Abstract

Health personnel, especially nurses, are often victims of workplace violence. Unfortunately, little is known about the nurses’ experience of violence. A research study was initiated to further explore the nurses’ accounts of workplace violence so as to make dimensions of the nurses’ experience visible and more fully understood.

Interpretive description was the research methodology adopted for this study. Using theoretical sampling, ten Registered Nurses from the lower mainland and Vancouver Island, British Columbia participated in semi structured, audiotaped interviews.

In this research, the nurses’ experience of workplace violence emerged as a highly complex entity, deeply embedded in relationships and context. How nurses perceive the contextual factors of the organization, their immediate work environment and their individual attributes were found to play a significant role in how they respond to the phenomenon.

The findings of this study suggest that organizational culture is an important determinant in managing workplace violence and that policy and administrative personnel play a pivotal role in influencing the problem. Nursing culture also influences the nurses’ expectations, assumptions and actions towards violence. Participants voiced that role conflict often challenged their ability to enact acquired professional ideals and that they routinely undertake roles in dealing with violence that are not appropriate to their level of knowledge or skill.

Within the nurses’ immediate work environment, bullying as well as physical and verbal abuse was commonplace. Overcrowding, long waits for service, poor
environmental design and inadequate staff to patient ratios were seen as factors that increased nurses’ risk.

Individual factors were associated with emotional and psychological harms that nurses endured. Workplace violence affected self-concept, self-esteem, self-efficacy and the nurses’ sense of control. Moral distress, self-blame, feelings of failure, loss of motivation and leaving the nursing profession were significant findings.

The results of this study demonstrate a need to re-think how we can address workplace violence in nursing. Research and intervention is needed to further explore organizational policy and governing structures, the culture and climate of practice environments, and the fundamental role nursing education programs have in preparing nurses to manage workplace violence.
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Chapter 1

Introduction to the Study

The topic of workplace violence within nursing is approached by many with trepidation. Often this is because it is a complex and difficult subject. During the course of their work, Registered Nurses become aware of workplace violence. Many are the direct recipient of aggressive and violent acts and draw upon these situations to reach conclusions about the nature and the effects of the violence they experience.

What is ethically and practically important is that these observations of workplace violence have two implications. Firstly, the reporting of violence upon the nurse is perhaps greater now than at any time in our history. Nurses function within increasingly complex workloads, hostile environments and operate with diminished resources. Secondly, workplace violence has become an increasingly salient factor within our complex health care system. The potential for violence spans every work environment and affects the nurse’s physiologic reactions, cognitions and emotions including their social and group behaviour.

Unfortunately workplace violence within nursing is poorly addressed. A void in the literature exists concerning our understanding of the experiences and needs of nurses who have been exposed to violence. Therefore, the purpose of this study is to further explore the nurses’ accounts of the violence directed towards them so as to make dimensions of the nurses’ experience visible and more fully understood.
Background to the Problem

Workplace violence is an area of rising concern. Though violence can occur in any environment, this problem has become a high-profile issue within the healthcare setting. Violence occurs more often in healthcare than in any other industry (Lyneham, 2001). Growing evidence suggests nurses experience disproportionate levels of violence when compared with other healthcare workers and high risk occupations outside of the healthcare system (Saines, 1999). Despite these findings, it is widely accepted that violence-related incidents in healthcare are under reported, and the actual prevalence is grossly underestimated (Levine, Hewitt & Misner, 1998).

The economic cost of violence is apparent. The financial state of the healthcare system is implicated in increasing susceptibility to violent encounters through low staffing levels and high acuity patients (McKoy & Smith, 2001). The system is burdened with violence associated expenditure, including employee absenteeism, decreased productivity, compensation and litigation (Gates, Fitzwater & Meyer, 1999). Costs inherent in the current system can be expected to increase.

Violence towards healthcare workers has only recently been identified as a workplace health hazard. Human costs include emotional trauma, chronic pain, changes in functional status and depression (Gates, Fitzwater & Meyer, 1999). Workplace violence has been associated with job stress, burnout, and attraction and retention of nurses and other health care workers (McKoy & Smith, 2001).

In 1999, the International Council of Nurses (ICN) acknowledged workplace violence as a significant issue in nursing, and requested attention be given to clinical issues and competence in dealing with violence (Duncan, Estabrooks & Reimer, 2000). It is
therefore crucial that nurses play a role in identification and management of violence in their workplace.

Problem Statement

With the advent of the ICN’s request to increase competence in identifying and managing violence in the clinical setting, nurses need to clarify what constitutes violence in the workplace. Despite the apparent interest, it has been difficult to find information about the nurse’s experience of violence. Relatively few studies have been published that describe violence occurring in psychiatric, emergency, nephrology, medical, surgical, obstetrical and long term care areas.

I believe that describing workplace violence from a nurse’s perspective is a necessary first step in addressing the problem. A clearer understanding about violence in the nursing workplace will support planning of appropriate intervention/prevention strategies aimed at management of this critical problem.

Purpose

The purpose of this study is to explore nurses’ accounts of workplace violence.

Research Questions

In this study, the central question to be answered is:

1. How do nurses make sense of violence directed towards them in the context of their work?

Answers to this central question may be used to explore the following:

i) How do nurses recognize violence in their workplace?

ii) How do nurses interpret the violence in their workplace?

iii) How do nurses feel about violence in their workplace?
iv) How do nurses describe violence in their workplace?

v) How do nurses define violence in their workplace?

Definition of Terms

For the purposes of this study, a nurse or study participant refers to a Registered Nurse who is registered with the College of Registered Nurses of British Columbia. The term patient refers to persons receiving care by health care personnel. The term patient has been utilized because it was the term most often used by the participants and by authors within the majority of the literature.

Summary

This thesis will be presented in five chapters. In the first chapter, an overview and background to the problem, a problem statement, the purpose of the study, the research questions as well as a definition of terms are presented. In chapter 2, a review of both research and nonresearch literature is presented with regards to: understanding workplace violence; defining workplace violence; workplace violence and nursing; and workplace violence and nursing research. In chapter 3, an overview of the research method and demographic information about the interviewed participants is reviewed. Chapter 4 includes a discussion of the interview findings and further exploration of the literature. In chapter 5, a summary of the study findings, implications for organizations, nursing practice and nursing education as well as recommendations for future research are presented and discussed.
Chapter 2

Literature Review

Although violence can occur in any environment, violence directed towards workers has been described as a complex problem that has serious repercussions for the well-being of individuals, groups and society. The effects of violence not only have an immediate impact on their victim, but also have far-reaching effects on the larger system.

Attention is now focusing on the problem of violence towards healthcare workers. Health personnel, especially nurses, are often victims of violence. Unfortunately, little is known about workplace violence towards nurses. In this chapter, the literature is examined to offer insights about workplace violence through a description of various components, consequences and responses to the phenomenon.

Understanding Workplace Violence

A necessary step in understanding workplace violence is to try and define components intrinsic to the problem. Keith (1999) suggests how we define workplace violence will affect the scope, nature and solutions to the problem itself. To address workplace violence, a broad understanding of the associated elements is required. Elements include the concepts of violence, aggression, abuse, harassment and assault.

Violence

Violence is not a well-understood phenomenon and scholars have long debated over a consensual meaning of the word. Problems arise in the use of the term, as there is no unanimously accepted definition of what constitutes violence. The term violence has been discussed in the literature for the greater part of the last century. Theories have been generated by various disciplines including sociology, psychology and criminology.
However, difficulty in finding an inclusive, widely accepted definition has eluded scholars throughout the century. It has become clear that there is no one single explanation for violence. This has forced contemporary researchers to rethink their strategies. Violence as a phenomenon may require multiple theoretical approaches to gain consensus in defining the term.

Adeshead (2001) cites the following as well known explanatory theories for violence:

1) Violence as a human instinct – where violence stems from an innate evil or is biologically set.
2) Violence as a result of social frustration hypotheses – where aggression and violence are the product of frustration.
3) Social learning theory – where violent behavior is modeled, reinforced and rewarded.
4) Social dominance theory – where violence is the pursuit of power.

Violence occurs in many forms, and may be overt or subtle.

Aggression

It is suggested that there can be aggression without violence, but that violence cannot exist without aggression (Adeshead, 2001). Violence tends to be more prevalent where aggression is more common, and cultural support for aggression is enhanced (Gartner, 1997). Unfortunately, defining aggression also raises difficulties.

Most would agree that the intent to harm is the goal and motivation of aggression. This occurs when security is threatened. The behavioral based inclusion of delivery of a noxious stimulus is a widely accepted theory of aggression; however, this theory
becomes increasingly complex when intent and motivational factors are introduced. Russell Geen (1990) writes “aggressive behaviors are not as simple or unambiguous as a purely behavioral definition would indicate. Other elements must be added, and these elements create certain complexities” (p.2).

Hinde (1997) suggests that aggression between individuals depends on motivation and reasons for motivation vary. Common contributors include:

1) Defensive aggression – where behavior is motivated by fear.
2) Acquisitiveness aggression – where behavior is motivated to acquire an object or situation.
3) Assertiveness aggression – where behavior is intended to show off attributes.

The challenge lies in distinguishing the motivation aggression takes to accomplish its goal. This distinction was addressed as a fundamental principle in Lorenz’s (1981) ethology. Lorenz asserts that what the purpose of aggression is, should not be confused with how aggression occurs.

Adshead (2001) suggests there is an important distinction between aggression and violence. She states that in humans, a certain amount of aggression is necessary for motivated functioning. This aggression is highly regulated by complex rules, relationships and boundaries. Although differences in social and cultural rules exist, aggression within a cultural group is regulated and maintained. Violence occurs when the boundaries for containing aggression are broken.

*Abuse*

Abuse may be defined as a behavior which seeks to communicate to others that they are bad, possess negative qualities, or are not meeting some internal or external
standard (Goldstein, 1999). This behavior is an intentional use of power, intended to attack self-concept and cause psychological pain. Abusive behaviors include teasing, cursing, gossiping, ostracism, bullying, mobbing and harassment.

Harassment

In Canadian law, harassment is classified differently than violence. Harassment is viewed as a threat or minor act of violence that occurs from one person to another. Keith suggests that harassment is often viewed as separate and apart from violence. Harassment is thought of as a human rights issue, whereas violence is a criminal or health and safety issue. Though the two are characterized differently, the only distinction may be a question of degree, not diversity in the subject matter (1999).

In the United States, harassment in the workplace is clearly articulated under the Title VII of the Civil Rights Act. Two types of harassment are defined. The first is hostile environment. This occurs when an abusive environment is created through intimidation, hostility or offensive conduct that results in interferences with employee performance. The abuser may be a co-worker, non-employee or supervisor (Flanagan, 1995).

The second is quid pro quo or ‘this for that’. This occurs when an individual utilizes their authority to extort sexual conduct from an employee. Flanagan (1995) suggests sexual harassment falls into the following categories:

1) Verbal – includes sexual innuendos, suggestive comments, sexual propositions, references to gender-specific traits, threats and insults.

2) Nonverbal – includes suggestive or insulting noises, gestures, whistling and leering.
3) Physical – includes touching, pinching, brushing the body, assault or sexual intercourse under coercion.

**Assault**

Assault is a legal wrong that may be defined as “any willful attempt or threat to inflict injury upon the person of another, when coupled with an apparent present ability to do so, and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm” (Blacks Law Dictionary, 1990). In Canada, assault is the intentional application of force to another individual without their consent. Sexual assault is included in this category. Assault may be physical or psychological and can include attempts or gestures to use force that imply serious threat. Threat involves a communicated intent to inflict physical or psychological harm on a person or property (Keith, 1999).

*Defining Workplace Violence*

Workplace violence may be viewed as any incident where a worker is threatened, abused, coerced and experiences physical or psychological harm. Violence may include any behavior that results in a real or perceived injury. The workplace is understood as the place where the employee engages in productive activity. However, incidents that occur in, at, or are related to the workplace, also may be classified as workplace violence (Keith, 1999).

Workplace violence is committed by members of several identifiable groups. These include clients, strangers, co-workers and domestic situations.
Violence Committed by Clients

This violence is committed by an individual who receives a service/product by a business or organization. The violence occurs while the employee is providing a job related function. Canadian occupational health and safety legislation define the workplace as anywhere that the employee performs work (Keith, 1999).

Two subtypes of this category exist. The first is violence from individuals who are inherently violent. The second is violence from individuals who are not inherently violent. Violent incidents are triggered in the otherwise non-violent individual by provoking factors such as denial of a perceived need/want, an inappropriate expectation of service/product that is not met, or receipt of an expected service/product that is delayed (Keith, 1999, Leather et al., 1999).

Violence Committed by Strangers

This violence is committed by an individual who has no relationship to the worker. Violence is often random and the worker becomes a victim while performing a job related function. Workers can also be victimized outside of their traditional workplace environment, if violence occurs within the scope or course of their employment (Keith, 1999).

Violence between Co-workers

This violence is committed when the victim has an employment relationship with the perpetrator. Perpetrators can include prospective, current or former employees. Two types of co-worker violence exist. The first is violence between supervisors and subordinates. This is also known as reporting authority violence. The second is peer
level violence, where incidents occur between workers at the same level. This is also known as horizontal violence (Keith, 1999; Abdennur, 2001).

*Domestic Violence in the Workplace*

This violence is committed when the perpetrator brings a domestic problem to the workplace. The incident occurs between the employee and an individual who has a personal relationship to the worker, while the employee is performing a work related activity (Keith, 1999).

*Workplace Violence and Nursing*

Though violence can occur in any environment, the problem has become a high-profile issue within the healthcare setting. Nurses are at high risk for workplace violence related to the nature of their work. Nurses care for individuals who may be compromised by illness, injury, pain, medication, emotional disturbances or cognitive impairment. These changes may inhibit their capacity to understand or control their behaviors (Duncan, Estabrooks & Reimer, 2000). Provision of nursing care may also violate a patient’s personal space and reduce their personal control.

The financial state of the healthcare system also increases risk. Effects from organizational restructuring, downsizing, low staffing levels and high acuity patients are implicated in rising levels of workplace violence towards nurses (Henry & Ginn, 2002; McKoy & Smith, 2001).

*Incidence*

Violence occurs more often in healthcare than in any other industry (Lyneham, 2001). Nurses are at greater risk for occupational injury from violence alone than workers employed in high injury work settings including mining, lumber, manufacturing,
heavy construction, policing and prison officers (Lanza, 1996; Leather et al., 1999; Saines, 1999).

**Underreporting**

In a 1981 study, formal reports of violence related incidents were compared to ward nursing notations. Researchers found the actual number of incidents were five times higher than those formally reported (Lion, Snyder & Merrill, 1981). In 1994, Crowner et al. examined 3,300 hours of videotape on a psychiatric unit. The researchers identified 155 violence related incidents, of which only 12 were reported. In a Canadian study, Duncan et al. (2001) found that 70% of nurses who were victims of violence, did not formally report the incident.

It is widely accepted that the reported statistics represent only the tip of the iceberg. Lanza (1996) suggests that workplace violence is underreported by as much as 80%.

Nurses give a wide range of reasons for not reporting violence. These include: fear of blame; fear of revenge or retribution; the perceived degree of the perpetrators intent to inflict harm; becoming accustomed to violence; peer pressure not to report; differential reporting based upon the gender of the victim; difficulties with reporting systems; excessive paperwork; the feeling of failure in their professional ability; and role conflict (Lanza, 1996; McKoy & Smith, 2001).

**Role Conflict**

Role conflict is reported by nurses who have been victimized by workplace violence. They report disagreement between their role as a professional and a victim. Divided loyalties exist between allegiance to the professional mandate of putting patient’s needs first, and attending to their own needs as a victim (Leather, 1999).
Tolerance for violence in nursing has often been referred to as 'a part of the job'. Lanza suggests that some nurses feel that they expect to be hit as part of their job and have no right to react. Others stated that if they allowed themselves to admit their feelings about the likelihood of assault, they would not be able to function in their nursing role (1996).

*Human Impacts*

Violence towards nurses has only recently been recognized as a workplace health hazard. Human costs include emotional trauma, chronic pain, changes in functional status and depression (Gates & Fitzwater, 2000). Other reported responses include anger, anxiety, shock, apathy, stress, fear, post-traumatic stress disorder, sleep pattern disturbances and headaches. Feelings of disbelief, self-blame, dependency and helplessness have also been identified. Co-workers witnessing violent incidents also reported increased levels of stress related to fear of becoming a victim themselves.

Workplace violence has also been associated with difficulty returning to work, changes in relationships with co-workers, job dissatisfaction, low staff morale, job change, leaving the profession, burnout, and attraction/retention of nurses (Lanza, 1996; Leather et al., 1999).

*Organizational Impacts*

The organizational impact of violence is evident. The healthcare system is facing a serious problem in recruitment and retention of nurses. Increasing levels of violence may deter students and new graduates from entering into the nursing workforce. Workplace violence is also implicated in the resignation of experienced staff (Jackson, Clare & Mannix, 2002).
Economic costs are apparent. The system is burdened with violence associated expenditure, including employee absenteeism, decreased productivity, increased staff turnover, compensation and litigation (Gates & Fitzwater, 2000). Costs inherent in the current system can be expected to increase.

Workplace Violence and Nursing Research

Workplace violence towards nurses has become an indisputable occurrence. Unfortunately, it is neither well understood nor researched. Labig (2000) suggests that because workplace violence is a recently recognized phenomenon, there are too few studies available that would permit a definitive conclusion about causes, predictions or solutions.

Gaining an accurate description of the extent of workplace violence is also made difficult through differing standards utilized in research studies. Methodological problems exist when attempting to analyze published research studies. Variations occur in the criteria for what constitutes violence, who is involved, and where the incident takes place for it to be classified as workplace violence. Methods of data collection also vary. Methods have included officially reported incidents, confidential interviews and anonymous questionnaires (Duncan et al, 2001; Leather et al, 1999).

Review of the Nursing Research Literature

A search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) revealed a number of research studies addressing violence towards nurses. These studies have attempted to describe and further examine the extent of violence in the nurse’s workplace.
Providing care to mental health patients has been traditionally viewed as a high-risk area for nurses. In a United Kingdom study, mental health nurses and psychiatrists were surveyed to investigate the extent and nature of workplace violence. Though both groups experienced violence, nurses were exposed to significantly higher levels of violence, and one-half of nurses surveyed had sustained a violence related injury during the previous 12 months. Researchers suggested that younger nurses with less experience are more likely to be at risk for experiencing violence in their workplace (Nolan, Dallender, Soares, Thomsen & Arnets, 1999).

In Saverimuttu and Lowe’s (2000) research, violence in the psychiatric setting was categorized into four groups. They include: those that result in damage to property; assault of staff; assault of fellow patients/visitors; and self harm. Researchers suggested that a disproportionate number of incidents are related to patients suffering from personality disorders and schizophrenia. Studies conducted by Oster (2001) and Hlebovy (2000) found a positive correlation between perpetrator substance abuse and violence towards nurses.

A staff survey at Vancouver’s St. Paul’s Hospital emergency department was conducted to measure the incidence of violent behavior. In a one-year period, 97% of respondents reported experiencing physical threat, 92% experienced physical assault and 92% reported verbal abuse. Substance abuse and psychiatric disorders were found to be main factors contributing to violent incidents (Fernandes, Bouthillette, Raboud & Bullock, 1999).

Levin, Hewitt and Misner (1998) explored the insights of emergency room nurses about assault. Assault was defined as physical or verbal. Physical effects of assault
included injury, broken bones, wounds, muscle tension and long-term chronic pain. Psychological effects included anger, isolation, loss of sleep, nightmares, flashbacks and callous treatment of patients. Findings suggest that the presence of a uniformed security officer and/or a nurse’s confident, respectful attitude and body language reduced the nurse’s risk of assault.

Geriatric and long term care settings divide violent behavior into verbal abuse and physical abuse. Physical abuse includes behaviors such as pushing, hitting, banging, kicking, pinching, scratching, grabbing, pulling hair, spitting, throwing, smashing and self harm. Verbal abuse includes ridicule, cursing and demeaning/threatening comments (Fagan-Pryor, Femea & Haber, 1994; Kemmerlin, 1998). Patient populations cited include those with cognitive impairment, specifically dementia.

In the United Kingdom, a recent study suggests that hospital nurses experience a three-fold increase in assault risk from clients when compared to other healthcare workers. The researchers found no link to gender, but found a significantly higher rate of assault towards nurses who were younger and less experienced (Wells, J. & Bowers, L., 2002).

In 2001, 8,780 hospital nurses from Alberta and British Columbia were surveyed for exposure to violence in their workplace. Nearly half of those surveyed (46%) had experienced one or more types of violence within their previous five shifts and seventy percent had not reported it. Type and frequency of violence identified were: (a) emotional abuse 38%; (b) threat of assault 19%; (c) physical assault 18%; (d) verbal sexual harassment 7.6 %; and (e) sexual assault 0.6%. Nurses reported abuse perpetrated by patients, physicians, patient’s families/friends, supervisors and co-workers, with the
greatest risk in the late evening and on night shift. Findings suggest the hospital workplace is potentially stressful and hazardous to a nurse’s health (Duncan et al., 2001).

A recent study examined the extent and impact of workplace violence among nurses in Alberta and British Columbia. Overall, one in five nurses experienced violence within their previous five shifts. Results found the highest level of violence occurred in emergency and psychiatric settings, and lowest levels within critical care. Though not traditionally considered a high-risk area, medical-surgical nursing reported the highest level of physical assault. Findings indicate that patients perpetrate most violent acts. Acts included the threat of, or actual physical assault, and these incidents were reported only 40% of the time. Emotional abuse and sexual harassment perpetrated by co-workers was also identified as a problem and was less likely to be reported. Results suggest violence in the workplace decreases job satisfaction and impacts the provision of quality care (Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Hyndman & Acorn, 2003).

In William’s (1996) research, 1130 registered nurses were randomly sampled for incidence and impact of violence in the workplace. Of the respondents, 26% reported assault, most frequently committed by patients and clients. Occurrences were negatively correlated with the degree of job satisfaction.

Workplace violence towards nurses was also examined in a qualitative study by Findorf-Dennis, McGovern, Bull and Hung (1999). Random selection of 10 workers who had filed wage loss claims related to workplace assault, were interviewed four years after the incident. Significant findings included job change, chronic pain, depression and changes in functional status, all related to their experience of workplace violence.
Summary

This review of the literature supports the need for further research to assist in clarification of what workplace violence really is. As many unanswered questions remain, this study will endeavor to provide more knowledge about the nurse's experience of workplace violence and their associated needs. It is anticipated that this research will help to lay the foundation for designing appropriate interventions and assist nurses in their practice, specifically in recognizing, managing and reducing workplace violence.
Chapter 3

Method

Considering what we already know about workplace violence, it is expected that this study will contribute to the literature by addressing areas that have not been adequately investigated. A need remains to further our understanding as to how relational and contextual influences of workplace violence act upon nurses during the course of their work. To do this, it is my belief that we must further examine the very nature of nurses as human beings as well as the history and traditions that nurses bring to their workplace.

Research Design

As outlined in chapter two, I was interested in further exploring the nurse’s experience of workplace violence and refining knowledge about the nuances and the deeper meaning behind how nurses experience their situation. I recognized that individuals have unique perceptions and respond differently to their experiences; therefore I wanted to obtain knowledge from the emic perspective where informants could describe and identify their own realities (Morse & Field, 1995).

In general qualitative approaches indicate that multiple realities exist, that these approaches are committed to the participant’s viewpoint and that phenomena is conveyed by reporting it in a literary style rich with participant commentary. For these reasons, a qualitative approach was chosen for this project.

A number of qualitative approaches exist originating from the disciplines of nursing, sociology, philosophy and anthropology, with each adhering to the philosophical tenets of their respective disciplines. The very nature of the problem of workplace
violence towards nurses is extremely complex. As such, it requires experiential examination to identify the individual subjectivity of the experience, as well as being sensitive to commonalities that exist. Interpretive description was chosen for it’s inductive analytic approach that facilitates the understanding of clinical phenomena as well as yielding implications that can be applied to the clinical environment (Thorne, Kirkham Reimer & O’Flynn-Magee, 2004).

Interpretive description was first described in 1997 by Thorne and colleagues. It is an approach that acknowledges the contextual nature of an individual’s experience while allowing for the construction of a shared reality. The interpretive descriptive approach is grounded in nursing and adheres to the systemic reasoning of the nursing discipline. This approach recognizes that experiences are comprised of complex interactions where common patterns emerge that are representative of core nursing knowledge. From this, practical principles are derived that have meaning for both the individual and for the larger context. Therefore, interpretive description provides a basis for the generation of practical knowledge for nursing practice (Thorne, Reimer Kirkham & MacDonald-Emes, 1997; Thorne et al., 2004).

Interpretive description allows the researcher to use existing knowledge as the foreground for the area of inquiry (Thorne et al., 1997). Although it appears that formal research has not yet explored nurse’s accounts of workplace violence, there is much informal conjecture about the negative experiences associated with violence in the workplace.

It is my intent to examine these previously unexplored experiences through the use of interpretive description. Participants will describe their thoughts and feelings
concerning workplace violence in their own words. An interpretive descriptive approach allows the perceptions of these nurses to be examined and more fully understood. This will enable me to move beyond the descriptions of the experiences and engage in interpretation of the experiences from the nurses’ perspectives. These interpretations will assist in constructing nursing knowledge and form the basis for further research opportunities (Thorne et al., 1997).

**Recruitment Procedure**

Recruitment for the project included snowball sampling or ‘word of mouth’, as well as a written poster advertisement (Appendix D). I had presented literature reviews on workplace violence at four nursing conferences and asked for expressions of interest in study participation following each presentation. A written poster advertisement (Appendix D) was made available following each presentation as well as a letter of introduction (Appendix A). Five participants were recruited through this avenue. Five other participants approached me having learned about the study from advertisements or from other participants. As there was expressed interest, I had little problem with subject recruitment. It was interesting to note that I also received inquiries from physiotherapists, respiratory therapists, Licensed Practical Nurses and nurses aides. All had expressed interest in being interviewed but unfortunately they did not meet the selection criteria.

The selection criteria included Registered Nurses who were employed in British Columbia’s lower mainland. Each participant: had experienced workplace violence; been reflective about the experience; was willing and able to articulate their experiences; was
tolerant and patient of the research questions; and was able to devote uninterrupted time for the interview (Morse, 1991; Thorne et. al, 2004).

**Sampling**

Thorne et al. (1997) recommend that purposeful, theoretical sampling be utilized in interpretive description research. Theoretical sampling is a non-probability approach where the investigator makes a judgment regarding the participants who will provide the most useful information about the phenomenon being studied. Because the positions or experiences of each participant were not known at the onset of the study, theoretical sampling allowed me to select participants on an ongoing basis according to the relevance of the evolving theory. Maximum variation sampling was also implemented. This sampling documented diverse variations and assisted in identifying important common patterns (Creswell, 1998; Thorne et al., 1997).

Convenience sampling was used to recruit subjects who were easily accessible and who met the criteria for the study. Convenience sampling enabled access to nurses who had a willingness to participate and who could clearly articulate their experience of workplace violence.

**The Participants**

Ten Registered Nurses took part in this study. In order to create a diverse data set, I attempted to gain access to participants of varying ages, gender, workplaces and experiences. Ages of the participants ranged from ages 27 to 55. Two men and eight women were interviewed. Three nurses were from rural settings; two participants were employed as community nurses. Current workplaces represented acute medicine, surgical, mental health, emergency as well as community mental health and home care.
Previous areas of nursing practice included acute medicine, surgical, neurosciences, critical care, emergency, operating room, diagnostic procedures, geriatric, psychogeriatric, mental health, education and administration.

Three health authorities including Fraser Health, Coastal Health, and Vancouver Island Health currently employed the participants. Utilizing participants from these health authorities provided a sample of acute and community nurses in both urban and rural areas.

The participant breakdown was as follows: two participants were in the 25 – 29 year age range; one participant was in the 35 – 39 year age range; three participants were in the 40 – 44 year age range; three participants were in the 45- 49 year age range; and one participant was in the 55 – 60 year age range. Years of Registered Nursing experience were as follows: two participants had 0 – 4 years of experience; two participants had 5 – 9 years of experience, three participants had 10 – 14 years of experience; two participants had 15 – 19 years of experience; and one participant had 25 – 29 years of experience.

Three participants held a Registered Nursing Diploma; five participants held a BSN degree; and two participants held a MSN degree. Three participants had obtained specialty certificates. These included critical care, emergency and neuroscience nursing. One participant was enrolled in a BSN program and another in a MSN program.

Ethical Considerations

Ethical approval from the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects (Appendix E) was obtained prior to the recruitment of participants. An information letter was circulated to participants who showed interest in the study (Appendix A).
Participants were then screened to ensure they met the requirements for the study. An explanation of the study was given and the voluntary and confidential nature of the study was emphasized. Subjects agreeing to participate gave verbal consent and written consent (Appendix B) was obtained prior to the first interview. This included consent for audiotaping, transcribing the interviews and for reporting their descriptions.

Participants were informed verbally and in writing that they did not have to take part in the study and that they may refuse to answer questions and may stop the interview at anytime. These interviews were conducted during the participant’s own time and did not take place at their work setting, but at a mutually agreed upon location.

Every effort was made to protect anonymity. Code numbers were used in place of subject’s names during the collection and analysis of the data and only I had access to the match between codes and subjects. The data, including audiotapes and transcripts are kept in a locked office. Five years after completion of the study, the key and the tapes will be destroyed. Transcripts and informed consents will continue to be stored in a locked drawer. These will be retained for future educational and research use with written consent from the participant. Though the research may be published, names or identifying information will not be used in publications.

Subject risk was not anticipated. If participants were to encounter problems related to the subject matter, they would have been referred to an appropriate agency service. Participants were aware that there was no direct benefit to them from participating in this study. A summary of the research findings as well as any publications will be provided to all participants as well as to the project’s funding source, Work Safe British Columbia.
**Data Collection**

Several data collection techniques were used to solicit information concerning the experience of workplace violence towards nurses. This included interviewing of individual participants, field notes and reflective journaling.

**Interviews**

Data were obtained through unstructured and semi-structured interviews conducted at a time and location chosen by the participant, on a day that the participant was not scheduled to work. Research interviews were conducted over a four-month period and took place in a variety of settings. Some took place in coffee shops, others in formal meeting rooms, however, most interviewing took place in the participant’s home.

In general, the goal of the interview was to learn more about the perceptions of the nurses regarding workplace violence. After written consent for subject participation was received (Appendix B) demographic information was collected (Appendix C) and an informal interview was initiated. Each interview took approximately two hours. Unstructured, informal, open-ended broad trigger questions were used to stimulate and motivate discussion. During the interviews, participants were encouraged to articulate the salient aspects of their experience. Subsequent interviews were aimed at gathering insights towards conceptualization of the data (Thorne, et al.). Ongoing interviews generated new questions that assisted in narrowing the scope of the phenomena. As the research progressed participants were asked questions that shifted from a broad perspective to questions that search for similarities, differences or attributes of the experience of workplace violence (Morse and Field, 1995).
Reflective Journaling and Field Notes

Thorne et al., (1997) suggests the use of reflective journaling to help guide the research and to document reactivity during the research process. Reactivity considers the influences that occur between the participants and the researcher during the data collection process and also assists with interpreting and countering bias within the study (Gillespie, 2001; Thorne et al., 1997).

Reflective journaling and field notes were written after each interview as well as during data analysis. Entries were made according to personal insights – information about my reactions, experiences, insights, problems and decisions. A journal was kept to record subjective thoughts, hunches and reflections as well as the progress of the research project.

Data Analysis

In the interpretive description method, data analysis is not a linear, distinct stage in the research process. Instead, it begins with the first data collection and continues through to the write-up of the report (Lincoln & Guba, 1985).

Thorne et al. (1997) recommend that researchers repeatedly read and immerse themselves into the data prior to coding, classifying or attempting to link the data. This immersion assists in understanding the overall sense of each story and may be guided by questions such as “what is happening here?” and “what am I learning about this?” (Thorne et al., p. 174). Incorporating these analytic procedures availed me to synthesize, theorize and recontextualize the data as well as to refrain from prematurely coding the information.
The process of constant comparative analysis was conducted simultaneously with data collection. Data analysis consisted of a search for patterns. Thorne et al. (1997) suggest that common patterns typify the overall picture and are representative of core knowledge. This analysis included: a) reading the data through for a general sense of the participant’s meaning; b) reading the data again to pull out themes related to workplace violence; c) labeling the themes; d) interpreting the psychological and descriptive aspects of the themes and searching for patterns; and e) synthesizing the participants’ experiences (Giorgi, 1985).

A transcriptionist transcribed each interview. Following transcription the data was read, reviewed, considered and cross-examined. As the data was complex, considerable time was given to tentatively labeling sections of the transcripts. After much deliberation, the emerging patterns and connections were coded. Coding involved identification of words, phrases, themes or concepts that reoccur or stood out within the transcriptions. This approach to coding the data was useful for ease in sorting and later retrieval of information. All interviews were coded and compared with other collected information. Clusters of common elements were grouped together and patterns that emerged were compared to existing literature. It was then determined if the emergent patterns either supported or refuted previous knowledge. The overall goal of this process was to determine a context-bound view of violence, reflecting normative patterns of the subject’s culture and to help shift current theoretical understandings about workplace violence.
Rigor

It was my intention to represent the voices of the participants who took part in this study. My objective has been to capture and interpret the participants’ viewpoints, thoughts, intentions and experiences in a credible and defensible manner. I also wanted to grasp these experiences to ensure that the individual and collective perceptions as well as the contextual nature of workplace violence could be further clarified and described.

I felt it necessary to consider the integrity of this project including practical problems that might jeopardize the validity of the study, and pay attention to what procedures that would augment the trustworthiness and relevance of the research.

Considerable debate exists within nursing literature about whether or not one set of criteria can be used to evaluate the trustworthiness of a qualitative research project. For this reason, several measures and criteria were undertaken to ensure rigor within this project. Measures described by Thorne et al. (1997), Thorne et al. (2004), Morse and Field (1995), Morse and Richards (2002), Lincoln and Guba (2000) and Sandelowski (1986) were undertaken.

For auditability purposes, a clear decision trail was maintained from beginning to end and a traceable audit was structured for inductive reasoning processes. This decision trail encompassed how participants were selected for inclusion, the period of time for data collection, the nature of the data collection setting and the data analysis process. Data was obtained that provided rich and varied descriptions of workplace violence. Field notes were used to link the contextual aspects of the interviews with the phenomena. Most importantly, a reflective process was utilized to help shape, challenge
and make sense of how the data reflected both the participant’s as well as my own voice in addressing the issues associated with workplace violence.

I came into this research project with beliefs and assumptions that helped to shape the study and outline what I was looking for. I recognized that as a researcher I brought forward my own understanding of the experience of workplace violence and that this may have influenced my dialogue with the nurses. These assumptions and my understandings were consciously challenged, revised and refined throughout the course of the project.

I attempted to maintain evidence of logic as well as to counter bias within my analysis through the use of reflective journaling. Journaling encompassed my reactions and thoughts about the interviews as well as chronicled the feedback sought from various parties including other nurses, academic mentors, field experts, administrators and policy makers. In every situation, insights were raised that challenged, confirmed or raised additional questions about clarification of my concepts. As is evidenced in chapters four and five, I saw the interpretations of my data shift as I began to view the issue of workplace violence in different ways. This was in part due to what I reflected upon, what was of interest to me as well as what I grew to understand.

Summary

This chapter presents a description of the study design, an introduction to the interpretive description approach as well as details about recruitment, sampling, data collection, data analysis and rigor practices within this study. As I examined the data set, I began to reshape my thinking about workplace violence against nurses and comprehend what might enhance as well as to impede this complex problem.
Although these findings are not meant to be generalized, I anticipate that the findings of this study will elicit significant data, assist in building unique theory and convey important insights. In chapters four and five, I will describe my current understanding of workplace violence. It is hoped that these insights will lead to a greater understanding of violence in the workplace, specifically within the context of nursing.
Chapter 4

Presentation and Discussion of the Findings

When I first began the analytical process of researching workplace violence, I found myself wanting to move beyond what the literature presented. I realized that fundamental knowledge about the problem of violence within healthcare was sparse and that the very nature of the problem itself was difficult to articulate. In this chapter I present my interpretations of what I heard during the interviews, what I reflected upon, and what I came to understand about workplace violence towards nurses.

As previously stated, the purpose of this research was to explore nurses’ accounts of workplace violence. My analytic process was guided by the following questions: how do nurses describe and define the violence in their workplace; how do they recognize and interpret the violence directed towards them; and how do they feel about the workplace violence they have experienced.

Thorne (2004) suggests that the emergent patterns and themes should be ordered so that we “might make sense of the most important ideas to be conveyed and access their meaning in a new manner” (p.15). Drawing upon these principles, important ideas inherent to the study are presented as themes. Each theme will be compared to the existing literature and similarities or differences of the findings will be discussed.

As analysis of the data proceeded, the findings highlighted the extremely complex nature of workplace violence. I began to unravel the perspectives of each nurse to into macro and micro level influences. I also looked for commonalities that influenced the participant experience. As the analysis progressed, it was important for me to conceptualize what was meaningful to each nurse and establish a reference point from
which I could frame my interpretation of his or her experience. This resulted in a
differentiation between: the organizational influences upon each participant; the nurses’
immediate work context; and how personal factors impacted the nurses’ tolerance of and
capacity to cope with, workplace violence. As a result, organizational, environmental
and individual factors became the major themes of this study.

This chapter is divided into three sections. The first section investigates the
perspectives and experiences within organizational culture. This will be reviewed in
terms of both corporate and nursing culture. The second section will explore
environmental factors including exposure to violence, types of violence and practice
setting issues. Individual impacts will constitute the third section. This will examine the
psychological impacts nurses experience as well as how they cope with workplace
violence.

Organizational Factors

Existing research in the area of health and safety within healthcare makes claims
about the importance of organizational culture in addressing workplace violence.
Organizational culture is a difficult concept to grasp, both literally and metaphorically.
Yandrick (1996) suggests that organizational culture is not a palpable entity that can be
seen, felt or even empirically measured; yet examination of organizational culture can
provide insight into the internal dynamics that affect workplace violence (Faugier &
Woolnough, 2002).

Organizational culture can be described as a system of shared values and beliefs
that shape an institution’s employees, organizational structure and control systems.
These components result in behavioral norms or ‘how we do things around here’.
Culture permeates into the fabric of all levels of the healthcare system and has a pervasive influence (Faugier & Woolnough, 2002). Schein (1984) offers a comprehensive definition of organizational culture:

Organizational culture is the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think and feel in relation to these problems (p. 3).

It cannot be assumed that any one healthcare institution will have one unified culture that workers will ascribe to. In fact, Hewiston and Stanton (2003) suggest that if we restrict our conception of culture to one large monolith, we will be ignoring a range of competing subcultures that exist.

Within the larger organizational context, it became clear that the participants were able to identify a number of subcultures. These included the subcultures of management, nursing, practice areas and nursing education. However, the most divisive and widely expressed subcultures were between corporate management and front line nurses. The prevalence of the stressful effects of corporate culture and harmful management practices that ensued, form a compelling argument to further examine the role of management in relation to workplace violence.

Corporate Culture

Corporate culture will be reviewed under the domains of the role of management, policies, reporting, education, code white, reactive strategies and support.
Role of Management

The literature suggests that although leaders are not directly responsible for the creation of organizational culture, the attitudes of administrators and managers has a great impact on the ethos of the entire organization (Faugier & Woolnough, 2002; Hewison & Stanton, 2003; Schein, 1984).

Ideal professional practice environments include organizational attributes such as decentralized decision making, interdisciplinary collaboration, adequate resources and managerial support. These attributes are essential in performing complex nursing functions and in providing high quality care because nurses are more likely to participate in an organization where they feel valued and have a choice (Flynn, Carryer & Budge, 2005). When conflicting cultures operate within an organization, these clashes lead to dysfunctional or sub optimal working relationships.

Particular styles of management resulted in increased levels of stress for nurses. These included inappropriate and coercive management styles. High job demands coupled with a lack of managerial support predicted poor outcomes for managing aggression and violence. Terms used to describe management included “they just don’t care” and “their (management’s) lack of support is the key issue in our clinical demise”. An effort-reward imbalance was also described. Several participants spoke of being sabotaged by middle management in their attempts to manage workplace violence. For example, three participants stated that management had inappropriately cancelled a code white call. Another described the sabotage of limit setting by their immediate supervisor:

A terminally ill patient and the patient’s family had asked that a visitor not be allowed to stay the night. The staff had foreseen the problem and decided to limit the visitation to official visiting hours. The head nurse (from days) had spoken with the visitor about the limitations. When the visitor arrived outside of visiting
hours, he became aggressive and verbally abusive towards staff. The supervisor was called and unfortunately the supervisor did not back the staff. The easiest way to for her to deal with it was to give the visitor what he wanted so she let him stay the night. I was quite upset because the patient and the family didn’t want him there. It is absolutely frustrating if you are willing to stand up to it (the violence) because you can only stand up to a point.

When the nurses were asked about the organizational culture and the role of management operating within that culture, a number of participants were clearly angry. It was felt that corporate healthcare administrators were restricting their conception of workplace violence to its superficial manifestations, such as the ‘no-violence’ policy espoused by top management. This is evidenced in the following excerpt. It details the stark differences between positive administrative support and a lack thereof within the same institution:

The biggest problem I think that they’re having in hospitals, and the one that I’m having the hardest time understanding is administration. I quit from one job because of the lack of staff and the lack of (administrative) support. I handed in my resignation and the supervisor pulled me from the floor a week later. She wanted to know what had happened that night (violent incident). I said this is unsafe and they (administration) don’t listen to us. I said I’ve got about ten minutes because I’ve got patients to look after. I was there for two hours because people kept popping by, the phone kept ringing and she’d be interrupted. I felt like what the hell am I doing here, I’m not important. Now I work on a unit where the staffing is even less, but my stress level has dropped. When you go there, administration listens to you. I was in the supervisor’s office and someone knocked on the door. She did not answer the door. The phone rang four times and she did not answer the phone. I was there and she was listening to me.

Experiences with management were polarized into two groups: those who felt management supported them and those who perceived that they were largely unsupported. Those who felt supported cited that they had a higher level of control over managing aggression and violence while those who were unsupported experienced a lower level of control.
It also became clear that the degree to which the nurse’s personal, professional and organizational values were in congruence with, and supported by, the organization affected the degree to which the nurses were committed to their work and to management of violence. This is in keeping with Tschannen’s (2004) suggestion that when values held by employees are congruent with values held by administration, there is a greater degree of commitment and assist employees in remaining resilient in times of conflict.

The nurses spoke of a need for a greater degree of commitment towards a supportive work environment. They felt that the gap was widening between supportive and non-supportive environments, and that the few supportive work environments in existence were fast becoming “a thing of the past”. When asked about what constituted an ideal work environment, they stated that they wanted an administration that valued and encouraged openness, trust and collaboration.

Collaboration is a partnership where power, knowledge and expertise of each party is acknowledged and valued when working towards a shared goal. The work group’s success depends upon their ability to perform the task and also it’s ability to manage it’s own interactions effectively. This includes cooperation, communication and coordination of its collective efforts (Tschannen, 2004).

Four nurses described positive scenarios where they felt supported in addressing and managing workplace violence. Each of these scenarios portrayed a commitment between administration and staff where there was a strong desire to connect with each other and also to expend considerable effort in accepting and actualizing the values that the organization portrayed in addressing workplace violence. One nurse stated:

It’s huge, huge and if you don’t have the team support to uplift you through those times, I don’t think you can get through it (the violence). I don’t know about
other careers, but in nursing there’s just too much you deal with on a constant basis. There’s a lot of stuff that drives me crazy about this job, but I’m here because the team is really a team. We’re not just a team for the public; we’re a team for each other as most of the people have worked with each other for twelve to twenty years. That’s one of the biggest reasons I’m still there, this team is really a team.

The dominant factor in clinical effectiveness, practice development and in successful outcomes is that of culture. Culture demonstrates ‘the way things are done around here’ and it is culture at the individual, team and organizational levels that creates the context for practice. The context for practice is made up of ‘forces that give the physical environment a character and feel’ (McCormack, Kitson, Harvey, Rycroft-Malone, Titchen & Seers, 2002).

Culture is not something an organization has, but rather it is something that an organization is. Therefore, understanding the organizational culture through the context of the nurses’ practice is essential to comprehend how to bring about changes in managing workplace violence.

Policies

It became obvious that there was a serious disconnect between the nurses and the way they perceived administrative policies, especially in relation to violence. Five participants stated that administration did not send a strong enough message in regards to not tolerating violence. One participant stated:

We do have signage up at the hospital but I find that it’s really sort of airy-fairy. It sort of says that we don’t put up with any kind of verbal or physical abuse in this caring environment…but you have to have follow through, you have to have the support across the board. Right now it’s just rhetoric; it’s just a sign. People read it but it’s meaningless.

Hope and Hendry (1995) suggest that prescriptive approaches such as the
“zero tolerance for violence” policy often work in the opposite direction to the values being supported. Prescriptive mandates are often counter productive as they cause employees to feel disenfranchised, manipulated and cynical (Hewinson & Stanton, 2003). Indeed, many of the participants shared that they felt jaded and that policies addressing violence were often “not worth the paper they were printed on”. One participant described this cynicism and sense of hopelessness:

Oh yeah, the management will often talk with us. They say they support you but then nothing will happen. Then the staff at our level starts to go down because we feel like we’re not supported at all. There is the trust issue that happens because they (administration) say one thing but they can’t do it. There is frustration on both our parts and a difference in understanding. Things have been so bad for so long that you think nobody cares.

And another:

I’m still angry but the effort to try to change the system or to change the policies in this hospital requires more time and effort than what I have to give at this point in my life.

Reporting

It is widely accepted that the reported statistics represent only the tip of the iceberg. It has been well documented that nurses underreport workplace violence and comparative international studies confirm that only one in five incidents are actually reported (Hesketh et al., 2003; Mayhew & Chappell, 2002).

Seven of the participants described experiencing workplace violence on a “daily basis” and cited that they rarely, if ever, formally report it. Reasons for underreporting the violence included: lack of perceived severity of the injury sustained; a belief that the patient is not always responsible for their actions; fear of retaliatory action by the aggressor or by management; lack of time to fill out the report; not knowing how to report the incident; and lack of follow through by management or the organization once
the incident had been reported. Several of the participants cited that there was “no pay-off” for taking the time to report the violence. One participant stated:

You report (the violence) to your team leader, what does she do about it? Probably nothing because she’s swamped with what, with other critical nursing things to do. You can report it to your manager and she can say to you well, I’ll check into it but there’s no, no way that you’ll ever find out what has become of that.

Furthermore, the organizational culture may influence the nurses to expect that reporting will produce a negative reaction such as putting their professional competence in question (Leather, Brady Lawrence, Beale and Cox, 1999). Several participants alluded to this stating that they felt “incompetent” and “blamed themselves” consciously or subconsciously for the violence that they had experienced.

Other nurses felt that it was important to report the violence that they had encountered as it was a way of validating their experience. When they were unable to formally validate the violence they spoke of feeling “isolated”, “not cared about” and having “diminished self worth”. All of the participants experienced anguish in not knowing how to deal with the violence. One nurse said “my family just couldn’t even comprehend what I was going through at that time nor could administration, even though I wanted advice with a situation like that.”

**Education**

Employers of healthcare workers and nurses have a legal requirement to provide a safe work environment for their employees and it is up to each employer to develop its own plan for violence prevention strategies. The majority of articles written in the last twenty years cite that education is the most effective intervention in reducing workplace violence towards nurses (Piere, 2004).
Health Authorities in British Columbia have developed training modules to educate nurses about managing violence and aggression. All of the participants had taken the violence prevention training offered by their health authority. These prevention programs are intended to identify potential problems in advance and to equip nurses with the skills necessary to manage the situation effectively.

The participants unanimously agreed that the training they had received was not adequate to deal with the workplace violence they routinely encounter. They cited that the violence prevention content is too heavily focused on how one escapes a violent situation, that there was minimal information on recognizing and preventing violence, and that the techniques taught offered minimal benefit:

I find them (non-violent crisis intervention programs) a total waste of time. I just find that people don’t present the way they present in a controlled setting in the non-violent crisis intervention class. Usually arms are flailing, they’re biting and spitting and kicking and punching and they get this force when they are really angry. I think the violence can be unpredictable and it (the non crisis intervention) has never worked.

Participants felt that the content being taught was also unrealistic and did not give credence to their personal safety:

I mean I really didn’t learn a lot. If you’re actually assaulted by a patient, I wasn’t too impressed with how they wanted us to get out of things...they talked a lot about run with pride but if you’re actually being choked from behind, I’m not going to be too concerned about whether I stomp on a person’s foot or not and they get a bruised toe. I wasn’t too impressed with the whole non-violence response because you can have a lot of damage done.
Code White

"I think that the violence is unpredictable and code whites have never worked"

Participant Quote

The Health Association of BC, Worksafe BC and the Occupational Health and Safety Agency for Healthcare in BC have developed guidelines that assist nurses in dealing with aggressive or violent behaviour (2000). A Code White is to be called when an actual or potentially dangerous situation is or will escalate beyond the ability of staff to control the situation. Non-violent crisis intervention strategies that do not use pain compliance are to be used. These include verbal techniques to diffuse the situation, hands on physical restraints, mechanical restraints (e.g. four point restraints) and seclusion.

Several of the nurses felt that theoretically the Code White response was a positive technique, but had reservations about the implementation and efficacy of the strategy:

There is a code white procedure where when a violent incident occurs or is about to occur, is imminent that we call a code white. What that is essentially on paper is supposed to do is to provide on an emergency basis, two security guards, an orderly from emergency, a nursing supervisor and any other staff member within the hospital that has been trained in a code white situation. Since my injury, I've been involved in four or five code white situations and very few people attend them. In one case, nobody came and there were no security staff. The nursing supervisor called up, the hospital was busy and there was nobody available to attend.

It became apparent that further exploration is required as to how healthcare organizations can increase their efficacy when educating nurses about managing violence. Traditionally, training programs have centered on nurses employed by a healthcare organization. However, several of the participants suggested that
management of aggression and violence should be a mandatory component of nursing curricula as the entire nursing community shares a collective responsibility for developing and maintaining safety for both nurses and patients alike. This will be further explored in chapter five.

Reactive Strategies

Integral to addressing such effects of violence is both the recovery and the review process for workers who have been violated. Not only were there no disciplinary actions taken towards the perpetrators, but also three of the nurses felt that the lack of disciplinary rules actually helped to trigger the violence because the few rules or procedures in existence lacked "fairness towards nurses" and "consistency".

All participants had experienced workplace violence and many had sustained physical and/or psychological injury as a result. It was therefore surprising to hear about the lack of formal support and follow-up for those who had actually experienced violence. In theory, reactive strategies should: 1) determine what nurses do when faced with violence; 2) develop user friendly responsive procedures backed up by adequate training; and 3) provide continued support (Leather et al., 1999).

In reality, few resources or reactive strategies that aid in problem solving and improve the organization's ability to recognize and deal with problems as they arise actually exist. For example, participants felt that the problems they experienced post incident were poorly handled by the organization and that assistance in coping with a violent related incident were non-existent. One nurse described her situation as being "between a rock and a hard place" as she felt pressured by the organization to turn a "blind eye" to the violence she had experienced. This resulted in incongruence between
personal and organizational values, and leading to major personal and professional
distress. Courses of reactive strategies that the participants chose included ignoring the
effects of the violence, conscientiously objecting to the lack of support, and leaving their
job or workplace.

Support

Employee assistance programs and rehabilitation services aim to support
employees in coping with the after effects of an incident and focus attention towards
assisting the individual physically, psychologically and emotionally (Leather et al.,
1999). Although the majority of participants stated that their healthcare organization
offered an employee assistance program, it was again surprising to hear about the lack of
formal support and follow-up for those who had experienced workplace violence.

Employee assistance programs offer individual counseling that can help nurses
cope with personal stressors and are often used to debrief employees after involvement in
a violent incident. Although all of the nurses had experienced significant violent
incidences, not one participant had been immediately connected with these services nor
did they have knowledge as to how to access them. One participant did receive timely
critical incident debriefing by members of the community mental health team who had
witnessed the event:

Well the particular psychologist that was in the room was fabulous and she
basically debriefed the whole thing right then and there, we sat there for an hour
and we just talked it out and she really reassured me that I hadn’t been out of line
because that was my immediate response...

The participant went on to say:

Our psychiatrist also phoned me because she had been in the next office dictating
and she’d heard it happen so she called me that night to see if I was okay and
check in… Well I thought it was good, it made me feel cared about and that it
confirmed for me that what I was feeling was not over the top so, yeah it made me realize that it was a scary situation and that I wasn’t reading it wrong, that he was out of line…I think if the psychologist hadn’t done that initial debriefing and then if they both hadn’t sort of checked in with me, if that hadn’t happened, I might have gone away thinking, okay, I did something that caused that, its my fault and I’m bad and I can’t do this job very well.

Other participants who had sustained significant physical and/or psychological injury had to seek out their own rehabilitation and experienced difficulty in obtaining services from the broader organization. The broader organization included management support and services offered by the immediate employer (i.e. the hospital or community agency), the health authority, the British Columbia Nursing Union, and the Workers Compensation Board.

Negative attitudes prevailed amongst the participants in relation to obtaining services. For example one nurse angrily stated:

I’ve never had any conversation from my manager…I’ve had no follow-up from the union, from occupational health and I heard that my injury from WCB’s point of view would be recorded as a head injury…I would be a stat for the year.

Another participant demonstrated frustration when recalling a meeting to clarify who would assist her rehabilitation: “when I was injured and was meeting with the union, the occupational health representative, management and the WCB rep, nobody was taking responsibility for my injury”. She was not alone. Many participants found they had to be insistent and proactive in obtaining support. One nurse described the process as follows:

I incessantly ask questions … my intention is to know, is to gain knowledge, to understand so that I can act in a way that is knowledgeable. So with WCB I phoned up and I talked to at least half a dozen people of which neither one of them was saying the same thing. The left hand doesn’t know what the right hand is doing. Finally, I started getting all these little pieces of puzzles so I put it all together and I managed to navigate my way around this incredible maze, which was very, very frustrating. I found out information about benefits that they don’t
tell you right up front and I’ll tell you, I was just choked but because I had this investigative nature and wanted to assess the whole thing out, I found resources and little bits of stuff that I could use for my support.

And another:

I phoned them (the WCB) the next week to ask what happens because I knew I had been injured at work but I didn’t know what the process was in place and they didn’t know anything about it...everyone (colleagues) was in shock at how poorly it was handled.

Alternately, one participant spoke positively of the support received post incident and stressed the importance of the occupational health nurse in offering assistance:

She was very, very good I have to say about her (the occupational health nurse). I started chatting with her and then I had a little bit of a tearful episode and I gave her the information she needed and I had fill out this form... she said you do this and I’ll fill in the rest and I was just so grateful for that because she walked me through it. She just walked me through it and because I wasn’t thinking very well and I couldn’t look at all these words on this form and organize it and figure out. I was too upset.

Culture affects the effectiveness of and level of commitment of the people within that culture. While corporate culture is comprised of the attitudes, experiences and beliefs of the organization, the collective values and norms that are inherent to nursing are distinct from organizational culture. These findings will be further examined.

Nursing Culture

"A lot is to do with nursing culture, where we’re coming from"

Participant Quote

Culture is a learned set of beliefs, values and behaviors that are shared amongst a group. Beliefs represent acceptance of what one feels to be true or existing. We use beliefs to set up structures to make sense of our world on an individual and collective basis. Beliefs contain assumptions and convictions about the manner in which people
should behave and the principles that should govern their behavior. These are known as values.

Value systems provide the basis for the ideals and beliefs that individuals and groups uphold. Personal values are reflected in individual attitudes; likewise, group values are represented through a collective voice. Values are integral in forming the rules that people live by, therefore, people make choices about their behavior and actions based upon their value system. Values often exist on an unconscious level. Because of this, they are often difficult to identify, describe, and to assess objectively. In keeping with this, the participants had difficulty in articulating the values they upheld.

The values of nursing include basic assumptions about what is of fundamental importance within the practice and profession of nursing. Together, these values make up the organizational culture of nursing. Prevailing values in modern day nursing culture include the values of aesthetics, altruism, equality, human dignity, justice and truth (Faithfull and Hunt, 2005). These values will be further explored.

Aesthetic Values

The word aesthetic is derived from the Greek word aesthesis, which means sense knowledge. In the aesthetic art world, aesthetic values are associated with beauty and form. In literature, aesthetic values are linked to beauty, ugliness, harmony, balance, tragedy, comedy and the sublime (Sarvimaki & Sandelin Benko, 2001).

Aesthetic values in nursing differ from the art world in that nursing is viewed as a practical art, characterized by competency and skill rather than by the philosophy of what is beautiful. Definitions and descriptions of aesthetic values are not easily found in
nursing literature, however they appear to involve the qualities of objects, persons and/or events that provide satisfaction to the individual (Altun, 2002; Paterson & Zderad, 1976).

Participants spoke of aesthetic values only in relation to the dissonance they had experienced:

I think when that sugar coating, all that hokey stuff of being lovey dovey, when that wears off. I’m sorry to say that you’re going to get hit by someone at some point, so you’ve got to be ready for that. I think by being totally honest and it might scare some away, but at least they won’t go back and say you know they never told me this.

And another:

I’m working myself to death, I’m not getting tremendously well paid and this is not the environment that people think it is. My reason and motivation for entering this profession was the fact that you went to work and you came home feeling enriched, feeling positive. This is not how it is.

Altruism

“Don’t have your own needs, don’t be human, serve the patient, its all about the patient, and suspending your own humanity for twelve hours”

Participant Quote

Altruism is a descriptive term for the selfless caring of others. The term altruism is used to describe both unconditional and reciprocal acts of giving. However, pure altruism is rare because self-interest routinely guides personal action. Altruism is not an isolated process in one's life. Instead, there are specific capacities that must be present for an individual to respond altruistically. Smith (1995) suggests that these include an ability to perceive alternate perspectives, awareness that one's behavior will have a consequence on another, and an ability to transcend the ego.

In nursing, altruistic acts have an effect upon the care provider. Caring for others is considered as ‘doing good’ and the nurse often experiences a vicarious pleasure or
sense of relief in meeting another’s needs. However, to be involved in a self-sacrificing act where the giver has nothing to gain and potentially much to lose implies that another’s needs are more worthy than one’s own.

Caring for one’s self may be considered as selfish, and the exclusion of one’s self may result in disequilibria within the relationship if only the care recipients are legitimized (Gilligan, 1982; Smith, 1995). The most exploitative form of altruism is self-sacrifice, where the position of the recipient is enhanced to the detriment of the giver (Rapport & Maggs, 2002). One nurse commented:

I don’t think people realize the extent that we go to to like ourselves. We put it upon ourselves to care for people and were rushing around constantly to give the best care possible. It just seems like we don’t get much acknowledgement and we even get abuse along the way.

In relation to workplace violence, participants were very torn over whose needs came first, the patients or their own. Several nurses spoke of how nursing culture is misrepresented, that nurses were not “Angels of Mercy” or “Mother Angelica”. One participant offered this perspective:

We should really think of the counter part, the opposite. I think of the police force, where its pretty much shoot first, ask questions later. Nursing has all that nurturing. It carries that baggage with it and as a result imposes on the nurse this responsibility to try and understand, to try to be therapeutic. When you’re faced with a violent situation, you are torn between the nurturing aspect and your own protective aspect. This puts the nurse at risk. I mean you never hear a policeman really caring whether he said the wrong words, he goes, okay, did I protect myself, did I protect that innocent party and did I use appropriate force or intervention but he’s not going deeper. It’s all that internal angst which is a tremendous burden for the nurses to bear.

The ability to address issues associated with violence was influenced by the participants’ perception of the ethical climate within their workplace. The Code of Ethics (Canadian Nurses Association, 2002) is a public statement about the profession’s
responsibility to society when providing nursing care. Nurses are dedicated to not inflicting harm, preventing harm and reducing the risk of harm to others (Erlen, 2004).

The Code of Ethics (Canadian Nurses Association, 2002) sets up a potential ethical dilemma when dealing with violence directed towards the nurse. The language of the document does not imply support for balancing the need to care for ones’ self with caring for others. Therefore, these nurses felt that their values were often in conflict. Questions such as ‘what am I doing here’ and ‘how much am I to sacrifice’ were of paramount importance as these participants faced divided loyalties.

*Equality*

Equality contains the idea that no matter how different from one another people may be, each has an equal right to fair and just treatment. In nursing, equality encompasses personal qualities such as fairness, where individuals share the same rights, privilege and/or status. Care is provided based upon the individual’s needs and personal characteristics are considered irrelevant and nurses require a non-discriminatory attitude in order to allocate resources (Altun, 2002). Fairness also means to be even handed between different groups of people.

Whitehead (1994) argues that the ideal of equality in health care is unachievable, as true equality would entail an equal distribution of services where each individual receives the same amount. He proposes that equal shares for all, regardless of need or disadvantage, would in reality be unfair and unjust.

One approach to deal with the misallocation of nursing resources is to employ vertical and horizontal equality. Vertical equality means that people with an unequal need, be treated in a dissimilar way, meaning differential treatment of unequals is
necessary. Horizontal equality indicates that people with equal need will be treated equally (Almond, 2002).

Participants mentioned equality in terms of the provision of patient care and were quick to point out examples where inequalities existed in relation to their personal experience of nursing practice:

Put a violent person on the street and he’s wrong. Put a violent person in the hospital, he’s not wrong, he’s sick. You’ve taken away from the individual anything of guilt. If you’re sick, somehow you’re relieved of certain responsibility...there’s a tendency to, when sickness is involved or illness, like well, that’s not so bad. But put that into a different scenario and suddenly the illness aspect of it isn’t, minimized and the person’s responsibility in the guilt is also heightened.

*Human Dignity*

"*You need to minimize the violence, the impact of it in order to feel that good feeling. That good feeling is so effective – I'm helping the world*"

*Participant Quote*

Human dignity is inclusive of qualities such as kindness, respect, honesty, trust, empathy and promise keeping (Altun, 2002). Gallagher suggests that dignity should be considered a double faceted professional value: other-regarding and self-regarding. Other-regarding refers to respecting the dignity of others whereas self-regarding refers to maintaining self-respect. Other-regarding dignity practices benefit others, while dignity as a self-regarding value benefits the nurse himself or herself (2003).

Eriksson describes human dignity as “accepting the human obligation of serving with love” (p.76, 2002). In this view, no person should ever be violated as everyone holds equal worth. Human dignity also implies inner freedom and responsibility for one’s own life as well as the lives of others (Naden & Eriksson, 2004).
Dignity appears as a right as well as a duty in nursing professional codes. A statement in the Code of Ethics for Registered Nurses (2002) is: “nurses recognize and respect the inherent worth of each person and advocate for respectful treatment of all persons” (p. 8). However, respecting the nurse’s own dignity has received far less attention and is not articulated in the Canadian Nurses Code of Ethics (2002) nursing values and responsibility statements.

Justice

The value of justice represents what is owed to an individual, group or society. It embodies personal qualities such as morality, courage and objectivity as well as the ability to uphold legal and moral principles (Altun, 2002). Justice has several underpinnings that are worthy of consideration. The principle of justice has autonomy as well as fairness as it’s underpinning. This embodies a supply and demand scenario where some individuals may benefit more than others.

In nursing a need exists to ensure that basic rights, obligations and fairness are offered to the least advantaged. Within this view, justice involves the interplay between circumstances and resources. Inequalities exist within societies burdens and benefits, and there are difficulties honoring justice when resources are scarce or finite (Ludwick & Cipriano Silva, 2000).

Participants suggested that disparity existed between justice for the clients they cared for and justice for themselves as a professional. It was felt that the value of justice could be clearly delineated for their patient population but they had difficulty in articulating personal injustice in relation to their experience of workplace violence.
Several participants suggested that a status quo of discrimination within nursing as well as within the larger healthcare system existed. It was difficult to ascertain what sustained these disparities but participants alluded to the lack of a “culture of safety” for nurses and that nurses themselves, the corporate healthcare organization and society as a whole help perpetuate this:

I don’t really think nursing should take that on as more than anybody else, in other words because I’m a nurse doesn’t mean I have to take abuse...I think it should be the same for everyone, safety should come first. One person’s rights are subjected to another, we do that all the time but we have to consider the safety of everybody.

A second participant shared her concerns:

These are hard incidents to undo because society helps put us there. We have learned to put what we need second and sometimes we don’t even recognize those needs even exist.

Freedom

The value of freedom suggests that every person has the right and obligation to be responsible for his own life. Freedom involves personal attributes including self-direction, self-discipline, independence and the ability to exercise choice. When these principles are applied, they result in enhanced social awareness, self-reliance and self-determination of individuals, groups and society as a whole (Altun, 2002; Raatikainen, 1989).

Participants felt that they had little freedom and therefore diminished autonomy within their professional practice as well as within their work environment. They acknowledged that a lack of freedom hindered their ability to work optimally and effectively. Impeding factors included increased workload and poor relationships with management and colleagues. The politics surrounding negotiating and exercising
personal choice were cited as a source of severe anxiety and frustration for a number of the participants. One nurse spoke of the lack of freedom in relation to the horizontal violence she had experienced:

Where the nurses have zero autonomy and everyone shits on them, what nurses do when they feel this loss of control is they’re mean to each other… when they’re pushed down by the system, they take it out and are aggressive to each other…

It is interesting to note that Freire (1972) suggested that oppressed groups fear freedom. His theory has two parts. The first is that the oppressed fear freedom and the second is that a fearfulness of freedom exists that leads the oppressed to choose either to remain oppressed or to follow the oppressor (p. 23). Hockley (2002) suggests that because nurses have continued to be disunited, the status quo has remained and therefore, nurses continue to have diminished freedom and autonomy over their practice.

Role Conflict

Social norms consist of people’s beliefs about the attitudes and behaviours that are acceptable and/or expected within a particular social context. However, contexts have multiple purposes and functions. In healthcare, the primary function may be the provision of patient care but the nurses they employ bring with them a diversity of personal expectations, values, and cultural norms that may be in conflict with the organizational norms and values.

Participants who were victimized by workplace violence reported role conflict, reporting disagreement between their role as a professional and as a victim. As Leather (1999) suggests, divided loyalties existed between allegiance to the professional mandate of putting patient’s needs first, and concurrently attending to their own needs.
Tolerance for violence in nursing has often been referred to as “a part of the job”. Lanza (1996) suggests that some nurses feel that they expect to be hit as part of their job and have no right to react. For example, in this study, all participants assumed the principle of beneficence. However, in managing workplace violence, their professional duty to promote good was often drawn into conflict with their personal value system. Participants also voiced that healthcare management and the educational institutions they attended did not recognize their lives outside the context of their work. Participants became frustrated and angry when their individual beliefs and values were violated.

Issues were raised about accountability. Accountability was seen as answering to someone for something that had been done. This encompassed being able to provide an explanation to one’s self, one’s colleagues, the healthcare organization, the nursing profession, and to society. Participants separated accountability into macro and micro levels. Macro level accountability involved societal, organizational and professional standards that provided internal rules and norms for their behaviour in dealing with violent situations. On a micro level, participants assumed responsibility for their personal actions and decisions, feeling obligated to answer for resulting consequences.

Ultimately participants wanted their nursing practice to contribute in a positive way towards client care, but in situations of violence they often found themselves concurrently balancing the rights, needs and legitimate interests of both client and themselves. Attempting to maintain this equilibrium between the boundaries of their individual value system, the values associated with the organizations in which they worked, and ascribing to the tenets of the ideal nursing culture, these participants often found themselves dealing with role conflict and blurred boundaries.
Blurred Boundaries

In nursing, formal boundaries are defined by rules that either formally or informally governs practice. Formal boundaries are set down by legislation such as the College of Registered Nurses of British Columbia’s Practice Standards (2003) and the Canadian Nursing Association’s Code of Ethics (2002). From an organizational perspective, these legislative guidelines dictate what constitutes acceptable nursing practice.

Professional boundaries help to define the role of the nurse in relation to patients and their significant others. However, it has been suggested that appropriate behaviours in professional relationships are seldom rigidly established (Morton, 2004).

Typically, the nurses in this study felt that their professional boundaries were not absolute. Differences existed in the way their formal boundaries were interpreted and that variations occurred. Nurses also voiced that policies or legislation that addressed workplace violence were “lacking”, “not clear” or were simply “given lip service” but not enacted.

One participant spoke passionately about the role of boundaries within her professional practice. She stated:

We are encouraged to be boundary less and I don’t think nursing school helped at all in terms of that. It’s hard to get clear on it but it’s a don’t have your own needs kind of thing. Don’t be human, don’t have your own needs, serve the patient. It’s all about the patient. Suspend your own humanity for twelve hours.

Hartmann (1991) argues that boundaries cannot be fixed; instead they can be thick and solid or thin and permeable (Bruhn, Levine and Levine, 1993). Participants concurred with this description. Interestingly, there was a variation in responses as to how participants used organizational policy when addressing workplace violence and
how these institutional boundaries were interpreted. One nurse commented that when they tried to be absolute and enforce organizational policy they were being “thick skinned” and that their actions were not valued by their patients or their colleagues. They provided the following example “I was very clear, I said this is the policy... but because I was clear-cut as to the policy and what need to be done, I was told that wasn’t being a nurse.”

At the other end of the spectrum, many of the nurses described themselves and their coworkers as being sensitive and open or vulnerable to boundaries. There was a feeling that interpreting and enforcing institutional policies could not be absolute because most nurses have a mix of professional and personal boundaries that they maintain. One nurse made this analogy:

You run counter to the (organizational) culture and you have problems... they (the organization) have their rigid boxes and it just seems as if you don’t fit in. I just have to find my square peg or round hole.

Norms

Norms are agreed upon standards or rules that govern behaviour. When dealing with workplace violence, the spectrum of the individual nurse’s boundary for violence may be stricter or more liberal than the larger societal or organizational norm. In most circumstances, a degree of freedom is in violating norms exists as long as the values of others are not infringed upon (Bruhn et. al., 1993). However, several nurses pointed out that their values were infringed upon, and that a different set of norms or standards existed for aggression and violence perpetrated within the health care organization.

Consider the following:

When I said the culture of nursing, I meant also the culture of health. You know, the idea of being a patient creates a sort of the abrogation of responsibility within
the setting. If you’re sick, somehow you’re in a way relieved of any responsibility for (violent) behaviour.

One nurse had an issue with the “labeling” of norms within nursing culture:

By no means can you say, “Oh this is just the culture of nursing”. Imposing that on it, tying nursing down in particular, gives it something different than in another area. Not even medicine is tied down as much as nursing is tied down, you know. It’s sort of an obligation to care. I really think we need to struggle and redefine that.

In 2002, the Code of Ethics for Nurses was published by the Canadian Nursing Association (CNA, 2002). This document articulates the link between nursing values, patient rights and the obligations of the nurse. The ability to implement the code is instrumental in defining the professional identity and role of the nurse (Biton & Tabak, 2003).

The Code of Ethics stresses the individual rights of patients, however, support is not given in addressing the rights of the nurse. It would seem that there would be situations where patient rights may be outweighed or limited by nurses’ rights, particularly in issues related to maintaining the nurses’ personal safety.

One participant illustrates this:

I value protecting safety for the nurses. Safety first. One person’s rights are subjected to another, we do that all the time but we need to recognize the safety of everybody else.

Bekemeier and Butterfield (2005) put forward that the language used in Code of Ethics texts suggest that such ideological inconsistencies are not reconciled. They propose that role conflict has a great deal to do with the context in which nursing exists today and that uncertainty exists around the individual nurse’s commitment to the values espoused within nursing culture. One participant used the policy of restraining patients as an example:
This least restraint nonsense, there is all this education (sighs) but I have never in my fourteen years of nursing encountered a nurse who was tying down someone inappropriately. We're doing it to protect them and ourselves. The word safety applies to me too because I matter. I matter and the patient matters. So does the nurse who is a single parent who now can’t work and has a flipper instead of an arm, she frigging matters.

Research findings suggest that nurses experience the ethical climate of their work through their perceptions of organizational practice (Hart 2005; Olson, 1998). Hart defines ethical climate as “the organizational conditions and practices that affect the way difficult care problems, with ethical implications, are discussed and decided” (2005, p. 174).

One participant offered “these violent incidents are hard incidents to undo. We’ve talked about society. We’ve talked about the role of the organization. What we need to do is to finally put ourselves first and have recognition that these problems really do exist”.

_Psychological Boundaries_

Psychological boundaries set limits on our human behaviour and tell us what we should or should not do. They influence the attitudes and feelings of those who erect them as well those who are confronted by them. Boundaries exist amongst, between and within organizations, groups, and individuals.

We cannot assume that all boundaries are facilitative or inhibitive, nor can we presume to have an answer for managing all boundary problems. Instead, Bruhn, Levine and Levine suggest boundary issues must be recognized and managed by those who know the unique situations in which they occur, their history, and the players (1993). One nurse gave an example of boundary problems:
There are external forces in the culture of nursing. The external force comes from
the nurse themselves (when dealing with violence). There is one part of me that
takes over and subdues or controls the situation and there is an opposite internal
force that says if you hit me, I’ll hit you back. I’m sorry that you’re not well but I
have to protect myself. This doesn’t go down well in nursing culture; you can’t
hit the person back. It’s not therapeutic.

The source of boundaries and boundary problems that the participants speak of appears to
lie within the intersection between the history and traditions of nursing culture, and how
the individual nurse’s uniqueness plays into the mix.

*Professional Image*

It has been well documented that the role of nurses within the context of the larger
health care organization have never been fully understood or valued. A conflicted image
of the nursing profession exists – one that is linked to dichotomous roots of disreputable
women and saintly figures. Characteristics of nursing such as autonomy, sophistication,
and role complexity have not been evident, perpetuating stereotypical images of nursing
and contributing to a devaluing of the profession (Jackson, 2004).

Internally, current portrayals within the profession often depict myths and images
that do not reflect the reality of nursing. A “good nurse” ideal exists and this is
inseparable from the values that construct nursing practice. One participant said:

I just think it would be nice for the public and everyone else to know the reality of
what goes on, that we get really tired of people saying, being a nurse is such a
lovely job. I would like people to realize it’s a really hard and shitty job. I’d like
the public to have a better understanding of what reality is because they don’t
have a clue. I was reading somewhere that emergency nurses and police officers
deal with the same amount of violence.

Nursing education has been instrumental in cultivating, confirming and sustaining
this ideal and this has ill-served the development of the profession. Through propagating
the ideal, nursing has experienced difficulty in challenging this stereotype. As a result
many nurses have internalized the values associated with the ideal, and have adopted characteristics of the "good nurse" within their professional practice. Participants did not feel that this served the profession well. For example one nurse stated, "the majority of people just don't have a clue, they're misinformed and most nurses are misinformed. They walk right into the violence".

Gender

A number of the participants suggested that these professional identity issues were influenced by the fact that the majority of nurses are women. Key issues related to gender included that the reactions of males towards violence tended to be different from that of females. This became evident when discussing this topic with both genders. One female nurse stated:

I think society doesn’t do a good thing to women. I think that we are encouraged to be boundary less and my task as a growing woman has been to survive the transgressions of my boundaries. Usually these (transgressions) are at the hands of male intimidation, so it’s been my journey to recognize that it’s happening, recognize how to identify it and within the limits of my power, to stop it.

She went on to say:

I know it just makes intuitive sense that this has worked in my private life and in my work life. I am much stronger at saying no. Its not okay for you Mr. Smith to get red in the face and take two steps towards me and move into my space and it is okay for me to put my hand up and say I don’t want to be treated like this, I’m going to leave now and just walk away, I don’t have to be all therapeutic. It’s also okay for you (the patient) because you’re upset, because you’re sick and you’re feeling powerless and all of that, and I totally buy that actually, I absolutely can understand that. I can understand it but I can also say hey, I’m leaving. You’re scaring me, I’m leaving, its not okay, its not okay to treat me like that, I’m worth standing up for.

Male and female nurses came into the workplace with different rules and motivations. These differences affect how they act and help to clarify what is important.

In relation to violence, stereotypical feminine traits include caring, nurturing, dependence
and submission. These traits are in stark contrast to the masculine characteristics of
strength, aggression, self-control, dominance and objectivity (Briles, 1994; Evans, 1997).

One nurse said “you’re in emergency and you’re supposed to be tough and strong
and deal with these situations on your own and that can be hard because unfortunately
there’s a lot of females in our profession”. Another participant pointed out that gender
could work for or against you:

There is an aspect of gender related to power and respect. Some people respect
nurses provided they fit within the mode of mother, nurturer. If you fit into that
mode they give you the respect they would give their mother, however you are
only respected within the context, provided you fit into that mode. If you come
out of that mode and treat persons based on ‘I’m here to do a good job but I’m not
this angel syndrome,’ I’m coming across in a masculine way and you lose that
respect.

The male participants made reference to the coercion and cajoling tactics of their
female colleagues. They felt that this was in stark contrast to their direct approach in
dealing with violent situations. One male stated, “you hit me, I hit you back” and the
other said “you direct violence at me and I direct my violence back”.

**Oppressed Group Behaviour**

It has been argued that women are an oppressed group by virtue of their
subordinate status in patriarchal society. Health care organizations are themselves a
product of patriarchal social mores in which woman as a group, are least powerful
(Hockley, 2002). Therefore the violence experienced by nurses may in part be explained
by the social structures and organizational context in which nurses’ work.

Five participants spoke about nurses being an oppressed group. An oppressed
group consists of individuals who share low status, absence of power, diminished
autonomy, reduced mobility and limited access to resources (Lee & Saeed, 2001).
Several decades ago, Roberts utilized oppressed group theory to examine nursing subcultures. She was able to identify a number of important factors that linked nursing to oppression. These included characteristics of the oppressed, a dominant-submissive relationship, a lack of nursing leadership, and outcomes associated with being a member of a marginalized group (1983).

A number of nurses spoke about the need to become champions for what they do and to make their work visible. Another spoke more broadly, linking the oppression of nurses to the role of women in society. She stated “we need to change the culture of stoicism and recognize that when we as nurses deal with violence, we are connected to women’s culture and also to the culture of violence towards women within our society”.

**Power**

Given that nursing practice is embedded within the social context of our society, it is not surprising to find that patriarch values have helped to shape nursing culture. Volbrecht (2002) suggests that the organization of Canada’s health care system is reflective of male-controlled values and hierarchy. Power remains concentrated within Caucasian male elitists whereas the current health care system relies upon the dedication of a subordinate and almost entirely female nursing staff.

The end result is a nursing culture with low self-esteem, problems with assertiveness and a lack of initiative. Nurses experience control and exploitation by external forces that possess greater prestige and power over them. These conditions perpetuate dominate-submissive relationships with the oppressed group adopting characteristics and beliefs of the dominant oppressors (Hockley 2002; Roberts 1983). One nurse stated:
From my experience the men dominate. That's why women have emasculated themselves in order to fit. There is additional personal pressure on you as a nurse to fit and when you don't, for whatever reason, you are penalized over and over again. Innuendos can even be made towards your career and your career can be ended quite abruptly. I've seen it happen.

Another participant spoke of their sense of this:

Society says that no power is given to nurses. When violence manifests itself nurses scream for help and then the external forces come in to the rescue. It's kind of like the damsel in distress, and until we are in distress, we are powerless. We actually are rendered powerless. We have to rely on others to help us.

Various forms of oppression exist and are linked by an underlying imbalance of institutional power. These include cultural imperialism, discrimination, exploitation, marginalization, powerlessness and violence (Lee & Saeed, 2001; Roberts, 2000). Each of these will be briefly explored.

Cultural imperialism consists of an ideology that a dominant group holds the position of being the 'norm', while those outside the group are viewed as inferior or atypical. One participant stated:

You have to clue in; you have to fit into the culture that exists. If you run counter to the culture you have problems... it will lead to marginalization.

Marginalization is a course of action where a person or group is excluded from performing work or a fulfilling a role normally occupied by persons within the larger group or societal context. Nurses may lack a cultural identity because they are no longer perceived as being a member of the nursing group, whereby the dominant group does not accept them (Hockely, 2002).

Discrimination refers to differential treatment that leads to disadvantage. Nurses who are marginalized are often discriminated against and their position of being on the margin helps the oppressor justify the discriminatory treatment they receive. In nursing,
this includes exclusion from decision-making with regard to issues such as autonomy
(Lee & Saeed, 1997). One nurse offered an interesting perspective. They stated:

You quickly learn how to play the political game. I soon realized that
marginalization wasn’t so much operated in terms of your boss or employer but
that the politics really get displayed amongst yourselves. For example, I’ve seen
nursing teachers isolate a student and that person gets flunked. It’s over. It’s not
direct, no one will ever tell you that…it’s just a way of gathering the chicks she
wants and excluding the chicks she doesn’t. They never are entitled to a
consultation.

Another participant offered:

That’s the internal cultural balance. You don’t fit and bam, you are penalized.
That’s also violence you know. Discrimination is violence and it’s all about
power.

Exploitation is misuse of an individual for the oppressor’s gain. If one is
exploited, feelings of powerlessness and hopelessness often result. This may lead to
apathy, poor performance and further discrimination of the nurse (Kuokkanen & Leino-
Kilpi, 2000; Lee & Saeed, 1997). One participant spoke about “prostituting themselves
for the client, becoming whatever the clients wanted” as they felt they received little if
any support during times of conflict, especially when dealing with issues related to
aggression and violence.

Powerlessness refers to having little autonomy or control over aspects in an
individual’s or a societal group’s lives. Powerlessness often leads to apathy, as those
who hold the power will often not support the nurse if conflict arises (Lee & Saeed, 1997;
Wessel Krejci & Malin, 1997). Interestingly, seven of the participants stated “nurses eat
their young”. One nurse clarified this further, saying that “nurses are actually self
depreciating and destructive, eating their young because the young don’t quite fit in”.

The traditional view of violence suggests that it occurs when an individual or group perceives an actual or potential threat to one's physical, mental or spiritual well-being. It may be considered a form of discriminatory treatment if the violent act disadvantages the nurse by causing physical or psychological harm (Hockley, 2002; Lee & Saeed, 1997).

While this examination of nursing culture exemplifies the participants' shared norms within nursing practice, it also pertains to their beliefs about nursing values. Although participants voiced a desire to support positive cultural norms, environmental factors within the nurses' immediate work context were identified as obstacles in their ability to do so.

*Environmental Factors*

Environmental factors contributing to violence in the workplace are explored under exposure to violence, types of violence and practice setting influences.

*Exposure to Violence*

The highest risk occupations for workplace violence are found in the health care provider sector and nurses hold the dubious distinction of being in the greatest danger of experiencing violence in the course of their work (Sofield & Salmond, 2003). The nurses who participated in this study concurred that workplace violence is a common occurrence and there was unanimous agreement that they dealt with violence on a daily basis.

Consider the following comment:

Its guaranteed within my set of four (shifts) when I come on, something will be said or something will happen by one of my patients every time. Physical as in people trying to hit you, bite you, pinch you, having things thrown at me, and then there's also sexual abuse - it happens a lot. At first I was just horrified that patients could talk to you like that but now its really bad because you just kind of expect it. You know they're going to say or do something.
All participants had experienced violence within their workplace. Informants felt that they were more likely to be exposed to violence because of their role as front line workers who interface directly with patients and their families and friends. Dealing with physically and emotionally compromised patients, providing care that invades personal space and autonomy, and experiencing concern for patient welfare were viewed as trigger factors.

Types of Violence

It is a challenge to describe and define violence within nursing. As Rogers and Chapell (2003) suggest, behaviours that may be included in the definition are numerous, boundaries between acceptable and unacceptable behaviours are vague, and perceptions in different contexts about what constitutes violence are diverse.

Within healthcare, occupational health and safety definitions of violence have historically been used. While these definitions are broad and incorporate coercion, threats, abuse, physical, emotional and psychological harm or injury, they do not take into account the perceptions of the victim or the context in which the violence occurs.

Hockley suggests that it is important to both interpret and name the act within a particular context, as it is important to keep the focus on the harm endured by the individual or group (2002). To be consistent with this, participants were asked to clearly describe behaviors that they thought were associated with violence, and to further describe how these behaviours affected them. Categories that emerged included physical abuse, verbal maltreatment, bullying and sexual harassment.
**Physical Abuse**

Physical assaults on nurses are common and are on the rise within primary care settings (Sheperd, 1994; Duncan et al, 2000). Descriptions of physical violence included hitting, throwing or smashing objects, pushing, kicking, spitting, scratching, biting, hair pulling, pinching and choking. Eight of the nurses said that they had sustained minor injuries from physical violence and six stated that they had missed work related to a major musculo-skeletal and/or head injury. One participant explained:

> It's not unusual to get spit at or punched or kicked. Many nurses have been kicked in the abdomen by people (patients) or have had equipment thrown at them.

Four of the participants stated that they felt as if the physical abuse they endured was somehow related to their own inequity or performance failure. One nurse said:

> I couldn't believe it happened...I should have seen it coming. I blame myself over and over again that I was so stupid and didn’t see his cues... Next thing I know is bam, I've had my lights knocked out.

Participants cited that physical attacks arose for a multitude of reasons including instrumental aggression, drug or alcohol intoxication, altered level of consciousness/mental states and because of disease or illness.

The effects of the physical violence upon the nurses were profound. Participants spoke of experiencing depression, anger, anxiety, insomnia, nightmares and a loss of confidence in both their personal and professional lives. Following an incident of physical abuse, one participant left nursing all together.

**Verbal Maltreatment**

Verbal maltreatment is generally defined to be a verbal behaviour that demeans, humiliates, annoys a person, and that is known or is reasonably expected to be
unwelcome. It seeks to communicate to others that they are bad or possess some negative quality, or that they are unable to meet some sort of internal or external standard. They include comments that intimidate, seek to control, corrupt, degrade, exploit, induce fear, sabotage, punish, threaten, reject, induce powerlessness and isolate others. These are all actions that intend to attack another’s self-concept in order to inflict psychological pain (Rogers & Chappell, 2003; Goldstein, 1999).

Three of the participants stated that they endured verbal abuse from patients and families on a daily basis. These verbal infractions included criticism, ridicule, yelling/shouting, insults, swearing and threatening comments.

Several of the nurses stressed that verbal abuse was becoming increasingly prevalent:

I think that we put up with a lot of verbal abuse from people that now it’s almost like it’s a standard. It’s so present on a day to day basis that you get your back up, or at least I get my back up but I think its because its just always there. People are frustrated and they lash out at you.

The nurses described the verbal abuse as a way for the abuser to gain control over his or her situation and they noted that the verbal insults often intensify when the abuser was disoriented or experiencing stress:

It’s never acceptable but maybe a little more understandable if its somebody whose demented or maybe somebody whose a psychiatric patient whose totally not aware of what’s going on around them but I think we’re seeing more of it from other people. Certainly with people just frustrated especially if there are waits, they are angry at whatever is going on. I think that its gone too far and that people now are thinking that its okay for them to be abusive if they don’t get what they want or if they perceive that things are not going their way.

Several participants identified the verbal abuse they encountered as the most damaging form of maltreatment:
It's very powerful, they're right there yelling at me and calling me names, it was just like my goodness, you know, is this something that I should be accepting here?

And another:

Oh yeah, I feel way more drained when I've had a patient yelling and swearing at me and threatening me. You know, I'm a bad nurse and they're going to the media. I'm much more exhausted from that than when I spend the day in the trauma bay with twenty traumas and six MI's. I'm far more tired from people being violent and aggressive in this way than from any actual emergency.

Participants acknowledged that had all suffered verbal maltreatment in the course of their work and identified that this type of abuse was the most frequently encountered. There was however, an important distinction made about the origin of the maltreatment. Several of the participants suggested that it was necessary to identify the source of the maltreatment, stating there was a need to distinguish between maltreatment that originates from patients and their families and maltreatment originating from co-workers.

This is an important distinction as the participants found that motives for verbal maltreatment varied. 'Overt' maltreatment was found to be driven by a lack of nursing/healthcare service or by an unmet need, and was perpetrated by the patient or their family. Conversely, the most frequent 'covert' maltreatment were from co-workers, including nurses and physicians, with the intention of the comments aimed undermining the nurse’s self concept.

One participant described it as:

There’s the doctor screaming at you. It’s the way you process that type of violence. You start to feel like there is no halo. It’s all just a mirage and I’m just a widget. It’s all this internal violence that is so hard to take.
Participants stated that the most damaging form of covert verbal maltreatment was that of ostracism. Ostracism includes being banished, ignored, excluded, rejected, isolated, and being made invisible. It deprives individuals of their sense of belonging, threatens their self-esteem and robs them of their sense of control and self-worth (Goldstein, 1999).

One participant linked ostracism to coercion. They said:

If we’ve got someone doing what we don’t want, we can’t force them because it’s not part of our culture. Instead we use subtle forms of power. We ignore them, we exclude them and we put all our energy into this coercive kind of thing.

Ostracism of new graduate nurses was exceptionally prevalent. One recent graduate expressed:

I thought I’d be so valued but it wasn’t what I thought. I felt stepped on, I felt like so small. It’s almost like you have to meet aggression with aggression to survive. They ignore you. No one helps you. You are just trying to save your ass each shift.

Bullying

Verbal maltreatment, including ostracism is often a form of bullying. Goldstein (1999) defines bullying as a harmful behaviour that it typically unprovoked and repeated and may be direct or indirect. Direct bullying involves face-to-face contact while indirect bullying involves ostracism and scape-goating and the spreading of rumours.

Because bullying is poorly documented and remains largely ignored, its prevalence is difficult to estimate. Direct bullying consists of hitting, taking things, pushing, tripping as well as yelling and cursing. Examples cited from this study included tripping, yelling and cursing. For example:

I’ve seen it happen. In fact, on my last shift this senior nurse stuck out her foot to trip a new graduate nurse right in the desk area. The young nurse actually fell. It was clearly done on purpose. Now what are you supposed to do with that?
and:

Nobody really talks about it but they (the nurses) take it out on each other. They’re so mean to each other. I think it’s crap but that’s what nurses do. I mean honestly, why do I always have other nurses swearing and yelling at me?

Indirect bullying involves more covert processes which are often conducted by a third party and involve social manipulation by the spread of rumors, backstabbing, and persuading others not to associate with the target person (Goldstein, 1999). This particular type of psychological violence was perpetrated through repeated covert behaviours and over time had devastating effects:

Yes, unfortunately there are cliques. If you are in the power group, any of your behaviour is totally accepted. If you are late, don’t do something or inappropriate, that’s accepted. But if you are someone outside of the clique, you are not accepted. Reports are filled out, things are blown out of proportion and you are talked about over and over again. The person is made to feel bad and they are talked to inappropriately by the staff. You hear about people leaving because of this. Some never return to nursing.

Another participant said:

This particular group is very detrimental. They have a lot of power. They aren’t supportive of you and you are left there as a sitting duck. It’s abusive and it wears on you. This is where you get burnout. It’s this business of these negative experiences. We’ve had many fabulous nurses who say I’ve had it, I’m not staying. I’m not tolerating this abuse any more.

Participants spoke of being devalued and humiliated by indirect bullying practices. This led to feelings of anger and resentment, inhibited teamwork and ultimately had a negative impact on patient care. It is not surprising that these nurses described the effects of covert bullying as wanting to change jobs, as they did not have the skills or the support to respond to the bullying behaviour.

One nurse said:
For me there is something wrong. Most people just bitch and bitch about it, they don’t know what else to do. Lots have left. Then there are the other nurses that
just are quiet about it. They make their money and they go home. No one knows how to even to begin to fix it.

Sofield and Salmond (2003) suggest that there are two reasons for bullying behaviour in nursing. The first is that nurses lack the skills to be able to respond to the abuse. The second is that organizations perpetuate the problem by not taking action. Both reasons resonate with oppressed group behaviour as outlined earlier within this chapter.

Sexual Harassment

Sexual harassment consists of inappropriate gender-related conduct or comments. These include non-verbal gestures as well as physical conduct. Sexual harassment is a violation of human rights, however, British Columbia is one of the few provinces that does not expressly prohibit it. According to Canada’s human rights legislation, key elements include: conduct of a sexual nature, which is gender based; it is unwelcome conduct; and it detrimentally affects the work environment and/or leads to adverse job related consequences (Kuretzkey & MacKenzie, 2003).

Nurses acknowledged that sexual harassment occurs although most cited it as an infrequent occurrence. Participants who experienced it most were working in inner city emergency departments. For example one nurse said:

I can go down there and have someone yell at me, telling me I’m a bitch or as soon as he (the patient) gets out of emergency and he sees me on the street, he’s gonna fuck me.

Power differences between the perpetrator and the target lead to the employee being less comfortable and therefore less likely to speak up about the matter. This was exemplified in the following excerpt:
Some doctor, and I still see him all the time, I had some doctor say, we had a
patient that we couldn't get a Foley into and he had prostrate problems, right, and
he's like, 'P, you've just got to, you've got to hold it up', you know, and sexual
things like 'hold it up and make it hard, you could do that'. It was just a lot of
little things. I mean a lot of those doctors are your age or a little bit older and
they're over stepping their boundaries and its becoming not a doctor, nurse
relationship but an outside relationship, you know, like inappropriate. That went
on a lot.

Practice Settings

Many factors in the practice setting helped to create or inhibit the nurses'
ability to manage workplace violence. These included the physical environment,
use of restraints, workload, organizational change and public communication. Each
factor will be further discussed.

Environment

The quality of the physical environment will often set an individual’s expectation
of appropriate behaviour, and incidents of aggression have been linked to environments
that are unpleasant (Leather et al., 1999). Hot or cold temperatures, inappropriate
lighting, irritating noises and crowding were environmental factors cited that contributed
to workplace violence. Participants particularly felt that overcrowding in patient-waiting
areas and long waits for service transformed the hospital into a hostile and potentially
hazardous setting.

The physical design of patient reception areas was also seen as an important
factor in defusing or triggering violence. Nurses who found themselves isolated because
of a poor environmental design felt much more at risk. For example, triage nurses in
emergency departments are often the front line reception staff. These individuals are
often in a vulnerable position as they are often the public’s first encounter with the
organization and if they are unable to deal with demands placed upon them, they may
become a target for hostility (Leather et al, 1999). One nurse spoke of her sense of vulnerability:

I’m out there in the triage area. There’s no one with me there. I’m not behind any glass to protect me, I’ve got frosted windows at the entrance way and basically got a bunch of people that are in the waiting room that are watching some altercation happening. I don’t really feel like anybody is going to come to my aid.

**Restraints**

When participants were unable to access restraint devices or did not know how to use them, they felt irritated, angry and unsafe. One participant shared:

They are supposed to teach everyone how to use restraints. The reality is that it seems as if only a handful of us really know how to use them. The way those things have been tied or attached to side rails is shocking and dangerous for everyone. That is on top of the fact that half the time you can’t find them when you really need them. And like, when you need them you need them now.

And another:

I’ve seen nurses get really angry because they can’t figure out how to tie someone down. That’s like (nurse) aggression feeding (patient) aggression.

In support of this, Leather (1999) argues that clear instruction is required as to how to use equipment and what to do if problems are encountered as the more control people feel they have, the less likely they are to behave aggressively.

**Workload**

One of the most commonly cited factors associated with workplace violence was that of workload demands. Participants often described their capacity to respond to patients and their family needs as “lacking”. They described a deficiency in their ability to attend to the patient’s anxiety and worry. This in turn, resulted in aggression being directed towards them.

Participants unanimously felt that their workloads were too high and that they
were often unable to provide adequate nursing care. One nurse said:

   We run around all day. We are focused on these menial tasks at times. We do what we think is necessary for the patient but at the end of the day, it’s just not enough. That’s a big part as to why our patients become aggressive.

Participants often felt a sense of chaos and turmoil in their workday, stating that many times their work demands were “out of control”. This led them to increased work stress and several nurses alluded to the fact that this minimized their ability to cope with and to diffuse potentially violent situations. Another nurse offered:

   It’s like I’m fighting from the moment I walk into report. I’m fighting the system before I even start shift. I don’t have time to take a breather, to regroup and even think what am I doing here? How am I able to help people when all I’m doing is running around and becoming more agitated myself? That’s what I think makes them (the patients) lash out. They see me being completely non-therapeutic because I simply don’t have time.

Not having time to listen to patients, caring for too many patients simultaneously, a lack of knowledgeable staff, and an overburdened health care system with long waits were reasons given for increased workload demands that resulted in workplace violence.

**Change**

Organizational changes create challenges for employees and affects worker’s morale as well as performance. The nurse’s job performance is vital to patient care, however, they suffer tremendous stress in striving to maintain essential performance levels while implementing changes to keep pace with a growing workload (Decker, Wheeler, Johnson, Parsons, 2001).

The participants felt that workplace violence was directly impacted by organizational change. Factors included integration of new graduates as well as increasing numbers of full scope Licensed Practical Nurses, the loss of senior nurses due
to retirement, the loss of middle management, a higher patient acuity, and increasing job responsibilities. These changes influenced the amount of trust that the nurses placed upon the organization as well as their loyalty to the organization. One nurse commented:

They (the organization) tell you that they are there for you. Then when all this violence hits, you're standing there alone. There is no one left to help you. The policies don't mean a thing. Administration certainly doesn't care and you're working with a bunch of neophytes who you can't trust. It's so different now. I don't know how much longer I can last with all of this.

Public Communication

Leather suggests that it is important that clear rules outlining appropriate behaviour are explicitly communicated. When standards for behaviour are clear, consistent and well established, an atmosphere is created where aggression may be condemned (1999). Unfortunately, despite the efforts of displaying zero tolerance for violence posters throughout the healthcare environment, participants felt that these posters were of little benefit as organizational response was lacking. It was perceived that the organizational response to aggression and violence was not well integrated and that only "lip service" was given to the issue. It was surprising to learn that no uniform or common strategy existed that targeted violations of the zero tolerance poster and that in fact, there was no written policy that supported a zero tolerance approach.

Several participants suggested that a lack of a written zero tolerance policy was a statement about deficiencies within the system to take the issue of violence seriously. One nurse went further to suggest that because such a policy did not exist, it was a statement about how the organization did not truly value healthcare workers safety in relation to workplace violence.
Individual Factors

Individual factors help to shape a nurse’s belief system and influence the way in which they view and manage workplace violence. Following a violent incident, personal belief systems were found to play a significant role in the level of psychological impact a nurse experienced. These will be further explored.

Psychological Impacts

Apart from physical injury, the most serious repercussions from an aggressive or violent incident stem from the emotional and psychological harms nurses endured. Although the degree of reaction was complex and influenced by personal characteristics of each individual nurse, four categories emerged from the data that affect how nurses responded to violent and aggressive incidents. These include their sense of self-concept, self-esteem, self-efficacy and control.

Self—Concept

Self-concept forms the center of individual personality. It leads to individualistic thinking and behaviour and is greatly influenced by interactions within one’s environment and with other people. Self-concept also forms a composite image of what we think we are, what we think others think of us and what we would like to be (Faugier and Woolnough, 2002). Dunham (2001) suggests that an individual’s self concept also contains one’s own experiences, their motivations and their feelings of pride or shame associated with these aspects. Positive self-image can sustain or enhance psychological resistance to aggression and violence therefore protects nurses from the adverse effects of these stressors.
Participants who had experienced a violent or aggressive incident at work displayed convincing evidence that their self-concept had been affected. While several participants suggested that they had a strong sense of self-concept within their nursing practice, the majority felt that their self-concept was greatly affected by both internal and external blame.

The experience of violence led participants to question their own responsibility for the assault. Internal blame was derived from the participants’ belief that in times of crisis, their primary commitment should be to the patient and their coworkers. The nurses frequently suggested that the violence directed towards them was due in part to personal failure. This sense of failure was then redirected into feelings of guilt and self blame.

Many participants suggested that they had somehow “triggered” the patient’s aggressive behaviour. One nurse offered “I think that we as nurses sometimes even trigger the violence. I’ve seen situations where nurses have truly set patients off”.

Another stated:

Here we are running around trying to give the best care possible, you are very cognizant of that...you’ve got all these pressures on you and unfortunately sometimes I think I just take it out on some of the patients. I’m aware of it and it’s really something I’m not trying to do but it’s really easy to do. I think I trigger it sometimes. It’s kind of like the kicking the dog syndrome.

Several spoke of the distress they experienced because they were simply trying to assist a patient who needed their help. Afterwards, they found themselves trying to make sense of the attack through questioning whether or not they had actually provoked the patient. One participant said:

You are in emerg and you are supposed to be tough and strong and be able to deal with all these (violent) situations. I know that I’m just trying to help the patient,
that is my motivation. But then it happens and I go through it over and over in
my mind. I always ask myself what did I do to the patient? Was it a case of
cause and effect?

The tendency for these nurses to feel in some way responsible for the violence
experienced was often exacerbated by an unsupportive organizational response. Many
participants related that when patient aggression occurred, they feared retribution from
management, more specifically from intermediate management.

Many perceived that the organizational response blamed the nurse. Several
nurses also believed that this blame resulted in the nurse being open to disciplinary
measures. One participant said, "no one really cares. You just have to protect your own
ass."

Although the organization is entitled by law to adopt a strong stance on issues
related to violence, the employer was seen to have broken this implied obligation of trust
and support. Unanimously all participants said that the organization had failed to take
their concerns about violence seriously.

Three of the participants stated that they had pressed criminal charges against
patients who had suffered physical injury as a result of workplace violence.
Unfortunately only one of these charges was stayed. In each case, the organization and
the legal system were perceived to be negligent in giving these charges serious
consideration.

The prevailing culture appears to be that patient aggression and violence is
inextricably linked to moral failings of the nurse. It became apparent that many
participants internalized criticisms and this resulted in guilt and self-doubt. One nurse
stated:
We as a group have brought this to some degree upon ourselves. We accept it. We are always trying to rationalize it and we beat ourselves up emotionally about it when something does happen. And I mean we really do chastise ourselves...we are always on some level blaming ourselves.

*Self-Esteem*

Self-concept is intrinsically linked to self-esteem. Self-esteem is generally understood to be a major predictor of behaviour and refers to the individuals’s perception of themselves. Self esteem is malleable and can be enhanced or diminished within a social interaction through feedback about how others view and judge one’s conduct (Roberts, 2000). Therefore, in relation to the work environment, self-esteem fluctuates in terms of response to the environment and variables that are specific to the environmental context.

Nurses talked in strong terms about the way an aggressive situation was handled by coworkers as well as by management. This in turn had a bearing on the nurse’s self esteem. Phrases such as “I’ve been burnt”, “I’ve been changed forever” and “I feel so stupid” demonstrated the far-reaching effects following the violence.

An interesting finding was that younger participants with a lesser number of years of experience tended to hold a more positive evaluation of how others viewed them following a violent incident. These nurses did not appear to assimilate guilt nor personalize the violence that they had experienced. This was in striking contrast to many senior nurses who referred to “the old school” where the aggression was seen as “your fault” and who displayed uncertainty about how others viewed them.

*Self-Efficacy*

Self-efficacy is one’s belief in their ability to perform and successfully carry out a specific task. Bandura (1982) proposes that there are two kinds of expectancies that
influence the choice of activities that people will engage in, in the effort they will expend, and in how long they will persist when facing obstacles or aversive encounters. These are outcome expectancy and self-efficacy expectancy.

Outcome expectancy is the belief that certain behaviours will lead to certain outcomes and self-efficacy expectancy is the belief that a person can perform the behaviour in question (Dunham, 2001). Bandura (1982) also suggests that people who have a poor sense of self-efficacy often doubt their capabilities and as these doubts grow, they often lessen their efforts or even give up. Alternately, those with strong self-efficacy exert greater effort in overcoming challenges, resulting in a high level of performance.

Several nurses cited that their experience of violence became a personal challenge and they had a need to confront their experience in order to subsist. One nurse offered:

I had to face up to it (the violence) and say this is the right way to think. Before I became a nurse I wouldn’t pay attention to how I felt about violence. But as a nurse I’ve been frightened, I’ve been hit, I’ve been psychologically intimidated and I’m not a retiring violet. I am a tall strong woman who needs to present a strong front...I’ve gotten to a place where I say the violence is not okay, I’m allowed to say no, I’m not going to accept it. I’m allowed to disagree with it.

Conversely, several participants viewed their experience of violence as debilitating, seeking to avoid similar situations. One nurse said:

In your memory bank you’ve had experiences. As soon as you see them you are trying to prepare yourself but you are already in a position where you end up being tired from just the emotional thought of ‘this happened the last time I worked’. I want to pack my bags. I just can’t deal with this anymore.

Another offered:

Sure it’s abusive. It wears on you and this is where you get burnout, this business of negative experiences in the setting. We’ve had many great nurses who just say I can’t tolerate this abuse anymore, I’m leaving.
Control

Nursing is a profession that has a self-image of being in control. Unfortunately, patient aggression and violence is often unpredictable and is difficult to respond to. Many participants recognized feelings of helplessness in their inability to control such incidents.

One nurse offered:

It’s very scary because we cannot control another’s behaviour. In fact, often times the patients can’t even control their own behaviour. It’s something beyond them, for example it’s either chemical or physiological. We are supposed to be able to bring them to a safe place but in that moment, we don’t know how.

Several participants discussed the disparity between the rational versus the reflexive/emotional side of personal control and their struggle to maintain control during an aggressive event. One nurse said “you hit me, I hit you back”. Another participant gave this account:

I always thought I could maintain control. That was until a patient grabbed me and bit me. I immediately grabbed the patient’s hair and pulled as hard as I could. It was completely instinctual. They were hurting me. Afterwards I beat myself up about it. How could I do that to a patient? A nurse shouldn’t behave that way. But he was hurting me. Sometimes you feel so defenseless in this job.

These experiences clearly challenged a number of assumptions about their self-image, their personal safety and their vulnerability.

Individuals have generalized expectancies as to whether or not they can control situations through their own actions. Rotter (1966) proposed that this control is related to an individual’s locus of control. Locus of control describes a person’s beliefs between his or her behaviour and actual outcomes. Individuals who have a sense of personal control are deemed to have an internal locus of control. These people feel that they have influence over everyday events and because of their belief in their own control; they facilitate the use of problem-focused strategies (Naswall, Sverke & Hellgren 2005).
Conversely, those who do not have a sense of personal control have an external locus of control. External locus of control individuals tend to experience more workplace stress, be more vulnerable and display emotion centered behaviours. This furthers their chances of experiencing psychological ill health as a result of exposure to workplace violence and aggression (Dunham, 2001; Naswall et al., 2005).

A moral responsibility towards preventing harm towards both the patient and nurse emerged with an emphasis on the nurses’ right to be protected. Many participants stressed the need for organizations to be accountable in protecting their employees as they felt organizational responsibility was often lacking. This inadequacy led to feelings of personal disempowerment and mistrust, often because these individuals were subjected to criticism and negative feedback:

I’m not used to being rattled and pissed off but I am. This is a job where your physical safety is in danger. I mean my brother is a lawyer and he’s not in danger at work. My sister-in-law is an accountant and she’s not in danger at work. But here I am, a sitting duck. I’m just pissed off that violence is just so commonplace and yet so preventable. Administration need to take it upon themselves to protect us. Fat chance of that happening. All they do is blame us.

Those with a perceived external locus of control spoke about feelings of isolation, being disregarded and displayed despair over their situation, voicing that they felt they could not change the way things were.

In contrast, nurses who displayed a stronger internal locus of control appeared to experience lower levels of strain and did not rely as much on external forces such as management to care for them. These nurses also recognized their need for assistance when dealing with aggression and violence. These needs were met within a tight and well-defined team structure and strong social support from teammates was discussed as a protective factor in maintaining personal control. One participant said “you’ve got to
work as a team, otherwise it's detrimental as you have no power. Even when you are
doing individual care you have to have others to rely on and help you”. Another offered:

I think we are here to do a job with the patients and community as a whole. I think if we act like professionals and we're all there acting ad a team working together we empower each other. We reinforce each other with good behaviour. We support each other and learn from each other’s experiences. This is critical.

These team structures symbolized complex systems where there was cohesion as well a need to maintain individual viability. Central to all the interviews were issues about the teams in which the participants functioned. Such issues were mainly in relation to how participants related on a personal level to the internal team dynamics. Participants who viewed their teammates as having a social conscious and who exercised shared decision making to solve problems felt that they had a greater degree of autonomy over their nursing practice.

Control was also affected by staffing competence and level. Participants repeatedly voiced that more staff is needed. This concern was seen as difficult to resolve related to the current nursing shortage and because of ongoing recruitment and retention issues.

Coping

Coping is often defined as constantly changing cognitive and behavioural effort to manage both the internal and external demands that strain an individual’s resources (Dunham, 2001). In 1984, Lazarus and Folkman introduced a theory that linked both stress and coping. They suggested that how individuals cope with a stressor is highly complex, however, the intention is to moderate the effects of these impacts on the individual’s physical, social and emotional functioning. The purpose of coping is not mastery over a demand; rather it is to tolerate, minimize, accept or ignore the demand.
This theory supports the notion that although stress is present in all human interactions, it is coping that makes the difference in how one adapts to stress (Lazarus & Folkman, 1984; Hays, All, Mannahan, Cuaderes & Wallace, 2006).

Dunham further refined this theory by suggesting that coping can be defined as either problem-focused or emotion-focused. Problem-focused coping addresses the stressful situation and decreases emotional distress. On the other hand, emotion-focused coping addresses the feelings and reactions associated with the stressor and results in increased emotional distress (2001).

In this research project, participants had developed a range of coping mechanisms ranging from constructive, problem-focused approaches to emotion-focused coping mechanisms that did not seem beneficial to the interaction. While differences exist between problem-focused and emotion-focused coping approaches, either way of coping was seen to be effective when the individual’s approach to the situation brought relief to the participant. Distinctions however did exist. It appeared as if the main strategy for enduring the aggression and violence was to redefine the participant’s experience in order to deal with it.

I found that nurses who possessed problem-focused coping skills appeared to have the following attributes: they had a clear understanding of the problem they were faced with; they utilized their colleagues and team members for assistance; they intervened earlier; they were less impulsive; and they were more systematic in their approach to deal with the aggression or violence.
For example, one participant stated:

I knew that she really couldn’t help it. I mean here she is swearing at me and hitting me. I have to take a breath and remember that she is psychologically compromised because of a physical entity... that really helps me to regroup and I’m better at dealing with her on a compassionate level. I’m also happier with myself at the end of the day.

Nurses who employed problem-focused coping recognized conflicting interests and weighed their own needs against the patient’s need for care. They were most often associated with strong team support and saw the value in employing external resources to deal with the situation including colleagues, personal security devices and security personnel. One nurse expressed:

He’s got dementia, he’s septic and now I have one hell of a sick and violent guy on my hands. I know from experience that I’m not going to try to deal with this myself so I called security in. We restrained him with the help of two security guards and two nurses. That’s what you can do when you have a good team. No one gets hurt, not the patient, not me.

Perhaps the most striking finding was that participants who perceived that their co-workers and middle management supported them, coped more effectively with the workplace aggression and violence they experienced. One participant described:

I had this great manager. If we were in a bad situation she would make sure that we were taken care of. I mean she really cared. I was punched quite badly in the face while on shift and was really scared to even return to the ward. She (the manager) told me to take time off and only return to work when I was ready. That made all the difference...just to know that she cared about me and what I was going through.

This offers strong evidence that nursing within a supportive environment significantly buffers the negative effects of patient aggression and violence. Participants who perceived they had a supportive work climate displayed a sense of well-being, productivity, and pride in their work.
Conversely, when nurses felt as if they were in an inescapable situation where they assumed the role of caregiver, they often felt victimized. They expressed negativity about their nursing role and utilized emotion-based coping mechanisms such as swearing under their breath. While this appeared to give momentary relief to the nurse, it did not result in a greater sense of well-being. In fact, this approach to coping could make the nurse’s situation even more difficult.

One nurse said:

I’m just sick of it. I get so frigging angry. They swear and curse at us. And what are we supposed to do? Just smile and take it. Well inside I’m all torn up. I even swear back at them under my breath. I know sometimes they hear me and this fuels the fire between the two of us even more. It’s not a good situation.

How participants coped was also related to their previous experience. Participants expressed that a pattern of emotional exhaustion existed according to the frequency of aggression and violence experienced, and more specifically from how often they encountered verbal aggression. Several participants who had experienced verbal aggression and/or physical violence described depersonalization and emotional withdrawal from their work.

Nurses who were aware of a colleague’s experience with physical assault also described an emotional detachment between these colleagues and their patients and team members. These and other negative emotional reactions appeared to be cumulative and impacted both the patient’s and the team’s sense of well-being. This led to interpersonal conflict between team members and often resulted in emotional distancing amongst colleagues. One junior nurse also described emotional distancing of senior staff:

They set a very negative tone for us. We are dealing with very long shifts. You’re already dealing with staffing problems and problem with patients who need things you don’t know how to provide. They (the senior staff) are
unapproachable and think we should just learn on our own. Trial by fire is what I call it. It’s why many of us leave.

Stress from a high level of demand, coupled with a low resource level to cope with the demand negatively impacted these previously committed and motivated nurses. This was also seen as a causative factor impacting the commitment of nurses towards their profession.

Summary

How we understand workplace violence and what we deem to be important about the problem has much to do with how we perceive the contextual factors of the organization, the immediate work environment and the attributes of the individual nurse. At the core of these findings is the notion that issues related to violence are often interrelated and compounded.

The problem of workplace violence is situated across various spheres of influence. These range from the philosophical questions surrounding what compromises nursing culture to very pragmatic issues including how nurses communicate with one another. These findings have delved into and raised both practical and moral questions, primarily surrounding what the experience of violence means to nurses.

Nurses can respond to workplace violence with an enhanced awareness as to how the phenomenon can be further scrutinized and inspected. With this in mind, in chapter five I present a summary of the findings and locate them within the broader field of knowledge development for health care policy, nursing education and practice.
Chapter 5

Implications and Future Directions

My intent in this project was to contribute to foundational knowledge about workplace violence towards nurses. I entered into this research believing that a greater understanding of workplace violence was necessary to inform both policy and practice. In this chapter, I offer a summary of the research findings and highlight what I believe to be reasonable conclusions drawn from the study. I conclude with a discussion about implications for organizations, nursing practice, nursing education and offer recommendations for further research.

Summary of the Findings

The purpose of this research was to explore nurses’ accounts of workplace violence. This includes questions surrounding how nurses describe and define violence in their workplace, how they recognize and interpret the violence directed towards them, and how they feel about the workplace violence they have experienced.

This study was qualitative and interpretive description was the research approach utilized to provide a framework for the project. Ten Registered Nurses were interviewed, including eight females and two males. These participants came from British Columbia’s lower mainland and Vancouver Island. Their level of nursing experience varied from 2 to 27 years, and the ages of participants ranged from 27 to 55 years of age. Current workplaces represented acute medicine, surgical, emergency, mental health, community mental health and home care.

Workplace violence in nursing is a complex and difficult subject. It is recognized that the context in which violence occurs has an impact on the perpetrator, the
nurse and on organizational outcomes. The context of the workplace violence is influenced by many factors that are interrelated and dynamic by nature. Throughout this research, it became important for me to capture and map out the dimensions of these factors, to have clarity in articulating their specific influences on the phenomena and to recognize the importance of their interrelatedness. The framework I have employed places organizational, environmental and individual factors as a central focus in considering the way violence towards nurses can be understood. Clearly, the relationship between these contextual factors is complex. Therefore, in this summary I will delineate what I believe to be of pressing concern within the realm of the organizational, environmental and individual factors presented.

Organizational Factors

Existing research in the area of health and safety within healthcare makes claims about the importance of organizational culture in addressing workplace violence. Organizational culture can be described as a system of shared values and beliefs that shape an institution’s employees, organizational structure and control systems. These components result in behavioural norms or “how we do things around here”.

Corporate Culture

Participants commented on the pivotal role that hospital and nursing administration play in influencing staff attitudes towards workplace violence. Moreover, the implications of the unit manager’s role were identified as being a vital link in how nurses were reporting, addressing, and managing the problem. Concern was expressed
that many nurse manager positions have been reduced and/or restructured, resulting in increased demands being placed upon both the manager and the staff nurse.

It also became clear that the degree to which the nurse's personal, professional and organizational values were in congruence with, and supported by, the organization affected the degree to which the nurses were committed to their work and to the management of violence. When nurses were faced with a neutral or unsupportive administrative body, they reported increased feelings of apathy, vulnerability, anxiety, fear, helplessness and anger. Anger was directed towards oneself, towards patients and their significant others, as well as towards co-workers and management. Not unexpectedly, when nurses did not feel supported, they had difficulty in returning to the setting in which they had experienced the violence.

It also became obvious that there was a serious disconnect between the participants and they way they perceived administrative policies in relation to violence. Prescriptive approaches such as the "zero tolerance for violence" policy were viewed as idealistic and counterproductive for the reason that healthcare workplaces could never be free from violent encounters. Creating effective policies to deal with violence was seen as a positive step in changing the belief that violence should be accepted as "a part of the job".

Nursing Culture

The values of nursing include basic assumptions about what is of fundamental importance within the practice and profession of nursing. Together these values make up the organizational culture of nursing. Prevailing values in modern day nursing culture
include the values of aesthetics, altruism, equality, human dignity, justice and truth (Faithfull and Hunt, 2005).

Participants cited that their encounters with workplace violence frequently challenged their ability to enact acquired professional ideals. When participants encountered violence, they experienced a division between their nursing professional values and their rights as individuals. Role conflict became apparent between maintaining one’s own rights and in offering patient care. The boundaries between protecting the nurse and meeting the needs of patients were blurred, leading to the nurses’ confusion and frustration.

Nursing culture is also created through the nurses’ expectations, assumptions and actions. Participants identified that nurses are initially introduced to and integrate expected knowledge, behaviours, attitudes, values and norms through nursing education programs. While nursing education is bound by it’s agreement with society to adequately prepare nurses with knowledge and skill that will enable them to provide quality care, participants voiced that a gap exists between education and practice. Undergraduate educational preparation in dealing with issues of workplace violence is sorely lacking. This includes both curricular content as well as how nurses are socialized into managing violence within clinical practice.

Educational preparation was seen to be a key factor towards the nurses’ ability to effectively participate in preventing, assessing and caring for violent individuals. Participants put forth that they routinely undertake roles in dealing with violence that are not appropriate to their level of knowledge or skill. Inadequate training in recognizing
and managing violence was viewed as being detrimental to both the physical and mental well being of the nurse and of the patient.

Although existing violence prevention programs offer training in dealing with aggressive behavior, participants felt that they do not account for the complexity and variability within their work settings. Furthermore, participants felt that because of the current nursing shortage, mentorship from experienced and knowledgeable nurses who were familiar with managing volatile situations was in limited supply. Nurses also experienced stress from the dissonance between their expectations and level of experience. Influencing factors included personal expectations as well their perception of status within the work environment.

Environmental Factors

The nurses who participated in this study revealed that workplace violence is a frequent occurrence. Physical and verbal abuses originating from patients and patient’s significant others were commonplace. Informants felt that they were more likely to be exposed to violence because of their role as front line workers who interface directly with patients and their families/friends. Dealing with physically and emotionally compromised patients, providing care that invades personal space and autonomy, and experiencing concern for patient welfare were viewed as trigger factors.

Participants also identified that bullying and harassment by peers was widespread. Acts of colleague-to-colleague aggression included verbal, emotional, physical and sexual abuse. This abuse took both subtle and overt forms and resulting in psychological effects such as fear, personal insecurity and non-communication. All forms of violence
were associated with adverse working conditions, having a direct impact upon the retention of nurses in the workforce.

Participants identified that overcrowding in patient-waiting areas and long waits for service transformed their work environments into hostile and potentially hazardous settings. Therefore, the physical design of the workplace was seen as an important factor in defusing or triggering violence. Nurses were clear that those who found themselves isolated because of a poor environmental design felt vulnerable.

Concerns were also raised about current staff to patient ratios. Inadequate ratios were seen to have a damaging effect on the provision of safe and competent care leading to both nurse and patient dissatisfaction. Working alone, inadequate security response systems, working with people in distress, and providing care within a culture that has become increasingly tolerant of violence were seen as factors that greatly increased risk.

*Individual Factors*

As nurses accumulate experiences, their values and ways in which they individually view the world and their profession are shaped. This includes behaviours that are seen to be permissible, their perception of risk and acceptable ways of solving problems.

Individual factors were associated with the emotional and psychological harms that nurses endured. Although the degree of reaction was complex and influenced by personal characteristics of each individual nurse, the participants' self-concept, self-esteem, self-efficacy and sense of control affected work satisfaction.

Participants spoke of moral distress from self-blame, feelings of failure in their professional ability and from setting unrealistic standards for themselves. It was
unfortunate to learn that several of the participants had lost motivation to work with and to relate to their patients in a positive and caring manner.

The intensity of the nurses’ moral distress was mitigated in part by a supportive and ethical organizational culture. Supportive environments role modeled acceptance, assistance and advocacy from others within the organization. Working as a part of a cohesive team provided a buffer against the detrimental effects of violence on the nurses’ physical and emotional well-being. Likewise, the commitment of management towards supporting front line nurses was a found to be a key element in fostering positive self-concept, self-esteem, and self-efficacy. Participants who felt that the organization valued and respected them were able to more effectively cope with the aftermath of workplace violence.

Nurses found they had to be proactive in the face of the physical injury and the emotional trauma that they had sustained. Comments suggested that post violence assistance was seldom offered, difficult to acquire and that a considerable amount of personal money, time, and effort were expended in order to obtain support.

**Implications for Organizations, Nursing Practice, Education and Further Research**

While many categories and themes were derived from the data, the negative effects of violence directed towards nurses were most apparent. Of pressing concern are issues that deal with organizational policy and governing structures, the culture and climate of nursing practice environments, and the fundamental role nursing education programs have in preparing Registered Nurses to manage workplace violence. Each will be further examined.
Implications for Organizations

The current climate of the healthcare system has necessitated that organizations must evolve to meet the demands and challenges in addressing workplace violence. To ensure that nurses caring for patients are well prepared to undertake the role of preventing and managing violence, they require theoretical knowledge and practical experience specific to the needs of their clinical area. The overall aim must be to provide a high quality violence prevention program, fully supported by administration, and driven by the identified needs of nurses. The ideal program would include:

1. Involving nurses in developing site-specific prevention and management programs.
2. Analyzing workplace risk.
3. Addressing identified hazards.
4. Disseminating knowledge in identifying, preventing, and managing workplace violence within organizations and within nursing education programs.
5. Formalizing support systems for nurses who have been violated.
6. Monitoring and evaluating program effectiveness.

In Canada, a duty of care is placed upon the healthcare organization to take appropriate measures to protect healthcare workers from health hazards and dangerous situations. A preventative approach has been taken, one that attempts to understand violence related problems and offers remedial strategies. Strategies include the development of policies as well as guidelines and practices that attempt to prevent or
mitigate workplace violence. These strategies attempt to address violence within the organizational context.

Of particular concern was the nurses' discontent over the organization's ability to implement a clear and relevant workplace violence policy, to provide an environment conducive to lower levels of stress, and to provide adequate support for employees before, during and after a violent incident. Poor internal communications, lack of a supportive organizational culture, inability to access supportive programs, services and benefits, and a high level of sustained organizational stress were factors that participants identified as contributing to risk. Each of these identified factors needs to be addressed at the organizational level.

Policies form an essential element in providing guidance for organizations, as well as in accountability for both public and employees alike. Whereas agreement exists about the broad objective of diminishing workplace violence, there is disagreement between the participants and administration about what constitutes violence as well as the correct way to tackle the perceived problem.

Future policy development ought to be strategic. Furthermore, such policies should be the result of addressing a necessity and ideally be grounded in research. As a good deal of what goes on in recognizing and addressing violence is subjective and not yet guided by a well-defined knowledge base, it is imperative that nurses be involved in current policy development.

*Influencing Change*

The findings suggest that nurses continue to feel powerless to influence change. Formally addressing this powerlessness is a key component in effectively managing the
problem. The findings also suggest that although nurses have legitimate concerns about issues associated with workplace violence, they have experienced difficulty in gaining access to policy and decision-making at the organizational level. The participants’ ability to contribute was therefore limited by their view of their relative value as well as their preconceptions about their ability to influence policy.

This challenge needs to be met directly. Nurses who offer direct patient care need to be involved in decision-making regarding policies and procedures that affect the clinical setting and patient care delivery. Likewise, clinical nurses need to be willing to participate when asked to share their insights, experiences and problem-solving skills within the organization. Nurses should also be willing to work through limitations and policy design flaws.

It is critical that the nursing profession become involved in identifying, implementing and evaluating interventions to reduce workplace violence. Focusing on individual and social interventions aimed at providing a safe and secure work environment is of paramount importance. The CNA (2007) suggests that the responsibility to ensure a safe workplace is shared by individual nurses, nursing organizations, employers and government.

This responsibility includes a need for:

1. Nurses to increase their knowledge base, develop their management and prevention skills and report workplace violence.
2. Nursing organizations to provide leadership, information and advocate for nurses.
3. Employers to provide pertinent ongoing prevention/management programs, relevant policy and protocols, effective reporting mechanisms, implement safety measures and support employees experiencing work related violence.

4. Government to provide proper legislation and appropriate legal response to workplace violence.

_Nursing Culture_

Organizations direct behavior through goals, policies and governing structures. They have the ability to shape the social climate, customs, manners as well as the beliefs and values of their members. Because our modern day personal lives are so closely interwoven with our organizational lives, organizations have the potential to positively or negatively affect the nurses’ well being.

Likewise, the nursing practice environment is greatly affected by nursing culture as well as the climate of the larger health care organization. Unfortunately, addressing workplace violence remains a challenge as little direction or experience exists in managing this difficult problem. For example, little attention has been paid to addressing the role conflict that exists for nurses.

In relation to workplace violence, the altruistic professional values espoused by current nursing culture often differ from the realities of clinical practice and from personal values held by participants. In particular, self-concern was found to be as important as the concern for others. Ascribing to the tenets of the ideal nursing culture and balancing the rights, needs and interests of both the client and the nurse often resulted in ethical dilemmas and in the case of workplace violence, role ambiguity. In fact, this was seen as a major contributing factor to nursing dissatisfaction and burnout.
Findings of this study suggest that professional ideals be re-examined. There is a need for greater congruency between one’s own belief/value system and the reality of clinical practice. In particular, disparity between the values espoused by the educational establishment and those expected in the clinical area need to be further addressed.

Educational programs for nursing students need to take into account the reality of these conflicting values in an effort to address the role ambiguity, ambivalence and disappointment that this research has identified. Recognition that such conflicts do exist is of increasing importance if nursing is to take more control of the issues associated with workplace violence.

_Implications for Education_

Participants in this study have acknowledged that workplace violence is a significant issue in nursing and identified that greater attention needs to be given to clinical issues and competence in dealing with aggression and violence. In response, nursing educational programs will need to evolve in order to meet the current demands and challenges in addressing the problem.

Although occupational health and safety regulations mandate that organizations are required to adhere to policies and procedures that mitigate risks to workers, findings of this research suggest that both Registered Nurses and nursing students feel that they routinely undertake roles in dealing with aggression and violence that are not appropriate to their level of knowledge or skill. Furthermore, participants feel that because of the current nursing shortage, mentorship from experienced and knowledgeable nurses who are familiar with managing volatile situations are in limited supply.
While current prevention programs offer training in dealing with aggressive behavior, they possess limited scope, as they do not account for the complexity and variability in situations within the work settings. Nursing students are further disadvantaged in responding to, and management of, potentially violent situations as they have less experience and even fewer opportunities to engage in formalized aggressive and violent behavior training.

To ensure that nurses and students caring for patients are well prepared to undertake the role of preventing and managing violence, they require theoretical knowledge and practical experience specific to the needs of their clinical area. The findings of this research suggest that formalized education about managing aggression and violence is sparse. There is a need to move beyond the perception that education about prevention and management of violence is primarily the job of the employer or larger healthcare organization.

Unfortunately within current nursing curricula, violence related content is generally introduced incidentally rather than systematically. There is a need for nurse educators to focus on both the theory and the clinical relevance of workplace violence and to incorporate these concepts as a part of the practice placement. Systematic evaluation of violence related content is also necessary, including identification of expected student competencies.

Appropriate intervention programs against workplace aggression and violence would help to counteract the problem and offer significant benefit for both individuals as well as for the larger health care system. The overall aim must be to provide a high quality program, supported by administration and nursing education programs that are
driven by the identified needs of nurses. A crucial component of such a program includes disseminating knowledge in identifying, preventing, and managing the workplace violence that nurses are likely to experience. It is hoped that such an approach will mitigate the reality shock that nursing students and nursing graduates currently experience.

**Implications for Further Research**

Several areas for further research were identified within this study. They include the need to further describe as well as to understand the problem of workplace violence.

*Describing the Problem*

To increase competence in identifying violence in the workplace, nurses need to clarify what constitutes violence towards them. The true nature and extent of the problem must be further examined. To avoid addressing more than the actual problem, examination should also include what is not considered workplace violence. Obtaining this information will assist in setting parameters and uncovering patterns associated with the problem.

Nurses must define where the boundaries for workplace violence are set and how and where variances occur. To develop a meaningful framework, those experiencing the violence must identify the boundaries. This will assist in illuminating and understanding workplace violence, and assist nurses with complex decision making processes associated with identification and management of violence towards them.
Understanding the Problem

Understanding workplace violence is a complex issue. Workplace violence is a deeply embedded global problem that crosses borders, work settings and occupations. In this study, variables such as organizational culture, nursing culture, education, gender, level of support and individual factors impacted the problem. Though these issues are broad, a further appreciation for their influences will assist in better understanding the nature of the problem. Enhanced understanding will provide us with a better starting point from which to uncover relevant and practical solutions.

A relationship also exists between the cause and effect of workplace violence. A concerted effort must be put forth to further research and uncover the links between cause and effect. This will help in the development of policy and management programs that are relevant to the problem.

Summary

The purpose of this study was to explore nurse’s accounts of workplace violence. Through offering an analysis of the participants’ experiences an attempt has been made to describe how nurses recognize, describe, define, interpret, as well as feel about and make sense of the violence they experience.

Nurses have a vested interest in addressing workplace violence. Findings of this research recommend that nurses obligate themselves to be committed partners in the campaign against workplace violence. This effort will be required if violence and its negative consequences are to be reduced.

Nurse participation is required to develop strategies for education, legislation, reporting of incidents, management of unsafe conditions, and support of victims. Nurses
must also become involved in improvements to the organizational climate and physical environment, as well as in enhancing competence in preventing, recognizing and managing violence in the workplace.

This research is by no means complete. Approaches in recognizing, preventing and managing workplace violence will continue to challenge the nursing profession. Further research is necessary to provide a sound and meaningful framework to assist our understanding of this complex phenomenon. Increasing awareness of the complexities of workplace violence will provide future directions for addressing the rising incidence and legacies that workplace violence leaves behind.

This study has offered a context-bound exploration of nurses’ experiences and perceptions of workplace violence and has proposed potential solutions to the problem. It is hoped that this research will convey important insights and meaningful connections that will help to keep the issue of violence towards nurses in the forefront and assist in shaping our understanding of workplace violence, specifically within the context of nursing.
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Participant Letter

Research Project: Workplace Violence Against Nurses

Principal Investigator: Dr. Angela Henderson Phone: (604) 822-7426

Co-Investigator: Shannon van Wiltenburg Phone: (604) 527-5057

Dear Participant,

You are invited to participate in a research study in which you will be asked to describe your thoughts and feelings about workplace violence against nurses.

I am a Registered Nurse and a graduate student who is completing the Master of Science in Nursing Degree at the University of British Columbia. As a part of my program, I am conducting a study to identify and describe the nurse's experience of workplace violence.

Participation in the study will involve a maximum of three two-hour interview sessions. You will be asked to respond to questions about violence you have experienced in your workplace. I will audiotape the interviews and transcribe what was said. Every effort will be made to protect anonymity. Only the investigators will know the identity of your agency and your personal identity.

Your participation is voluntary. If you participate, interviews will be conducted at a time that is convenient for you. You may refuse to answer any question. You may also withdraw data and/or your participation in the study at any time.

There will be no direct benefit from participating in this study. However, it is hoped that the results from this study will increase our understanding of workplace violence in nursing.
I appreciate your consideration to be involved in this study. If you would like more information about this research project, please do not hesitate to call me at (604) 527-5057.

Sincerely,

Shannon van Wiltenburg, RN, BA, BScN
Participant Consent Form

Research Project: Workplace Violence Against Nurses

Principal Investigator: Dr. Angela Henderson  Phone: (604) 822-7426

Co-Investigator: Shannon van Wiltenburg  Phone: (604) 527-5057

You are invited to participate in a research study in which you will be asked to describe your experiences, thoughts and feelings about workplace violence that was directed towards you.

Purpose:
The purpose of this study is to identify and describe the nurse’s experience of workplace violence.

Procedure:
The study will consist of a maximum of three interviews. Each interview will take about two hours. Interviews will occur at a time and place that is convenient for you. You will be asked to respond to questions about your experience of violence in your workplace. The interviews will be audio-taped and you can review your tape at the end of the interview. Upon request, the tape recorder can be turned off or tapes erased at any time. A transcriptionist will be used to transcribe the taped interviews.

Risks:
There are no anticipated risks to you, however in the course of talking about your experiences, things may come up that feel uncomfortable for you. Should this happen, you may choose to stop or end the interview.
**Benefits:**

There is no direct benefit from participating in this study. However, the results from this research may help other nurses understand violence within their workplace.

**Confidentiality:**

Every effort will be made to protect anonymity. All information will be kept strictly confidential. Your name and agency will not be used in any written reports of the completed study and any information that can personally identify you will be kept confidential. The data, including audiotapes and transcripts will be kept in a locked office. Tapes will be erased at the end of the study. The transcripts and notes will be retained for future research purposes.

**Participation:**

Your participation is entirely voluntary. You may decide to participate or withdraw from the study at any time. You may refuse to answer any question without affecting your continued participation in the study.

**Questions or Concerns:**

If there are questions or concerns regarding this study or your participation, you may call Shannon van Wiltenburg at (604) 527-5057 or Dr. Angela Henderson at (604) 822-7426. If you have any concerns regarding your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

**Consent:**

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

**I have read and received a copy of this informed consent form.**

---

**Participant’s Name**  
(Please Print Clearly)

__________________________

Signature of Participant

__________________________  
Date
Appendix C

Demographic Data

1. Age
2. Gender
3. Highest level of education completed
4. Number of years working as a Registered Nurse
5. Current job title
6. Current area of nursing practice
7. How long have you been in your current practice area?
8. Past areas of nursing practice?

________________________________________________________________________
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________________________________________________________________________
Workplace Violence Against Nurses

Are you a Registered Nurse? Are you an RN who has experienced violence in your workplace? If so, you are invited to participate in a research study to share your experiences, thoughts and feelings about workplace violence that was directed towards you.

The purpose of this research is to identify and describe nurses’ experience of workplace violence.

Interviews will be conducted one-to-one at your convenience. Interviews will take approximately two hours and each participant will be interviewed no more than three times. All interviews will be confidential and your identity and place of employment will be protected.

Contact Shannon van Wiltenburg @ 604 527-5057 or svanwiltenburg@shaw.ca for more information or to participate.

Principal Investigator: Dr. Angela Henderson
Co-Investigator: Shannon van Wiltenburg
Appendix E

Certificate of Approval

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INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT

CO-INVESTIGATORS:

Van Wiltenburg, Shannon, Nursing

SPONSORING AGENCIES

Workers' Compensation Board of British Columbia

TITLE:

Workplace Violence Against Nurses

APPROVAL DATE | TERM (YEARS) | DOCUMENTS INCLUDED IN THIS APPROVAL:
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CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of the following:

Dr. James Frankish, Chair,
Dr. Cay Holbrook, Associate Chair,
Dr. Susan Rowley, Associate Chair
Dr. Anita Hubley, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.