggests, then serious attempts must be made to intervene and improve conditions on behalf of our clients and nursing colleagues. At a time when hospitals are struggling to employ adequate nursing staff, psychiatric forensic facilities are experiencing an even greater dearth of nurses, in turn causing greater suffering for individuals with mental illness who, for the most part, are extremely vulnerable. Improving safety in psychiatric facilities will serve to enhance interest and retention in this valuable nursing specialty, improve care given to clients, and reduce morbidity or worse among both. This study hopes to serve as a catalyst for further investigations and interventions.

ACKNOWLEDGMENTS

We thank the Sonoma State University Sigma Theta Tau Lambda Gamma and Omicron Delta
chapters for grant funding. We also thank Paul Games, MSN, FNP, and Anita Catlin, PhD, RN, FAAN, for editorial assistance.

REFERENCES


