

TITLE: WORKPLACE VIOLENCE: AN EXPLORATORY
STUDY INTO NURSES' INTERPRETATIONS AND
RESPONSES TO VIOLENCE AND ABUSE IN TRAUMA
AND EMERGENCY DEPARTMENT.

NAME: MAUREEN ANGELINE KENNEDY

STUDENT NUMBER: *****

DEGREE: M CUR

DEPARTMENT: NURSING

SUPERVISOR: MRS. H. JULIE



KEY WORDS: Workplace violence, abuse, physical abuse,
perception, psychological abuse, sexual
harassment, bullying, threat, aggression,
occupational safety.

A Mini-Thesis submitted in partial fulfilment of the requirements for the
degree M.Cur (Nursing) in the Faculty of Community and Health
Sciences University of the Western Cape.

TABLE OF CONTENTS

Abstract	i
Declaration	ii
Acknowledgements	iii
CHAPTER ONE	1
1.1 Introduction	1
1.2 Background Statement	2
1.3 Focus of Study	4
1.4 Problem Statement	5
1.5 Aim of the Study	5
1.6 Objectives	6
1.7 Rationale and Significance of the Study	6
1.8 Assumptions	7
1.9 Operational Definitions	7
CHAPTER TWO	9
2.1 Introduction	9
2.2 Defining Violence, Workplace Violence	10
2.3 Types of Workplace Violence	13
2.4 Violence Against Nurses	16
2.5 Factors Contributing to Violence in the Workplace	17
2.6 Effects of Workplace Violence on Nurses	19
2.7 Occupational Safety of Employees	21

CHAPTER THREE	22
3.1 Introduction	22
3.2 Research Setting	23
3.3 Study Design	23
3.4 Participants and Sampling Methods	23
3.5 Data Collection Methods	25
3.6 Data Collection Process	27
3.7 Data Analysis	31
3.8 Ethical Considerations	33
3.9 Possible Limitations and Gaps in Data	34
3.10 Delimitation of Study	34
CHAPTER FOUR	35
4.1 Introduction	35
4.2 Presentation of Findings	36
4.3 Summary of the Main Results	53
CHAPTER FIVE	57
5.1 Conclusion	57
5.2 Recommendations	59
REFERENCES	61
APPENDICES	68

ABSTRACT

Violence in society has reached epidemic level and has permeated the walls of the workplace. Workplace violence has also spread across all occupations, especially those dealing with the public, and has escalated over the years.

In this mini thesis the researcher explore the experiences, perceptions and coping mechanisms used by nurses exposed to violence in the health setting. The main focus is to determine how the subjects interpret abuse, and does this interpretation determine their response to the abuse.

The research design selected was a qualitative one, as it focused on experiences and interpretations in an attempt to describe how nurses view things and why.

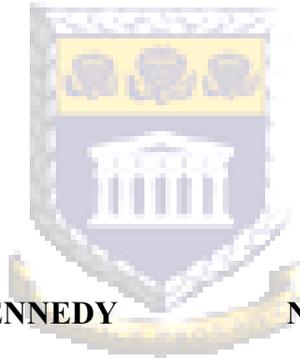
A thematic analysis was utilized based on semi-structured interviews conducted on a sample of nurses comprising 3 Registered Nurses, 2 Enrolled and 3 Enrolled Auxiliary Nurses, working in the Trauma and Emergency units.

Overall the findings indicate that the most common type of abuse nurses have experienced or was exposed to was that of verbal abuse. Uniformity as to their interpretations of abuse were evident and was understood as swearing, loud aggressive tone of voice, scolding and insults. Their responses were determined by distinction made between the severity and the context in which the abuse occurred.

The emergent themes indicated the difficulty nurses have in dealing with abuse in the workplace. This is indicative of the importance of psychological support for nurses working in trauma and emergency units and the need for training programmes, which may assist them in developing skills in dealing with this phenomenon of workplace violence.

DECLARATION

I declare that *Workplace violence: an exploratory study into nurse's interpretations and responses to abuse in Trauma and Emergency Department* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.



MAUREEN ANGELINE KENNEDY

NOVEMBER 2004

SIGNED:

ACKNOWLEDGEMENTS

I firstly thank God for the grace and guidance given to me during my endeavours to further my professional and personal development and growth.

To my wonderful, supporting husband PAUL, my sons JULIAN and CRAIG, who tirelessly and continuously supported and believed in me, a heartfelt thank you.

To Hester Julie, my inspiration, mentor and supervisor. Your support, encouragement and direction ensured this accomplishment. My sincere appreciation.

Finally, to all my colleagues, friends and family who supported me throughout; to the nursing staff who voluntarily participated in the study, I extend my thanks and appreciation.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

We live in a society where violence has almost become the norm. Over the years the violence in society has slowly also permeated the walls of the health care settings and healthcare workers are increasingly being exposed to violence and abuse in the workplace (International Council of Nurses Fact Sheet, 2003). Research findings conclude that abuse of health care professionals in the workplace, specifically nurses, by patients, is a common and widespread problem. (Jackson, Clare & Mannix, 2002). In the past, acts of aggression and abuse have to some extent been seen as inevitable in accident and emergency settings and it was ascribed to the patients' medical conditions and accompanying levels of anxiety (Kurlowicz, 1990; Marais, Van der Spuy & Rontsch, 2000; Tamra, 2002)

Much of the research done on workplace violence concentrated on aspects of violence relating to physical abuse and assaults with distinctions made between fatal and non-fatal assaults, but recent research (Steinman, 2001; Cooper, Hoel & di Martino, 2003) found that psychological abuse is one of the most common forms of abuse experienced by nurses, and it is substantially higher than physical abuse. For the writer, the interest evolved around whether workplace abuse contributed to the mental illness or decrease in work performance of the nurses. This interest is based on experiential involvement with psychological support for healthcare workers, of which the majority are nurses.

1.2 BACKGROUND STATEMENT

Initially most of the earlier documented occupational violence in health settings focused on the psychiatric wards, where mentally ill patients were known to be volatile and frequently became aggressive. In this type of health setting, psychiatric nurses appeared to be significantly more at risk to abuse or aggression than seemed to be the case for general nurses. General nurses were also affected, but to a lesser degree. Later studies refocused on nurses in general ward settings as well as on those in trauma and emergency departments (Wells & Bowers, 2002).

Most of the studies reviewed in literature (Tamra, 2002; Wells & Bowers 2002; Sofield, 2003;) were conducted in the United Kingdom and the USA. These studies increased over the years, with emphasis on the scale of the problem. The “re-emergence” of the issue of violence in the health sector in the 1990s, followed national reports on violence in the health settings by authoritative bodies, like Health and Safety Committees, Health Service Advisory Committees, Colleges of Nursing, etc. Most of the reported incidents of violence were related to severe physical injuries and this was captured through the reporting of injuries through the occupational health and safety channels. Non-physical injuries were often not reported and this led to the phenomenon of underreporting. (Wells & Bowers, 2002).

During the 1990s, researchers also began to explore aspects of workplace violence, by looking at other categories besides customer/client-related violence or external violence, e.g. violence related to individuals being involved in criminal acts. It was felt that the latter affected societal violence, which in turn infiltrated the health settings.

Diamond (as cited in Bowie, 2002) , in his definition of workplace aggression, strongly links the following contributory factors, which stem from the varied historical, individual, and organisational factors and include: external realities such as social class and unemployment, organisational structure, work processes, roles and culture, and emotions regarding perceptions and anxieties.

Bowie (2002) organised the above concepts in the following categories:

Intrusive violence – this involves external perpetrators who have no legitimate relationship to the workplace, e.g. those undertaking criminal acts, sabotage or terrorism.

Consumer violence – involves aggressive acts by customers or clients, and could include patients, prisoners or passengers.

Relationship violence – involves acts by current or former employees. It also includes cases of stalking, bullying and harassment.

Organisational violence – this involves organisations knowingly placing their workers in dangerous or violent situations, or allowing a climate of bullying or harassment to thrive in the workplace.

Another aspect of violence towards healthcare workers, which had also been highlighted in literature, is the abuse related to colleagues. This type of abuse is sometimes referred to as horizontal or institutional abuse. It could be classified within the ambit of psychological abuse, which will include verbal abuse, bullying, intimidation and harassment. “*Some of the worse attacks nurses undergo comes from within. The nasty words, vicious threats and even physical assaults occasionally arise not from angry or confused patients, but from the physicians with whom the nurses work*” Tamra (2002, p. 2).

Findings from an online survey conducted in the USA in 2000, on verbal abuse towards nurses, showed that the most common source of verbal abuse was a physician. (Sofield, 2000). Other research findings suggest that nurses are the major perpetrators of some forms of workplace violence. Highlighted was the fact that line managers were often identified as a continual source of violence and bullying (Jackson, 2000).

Documented increase in nurses being exposed to and experiencing abuse, not only in a physical sense, but increasingly in some form of verbal abuse, bullying and harassment, could be an indication that there may be different interpretations and perception of abuse in the workplace.

1.3 FOCUS OF THE STUDY

This study focused on the experiences of nurses working in the trauma and emergency units, who by the nature of their work would have been exposed to different types of abuse from patients, relatives and escorts in their work environment. Emphasis was on their interpretations of and responses to abuse. The researcher attempted to understand what the nurses' difficulties were and which coping strategies they used, in order to propose recommendations for future support to healthcare workers when experiencing abuse.

1.4 PROBLEM STATEMENT

From the evidence that violence against nurses is a common and worldwide phenomenon, it has become clear that this type of violence not only continues, but is also increasing. There is also evidence to suggest that workplace violence in health settings has increased over the years, as indicated in the findings of a study conducted by the American Organization of Nurse Executives. The findings indicated that 28% of nurses have experienced episodes of violence in the workplace in a year. It also states that between 1992 and 1996, about 69 500 nurses were victims of nonfatal incidents. (Tamra, 2002).

According to previous findings, as cited by O'Connell, there is a lack of standardised, well-defined operational definitions for the term *violence*. This could be a contributory factor to the underreporting of violence and aggression in the workplace. Sofield (cited by Stringer, 2001) , who has done numerous studies on violence against nurses, intimated that nurses might also have a role in perpetuating the cycle of abuse in that they often accept abuse, especially verbal abuse, because they feel they do not have the power to change it (Stringer, 2001). The question therefore is: what are the contributory factors to nurses not responding to abuse, and could it be that nurses define and interpret abuse differently? The latter is an area of enquiry that has not yet been explored in previous studies.

1.5 AIM OF THE STUDY

The aim of the study is to gain a deeper understanding of how nurses interpret and define abuse by patients, and to ascertain which coping mechanisms they use when exposed to abuse in the workplace.

1.6 OBJECTIVES

The aim of this study was:–

- to ascertain the most common types of workplace abuse experienced by nurses;
- to determine the nurses' behavioural response after such incidents of abuse;
- to determine the effects of abuse on nurses' performance in the work environment;
- to ascertain which coping strategies nurses use when experiencing or are exposed to abuse in the workplace.

1.7 RATIONALE AND SIGNIFICANCE OF THE STUDY

The Occupational Health and Safety Act, Act 85 of 1993, states that the employer should provide a safe working environment for employees. However, the Act does not include definitions or explanations of psychological or emotional safety. Furthermore, limited research has been done in South African hospitals and more specifically in the Western Cape, on the issue of violence against nurses.

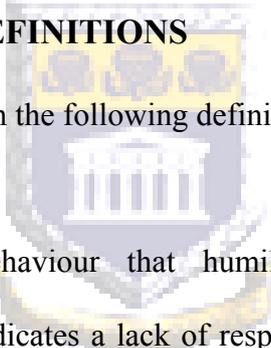
Based on the findings of research done in various health care settings by the Medical Research Council (MRC) (Marais, 2000) in which it is documented that nurses are more at risk of violent behaviour from patients, than doctors, this study will be significant in that it may provide insight into nurses' perceptions and reactions to abuse in the workplace. The results could give an indication as to what nurses may require with regards to psychological support or training in dealing with abuse in the workplace.

1.8 ASSUMPTIONS

One assumes that nurses, who are exposed or subjected to abuse in any form, would respond in a way that would give an indication that abuse is unacceptable. There may be a distinction between the types and severity of the abuse, which could influence the various feelings and reactions when abused. The assumption would be that abuse would be viewed and defined more or less the same by all nurses and that similar perceptions are shared. Another assumption could be that the respondents could have expectations of drastic preventative and corrective measures that will be implemented if their views and opinions are voiced and published.

1.9 OPERATIONAL DEFINITIONS

For the purposes of this research the following definitions apply:

- 
- Abuse:** Behaviour that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.
- Aggression:** Hostile unacceptable behaviour directed against an individual.
- Assault:** Intentional behaviour that harms another person physically or psychologically. Physical assault may include sexual assault (i.e. rape).
- Bullying:** Repeated and over time offensive behaviour through vindictive, cruel or malicious attempts to humiliate or undermine an individual or groups of employees.
- Occupational safety:** Safe work environment free from serious hazards.

Perception:	Refers to views of (in this case) nurses about violence and abuse.
Physical abuse:	The use of physical force against another person or group that results in physical, sexual or psychological harm. This may include beatings, kicking, slapping, pushing biting and pinching.
Psychological abuse:	The intentional use of power; which includes threats of physical force against another person or group that may result in harm to physical, mental, spiritual, moral or social development.
Sexual harassment:	Any unwanted, unreciprocated, unwelcome behaviour or behaviour of a sexual nature.
Threat:	Promises of physical force or power resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals.
Workplace violence:	Incidence when staff is abused, threatened or assaulted in circumstances relating to their work.

CHAPTER TWO

LITERATURE REVIEW

There has been growing recognition internationally that workplace violence across all occupational sectors has reached epidemic levels. The research literature shows that healthcare workers in particular face dramatically higher risks of nonfatal assaults than is the case in other occupations and there is a high incidence of assaults against caregivers. *“Most nonfatal workplace assaults occur in service settings such as hospitals, nursing homes and social service agencies”* National Institute for Occupational Safety and Health (1997, p.1).

2.1 INTRODUCTION

Most of the information from literature was taken from American, Canadian and Australian books and journal articles because of limited availability of documented research data in South Africa. South African data was obtained from studies done in the Western Cape and from a joint international programme on workplace violence in the health sector, of which South Africa formed a part. (Marais, Van Der Spuy & Rontsch. 2000; World Health Organization (WHO) Press Release. WHO/37 2002)

2.1.1 Structure

For this study, the literature review follows the structure as indicated below.

A macro perspective of violence is given by defining violence according to the perspective of the World Health Organisation (WHO) in order to understand the influence of societal violence on the workplace. Violence at the micro level of the

workplace focuses on the manifestations of workplace violence. Issues, like the types of abuse, the contributing factors and the effects on nurses are discussed by referring to aspects of occupational safety.

2.2 DEFINING VIOLENCE, WORKPLACE VIOLENCE AND IDENTIFIED RISK FACTORS

2.2.1 Violence

The wide variety of societal moral codes makes the topic of violence challenging to address because of the different interpretations of what constitutes violence. Notions of what is acceptable or unacceptable in terms of behaviour, are culturally influenced and constantly under review as values and social norms evolve. An example quoted is that of corporal punishment of children in the earlier decades as a means of discipline, which would today be regarded as an aggressive act against an individual and an infringement on his/her right to human dignity. The definition of *violence* by the WHO was adopted for purposes of this study. The WHO defines violence as: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” WHO Publication (2002, p. 30).

In the World Health Organization Report (2002) on violence and health, it is highlighted that violence can be divided into three categories, namely *self-directed violence* e.g. suicidal behaviour and self-abuse, such as self-mutilation; *interpersonal violence*, e.g. violence largely between family members and intimate partners or between individuals unrelated to each other; and *collective violence*, which can be

described as violence between members of one group against members of another group in order to achieve political, social or economical objectives. The report further states that violence has its roots in many factors, which makes the concept of violence and understanding it complex.

2.2.2 Violence in the Workplace

The spectrum of violence in the workplace ranges from offensive language to homicide. A reasonable definition of workplace violence would include violent acts, inter alia physical assaults and threats of assault, directed toward persons at work or on duty (National Institute for Safety and Health, 1997).

Workplace violence crosses all work settings and occupational groups. It is increasingly common in work settings where violence is expected, e.g. law enforcements, delivery services where robbery is common and in mental health settings, and it could be concluded that every occupation that deals with the public can expect incidence of violence in the work environment.

Earlier studies revealed that most of the violence comes from people outside the work environment. These involve aggressive acts by customers or clients of a service and could include patients, prisoners or passengers, but in addition, later studies highlighted *horizontal violence*, which is described as violence and aggression by staff on staff (colleagues), e.g. bullying and harassment. This brings into focus another perspective of workplace violence, namely that of *organisational violence*, described by Bowie (2002) as organisations knowingly placing their workers in

dangerous and violent situations or allowing a climate of bullying or harassment to thrive in the workplace.

In a press release on workplace violence by the World Health Organisation in 2002, it is alleged that new research indicates that violence in the healthcare workplace is actually a global phenomenon and an epidemic in all societies, including the developing world (Press Release WHO/37, 2002).

Work-related nonfatal assaults are a more common form of workplace violence. This includes not only physical assault, but also other forms of aggression, such as stalking and harassment. A study done in Nova Scotia 1995 revealed that the prevalence of workplace violence in the health sector is widespread and includes settings like acute care settings, emergency departments, psychiatric inpatient units and critical care units. (Registered Nurses Association Nova Scotia 1996). Literature also shows that from the subjects surveyed over the years, the majority had been subjected to at least one incident of violence in the course of his/her occupational experience. (WHO Press Release, 2002; Jackson,D, Clare,J & Mannix,J. 2002). In South Africa, 78% of employees confirmed that they had been bullied or victimised at least once in their careers (Marais-Stein, 1998).

2.2.3 Risk factors in the workplace

Identified risk factors involved in workplace violence include:

Environmental factors where violent societies, a violence prone neighbourhood or community and early release of mentally ill patients play a role. The violence within our societies often infiltrates the work environment.

Work practices include low staffing levels, long waits for services by customers/patients/clients, or working alone. The long waiting period often increases the emotional levels of patients, which in turn increases the levels of frustration.

Perpetrator profiles may include persons with a history of violent behaviour, or relatives of injured persons (National Institute for Occupational Safety and Health, 1997). Other factors could include patient diagnosis, e.g. head injuries or substance abuse, which could contribute to the violent or abusive behaviour (Registered Nurses Association of Nova Scotia, 1996).

2.3 TYPES OF WORKPLACE VIOLENCE

Specifically in healthcare settings, workplace violence have been found to be:

Aggression and *physical abuse* are found especially in occupations dealing and interacting with the public. The range of aggressive behaviour reported, include being grabbed, punched, pushed, pinched, scratched, kicked, stabbed with scissors and pulled by the hair (O'Connell, 1999; Hemmila, 2003). The assaults that involved physical contact were mostly ascribed to psychotic behaviour of the patient or behaviour that stemmed from the patient's substance abuse (mostly alcohol intoxication).

It should be noted that documented data on the prevalence of specific types of violence around this aspect (i.e. physical abuse) is limited. Authors explain that this could be due to underreporting (Hemmila, 2003; Sofield and Salmond, 2003). Available statistics are often retrieved or collated from records, like criminal injuries compensation, or via the occupational health and safety compensation claims.

Werner, (as cited by Wells and Bowers 2002) reports a significant association between *verbal abuse* by patients and *physical assault*, and states that verbal abuse often precedes physical abuse. Studies also revealed that the incidence of verbal abuse is not only related to patients, but quite often colleagues, especially doctors, are also guilty of such behaviour. (Sofield 2000; Stringer, 2001; Sofield & Salmond, 2003). *“Some of the worse attacks nurses undergo, comes from within. The nasty words, vicious threats and even physical assaults occasionally arise not only from angry or confused patients, but also from the physicians with who nurses work”*

Tamra (2002, p. 2).

The above can be described as *verbal intimidation*. It often manifests itself in a loud angry tone of voice, foul language, inappropriate jokes, or threats. This type of abuse is mostly hierarchically downwards, has a controlling effect, and humiliates the individual.

According to data from a global study on violence in the healthcare worker’s workplace, verbal abuse constitutes 60,1% of all types of abuse reported in the public sector (WHO/37, 2002). Despite this high incidence, verbal abuse is usually not reported, as it is viewed as “common practice”. *“The incidence of verbal abuse is believed to be underreported and this underreporting is hypothesized to stem from oppressed behaviour, because nurses blame themselves for the abuse instead of placing the blame on the abuser”* Sofield (2003, p. 3).

Emotional or psychological abuse may include verbal abuse, bullying, harassment and threats. Nurses are often called names or they are insulted, and this could cause emotional distress. Tamra (2002) also states that these attacks do not leave visible scars; however, the emotional damage to the inner core of the victim's self can be devastating.

Another aspect that may be considered as relevant for the underreporting is the cultural complexity of communication as different cultures communicate and use language differently. This complexity could result in the spoken word being interpreted differently. As nursing care involves interaction and service to multi-cultural client population, this difference in interpretation may lead to nurses accepting verbal abuse from all sources, as “part of the job” (Sullivan & Decker, 1992)

Workplace bullying is rife and is referred to as the “silent epidemic”, eating away careers and human potential. Emotional bullying can be crippling as most people identify very strongly with their jobs and their self-esteem is derived from the position they hold. Staff working in the emergency and trauma units is often subjected to bullying by patients who have a history of violent behaviour, especially those involved in gang-related violence. Often nurses are threatened or bullied even by the mere nature of the behaviour displayed.

Sexual harassment can involve a range of unacceptable behaviours, including unwanted physical contact, offensive sexual comments and sexual propositions. According to Hoyer (1994), very few victims of harassment in the workplace manage

to take effective measures to prevent or discourage such behaviour. He further states that it is consistently reported that disclosure of harassment often exacerbated the situation and penalises the victim more than the perpetrator. This could account for many unreported cases and the tendency to trivialise certain behaviours.

2.4 VIOLENCE AGAINST NURSES

According to literature, violence against nurses is not a new phenomenon, but greater emphasis is placed on the problem nowadays due to the increase in violence worldwide (Wells, 2002, Atawneh Zahid, Al-Sahlawi, Shahidn & Al-Farrah 2003). If we look at violence against nurses from a gender-based perspective, the issue of unequal power relations between men and women emerges. Chodoram states (as cited in Sullivan and Decker, 1992) that in patriarchal societies, women are assigned to attention-giving roles and men to attention-getting roles. These roles could create a sense of men being more powerful than women and in turn nurses may view physicians as being more powerful than they are. Sofield states (as cited in Stringer 2001) that nurses continue to accept abuse because they feel that they do not have the power to change it. Sofield continues by saying that nursing staff, a predominantly female profession, have been conditioned to accept behaviour from those they see as powerful, as women often have been socialised to be passive in communication and to relinquish power. Nurses are also easy targets for patients who hit, kick, bite and spit as they have the greatest exposure to patients, having to perform most of the uncomfortable procedures. One author quoted a response by a victim of abuse, “... *the patient is more apt to strike out at a nurse because they know if they target the doctor, they're not going to get what they need ...*” Hemmila (2003, p.2)

A gender issue related to the concept of violence against nurses brings another perspective to the fore. The question is: are female nurses at a greater risk of abuse? It is stated in the findings of a study done by the European Foundation that, although men and women experience violence in the workplace, women appear to be more vulnerable than men are. The authors further state that this is due to women being concentrated in high-risk jobs and occupations such as nursing, social work and teaching (Cooper, Hoel, & Di Martino, 2003). Data from the South African Nursing Council register (December 2003) indicates the gender distributions in the nursing profession as follows: Total number of male nurses, 11 347, compared to the total number of female nurses being 166 374 (Geyer, 2004) [ii]

2.5 FACTORS CONTRIBUTING TO VIOLENCE IN THE WORKPLACE

2.5.1 Situational factors

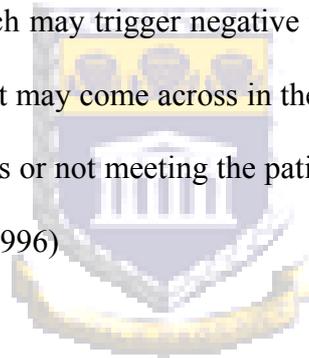
These would include working with the public, with people who are in distress, frustrated and angry. With the advent of restructuring and downsizing, staff shortages in the nursing profession have become problematic in the sense that it is difficult for nurses, who have become thinly spread, to deal with high acuity patients being treated in the trauma and emergency units, as well as with patients and worried families. Thomas (2003, p.105) states, “... *patients may generate feelings of vulnerability and powerlessness as they grapple with depersonalised institutional routines, intrusive procedures and the receipt of bad news about diagnosis, disability or prognosis, and express their anger and frustrations in an aggressive manner*”.

Often the anger and frustrations of the patients and their families are then highlighted and directed at the nurses, leading to violence against the nurses.

2.5.2 Individual factors

Factors of this kind would include patients with a history of violent behaviour, emotional disorders, e.g. agitated patients, anxious patients or patients being under the influence of an intoxicating substance.

Factors relating to staff could include “perceived” threatening tone of voice or body language as well as staff attitudes, e.g. anxiety or ambivalence towards management of aggression. Staff may also display rigid, intolerant or authoritarian manners in dealing with the patient, which may trigger negative responses from patients. These factors are often not overt, but may come across in the tone of voice, impatience with anxious or demanding patients or not meeting the patient’s needs. (Registered Nurses Association of Nova Scotia, 1996)



2.5.3 Organisational factors

Factors of organisational nature may include an organisational culture of allowing adverse conditions, e.g. climate of abuse, bullying or harassment to thrive in the workplace. Other factors could be poor environmental design, like easy access to visitors, inadequate security and unrestricted movement of the public. All these factors contribute to the healthcare worker being more vulnerable to the possibility of being abused by the public.

The strategies around the causes and cures of workplace violence have focused on the personality or pathology of the individual worker or perpetrator as the main contributing factor to workplace violence. However, it seems that the varying extents

of organisational culture as documented may have a direct effect by contributing to the types of violence experienced by workers (Bowie, 2002). Recent research findings have included and emphasised the organisational aspect by highlighting the employers' responsibilities with regard to prevention of workplace violence (Geyer, 2004). [i]

2.5.4 Societal factors

These factors may include a violent society, a violence prone community, or the large number of weapons in circulation (Bowie, 2002). Societal factors eventually also infiltrate the nurses' workplace, thus exposing the healthcare worker to aggressive acts by patients and their relatives.

2.6 EFFECTS OF WORKPLACE VIOLENCE ON NURSES

According to the National Institute of Safety and Health Fact sheet (NIOSH, 2002), the effects of violence include:

minor physical injuries, like scratches and bruising;

serious injuries, which could be stabbings, severe bruising from patients lashing out;

and

psychological trauma, resulting from fear and anxiety.

By far the most concerning effect of late is the psychological effect abuse has on the worker in the workplace. As Marais-Stein (1998) argues, the victims often feel shame and guilt, tend to blame themselves and replay incidents repeatedly in their minds, wondering if they could have done anything differently. In severe cases, victims may suffer from Post Traumatic Stress Disorder (PTSD).

Verbal abuse leaves no visible scars, however, the emotional damage to the inner core of the victim's self can be devastating. As remarked by Sofield (2003, p.1) "*It leaves the recipient feeling personally or professionally attacked, devalued or humiliated*".

A wide range of responses to violence and abuse has been experienced. Examples of these responses are anxiety and difficulty returning to work, decrease in job performance, and sleep pattern disturbance, headaches and fear of other patients. (Jackson, Clare & Mannix, 2003). Violence may also affect colleagues who witness any violence or abuse. It is documented in literature that some may even feel increased stress and fear that they might also become a victim of violence (Cooper, 1995).

Besides physical injuries, the above often results in serious and disabling psychological damage, which initially manifests as anger. On the other hand, the individual who often displays avoidant behaviour, minimising his/her feelings and forgetting the incident or situation, usually mismanages this anger. It has been found that nurses often respond defensively when angry (Thomas, 2003). Other responses include self-blame and fear of other patients. Evidence of this is often revealed in increased absenteeism and increase in staff turnover as affected individuals attempt to withdraw from the stressful environment (National Institute of Occupational Safety and Health, 1997).

2.7 OCCUPATIONAL SAFETY OF EMPLOYEES

According to the Occupational Health and Safety Act (OHSA) (RSA, 1993), employers are required to provide a workplace that is free of serious hazards (Section 8 (2)(d)) and in compliance with the OHSA standards . OHSA further stipulates, "*...every employer shall provide and maintain as far as is reasonably practicable, a working environment that is safe and without risk to the health of the employees*" (Section 8 (1)).

Literature however reveals a lack of legislation for employers who are not adhering to this regulation, responsible. What are however documented in literature, are guidelines as to how to prevent violence in the workplace. The South African OHSA also omits to include or specify psychological or emotional safety.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research design used in the current study, the study population, research setting, data collection methods, validity and reliability, data collection process, data analysis, ethical considerations and delimitation of the study.

The researcher elected to use a qualitative research approach for the study because the aim of the study is to ascertain how nurses interpret and respond to abuse in the work environment. *Qualitative research* is defined as “... *the detailed descriptions of situations, events, people, interaction, observed behaviours and direct quotations from people about their experiences, attitudes, beliefs and thoughts*” Patton (1990, p. 23). As the research question focuses on individuals’ personal experiences and interpretation of the types of abuse, the qualitative approach was deemed appropriate in order to obtain rich, in-depth information from a small focused number of participants, using one-to-one interviews.

According to Denzin and Lincoln (1998), the researcher should be able to put him/herself in the role of the respondent and should attempt to see the situation from the respondent’s perspective, rather than impose preconceptions upon him or her.

3.2 RESEARCH SETTING

The population selected for the study consisted of 1433 nurses, who worked at a tertiary health institution in the Western Cape Metropole Region.

The study was conducted in the Trauma and Emergency Department, which consists of four units. These units are divided into acute and non-acute sections for trauma cases as well as emergency medical cases. The first contact between patients and the nursing staff for both trauma and emergency cases are made in the acute sections. Once these patients are stabilised, they are transferred to the non-acute sections.

3.3 STUDY DESIGN

The phenomenological approach was used for the study. This approach allows the researcher to obtain the necessary information related to individuals' actions and interaction, through interviews and/or observation (Creswell, 1998). Using the phenomenological method, allows the researcher to study the human experiences as they are lived, and to ascertain how these experiences affect them, and why.

3.4 PARTICIPANTS AND SAMPLING METHODS

For the purposes of this study, nurses from the Trauma and Emergency Department were selected to participate in the study. The staff working in these areas are regarded as "key informants" because they are more likely to encounter incidents of abuse than the nurses in the general wards, as the units within this department are the first contact areas for traumatised and emergency patients coming to the hospital. *"Key informants are individuals who possess special knowledge, status or communication skills, who are willing to share their knowledge ... with the researcher"* Crabtree & Miller (1992, p.75).

The sampling population consisted of 113 nurses working day and night shifts in Trauma and Emergency Department, comprising 29 Registered nurses, 16 Enrolled nurses and 26 Enrolled nursing auxiliaries. Including all three categories added richness of data to the information that was collected.

Purposive, convenient sampling was used to ensure experienced staff was utilised for in-depth studying. *“Purposive sampling is the process of picking cases that are judged to be typical of the population”* Seaman (1987, p. 244). The decision for this method was based on the information obtained from the Assistant Director: Nursing (ADN), head of nursing in the Trauma and Emergency Department, namely that all nursing staff rotates throughout all units within the department on a regular basis and would have been exposed to the dynamics within the various units. The nursing supervisors in the Trauma and Emergency Department provided the researcher with a list of eight names including three Registered nurses, two Enrolled nurses and three Enrolled nursing auxiliaries. These three categories of nurses were included to represent the different professional categories working in the department.

The lower categories, namely the Enrolled nurses and the Enrolled nursing auxiliaries are often perceived to have less authority and are therefore more likely to experience more abuse because of lack of respect. This perception is generally shared by most of the nurses of these two categories.

3.4.1 Criteria

Respondents taking part in the research were selected on the basis of certain inclusion criteria, as indicated below.

A minimum of one year's work experience in the Trauma and Emergency Department because this timeframe ensured that all would have rotated throughout all the units of the department and could therefore be regarded as key informants. For the convenience of the researcher, only nurses on day duty at that stage were included because the assumption is that all nurses would have had exposure to night duty during departmental rotation.

3.5 DATA COLLECTION METHODS

As the researcher is employed at the institution and had access to the setting where the participants worked, semi-structured interviews were conducted in the work area of the participants. The reason for this decision was to assist the researcher in getting a “feel” of the work environment, and to allow the participants to relate their experiences in their natural work environment. Participants could therefore with ease relate their experiences around the phenomenon of abuse in the work environment. This way, probing could be done in an attempt to explore and understand the behaviour and reactions of the participants, without imposing restrictions on responses or being limited by too many set questions (Denzin & Lincoln, 1998). By repeatedly going back to the research setting for interviews and interviewing participants on different days, afforded the researcher an opportunity to gain insight into the dynamic nature of their work in the Trauma and Emergency Department. .

When a researcher wishes to conduct a more intensive study on a sample, semi-structured interviews are useful, as it allows the interview to be more fluid and allows the interviewer latitude to move in interesting directions with flexibility. (Seaman, 1987). Semi-structured interviews involve the implementation of a number of

predetermined questions. Although the researcher often structures the interview by using these questions as a guide, this method allows the interviewer to access information that may not be covered by the interview schedule, but by probing, the researcher is able to elicit the depth necessary for qualitative research (Babbie, 1999), and also to "... deviate from the schedule as long as the material is covered by the conclusion of the interview" Seaman (1987, p. 290).

The researcher, being involved in staff support, also felt the interview method would be appropriate as one of the key elements enabling participants to disclose details about their reactions and responses, is the establishment of rapport between the researcher and the participant(s). From an experiential point of view, having had contact with some of the participants before, in the context of support and having a trusting relationship with them, the researcher felt this could enhance the process, as well as facilitate her understanding of their related experiences. However, this hampered the spontaneity of some respondents, as individuals in positions of authority are often viewed with awe and this elicits discomfort around "being oneself", causing an obstacle in open sharing.

The initial intention of the researcher was to use interviews as the main tool for data collection. By default, when there were delays in starting the interviews, the researcher at times had the opportunity to observe participants in their work area, before commencing the interviews, and in doing so, became a non-participant observer. "*Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter*" Denzin & Lincoln (1994, p. 2). The mere nature of qualitative research enables the researcher to obtain information from

multiple sources, e.g. observation, interviews, documents and reports. The researcher therefore regarded this added, unplanned method of gathering information as triangulation and utilised it as an attempt to secure in-depth understanding of participants' experiences. According to Kuzel (1986, as cited by Crabtree & Miller, 1992) reliability and validity of qualitative research is enhanced by the use of triangulation, rich in-depth description and reflexivity. Non-participant observation, on the other hand, is the recording of events, e.g. social behaviour, like interactions amongst individuals, as observed by an outsider. (Patton, 2002).

3.6 DATA COLLECTION PROCESS

The researcher initially approached the Head of Nursing of the Trauma and Emergency Department in February 2004, informing her of the study and the intention of using staff to participate in the study. The researcher was supplied with contact details of the various supervisors of the different units within the department, who assisted in identifying suitable candidates (according to the inclusion criteria) for the study. Appointments were made with all identified staff members in order to brief them as to the process to be followed, and possible times of their availability was ascertained. These briefing sessions ranged between 10-15 minutes, as time was allowed for questions and clarity and also to start with the building of rapport. Two of the eight participants were briefed simultaneously, and this proved an advantage in the sense that it allowed them to feel free to express their initial reservations. Written consent was obtained at the same time.

The researcher did the data collection during the months of March and April 2004. The initial three interviews conducted during the month of February 2004, were not

successful, as the researcher discovered that inadequate information was obtained since the data lacked depth and richness. The researcher re-examined the questions that were asked and decided to intensify the probing methods, which yielded improved results.

The interviews were conducted during on duty times of the participants. Each interview lasted between 40 and 50 minutes. Being an Emergency Unit, the researcher was mindful of the possibility that the participants could be needed in the event of an emergency. At the start of the interviews, the participants were reassured of being excused from the interview in case of an emergency, with the understanding that the interview would be rescheduled. As already mentioned, only day duty nurses were interviewed. This decision was made as the nursing staff of this department rotates through the various units, on a regular basis. However, two of the participants had just completed night shifts a few months prior to the interviews. Being able to interview staff that had just been on night shift, was an advantage and it offered an opportunity to ascertain whether the experiences of night and day shift nurses differed in any way.

During the data collection the researcher was mindful of the principle of respect as explained by Hollway and Jefferson (2000), namely that everyone is entitled to respect in the sense of being paid attention to, and to be observed carefully, especially during interaction with them.

It was difficult to secure set venues for the interviews beforehand. On the days of the appointed interviews, the researcher had to be in the department a few minutes before

the time of the interviews, in order to secure an office or room for the interview. However, this afforded the researcher the opportunity to observe the participants and others partially in their interaction and execution of duties.

Each interview was commenced with an open-ended question, "*Tell me in your own words, how do you see or understand abuse in the workplace?*", followed by a list of possible questions, focusing on core issues around the problem under study. It must be noted that the questions were only lead questions, and the open-ended questioning technique was used, which allowed respondents to speak freely, elaborate where needed and for the researcher to probe when it was indicated.

Face-to-face interviews as a method of data collection allow for clarification and elaboration on the topic and offers high subject participation. One of the advantages of face-to-face interviews is that it allows probing around more complex feelings and perceptions. In the study, participants often used a common phrase like "*it's not so nice*" when describing a negative feeling. However, using this form of data collection enabled the researcher to probe and elicit a deeper, concise feeling, using the technique of reflecting and paraphrasing. This technique is also important during interviews as often misinterpretations of statements can occur or the interviewee may not understand or grasp questions posed to them immediately. For the researcher it was also important to eliminate any misunderstanding of the responses, especially when the interviewee responded in Afrikaans.

Wilson (1989), in his explanation of the advantages and disadvantages related to interviews, says that the interviewee may often have expectations that some sort of spin-off may result from participating in the interview. This was evident during the

interviews when some respondents expressed the hope that management would take note of what they are saying and do something about the abuse occurring in the work environment. The researcher tape-recorded the interviews.

3.6.1 Problems encountered during the data collection process

Although each interview was arranged for a specific date and time, the unpredictable workload and flow of patients dictated the availability of the staff. Two of the appointments had to be rescheduled when staff was too busy at the scheduled time of the interview.

Suitable venues were not available in all areas. Some of the interview rooms were in the busy ward area, where the noise factor interfered with the recordings. In order to ensure privacy a notice stating, “DO NOT DISTURB. INTERVIEW IN PROGRESS” was placed on the door of the room where the interviews took place.

Some respondents forgot about the interviews, with the result that when the researcher arrived in the work area, time was wasted waiting for the respondents and interviews were then delayed.

In order to minimise errors and to allow for counterchecks, the individual respondents were given a choice to listen to the recording immediately after the interview. None of the respondents exercised this choice. Some expressed their trust in the process. Each respondent gave permission for the researcher to come back with the recordings if, during transcribing, the spoken word was unclear or the researcher needed clarity.

The researcher ensured that all the findings were reflected in the report. Care was taken not to omit any data and methods of the various processes in the research design, which could affect the interpretation of the data.

3.7 DATA ANALYSIS

“In general, data analysis means a search for patterns in data, e.g. recurrent behaviours, objects, or a body of knowledge, and once a pattern is identified, it is interpreted in terms of a social theory or the setting in which it occurred”. Neuman (1997, p. 426).

To assist the researcher in analysing collected data, managing and preparing the data were critical. Various systems had been developed for this and a well-used system is that of coding the data, where different aspect or topics or sections of the data is colour- or number-coded for easy identification. This coding process was used during the current research, where the audiotapes were clearly marked with the date, respondents' names and professional category, namely Registered nurse (RN); Enrolled nurse (EN) or Enrolled nursing auxiliary (ENA). This assisted the researcher in identifying whose recordings were on which tape, if the need should have arisen that the respondent needed to be revisited to verify recorded data.

In order to uphold the confidentiality of participants' identities, the audiotapes were kept under lock and key.

3.7.1 Process for analysis

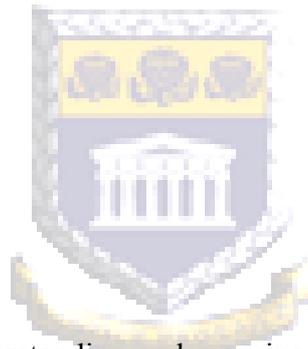
Coding was used to place texts into categories. These categories directly reflected the questions the researcher had asked during the interviews, and related the behavioural actions and events described by the informants during the interviews.

In order to facilitate understanding of the informants' views, the researcher added sub-categories, which further elaborated the meaning of responses of the initial categories. (Strauss, 1987)

Coffey & Atkinson (1998, p. 40) remarked: "Rather than using the interview extract as an extended reply to our one question, therefore, we pay much closer attention to the content of the talk".

A grid was formulated and the following headings were used to **categorise** the data

- *types of abuse*
- *behaviour response*
- *reporting*
- *coping strategies*
- *effects on performance*
- *support needed.*



In order to get a clearer understanding and meaning of the above responses, a sub-category for each individual category was identified as follows:

<u>RESPONDENT</u>	<u>ABUSE</u>	<u>BEHAVIOUR</u>	<u>REPORTING</u>	<u>COPING STRATEGIES</u>	<u>EFFECTS ON</u>	<u>SUPPORT</u>
<i>Id (code)</i>	<i>Verbal</i>	<u><i>/REPOSE</i></u>	<i>Verbally</i>	<i>Internal</i>	<u><i>PERFORMANCE</i></u>	<u><i>NEEDED</i></u>
	<i>Physical</i>	<i>Verbal</i>	<i>Written</i>	<i>(reflection/rationalization)</i>	<i>Mentally</i>	<i>Operational</i>
	<i>Psychological</i>	<i>Physical</i>		<i>External (exercise, speaking to others.)</i>	<i>Physically</i>	<i>Organizational level</i>

The researcher analysed these categories and sub categories and formulated themes and determined whether these behaviours or responses occurred in isolation, belonged to certain groups only, occurred at certain time periods or under certain conditions. The researcher was therefore able to identify similarities, differences and consistency of meaning among various groups of nurses.

3.8 ETHICAL CONSIDERATIONS

The researcher obtained written permission from the Chief Medical Superintendent of the institution, as well as the Deputy Director: Nursing, to conduct the research. In the letters of request, the following were emphasised:

- respondent anonymity would be assured;
- written permission would be obtained from those respondents who agreed to be part of the study; and
- respondents would be part of the study on a voluntary basis.

The research proposal was submitted to the Ethics Committee of the institution, and permission to commence the study was granted on 11 February 2004. The respondents were briefed on the process of the interviews and were given the right to withdraw at any stage of the study. They were also informed that the interviews would be recorded; they were reassured of their privacy in that their names would not be used in the report, except for the different categories interviewed, and confidentiality would be upheld by not referring to their identity during the recordings

3.9 POSSIBLE LIMITATIONS AND GAPS IN DATA

During the interviews, some responses to questions posed in English, were in Afrikaans. This could easily have implications of questions being misinterpreted.

The researcher took cognisance of this when data was analysed and processed.

As a result of the latter, the researcher often had to rephrase the question, explaining concepts in detail in Afrikaans.

Because some of the respondents use Afrikaans as their first language, responses were initially monosyllabic, with little elaboration on thoughts and opinions, unless the researcher probed or rephrased the question.

The researcher was aware that true expressions could only come from the mother tongue, hence decided to accommodate the respondents, allowing them to express certain views and thoughts in Afrikaans.

The researcher, being fully bilingual, was confident in her understanding of the responses.

There were often hesitations in responses when respondents were asked how they reacted in certain given situations. The researcher was aware that responses could be censored in order to give a more positive answer.

3.10 DELIMITATION OF STUDY

The scope of this study is limited to this department because of time constraints and the requirements of a mini thesis.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In order to identify differences and similarities amongst the three groups interviewed, (namely the Registered nurses, the Enrolled nurses and the Enrolled nursing auxiliaries), the responses of each group will be discussed under their specific category headings. By doing so, the researcher was able to ascertain how the experiences of the various groups of nursing staff differ, in what context the differences appeared and reasons for the actions or responses of the respondents.

A total of eight (8) nurses were interviewed over a two-month period – from March 2004 to April 2004.

One Enrolled nursing auxiliary decided to withdraw from the study after the initial briefing was done and the interview had already progressed for five minutes. Her main reason was that she was not comfortable having her signature on paper (the consent form which she had already signed). She also felt, after listening to the opening question, that there was no use taking part in the study, knowing that nothing will be done about the situation.

The eight nurses interviewed were divided into:

- 3 Registered nurses (females)
- 2 Enrolled nurses (male, female)
- 3 Enrolled nursing auxiliaries (1 male, 2 females)

The following questions were asked and used as a guide during the interview discussion:

What is your understanding or definition of *abuse in the workplace*?

Have you ever been abused in the work environment?

What was your response or action when you were abused?

Did you report the abuse?

Was your work performance affected in any way after the abuse?

Which coping strategies did you use?

Do you think staff needs support? If so, how often and from whom?

4.2 PRESENTATION OF FINDINGS

During the interviews, the participants verbalised many feelings, ranging from feeling embarrassed, to feeling demoralised. Many of the nurses initially appeared to be or thought they were feeling fine around the issue of abuse in the workplace, but with probing they started verbalising specific feelings. Despite these feelings, each of the interviewees felt strongly that they are "there for their patients" and expressed the fact that they enjoyed their work, especially working in the Trauma and Emergency Department.

4.2.1 Interpretation and understanding of abuse

4.2.1.1 Respondents

- Registered nurses

Two of the registered nurses interviewed were eager to answer the questions, they were co-operative and could articulate their responses. One junior sister was initially

apprehensive and expressed her discomfort, knowing the interview was recorded. She however agreed to continue and managed to relax as the interview progressed.

The participants' interpretation of verbal abuse, which in their opinion was the most common form of abuse they had been exposed to, ranged from swearing and shouting, to scolding and being rude. Physical abuse was viewed as any behaviour, which would cause physical harm, e.g. being kicked, slapped or having objects thrown at them. Although none of the research group had experienced any of the latter, they were emotionally affected by the mere thought that they are at risk all the time. This was evident when scenarios were shared where they had witnessed physical abuse or had heard of incidences in which their colleagues were physically abused. Physical abuse was less acceptable to them than verbal abuse. Verbal abuse was also viewed as "*not as bad as physical abuse*" and seemed easier to ignore than physical abuse.

"... and here in Trauma unit we are exposed to mostly verbal abuse, not really physical abuse. Most of the times it is just swearing, you know" (respondent 8)

"Baie keer is hulle maar onbeskof met 'n mens. Hulle slinger allerhande woorde en goed na 'n mens. Ons het al van hulle gekry wat jou vloek en uitskel" (respondent 4)
(Many a times they are rude to you, they hurl all sorts of words at you. We have found some of them swearing at you and scolding you)

"Ag, baie van hulle is bietjie gedrink, laat dit maar verby gaan"

(Many of them are a little drunk, so we rather let it pass) (respondent 4)

“Yes, like the head injuries ... you know he is confused, and you realise he does not really want to be like that, then one tends to ignore it” (respondent 8)

Based on the above statements, it appeared that the verbal abuse is sometimes tolerated, if they feel it is linked to the patient’s diagnosis. Verbal abuse coming from intoxicated patients is also viewed by this group as “*the patient not being in a proper frame of mind; do not know what they are doing*”.

• Enrolled
nurses

This group of respondents initially came across as cautious with their responses, almost having a need to say the correct thing. Contrasting opinions with regard to how they interpret abuse were verbalised, where one felt that abuse, whether physical or verbal, is a gross infringement on human dignity, whilst the other felt it was “*all in a day’s work*” –

“of hulle dit verbaal doen, of hulle dit fisies doen, dit is vir my ernstig” (respondent 7) (whether they do it physically or whether they do it verbally, for me it is serious)

“Well, I’m used to it ... so you work here everyday with these kind of patients, so I don’t stress myself, ... the swearing comes with the territory” (respondent 5)

The male nurse, in his responses remained cautious throughout the interview. Although he responded to all the questions, his responses were stilted and mostly monosyllabic, with little elaboration.

•

Enrolled

nursing auxiliary

This group of nurses, who are often the ones that really work directly with the patients and therefore have more exposure and direct contact with the patients and their relatives, had diverse interpretations and views of abuse in the workplace. As in the case of the previous two groups of nurses, this group also experienced mostly verbal abuse and was subjected to threats of a physical nature.

From their responses it became clear that abusive and aggression behaviour from patients is sometimes preceded by a negative attitude from the nurse. It was felt that the responses from nurses are often based on first impressions or interpretations of patients' behaviour. Examples quoted indicated that when individuals involved in gang-related crimes are admitted, nurses immediately behave defensively, assuming those individuals has an attitude of aggression.

It was also felt that nurses often have a harsh tone of voice, which could easily be interpreted as aggression. Another view of abuse was seen in the lack of respect that relatives and those people escorting patients showed towards nursing staff. A feeling of being powerless was expressed, especially when dealing with abuse.

Following on the above, the differences of opinions could be seen as the result of different experiences with regard to abuse, or gender differences amongst this group of nurses.

"sometimes they are gangsters, so you already put on an attitude" (respondent 1)

".....you explain to them that only three people can see the patient, the people does not understand ... you need to fight and argue, and sometimes they insist they want to see the patient and they just walk pass you. That I feel is abuse". (respondent 3)

"I don't know what role to play, I mean, you know you must go and talk to the people who don't actually listen to you" (respondent 3)

4.2.2 Experiences and reaction to abuse

- Registered Nurses

In this category, all respondents had experienced verbal abuse. In addition, they also experienced verbal and physical threats. The latter they seemed to have managed to keep under control by confronting abusive patients, be it by means of direct confrontation or securing assistance from security.

"I said to him, but you are very rude, your behaviour is unacceptable, don't talk to me like that" (respondent 2)

"I will confront the patient, you know, I speak to him, not rude, but in a loud tone, so he knows that I'm not going to take his nonsense"
(respondent 8)

By virtue of their authoritative position, this was easily accomplished. However caution was taken when physical threats deemed dangerous.

"I remember one incident ... a patient came in and he was rude to one of the nurses, and the next minute I just saw his hand grab for my scissors, and then I just backed

off and left. I thought here I must better stay away from this man, because I don't know if he wants to get me or ..." (respondent 8)

This group was also more aware of the possible contributory factors, e.g. head injuries that could cause confusion or aggression in patients. They would therefore first assess the patient, considering the patient's injuries or diagnosis before taking action.

It was evident that the nurses' experience of working in this type of environment and interacting with traumatised patients (physically or emotionally) has given them the insight into patient behaviours. Their ability to assess volatile situations rapidly and to act appropriately may be the reason that the physical and verbal threats were diffused, hence the low incidence of physical abuse. Despite their understanding of the abuse, especially when it was related to the patient's injuries or diagnosis, nurses' behaviour still changed to that of hyper vigilance and caution when interacting with abusive patients.

"When you know the patient is drunk, when he comes walking in, then you already see, like you know he's looking for trouble. But then I just stand back and we call security to sort him out" (respondent 8)

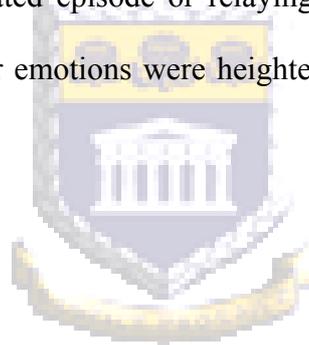
"I'll be around, but when it comes to being with the patient, then I'll just back off ... you know, just to avoid the next confrontation ... you never know what it can lead to" (respondent 2)

"I will be in the vicinity or around, but when it comes to being with the patient, then I'll rather stay clear, just to be on the safe side" (respondent 8)

The main feelings expressed were those of **fear** (of being hurt when confronting abusive patients); **compassion** (for the junior nurses who are unassertive when needing to defend themselves) and **anger** (especially towards patients who were deliberately abusive and who threatened the nursing staff).

One can assume that these emotions are not often freely verbalised and most probably suppressed. Based on the researcher's experiential involvement with this department in the form of staff support and maintenance of mental health, emotions are often suppressed due to the notion of "professional conduct demanding emotional control". Often these emotions are evoked and resurface when reliving an incident or event, either through a repeated episode or relaying the event, which was evident during the interviews as their emotions were heightened when they shared negative feelings.

•
Nurses



Enrolled

In general, the feelings of these nurses varied as they described their experiences, which ranged from mostly verbal abuse to physical threats. The male nurse, with ten years' trauma nursing experience, found it difficult to describe any of his own experiences. He could only describe incidents of abuse from a "witnessed" point of view, where he mainly comes in as a rescuer because of his gender. The female nurse had experienced only verbal abuse so far.

The responses from these two nurses were similar to those of the registered nurses, in that consideration for the patients' condition came to the fore. They often would try

to find out what the diagnosis was, e.g. whether the abuse was related to injuries, like head injuries. Based on their knowledge around signs and symptoms of the diagnosis, their response would then be according to that situation.

They showed insight into the effects of hospitalisation, where the nurses tried to understand that the hospital environment, in addition to the patient's injuries, could contribute to their abusive behaviour.

“Sometimes you must see the condition of the patient first ... you must see to that, some patients are 15, some may be 14” (the latter being the ratings of the coma scale, indicating whether the patient is oriented or confused, with 14 indicating disorientation). (respondent 5)

“Kyk, dis stukkende mense, almal wat by trauma ingekom het, of hulle is siek as hulle by casualty is ... dis 'n nuwe omgewing, ons is vreemde mense vir hulle; hulle sien die masjiene ... so jy moet dit ook in ag neem, as die pasient miskien onsteld of humerig is met jou”. (respondent 7)

(... look, these are broken people, those coming to trauma or those who are ill, coming to emergency unit ... it is a new environment, with strange people, machines ... we must take this into consideration if a patient is upset or moody towards the nurses).

In contrast to their statements above, these participants also responded differently to the abuse, where the one (female) would try to understand the behaviour based on her insight and would therefore try to diffuse the situation by acting calmly and

cautiously. The other nurse (male) would, in an attempt to stop the abuse, respond in an equally, though indirect abusive manner.

“I wanted to hit him”

“I don’t swear at him, I just say ‘same to you’” (respondent 5)

The male nurse also felt obliged to respond in a defensive or aggressive manner as he felt the sisters (Registered nurses) were not doing anything to stop the abusive/aggressive behaviour when it happened. He was also of the opinion that patients would more often be abusive towards female nurses.

“... cause I think girls are weak, ... most of the patients are scared of male nurses. They therefore take it out on the sisters and nurses” (respondent 5)

It was difficult to ascertain whether the socialisation process as to the expected gender roles, influenced this attitude of the male nurse. It is often in the nursing fraternity that male nurses are there for the tough and strenuous jobs and they are often called upon to “rescue” the female nurses during difficult situations, e.g. dealing with difficult patients. It is therefore understandable that male nurses deny being affected emotionally or in any other way by abuse.

- Enrolled

Nursing Auxiliary

Due to the nature of the scope of practice for this group of nurses, namely, delivering basic nursing care, their actions and responses are limited. Whereas the previous two

groups of nurses could, to a certain extent “stay away from the patient”, this group had minimal options in this regard, as constant patient contact is required during the execution of their duties. They found it easier sometimes just to ignore the patient and to do their "expected duty". Spending time with the patient in order to get to know the patient and building some kind of rapport was out of the question.

This response of avoiding the patient might be similar to the other two groups, but, based on the responses given, one may assume that this category may find it more difficult to ignore the patient completely, or not do the basic nursing care:

"If a patient abuses me verbally ... sometimes I just look at him or walk away, because to fight fire with fire is not gonna work" (respondent 1)

"So I will do my nursing care for you, but apart from that, I will not speak to you if I don't need to speak to you" (respondent 1)



"If a patient is abusive to me, then I don't worry with that patient, I will do my observations, I will ask him a question, and that's it" (respondent 6)

In contrast to their more senior colleagues, they do not confront the abusive patient. It appeared to be more acceptable or easier for the nurses to call on the sister to intervene on their behalf.

“If I feel that the patient like really abuses me, then I go to my sister in charge, and she must speak to the patient and like both of us will have to go to the patient”.
(respondent 1)

This group also shares their more senior colleagues' consideration of the patient's condition as the contributing factor for the abusive behaviour. They often would rationalise and accept the abusive or aggressive behaviour if the patient is confused or intoxicated.

"It depends, really it depends on the patient, it depends on the condition of the patient, and I'll see whether I should react to this"

"... well, if it's a "neuro" patient, I won't react, whether he is swearing or things like that" (referring to a patient with a neurological diagnosis) (respondent 3)

4.2.3 Reporting of abuse

- nurses



Registered

All the respondents in this category felt that it was important to report the abuse, but in practice, when it came to verbal abuse and aggression, they resorted to dealing with the incident themselves, using the available in-house resources, like the security personnel, or getting back-up from peers or doctors. They all stated however that they would report physical abuse.

"Why must we report it? You know people are going to get sick of the story "listen I have been abused" ... and I think we take it for granted, it's going to happen, why report it" (respondent 8)

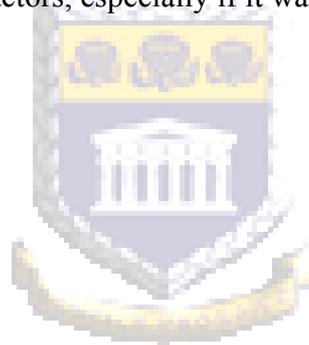
The Registered nurses often depended on their authoritative position when dealing with the abusive patient, using the immediate resources and assistance as they saw fit.

- Enrolled
nurses

Amongst this group of nurses there was also a strong feeling that the abuse should be reported. Yet from their personal experiences, as was the case with the registered nurses, they had preferred to use their colleagues as soundboards and did not report the abuse, especially verbal abuse.

What emerged strongly was the ambivalence in reporting the abuse and being aware of the possible contributing factors, especially if it was medically related.

- Enrolled
Nursing Auxiliary



This group of nurses also verbalised strongly the importance of reporting serious or "bad abuse". According to them this type of abuse included physical abuse and aggressive behaviour, e.g. threatening to throw objects at them.

An aspect, which emerged during interviews with all three categories of nurses with regard to verbal abuse and reporting, was that because it is such a common everyday occurrence, reporting this type of abuse was senseless.

"If the patient did not physically harm you, it's not necessary to report it"

(respondent 3)

"It depends also how serious the situation is, but I mean like the everyday swearing ... you just ignore it" (respondent 1)

4.2.4 Effects on work performance

- Registered nurses

Exploring this aspect elicited some hesitant and cautious responses. This could be due to the fact that the interviewer has had previous contact with them (as part of a staff support system) and that they feared being judged by the interviewer. Generally all felt their work performance was not affected in the sense of “the work not being done”. They related however that their attitude to the patients was affected. They described this as having minimal contact with the abusive patient.

"I won't say it affects my work, but it definitely affects my attitude towards that patient ... I find myself reluctant to do things for that patient ... I'm just doing it because it is expected of me, but it's definitely not by choice" (respondent 2)

The concept of duty versus care strongly emerged from their statements. Emotionally the negative feelings were there, but staff still had a strong feeling of obligation and loyalty to the ethos of care; hence they continued with their duty, despite feeling hurt or humiliated. They have therefore been able to set their emotions aside and continued executing their duties, be it with greater caution or under duress, and patient care was minimally compromised.

-

Enrolled

nurses

The effects patients' behaviour had on the work performance of the nursing staff varied. The male nurse, e.g. felt it did not affect his work performance as he was used to the abuse, whereas the female nurses felt that when someone verbally abused them, they were very upset and tended to avoid the patient. Once again the gender factor, as expressed by the male nurse, could be a contributing factor with the male nurse being less exposed to abuse, hence the minimal or no interference with his work performance.

-

Enrolled

Nursing Auxiliary

For this group, the effects on work performance, following an incident of abuse, ranged from a change in attitude toward the abusive patient, to minimal interaction with the patient. Similar to the other two groups, the obligation to render a service came across very strongly. This group also resorted to doing only the necessary nursing care required in the presence of abuse. From an emotional perspective this incongruence of feeling negative towards the patient and still performing their nursing duties was something most respondents in this group interviewed, struggled with.

4.2.5 Coping strategies

-

Registered

nurses

The coping mechanisms used when dealing with the abuse ranged from talking to colleagues around the tea table, taking a smoke break, and using support systems outside the work environment. The general feeling was, "take time out", speak to someone, and this seemed to have given him or her courage to face the situation and to continue with his or her tasks.

"You know, sometimes when I go home, then I will reflect on the day. Sometimes my brain is just running around, then I will call a friend and I will talk to them and just tell them what has happened to me" (respondent 2)

"I just walk away, do something else, or I'll go to the smokers room and have a quick smoke ... it depends how upset I am"

"Most of the time I will just discuss it or tell somebody about it and eventually it blows over" (respondent 8)

Although the staff shared the difficulties they have in dealing with abuse from patients, they intimated that they are supposed to cope, especially whilst at work. It was clear that they found it easier to let go of their guard in the safe environment of supportive colleagues and significant others, by sharing their experiences with them. A great belief in team spirit emerged from all respondents. For many, having a team to depend on for emotional support was valued more than depending on action following the reporting of abuse.

"There is always someone, one of my colleagues to back me up ... we work as a team" (respondent 8)

-

Enrolled

nurses

The participants felt that talking to their colleagues after an incident was helpful in the sense that, by talking about the abuse helps them to get it “off your chest”. The support from colleagues offered immediate relief and gave them courage to carry on with their duties, especially if the colleagues had had a similar experience. Like the registered nurses, this group of senior nurses also depended on the team spirit and camaraderie to help them through the day when they had been exposed to abuse.

Enrolled Nursing Auxiliary

Coping mechanisms used were similar to that of the registered and enrolled category. Peer support and availability of colleagues were what they valued. In addition to support in the work environment, some could use family and friends to talk to, which they felt helped them to cope and made it possible to face the next day.

4.2.6 Support system

-

Registered

nurses

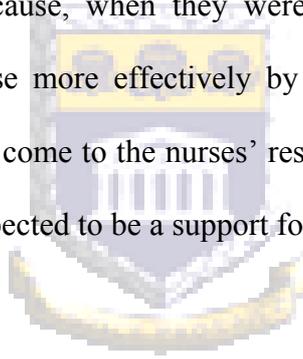
The need for formal, regular support for staff was verbalised. The participants realised that people may respond differently to abuse or their experiences of abuse may differ, therefore having support available was deemed important. Although this category of staff felt that incidents of abuse need to be dealt with directly by the

individual, with the necessary support from colleagues and security personnel, they were also aware of the possible psychological effects of abuse on individuals.

"I think most nurses are stressed out ... they take all that home, you know, and you hear they have arguments with their kids or husbands and it is so unnecessary"

"Everyone is different, you know, and I would not know what someone else is going through" (respondent 8)

As registered nurses, they viewed support for the staff as mostly necessary for the nurses (auxiliary nurses and staff nurses) and they expressed their concern in this regard. This could be because, when they were exposed to abuse, they most probably dealt with the abuse more effectively by confronting the issue directly, whereas they often needed to come to the nurses' rescue when the latter are exposed to abuse and they are then expected to be a support for the nurse in distress.



• Enrolled
nurses

During the discussions, the need for emotional support for the staff came to the fore quite strongly. They felt people, being unique individuals, react differently to different situations. The need for individual supportive counselling, as well as group support, was expressed, where sharing experiences with their peers would be valued. Hearing how others responded in similar situations helped them to validate their own actions, responses and feelings.

- Nursing Auxiliary

Except for one nurse, this group felt support in the work environment was important. The availability of someone to talk to was expressed as an imperative. This group however, expressed concern around confidentiality, should support groups in the work area be implemented. The advantages envisaged with regard to support groups, as expressed by all three categories, included:

the benefit of "getting it off your chest", learning from others' experiences, encouragement from peers and the opportunity to express your feelings.



4.3 SUMMARY OF THE MAIN RESULTS

The following were the trends and patterns, which emerged from the findings.

4.3.1 Interpretations of abuse

The interpretation in general was that abuse could be physical or verbal. Physical abuse includes threats of physical abuse as well as actual bodily harm. Verbal abuse was highlighted as a common occurrence, with most of the participants regarding swearing and being rude, as verbal abuse. It was clear that for the majority of nurses interviewed, verbal abuse was not regarded as serious enough to be reported or that something should be done about it.

4.3.2 Feelings and perceptions

A host of feelings and perceptions emerged from the study. Feeling demoralised, despondent, angry, empathic and understanding, used, and frustrated were verbalised. These feelings were so common, that it appeared that some of the nurses were not even aware what they were feeling most of the time. For the majority of the respondents, these feelings were not expressed towards the patients, it was easier to bottle up these feelings, which were then redirected and eventually manifested in avoidant behaviour or sulking when dealing with the abused patient.

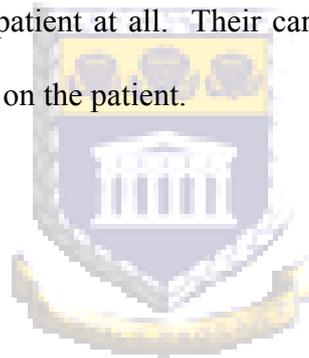
4.3.3 Behaviour adaptation

The reaction and behaviour following an incident of abuse were based on various factors. These included the condition or diagnosis of the patient; who the perpetrators of the abuse were and the category of nurse subjected to the abuse.

Avoidant behaviour, and treating the patient with caution, seemed to be the order of the day and an easier and a more acceptable way of dealing with the volatile situation. The feeling that the nurse needs to be professional in her behaviour and therefore cannot really respond in an equally abusive manner came through strongly. So, to remain professional was of paramount importance for these nurses. For the more senior nurses, i.e. the registered and enrolled nurses, making the patient aware of the fact that their abusive behaviour was unacceptable, preceded their avoidant behaviour. It is quite clear that behaving in an acceptable manner and maintaining professional conduct, when exposed to abuse, was not easy for most nurses and this could account for the suppression of feelings and avoidant behaviour.

4.3.4 Task-orientated care versus patient-orientated care

The nurses were at all times faced with the dilemma of responding to abusive behaviour from patients on the one hand, and on the other, continuing to execute their duties with care. All the nurses who had expressed feelings of dissatisfaction for being abused, also suppressed those feelings and could not, or preferred not to act on those feelings. Despite having this psychological burden to cope with, nurses continued with their tasks in rendering nursing care. Their coping mechanism of staying clear of the patient and doing the required duties, most times under duress, left them with feelings of anger, feeling demoralised and a strong feeling of not wanting to interact with the patient at all. Their care was therefore focused on the task only, and not necessarily on the patient.



4.3.5 Coping strategies

Three of the respondents in the research group were initially vague on this aspect. Generally the coping strategies were divided into two methods – firstly, coping mechanisms used at work revolved around using colleagues to “sound off” and to verbalise frustrations and feelings, which for many was helpful in the sense that immediate relief and validation of their feelings were obtained. Secondly, family and friends also played a big role in being there to listen to these nurses and to give them the necessary encouragement to deal with the problem of abuse in the workplace. One Registered nurse also felt that they are not supposed to be in a position of "not coping", saying,

“we are supposed to be there for our patients”. (Respondent 4)

4.3.6 Peer support

In the research group, five respondents valued this. They felt peer support helped them continue through a rough day. Dependency on each other for support was evident. The support was two fold: **physically**, peers backed each other up and this was seen as protection against the abuse. Often colleagues would help out and do the nursing care for the abuser, if the nurse who had been abused could not face the abusive patient again: **emotionally**, they felt it helped if their colleagues understood the situation and were available to listen to them and encourage them.

4.3.7 Non-reporting of abuse

A clear distinction was made between the types of abuse, which the nurses in the research group felt, should be reported. Four of the respondents interviewed felt that physical abuse should be reported. Verbal abuse however seems to be viewed as “not so serious” and definitely not serious enough to be reported. Of all the nurses in the research group interviewed, only one enrolled nursing auxiliary reported an incident of verbal abuse.

Five of the research group also felt that, if the patient cannot be held responsible for the abuse (behaviour related to the condition or diagnosis of the patient, as previously mentioned) the abuse should also not be reported. It was said that verbal abuse happens quite frequently and if every case of abuse should be reported, people would get tired of hearing of it.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSION

From the results of the current study, certain conclusions are possible. It became clear that nurses are experiencing workplace violence in the Trauma and Emergency setting on a regular basis. Most of the nurses interviewed during the eight sessions from March 2004 to May 2004, had experienced abuse of some form, with the majority (75%) having experienced verbal abuse. According to the findings of this study, there seems to be a trend of underreporting, especially with regard verbal abuse. Based on the objectives of this study, the following were highlighted, and an indication is given as to how this relates to the literature.

5.1.1 Research Findings

5.1.1.1 Interpretation and response to abuse

It was evident that abuse is interpreted by all the nurses (100%) as unacceptable behaviour. Their definition of the most common form of abuse they are exposed to, namely verbal abuse, was similar, although they did not initially refer to it as “abuse”. The majority (62%) seemed to have considered various factors, which determined for them their response to the abuse. Some of these factors included the diagnosis of the patient, the state or condition of the patient and the concept that verbal abuse is “the norm”, an every day occurrence.

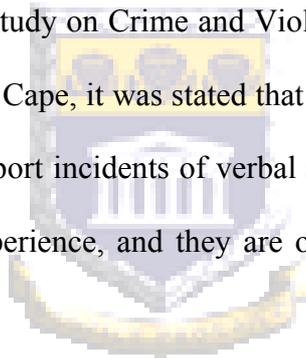
According to Jackson, Clare and Mannix (2002), many studies revealed and presented evidence suggesting that nurses believe violent acts and aggression are part

of the job and that it has therefore become accepted as a normal part of the workplace culture.

5.1.1.2 Underreporting

From the current research findings it is evident that the tendency to underreport incidences of abuse was common among all categories of nurses, as all shared the feeling that reporting verbal abuse was “senseless”. The perception of the nurses interviewed was that, due to its frequency of occurrence, people will become immune to hearing about it, and it will have little impact for reaction.

In the report discussion of a study on Crime and Violence in the Workplace done by Marais (2002) in the Western Cape, it was stated that fifty percent of the respondents indicated that they did not report incidents of verbal abuse. The reasons given were that it is a very common experience, and they are of the opinion that nothing will and/or can be done about it.



5.1.1.3 Compromised Care

In the current study it became clear that patients who are perpetrators of abuse, especially verbal abuse, received compromised care. This was evidenced by the findings that a large majority of the nurses interviewed (75%) ended up performing their nursing duties under duress and were prepared only to do what was minimally expected of them. Abusive patients were often avoided or ignored, sometimes subtly and at times overtly. Thomas (2003) says that it has been found that nurses often respond defensively when angry. The individual often displays avoidant behaviour,

minimises feelings and forgets the incident or situation, and usually mismanages this anger.

In a study done by Holden 1985 (as cited in O’Connell et al., 2000:604) it is concluded: “With patients clearly the main instigators of aggression, it is quite conceivable for nurses to experience dissonance when trying to fulfil their duty of care”.

The emotional responses from nurses were often in conflict with the basic creed of caring. The required professional conduct for nurses, which includes having control over negative emotions, resulted in nurses suppressing their negative feelings, experiencing professional disillusionment and making the philosophy of holistic care a distant reality.

5.2 RECOMMENDATIONS

Cognisance is taken that this study was limited to the investigation of specific aspects of workplace violence, namely abuse, and to a specific work area (the Trauma and Emergency Department) of a health institution in Cape Town.

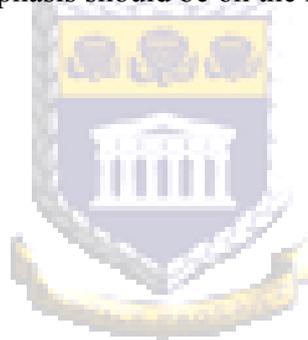
Further qualitative investigations are needed to understand the factors preventing nurses from effectively responding to verbal abuse in particular. Research could also focus on reducing verbal abuse and improving the nurse’s ability to respond to verbal abuse.

On an institutional level, the following should be considered as strategies to help nurses cope with this worldwide epidemic:

Regular support structures should be made available for the staff in the Trauma and Emergency Department. This support should be offered on an individual basis as well as in groups. Ideally, monthly groups should be held.

Training in self-management should be offered, empowering the staff to deal with abuse, aggression or any unacceptable behaviour from those with who they are in contact. This training should include assertiveness skills, conflict handling skills and negotiation skills.

Policies relating to the management of violence and abuse by patients and colleagues should be invested in, and emphasis should be on the reporting of incidents of abuse.



REFERENCES

Archer-Gift, C. (2003). Violence towards the caregiver. A growing crisis for professional nursing. *Michigan Nurse*. January 2003, Vol.76(1) Retrieved on 8/7/03 from <http://www.minurses.org/news/general/MN%20articles%202003/0203>

Atawneh, F. Zahid, M., Al-Sahlawi, K. & Al-Farrag, M (2003). Violence against nurses in Hospital: prevalence and effects. *British Journal of Nursing* Jan/Feb 2003. Vol. 12 (2)

Babbie, E. & Mouton, J. (2001). How to succeed in your Master's and Doctoral studies: A South African guide and resource book. Pretoria: Van Schaik Publishers.

Bowie, V. (2002). Workplace violence: A second look. Paper presented at the Crime Prevention Conference, Australia.

Coffey, A. (1996). *Making sense of qualitative data*. London: Sage Publication.

Cooper,C. (1995). Patient suicide and assault: Their impact on psychiatric hospital staff. *Journal of Psychosocial Nursing*. Vol.33 (6), 26-29,40-41.

Cooper.C., Hoel, H. & di Martino, V. (2003) *Preventing violence and harassment in the workplace*. Retrieved 5 June 03 from www.eurofound.eu.int

Crabtree, B.F. & Miller, W.L (1992) *Doing qualitative research*. California: Sage Publications. Inc.

Creswell, J.W. (1997) *Qualitative inquiry and research design. Choosing among five traditions.* California: Sage Publications.

Denzin, N. & Lincoln, Y. (1998). *Collecting and interpreting Qualitative Materials.* London: Sage Publications.

Elliot,P.P. (1997). Violence in Health Care: What Nurse Managers need to know. Retrieved on 9 May 2004 from <http://www.springnet.com/ce/m712a.h.tm> health.

Geyer, N. (2003). Violence in the workplace: Management's Role. *Nursing Update.* October 2003 Vol.27(9)

Geyer, N. (2004). Secondary Violence. *Nursing Update.* May 2004. Vol.4

Geyer, N. (2004). Abuse in words. *Nursing Update.* February 2004. Vol.28(1)

Geyer, N & Zondagh, C. (2004). Why should we deal with verbal abuse? *Nursing Update.* April 2004. Vol.28(3)

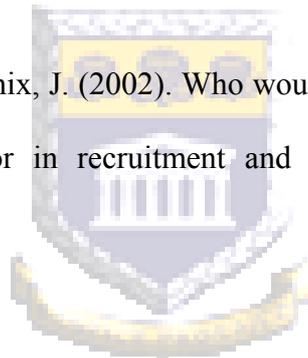
Gillmore-Hall, A. (2001). Violence in the workplace. Are you prepared? *American Journal of Nursing.* July 2001, Vol. 101(7)

Hemmila, D. (2003) In the line of fire. *Nurse Week*. Retrieved 23 May 2003. from <file:///A:\Nurseweek%29News.htm>

Hoyer, A. (1994) Sexual harassment: Four women describe their experience. *Archives Psychiatric Nursing*. June 1994. Vol. 8 (3).

International Council of Nurses Fact Sheet. Violence: A World-wide epidemic. Retrieved on 25/6/03 from: <file:///A:\International%20of%20Nurses%20Fact%20Sheet%20-%20Violence%20>

Jackson, D., Clare, J. & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management*. No.10.



Kingma, M (2001). Workplace violence in the health sector: a problem of epidemic proportion. *International Nursing Review*. Vol.48(3).

Kgosimore, D. (2004). Employing violence. *Nursing Update*. February 2004. Vol. 28(1)

Kurlowicz, L. (1990). Violence in the emergency department. *American Journal of Nursing* Vol. 90 (9).

Marais, S., van der Spuy, E. & Rontsch, R. (2000) Crime and Violence in the workplace – Effects on Health workers, Part 11. *Trauma Review*. December 2000 Vol.8 (2)

Marais-Stein, S. (1998). The changing workplace. *Work Trauma Newsletter*. Retrieved on 10/8/04 from <http://www.worktrauma.org/change.htm>

National Institute for Occupational Safety and Health, (1997) *Violence in the workplace. Fact sheet*. Retrieved on 3 May, 2003 from <http://www.gov/niosh/violfs.html>

National Institute for Occupational Safety and Health (1998) *Stress at work*. Retrieved on 27 May, 2003, from <http://www.cdc.gov/niosh/stresswk.html>

National Institute for Occupational Safety and Health. (2002) *Violence: Occupational Hazards in Hospitals*. DHHS (NIOSH) Publication No. 2002 - 101. Retrieved on 23/5/03 from: <http://www.cdc.gov/niosh/2002-101.html>

Occupational Health and Safety Act. No 85 of 1993.

O'Connell, B. (2000). Nurses perceptions of the nature of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing*. July 2000 Vol. (9) 4.

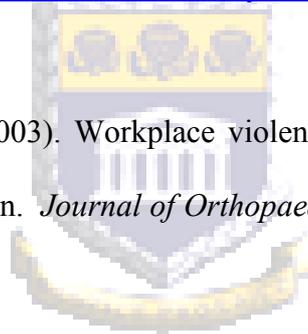
Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park: Sage Publications

Registered Nurses Association of Nova Scotia (1996). *Violence in the workplace – Resource Guide*. Retrieved on 10 July, 2003 from www.rnans.ns.ca

Robbins, I. (1997). The psychological impact of working in emergencies and the role of debriefing. *Journal of Clinical Nursing*, June 1999. Vol.8: 263-268

Sofield, L. (2000). Verbal Abuse: On line Survey. Article retrieved on 22 May 2003: <http://members.tripod.com/laura08723/survey.htm>

Sofield, L.& Salmond, S. (2003). Workplace violence: Focus on verbal abuse and intent to leave the organization. *Journal of Orthopaedic Nursing*, July, August 2003. Vol. (22) 4.



Steinman, S. (2001). *Workplace Violence in the Health Sector*. Report from Foundation for the study of work trauma. November 2001.

Strauss, A & Corbin, J. (1990). *Basics of Qualitative Research*. Newbury Park, California: Sage Publications

Stringer, H. (2001). Raging Bullies. *Nurse Week*. Retrieved on 22 May 2003 from: <http://members.tripod.com/laura08723/mary.htm>

Sullivan, EJ & Decker, P (1992). *Nursing Management: an experiential skill building workbook*. Third Edition. Redwood City: Addison-Wesley Nursing.

Tamra, B. (2002). Danger Zone. *Nurse Week*. Retrieved on 22 May 2003 from:
<file:///A:\\Nurseweek%2>

Thomas, S. (2003). Anger: The mismanaged emotion. *MEDSURG Nursing*. April 2003. Volume 12. (2)

U.S. Department of Labour. Occupational Safety & Health Administration. *Workers Rights under the Occupational Safety and Health Act of 1970*. Retrieved on 8/7/03 from: <http://www.osha.gov/as/opa/worker/rights.html>

Wells, J. & Bowers, L. (2002). How prevalent is violence towards nurses working in general hospitals in the U.K. *Journal of Advanced Nursing* Vol. 39 (11).

Williams Cosentina, B. (2000). When helping hurts: Vicarious Traumatization. *Nursing Spectrum. Career Fitness Online*. Retrieved on 30/7/03 from <http://community.nursingspectrum.com>

Wilson, H. (1989). *Research in Nursing*. Second Edition. California: Addison-Wesley Publishing Company Inc.

World Health Organization. Press Release WHO/37. May 2002.

World Health Organization: World Report on Violence and Health, Summary.
Geneva 2002.



APPENDICES

Letters requesting permission to conduct research study:

Medical Superintendent: Health Institution.....	1
Head of Nursing Division	2

Letter of approval

Institutional Ethics committee	3
--------------------------------------	---

