

The psychological impact of aggression on nursing staff

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Abstract

Aggression and violence towards nursing staff in UK health care is a growing problem. While the National Institute for Health and Clinical Excellence's (NICE, 2005a) guidelines 'The Short-Term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Setting and Emergency Department' offer a way forward in managing aggression for healthcare staff, the psychological impact of aggression remains an area of concern. Post-incident review has been identified as an approach to considering untoward incidents of aggression, yet post-incident support and interventions for staff experiencing the psychological effects of aggression remain inconsistent and curtailed in many areas. This article discusses the care of a nurse who experienced post-traumatic stress disorder as a result of aggression in the workplace. The process of assessment and treatment is presented with underpinning theories of trauma used to illuminate the discussion. Practical use of current recommended treatments of cognitive behavioural therapy and eye movement desensitization and reprocessing is offered as a method of addressing a growing problem in UK health care.

Key words: Aggression ■ Cognitive behavioural therapy ■ Post-traumatic stress disorder ■ Post-incident review ■ Violence

Aggression and violence in UK health care is a growing problem which is being addressed in a variety of ways – from local initiatives through to Government level in the form of the zero tolerance approach to aggression and violence (Department of Health, 1999; Health and Safety Commission, 1999; Whittington and Higgins, 2002; Farrell et al, 2006; Health and Safety Executive, 2006; National Health Service Employers, 2006). The focus of such policies is towards the prevention of aggression and the success of these initiatives will be measured over time. Despite attention being given to prevention of aggression and violence, it is unlikely that

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aggression will be eliminated and the psychological impact for staff remains under researched.

Aggression takes many forms, the most obvious being physical assault; however, less tangible and more common forms of aggression, such as bullying and verbal abuse, are gaining recognition as having as great a psychological impact upon staff as physical violence, with victims often experiencing, at the very least, fatigue, irritability, embarrassment, humiliation, low self-worth and anxiety (Whittington and Wykes, 1992; Walsh and Clarke, 2003; Needham et al, 2005; Rowe and Sherlock, 2005). The aftereffects of aggression for staff who have been involved in such encounters can range from being slightly shaken, through to being distressed and upset for some days or weeks, through to post-traumatic stress disorder (PTSD) (Bonner et al, 2002; Needham et al, 2005; Inoue et al, 2006).

Post-incident support for staff has been highlighted as an area worthy of attention, yet there remains little guidance as to what form of support should be offered (Nolan et al, 1999; Lee et al, 2003). National Institute for Health and Clinical Excellence (NICE) (2005a) guidelines for prevention and management of violence suggest that a review should take place within 72 hours for all parties involved, but offer little guidance as to how this should be implemented in clinical practice. While staff value post-incident review and support, it is not often available to them and clear systems of review and support are non-existent in some clinical areas.

Case study

Anne (pseudonym) was a staff nurse on an acute mental health ward who was attacked by a patient. The circumstances surrounding the incident had been that Anne had returned from leave and been given a handover of the new admissions to the ward. She had noticed that Peter (pseudonym) had been agitated, restless, interfering and was not responding to any verbal attempts by her to try and ascertain the reasons for his agitation. She was also aware before the incident that staff on duty were avoiding Peter and were reluctant to engage with him. His agitation escalated and she was subsequently attacked by Peter. She sustained physical injuries for which she had to take sick leave and she developed symptoms of post-traumatic stress disorder over the coming weeks, eventually being referred to the local trauma service by occupational health.

Studies have found that 7–17% of staff may experience PTSD as a result of aggression (Caldwell, 1992; Richter and Berger, 2006), as part of the first author's current PhD study it has been found that 67% of staff interviewed following an experience of restraint had sub-clinical trauma symptoms following the incident. Although these symptoms were not rated highly enough to warrant further assessment for PTSD, nevertheless they were distressing to the staff involved. This supports Caldwell's (1992) study which found that 61% of staff had PTSD symptoms but did not meet full criteria for clinical diagnosis following assault (see Case Study for how staff who have gone on to develop PTSD can be successfully treated and return to work following treatment).

Assessment and treatment

Anne completed a variety of assessment measures (*Table 1*) to ascertain the extent of her symptoms and establish whether she fulfilled diagnostic and statistical manual of mental disorders (DSM-IV) criteria (American Psychiatric Association, 2004) for PTSD. With the evidence gathered via the battery of assessment tools and through subjective assessment of Anne's presentation, she clearly fulfilled assessment criteria for PTSD and further treatment was warranted. She was keen to engage in treatment as soon as possible and a course of treatment was agreed with her.

According to NICE (2005b) guidelines for PTSD, the first line of treatment would be cognitive behavioural therapy (CBT), which is a well-established, evidence-based approach. CBT can be supplemented with eye movement desensitization and reprocessing (EMDR), which is also a recommended treatment within NICE (2005b) guidelines. Ehlers and Clark (2000) describe the cognitive model of PTSD as related to the manner in which the trauma has been processed by the individual. Two key processes impact upon the development of PTSD, one relates to the way that the individual has appraised or interpreted the trauma, and the second process involves the nature of the memory of the event and how it is linked to other memories.

Brewin (2001) explains that experiences of trauma are encoded in situational accessible memory (SAM) which encodes non-verbal data, such as smells, pictures and sounds; and verbally accessible memory (VAM) which is narrative based. VAM is linked to abilities to evaluate and integrate past and present experiences, as well as future consequence. When an individual experiences trauma these processes can be encoded differently to other experiences as a result of the autonomic responses that the individual experiences during the trauma. The fight, flight, or freeze response to stress results in distortions in focus and the encoding of the experience can be limited.

Table 1. Assessment scales used

Assessment scale	Type of assessment	Clinical range/cut off points
Impact of event scale (Horowitz et al, 1979)	Scores related to impact of the traumatic experience	Clinical cut off 26
Beck depression inventory (Beck, 1996)	Depressive symptoms	0–9 Normal 10–15 Mild 16–19 Mild-moderate 20–29 Moderate-severe 30–63 Severe
Post-traumatic stress disorder symptom scale- self report	Diagnostic tool based on DSM-IV criteria	At least one re-experiencing symptom At least 3 avoidance symptoms At least 2 arousal symptoms
General health questionnaire (Goldberg, 1981)	Measures somatic symptoms, anxiety, social dysfunction and depression	Clinical cut off 4/5 for each section
Hospital anxiety and depression scale (Snaith and Zigmond, 1983)	Anxiety and depression	0–7 Normal 8–10 Mild 11–14 Moderate 15–21 Severe

In terms of SAM the amount of detail may be distorted, for example, small detail, such as a smell, which may have been present at the time of the trauma is interpreted with more significance than in more normal circumstances.

Other detail may be missed, for example, images of the scene. To illustrate these points, in the case of Anne's recollection she could clearly remember the smell of the patient's clothes when he was attacking her but had difficulty in remembering other people who were present on the periphery during the attack. In terms of VAM, recollection of the memory may be inadequately integrated within the autobiographical memory, in other words the memory does not fit with that person's running narrative of their life view and experience. They are subsequently unable to place the experience within a context of time, place or person. To illustrate this in relation to Anne, she had felt overwhelmed by the attack and feared for her life. She had no prior experiences with which she could integrate this event and was therefore unable to mentally place or store the experience.

The result was that she could not assimilate that this event, which had been time limited, was now over, and she was now safe. The effects of these processes can result in symptoms of PTSD. These symptoms include a re-experiencing of the event, which may take the form of intrusive thoughts or images of the event; avoidance of stimuli associated with the event, which may take the form of avoiding thoughts and activities that are associated with the trauma; numbing of general responsiveness, which may be depicted as restricted affect, such as feelings of detachment or inability to experience feelings such as love; and increased arousal, which may manifest as irritability, hyper vigilance or exaggerated startle response.

Trauma-focused interventions

Anne's assessment had highlighted that she was experiencing symptoms related to all of these criteria. She had a re-experiencing of the event which took the form of nightmares and images of her attacker on the faces of strangers she passed on the street; she was avoiding work since the experience; she felt numb and felt unable to experience feelings of joy or happiness which was unusual for her; and she felt hyper vigilant, on edge, and jumpy most of the time.

The aim of trauma-focused CBT is to facilitate integration of incomplete processed material related to the trauma and to challenge negative appraisals of the event through restructuring of the narrative with the client. Ehlers and Clark (2000) suggest that the trauma memory needs to be integrated within the client's preceding and subsequent experiences in order to prevent continued re-experiencing of the event. This can enable the client to incorporate the trauma within the here and now, thus providing a context within which the experience can sit.

Working through the narrative or the client's story with the help of a trained clinician can assist in restructuring material through integrating the narrative within the here and now, highlighting hotspots (problematic appraisals of the event) through cognitive reprocessing, and challenging

negative appraisals through cognitive reframing. EMDR can assist in the processing of hotspots as well as reducing some of the more distressing symptoms of re-experiencing associated with these idiosyncratic appraisals. EMDR involves the use of dual attention stimuli to facilitate information processing (Shapiro, 2001). The client focuses on disturbing images related to the trauma while simultaneously focusing on an external stimulus, such as visually following set hand movements of the therapist or simultaneous hand tapping.

According to Shapiro (2001) this procedure activates the information-processing system and allows adaptive processing of the disturbing material. Homework exercises, methods of relaxation and educational material are provided at the outset to supplement therapy and assist the client in moving forward as quickly as possible.

An explanation of the treatment was offered to Anne and education material had been provided at earlier assessment. This had been helpful to her in terms of trying to normalize her feelings and symptoms, but she had not been given this material until 3 months after the incident when her symptoms of PTSD were well established. She was provided with further self-help references to which she agreed to access independently. Anne was particularly distressed with a recurring nightmare which involved her waking with her attacker's hands around her throat. This happened most nights and she had difficulty in bringing herself back to reality when this happened, feeling as if she was still experiencing the event even though she was awake in her own bedroom. Her sleep was greatly affected by this and she saw this as one of her main problems. Grounding techniques were discussed as a method of introducing an external stimulus which can help to revive individuals from this trance like state and return to reality.

Use of grounding techniques

Grounding involves use of distraction as a strategy to detach from emotional pain by focusing upon an external stimulus using mental, physical, or soothing techniques. Mental distraction can involve focusing the mind on activities, such as counting, describing surrounding environment, or describing activities to divert attention from distressing thoughts. Physical grounding involves focusing on the senses for distraction, e.g. by running cool water over the hands or smelling essential oils. Soothing grounding involves focusing on soothing thoughts or statements such as 'I am a good person, I will get through this' (Najavits, 2002).

Anne agreed that the use of an essential oil such as lavender (the smell of which had no connection reminiscent of the incident) may help with this. A narrative approach was discussed initially with a view to using EMDR if necessary at subsequent sessions. In addition, use of visual imagery techniques were facilitated to help Anne reduce symptoms of anxiety through a 'safe place' exercise.

Creating a safe place

Before embarking on this exercise Anne was asked to rate her subjective units of distress (SUDs). This is a way of

measuring distress when working with clients individually to ascertain levels of anxiety and discomfort. These units are usually ranked from 0–10, where 0 means that the client is experiencing no distress whatsoever and 10 means that they are extremely distressed. At the start of this exercise Anne rated her SUDs at 7.

Anne was encouraged to think of a 'safe place' that she may be able to recall. It is preferable that the safe place is not connected to any memories which may later affect the client's progress. For example, if the client remembers a seaside resort as a child and recalls feelings of happiness and relaxation but at a later session discusses how she was raped on a beach, the 'safe place' may no longer be symbolically safe and may worsen symptoms. It is also encouraged that family or close friends should not be included in the scene for similar reasons, for example, a happy event with a husband may not be as helpful if it subsequently transpires that the client's husband is being unsupportive to the client at the present time.

Anne was able to recall a landscape from her childhood which she had found relaxing and invoked warm memories for her. She was able to recall smells and sounds which were later to be helpful to her when using the technique. After the exercise she rated her SUDs as 2, a positive reduction from the previous assessment. Her homework was to read some of the material that she had been provided with and start work on her narrative which would be examined the following week.

Use of eye movement desensitization and reprocessing (EMDR)

Anne returned the following week and the challenging task of working through her narrative to integrate the trauma began. Facts, thoughts and feelings around her narrative were considered, keeping the discussion within the present tense. This assists in the process of contextualizing the event. She was able to recall many aspects of the trauma in great detail but other aspects were still curtailed. She was very angry with colleagues and through looking at facts, thoughts, and feelings in relation to this anger, she was assisted to depersonalize some of her colleagues' actions. Over the weeks, she began to contend with some of the areas of her life that she had been avoiding since the trauma, such as socializing with friends and family.

After working through Anne's narrative she still had some negative cognition which proved difficult to shift. For example, where she had felt confident and successful in her work before the incident she now felt that she doubted herself and she was unsure if she could succeed. She was still experiencing some sleep disturbance. EMDR techniques were used to target the remaining symptoms which had been proving difficult to shift through CBT. EMDR involves the use of bilateral stimulation to free information processing systems which in turn allow links to more adaptive information within the memory (Shapiro, 2001). The eye movements stimulate both hemispheres in the brain which enable processing in a similar way to rapid eye movement (REM) sleep on the unconscious mind. The assumption in this model is that the processing

Table 2. Pre- and post-treatment scores

Assessment scale	Before treatment	After treatment
Impact of event scale	55	6
Beck depression inventory	17	11
Post-traumatic stress disorder symptom scale - self report	13 (re-experiencing) 10 (avoidance) 13 (arousal)	2 2 5
General health questionnaire	5 (somatic symptoms) 7 (anxiety) 6 (social dysfunction) 0 (depression)	2 2 2 0
Hospital anxiety depression scale	11 (anxiety) 11 (depression)	4 8

of the trauma that was ineffectively coded through SAM and VAM can be spontaneously processed through use of EMDR to reconnect the networks, facilitating insight and change. Measurements of SUDs are taken throughout the process, the aim being to reduce them to zero.

EMDR had a significant effect on the residual symptoms that Anne was experiencing. Within two sessions her SUDs ratings were zero and she was actively planning her future with renewed confidence. Anne's ratings on all of the assessment scales had also reduced significantly and were all below clinical cut off points (Table 2). She was able to reflect on the event without the distress that she had previously experienced and, although she still wished that it had not happened, she was able to think about some of the positive aspects that had resulted in relation to her 'not taking life for granted', a common response from people who have successfully come through a life-threatening experience such as this.

Conclusion

With Anne's agreement she wrote a brief account of her experience of therapy which is included below with her consent:

'Quite a few of us have experienced trauma either as a child or as an adult and sometimes both. We freeze certain parts of ourselves after trauma, pushing the memories back out of sight. From this place, we lose our connection to all of who we are. Our fullness is repressed, our creativity suppressed. After the incident I never thought I was going to be affected that badly. I started counselling for my traumatic experience, which I found to be very helpful. After a couple of weeks the counsellor spoke

to me about EMDR, wanting to know if I had heard about this technique. I replied no, so she explained the process and procedure to me. I was very sceptical about the whole process and being negative about the procedure. I went away and did my own research and was impressed... the treatment had its positive and negative sides but the comments were more on the positive side. The process helped me to bring to mind negative thoughts caused by the incident, for example your mind acts like a moving train bringing the negative thoughts forward and changing them to positive and new thoughts you want to have. It also helped me to always return to my safe place at any given time when I am distressed or finding it hard to cope and deal with my thoughts on an everyday basis. I found EMDR to work safely and rapidly. It helped me to restore normal ways of dealing with my problems. EMDR is a creative and safe way to see what is in the way of living a full, joyful life. Therefore I will recommend this technique to anyone who wants a way out of that dark place and to safety, love and happiness again' (Anon, 2006).

The psychiatric impact of aggression towards nursing staff remains under researched and post-incident support remains curtailed in many areas. This case study has highlighted how staff who have developed PTSD as a result of aggression can be treated successfully and return to work to resume their careers.

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KEY POINTS

- Many nurses face aggression and violence in the course of their everyday work.
- The psychological impact of aggression can be great for some nursing staff.
- Post-incident review can identify nurses who may have experienced psychological effects following an incident of aggression.
- Trauma focused treatments, such as cognitive behaviour therapy and eye movement desensitization and reprocessing can help nurses who have developed post-traumatic stress disorder as a result of aggression and violence in the workplace.

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