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Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: Cross sectional questionnaire survey☆

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ABSTRACT

Background: Mental health nurses are exposed to patient aggression, and required to manage and de-escalate aggressive incidents; coercive measures such as restraint and seclusion should only be used as a last resort. An improved understanding of links between nurses' exposure to aggression, attitudes to, and actual involvement in, coercive measures, and their emotions (anger, guilt, fear, fatigue, sadness), could inform preparation and education for prevention and management of violence.

Objectives: To identify relationships between mental health nurses' exposure to patient aggression, their emotions, their attitudes towards coercive containment measures, and their involvement in incidents involving seclusion and restraint.

Design: Cross-sectional, correlational, observational study.

Settings: Low and medium secure wards for men and women with mental disorder in three secure mental health hospitals in England.

Participants: N = Sixty eight mental health nurses who were designated keyworkers for patients enrolled into a related study.

Methods: Participants completed a questionnaire battery comprising measures of their exposure to various types of aggression, their attitudes towards seclusion and restraint, and their emotions. Information about their involvement in restraint and/or restraint plus seclusion incidents was gathered for the three-month period pre- and post- their participation. Linear and logistic regression analyses were performed to test study hypotheses.

Results: Nurses who reported greater exposure to a related set of aggressive behaviours, mostly verbal in nature, which seemed personally derogatory, targeted, or humiliating, also reported higher levels of anger-related provocation. Exposure to mild and severe physical aggression was unrelated to nurses' emotions. Nurses' reported anger was significantly positively correlated with their endorsement of restraint as a management technique, but not with their actual involvement in restraint episodes. Significant differences in scores related to anger and fatigue, and to fatigue and guilt, between those involved/not involved in physical restraint and in physical restraint plus seclusion respectively were detected. In regression analyses, models comprising significant variables, but not the variables themselves, predicted involvement/non-involvement in coercive measures.

Conclusions: Verbal aggression which appears targeted, demeaning or humiliating is associated with higher experienced anger provocation. Nurses may benefit from interventions which aim to improve their skills and coping strategies for dealing with this specific aggressive behaviour. Nurse-reported anger predicted approval of coercive violence management interventions; this may have implications for staff deployment and support. However, anger did not predict actual involvement in such incidents. Possible explanations are that nurses experiencing anger are sufficiently self-aware to avoid involvement or that teams are successful in supporting colleagues who they perceive to be 'at risk'. Future research priorities are considered.

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What is already known about the topic?

- Mental health nurses' attitudes to the use of restraint and seclusion are related to their approval of their use
- Anger is also thought to play a role in nurses' responses to and management of aggression but its role is poorly understood

What this paper adds

- Mental health nurses who were more approving of restraint and seclusion also reported higher levels of anger, but were not more likely to be involved in these interventions
- Reported exposure to verbal aggression of a targeted, demeaning or humiliating nature was associated with greater anger provocation
- Nurses may require help to regulate their emotional responses to specific types of aggression

1. Introduction

Healthcare staff commonly experience workplace aggression (Farrell and Shafiei, 2012) ranging from verbal aggression to targeted physical violence by individuals including patients, their visitors, and even their colleagues (Jackson et al., 2002; McKenna et al., 2003). Given their proportionate contribution to the size of the clinical workforce, and their highly visible frontline role, it is perhaps unsurprising that they are the most frequently assaulted professional group (Royal College of Psychiatrists, 2007). Mental health settings are particularly affected: in one review, 55% of mental health nurses had experienced physical aggression at work, a higher rate than in any other health care setting (Spector et al., 2014).

Aggression by patients can negatively affect the social, emotional, and psychological wellbeing of nursing staff (Carmel and Hunter, 1989, 1993; Fujishiro et al., 2011). Serious incidents commonly result in injuries to the head (Carmel and Hunter, 1993), to major joints (Harris and Rice, 1986), open wounds (Flannery et al., 2003), and bruises, sprains, or welts (Daffern et al., 2003). The emotional and psychological effects of patient aggression on nursing staff include an increased risk of post-traumatic stress disorder (Richter and Berger, 2006), a tendency to question their own professional competency, emotional confusion (Deans, 2004), anger, fearfulness, guilt, and shame (Needham et al., 2005a, 2005b).

The impact of patient aggression on nursing staff has potential knock-on consequences for patient care itself. Bowers et al. (2011) proposed that emotional self-regulation is a key pillar of effective mental health nursing practice. When powerful emotions including anger are heightened in nursing staff it is possible that their performance in effectively carrying out patient care and teamwork duties could be compromised. Therefore, while many nurses report that workplace aggression is simply an expected part of the job role (Deans, 2004), there is a clear need to understand its impacts in the interests of workplace safety and in the delivery of therapeutic patient care; most specifically that related to the management of aggression.

The preferred approach to management of patient aggression as a first line intervention is de-escalation, 'the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression' (National Institute for Health and Care Excellence, 2015 p.14). More restrictive and coercive containment methods such as restraint and seclusion are, rightly, controversial due to a lack of evidence for their effectiveness (Stewart et al., 2009) and their use is considered an important indicator of care quality – or lack of – in mental health settings (Sacks and Walton, 2014). Two coercive techniques, physical restraint (i.e., physically holding the patient, preventing movement), followed or not by seclusion (isolation in a locked room) can be used, as a last resort, to manage behaviour that is otherwise likely to cause harm to self and/or others (Royal College of Nursing, 2008). Relevant factors in nurses' decisions to use coercive containment methods include their own characteristics (educational level, experiences, stress, training, and attitudes), the patient, the environment, and the organisation (Larue et al., 2009). Further, decisions made by nurses may in turn affect team norms (Paterson et al., 2013); thus it is important to explore, for example, staff experiences and attitudes in relation to coercive containment methods as part of an overall strategy to reduce their use.

Farrell et al. (2010) have discussed how nursing staff's emotional processes during the management of aggressive behaviour are important and may contribute to a vicious circle. Emotional reactions may sensitise staff to perceive patient behaviour as challenging, thus lowering their tolerance threshold to behaviour; further, they may influence staff behaviour, which might itself trigger or maintain patient aggression. This in turn may further reinforce staff perceptions of patients as challenging. This is supported by Chen et al.'s (2010) findings that poor psychological wellbeing in nursing staff, measured within seven days before an incident had occurred, was a predictor of patient aggression. There is some literature relevant to the connected issues of aggression management and nursing experience or attitudes. Bowers et al. (2007) found that positive attitudes among nursing staff were associated with the approval of less restrictive containment methods such as intermittent and continuous observations over seclusion and restraint. Concomitantly, however, nursing staff also reported feeling angry when they deemed patients' aggression to be unacceptable. As a result, the authors speculated that nursing staff's feelings of anger could be related to their preparedness to use containment measures. Indeed, this hypothesis has been to some extent supported by De Benedictis et al. (2011) who examined whether nursing staff's perceptions of team-related characteristics predicted the use of physical restraint and seclusion to contain patient aggression. The perception of increased levels of anger among team members, the frequency of patient self-directed physical aggression, and insufficient safety measures in the workplace all independently predicted greater use of physical restraint and seclusion. In a qualitative study of nurses' accounts of physical restraint, Sequeira and Halstead (2004) reported that anger was often experienced during the physical restraint process. Nursing staff made sense of this anger through the association of patients hurting them or colleagues, and because of the frustration with patients not responding to less restrictive containment methods. Interestingly, patients interviewed in the same study believed that physical restraint was used to punish them and perceived its use to be largely due to nursing staff being angry.

Further understanding of nursing staff factors, and emotional aspects in particular, in relation to patient aggression and its management could help to inform support mechanisms in clinical practice and advance training programmes for staff working in mental health services. This is especially important given that Needham et al. (2005a) found that a training course on the management of patient aggression had no effect on nurses' perception and on the negative feelings that arise from such incidents.

The aim of the present study was to clarify our understanding of anger in mental health nursing staff by using a standardized measure to explore its relationships with the prevalence of exposure to patient aggression, and with their attitudes towards, and actual involvement in, physical restraint and seclusion. The specific study hypotheses were i) that greater exposure to patient aggression would be related to higher levels of nursing staff anger; and ii) higher levels of nursing staff emotion (anger, fear, sadness, guilt and fatigue) would be positively associated with greater approval of physical restraint and seclusion, and with actual involvement in the use of these coercive containment methods.

2. Methods

2.1. Participants and setting

The current study was one of a series of investigations into the role