



Original article

Healthcare providers' neurobiological response to workplace violence perpetrated by consumers: Informing directions for staff well-being



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ABSTRACT

Aims: To examine the neurobiological response experienced by healthcare workers when exposed to workplace violence perpetrated by consumers, with a view to informing future training and self-care strategies for staff well-being.

Background: Considerable work has been undertaken internationally to identify the causes of workplace violence and to develop legislation and guidance for reducing the risk in healthcare. However, there is a gap in understanding workers' innate neurobiological response to workplace violence, and how to prepare staff to recognise the professional and self-care implications of such a response.

Design: This explanatory study was part of a larger descriptive study.

Methods: Individual and group interviews were conducted with managers, directors, health/safety staff, nurses and educators (n = 99) from rural and metropolitan health services in Australia. Inductive thematic analysis was conducted, followed by in depth analysis to answer the question: what neurobiological response could be occurring when healthcare workers experience workplace violence? The analytical framework was informed by polyvagal theory.

Results: With the increased risk of threat to physical and personal safety in the workplace, healthcare workers may experience activation of the fight, flight or freeze response, affecting their wellbeing and performance at work and at home. Participants recognised a need to care for themselves and understand their own reactions, so that they could better address the needs of consumers.

Conclusions: Education for health care workers should include knowledge of the neurobiological responses to threat, and techniques to increase their capacity to identify, and manage their responses. An understanding of trauma-informed care for staff, will enable them to recognise the cumulative effects of workplace violence, and identify strategies to manage their well-being.

Relevance to clinical practice: Information about the body's neurobiological response to stressors that threaten physiological and psychological safety can assist healthcare providers to better understand how to respond to workplace violence and aggression.

1. Introduction

There is major concern internationally about the increasing prevalence of workplace violence perpetrated by patients and visitors against healthcare workers, and the costs to individuals and organisations (Chappell & Martino, 2006; Kavanah Dwingeloo & Oud Consultancy, 2012). The incidence and prevalence of workplace violence and aggression (WPV) is difficult to determine, in main, due to the

varying staff perceptions regarding what comprises WPV and a lack of reporting (Hogarth, Beattie, & Morphet, 2016). However, the 2006 International Labour Office *Violence at Work Report* provides a compilation of reports and research findings of WPV in healthcare internationally which suggests that verbal and physical WPV is common (Chappell & Martino, 2006). This is supported by more recent studies which suggest that in the previous 12 months, at least 50% of nurses had experienced verbal abuse (American Nurses Association, 2014;

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Wei, Chiou, Chien, & Huang, 2016) and up to 20% had experienced physical abuse (American Nurses Association, 2014; Wei et al., 2016). The true extent and consequences of WPV is difficult to ascertain.

2. Background

The World Health Organization (WHO) defines workplace violence as “Incidents where staff are [verbally, physically or psychologically] abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health” (International Labour Organization, 2002, p. 3). Perceptions and attitudes toward WPV vary considerably. In a study by Hogarth et al. (2016), emergency nurses normalised WPV by considering it part of the job and did not report violence if no-one was physically “hurt”. Further, staff perceptions of the intent of the aggressor, influenced their reporting and response behaviours. For example, nurses considered violence perpetrated by “sick” people to be non-intentional, and were more accepting of such behaviour (Blando, Ridenour, Hartley, & Casteel, 2015; Hogarth et al., 2016).

The direct and indirect consequences of WPV to the victim, perpetrator, organisation and society are many and varied (Chappell & Martino, 2006). Victims may experience physical injury, and psychological injury such as anger, guilt, anxiety, fear, helplessness, acute stress and posttraumatic stress disorder, resulting in absenteeism, poor performance, decreased job satisfaction and patient avoidance (Chapman, Perry, Styles, & Combs, 2009; Ramacciati, Ceccagnoli, & Addey, 2015). Perpetrators may be physically or chemically restrained, suffer poor relationships with staff, or may not receive care (Chapman et al., 2009). For the organisation, there may be a loss in productivity, decreased quality patient care, low staff morale, safety concerns, a lack of trust and support from staff, and increased costs related to prevention and management of WPV (Chapman et al., 2009). Society as a whole, pays increased healthcare costs.

WPV perpetrated by healthcare consumers (patients and visitors) toward workers is a complex problem, requiring multi-faceted approaches and solutions. A few studies have identified healthcare staff characteristics which may increase their risk of experiencing WPV. Characteristics such as appearance, health, age, experience, gender, personality, temperament, attitudes and expectations have been identified as possible risk factors (Chappell & Martino, 2006). In addition, Anderson and Parish (2003) found that those with a personal history of childhood and/or adult violence reported more emotional-verbal WPV than did nurses without a history of childhood or adult violence (Anderson & Parish, 2003). Training in self-management has been shown to reduce the violence experienced by nurses (Eslamian, Fard, Tavakol, & Yazdani, 2010). Eslamian et al. (2010) found that an anger management program enabled nurses to more successfully manage their anger.

Participants reported experiencing less physical and psychological violence post-intervention. Thus, being able to manage anger decreased the violence perpetrated against them (Eslamian et al., 2010).

An understanding of the Polyvagal Theory (Porges, 1997, 2003) and the defense cascade (Kozłowska, Walker, McLean, & Carrive, 2015) can increase our understanding of health care workers' responses to WPV. Examining how the brain and body react to challenges, that is, the body's innate neurobiological response to stressors, can assist health-care workers to understand their reactions during threat to their physiological and psychological safety. Health care providers have an understanding that the autonomic nervous system (ANS), which consists of the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS) regulate bodily functions and assist in maintaining homeostasis. Polyvagal theory expands this understanding and describes the neurophysiological and neuroanatomical distinction between the two branches of the vagus nerve (myelinated ventral vagal complex unmyelinated dorsal vagal complex) within the PNS. This

distinction is important to understanding the different ways in which individuals respond to threat (Levine, 2010). Three evolutionary stages of development of the ANS have been described: social engagement and connection (ventral vagal response), fight or flight behaviours of mobilisation or action (SNS response) and shutdown, freeze behaviours (dorsal vagal response) (Porges, 2003).

Porges' theory relates to the stress response and proposes that it is hierarchical, so that when our safety is threatened, our most evolved strategy is employed first, that is, social interaction or engagement. However, if this is not possible, fight/flight (action) responses follow where the organism is mobilised either toward (fight) or away from (flight) the threat. Lastly, when there is a perception of no escape, freeze or immobility responses occur (Porges, 1997, 2003). “Thus, evolution has endowed all humans with a continuum of innate, hard-wired, automatically activated defense behaviours [often referred to as] the *defense cascade*” (Kozłowska et al., 2015, p263).

“The perception of safety determines whether the behaviour will be prosocial (i.e. social engagement) or defensive” [fight, flight, or freeze] (Porges, 2003, p39). The evaluation of risk occurs at the neural level as information from our environment is processed through the senses and visceral organs such as those of the gastrointestinal system (neuroception), and does not involve conscious awareness (Porges, 2003, 2011). As highlighted by Levine (2010) p121, “our guts have more to say to our brains than our brains have to say to our guts!”

Behaviours such as social engagement (connecting, communicating, curiosity), fight (glaring, speaking quickly and loudly, rough handling), flight (withdrawal, restlessness, staying away from) and freeze (numbness, disengaged, dissociated) are the organism's (staff member's) unpremeditated (and usually unconscious) response to a felt sense of safety, or stress, anxiety, fear or threat, and are common to all humans, whether they have been diagnosed with a mental health condition or not (Porges, 2003). While people presenting with substance abuse, personality disorders, major mental health disorders, and head injuries for example contribute to WPV, aggressive and violent behaviour develops as a result of complex interactions between neurobiological and environmental factors (Volavka, 1999).

While experiencing stress can be a helpful motivator for action, there can also be detrimental effects of stress on brain regions that facilitate the control and regulation of behaviour (Raio & Phelps, 2015). When under threat (perceived or actual), the SNS is activated and neurocognitive functioning is reduced. Thus, clinical judgement, decision-making, social engagement, and emotional and behavioural regulation is reduced (Porges, 2003). Further, in an effort to relieve the symptoms of SNS activation, such as muscle tension, increased heart rate, sweaty palms, and in an effort to reduce the threat, the individual may become very reactive in their thinking and behaviours (Kozłowska et al., 2015) which could lead to aggressive responses, of which they may not even be aware.

As such, stress responses can increase an individual's reactivity and interfere with the capacity to respond appropriately. Staff may be less able to regulate their responses to patients and assess their needs accurately when feeling threatened (Becker, 2016).

Furthermore, they may be less able to identify their own self-care needs (Becker, 2016).

Considerable work has been undertaken to identify the causes of WPV and to develop legislation and guidance for reducing the risk in healthcare. However, there is a gap in understanding workers' innate neurobiological response to workplace violence, and how to prepare staff to recognise the professional and self-care implications of such a response.

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