NURSES' RESPONSES TO WORK-RELATED AGGRESSION

by

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ABSTRACT

The incidence of work-related aggression as experienced by professional nurses has been extensively researched. The majority of studies reported have been conducted in nursing speciality areas including psychiatric hospitals, emergency departments, nursing homes, intensive care units and operating theatres. These studies have focused primarily on psychological and emotional outcomes, ignoring professional outcomes and have not identified reporting behaviours of nurses and interventions which may reduce the impact of aggressive behaviour experienced in hospital settings. The present study adopted the cognitive appraisal model of Lazarus and Folkman (1984) as a theoretical framework from which to examine the moderating effect of institutional social support on work-related aggression as it impacts upon the perceived professional competence of registered nurses. Quantitative and qualitative methodologies were used in a complementary way. The findings showed that nurse victims of physical, verbal and sexual aggression from doctors, other nurses and patients were reluctant to formally report aggressive behaviour to key staff within the institution, preferring to discuss their experiences with peers. Work-related aggression was found to have a detrimental effect on perceived professional competence of registered nurses but this effect could be moderated by supportive behaviours from staff, in accordance with the theory of cognitive appraisal proposed by Lazarus and Folkman (1984). Findings indicated that high levels of social support provided by institutional staff did reduce the negative consequences of work-related aggression on perceived professional competence. It was further revealed that factors hindering coping were institutional deficits, psychological states, professional deficits and negative emotions. Factors which were found to assist with coping were institutional and peer support, education and training, psychological states and nursing context.

The second part of this investigation utilised phenomenology as a method to explore and describe the lived experiences of nurses who had suffered work-related aggression. Five shared themes emerged from the data, showing that nurses experience feelings of powerlessness, expectations to cope, lack of institutional support, emotional confusion and doubts about competence. These experiences collectively produce a working environment for nurses which has the potential to negatively impact upon their emotional and professional wellbeing and contribute to a reduction in quality patient care.

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CHAPTER ONE

PHASE ONE: INTRODUCTION TO THE INVESTIGATION

1.1 Work-related aggression towards nurses as researched so far

The study reported in this thesis takes as its focus the area of aggression of various types and several key sources directed towards nurses in the workplace. This broad approach extended past research beyond patient initiated physical aggression which had been the primary focus of previous investigations.

The study was designed to be extensive in scope and to allow for meaningful analysis of both quantitative and qualitative data. A large sample was sought to be surveyed and follow up indepth interview was planned with a sizeable sub sample.

This chapter briefly relates the considerations of the findings of previous research on work-related aggression for nurses, which provided the background to determining the need for further research that was met by the conceptualisation of the present study. This consideration constitutes Phase One of the current investigation. In this chapter coping strategies is first discussed, followed by the significance of work-related aggression and stress. This discussion is then followed by exposing the risk of work-related aggression for nurses and the need for research into the problem. This chapter also presents theoretical perspectives and antecedents of aggression and concludes with the rationale and aims for the present investigation. Finally, an organisational overview of the investigation and thesis is presented and described.

There is abundant evidence that nursing is a stressful occupation. Some of the stressors include high workload (Gowell & Boverie, 1992; Lender, 1990), dealing with death and dying (Gowell & Boverie, 1992; Lobb & Reid, 1987), dealing with trauma (Michael & Jenkins, 2001), conflicting collegial relationships (Bargagliotti & Trygstad, 1987), and sexist treatment and sexual harassment (Dowell, 1992; Gray,

Chapman, & Fisher, 1995). Increasing acuity of patients in the acute health care sector, combined with new life-extending interventions and technology, has increased and intensified stressors associated with nursing. All of these factors have been accompanied in the 1990s by consumers becoming more aware of what can be offered to them and of their rights to high quality care.

Added to the stressful nature of the work itself is the stressful nature of the environment in which nurses are employed (Russel, 1999). Calhoun (1980:171) commented that "hospitals are stressful employers, especially for nurses, because of hospitals' inherent organisational characteristics, multiple levels of authority, specialisation and work interdependence".

In addition to these widely accepted causes of stress, there is a growing body of evidence that a significant source of occupational stress to nurses is work-related aggression (Engel & Marsh, 1986; Flannery, Fulton & Tausch, 1991; Lipscomb & Love, 1992; Morrison, 1987; Rippon, 2000; Turnbull, 1993; Whittington & Wykes, 1989).

There has also been a growing acknowledgement that nurses are reluctant to report the phenomenon, so that the true incidence of work-related aggression may not be known. Bowie (2000:7), for example, claimed that "at first victims were reluctant to speak out about what they were facing, fearing what others would think of them or blaming themselves for being 'weak' or 'non-professional'. Others kept quiet in order to retain their jobs or because their employers would not support them".

It has been argued that the stress process is a complex, holistic human response, which incorporates psychophysiological, cognitive, emotional and behavioural changes (Fleming & Baum, 1987; Steptoe, 1990, in Cooper & Payne 1991). Although aggression is by no means the only work-related stressor identified in the research

literature (Bacharach, Bamberger & Conley, 1991; Jamal, 1990; Motowildo, Packard & Manning, 1986), it has been considered to play a significant role in the health and wellbeing of employees (Lanza, 1984a, 1985).

The phenomenon of work-related aggression as a stressor has been observed to have extensive detrimental effects on the psychological, social, emotional and physical wellbeing of nurses (eg., Bowie, 1996; Croker & Cummings, 1995; Lechky, 1994; Mason & Chandley, 1999; Smith & Hart, 1994; Turnbull & Paterson, 1999).

Cognitive responses have been demonstrated through lowered levels of concentration at work (Rusinova, 1990), changes in motivation (Spera, Buhrfeind & Pennebaker, 1994; Yiu-Kee & Tang, 1995) and changes in performance (Abramis, 1994; Pithers & Fogarty, 1995; Strutton & Lumpkin, 1994). Implicated also appear to be emotional states such as anxiety (Bohnen, Nicolson, Sulon & Jolles, 1991; King, Taylor, Albright & Haskell, 1990), depression (Kinnunen, Parkatti & Rasku, 1994; Mc Knight & Glass, 1995; Murphy, Beaton, Cain & Pike, 1994) and irritability (Bohlin, Eliasson, Hjemdahal, Klein & Frankenhaeuser, 1986). Clearly, each of the above mentioned responses, or a combination, has the potential to impact upon the clinical performance of professional nurses. Of equal importance may be the fact that negative professional effects caused by work-related aggression have contributed to changes in how nurses perceive their own professional competence (Whittington & Wykes, 1992; Wykes & Whittington, 1992, in Wykes & Mezey, 1994).

Competency as applied to nursing is a vaguely and broadly defined concept (Bradshaw, 1998, in Australian Nursing Council Incorporated, 1998). Most of the literature on competency is linked to the quantity and quality of interventions and interactions that nurses implement with patients on a regular basis. Potter and Perry

(1993) have conceptualised competency in terms of the overall perceptions that nurses hold regarding their quality of functioning in delivering effective, direct patient care.

Given the important role nurses have played in society, it has been necessary to investigate ways in which such negative effects of work-related aggression on professional competence could be minimised. It has also been acknowledged that post work-related aggression support for nurses must be addressed (Bowie, 1996; Leadbetter & Paterson, 1993, in Kidd & Stark, 1995). Investigating the role of institutional social support for nurses who have been victims of work-related aggression could be expected to assist with this process.

The term 'work-related aggression' or 'workplace aggression' is a derivative of the more general term, 'aggression', which has many different theoretical underpinnings, including bio-physiological, psychological, sociological and legal dimensions (Bandura, 1982; Freud, 1920; Lorenz, 1966; Marx in Kanungo, 1979; Merton, 1939). Since the 1970s, researchers have struggled with the issue of defining workplace aggression or violence, and with the broader issue of defining aggression generally. Bowie (2000) has noted an ongoing discussion about the nature and definition of workplace violence. The key issues were identified by Bulato and VandenBos (1994, in VandenBos & Bulato, 1996:1) as how broadly to define violence; how to define the workplace; and whether to focus on the link between violence and work.

Budd (1999:1) made a similar observation: "There remains no consensus about how violence at work should be defined. There remain two hurdles to defining violence at work. The first is defining 'violence' and the second is defining 'at work'".

The lack of consistently agreed operational definitions has made empirical research into this field problematic (Blair, 1991; Hanson & Balk, 1992; Hunter & Carmel, 1992). It has presented a particular difficulty in the ability of investigators to compare studies across local, national and international boundaries. Researchers have concluded that the phenomenon of work-related aggression is vague and ambiguous (Blackburn, 1993; Mason & Chandley, 1999).

In the present investigation, the researcher took a comprehensive approach to definition and developed an instrument that empirically measures a range of critical components of work-related aggression, within the parameters of the conceptual and theoretical framework adopted.

1.2 Coping strategies in relation to the stress of work-related aggression

Accessing and utilising social support has been identified as a key strategy for coping with stressors (DeLongis, Lazarus & Folkman, 1988; Lazarus, 1966; Lazarus & Folkman, 1984; Folkman, 1984; Folkman & Lazarus, 1980, 1985, 1988), which is clearly implicated in the nature of stress itself.

The work of Lazarus and colleagues has been based upon the tenet that cognitive appraisal of a stimulus, an individual's interpretation of that stimulus, influences the strategies adopted to deal with the stimulus. Their proposal that cognitive processes moderate individuals' responses to the environment has been widely accepted in the stress literature (Croyle, 1992; Dewe, 1991, 1992; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986; Folkman, Lazarus, Gruen & Delongis, 1986; Gadzella, Ginther, Tomcala & Byrant, 1991; Larson, Kempe & Starrin, 1988; Ptacek, Smith & Zanas, 1992).

One outcome of cognitive appraisal by the nurse who has experienced work-related aggression would be to decide whether he or she should report the experience.

This decision would be predicated upon the appraisal of whether reporting would assist in alleviating some of the negative consequences being experienced currently or likely to be experienced in the future.

The documented failure by nurses to report incidents involving aggressive behaviour directed toward them to their employing institution (Haller & Deluty, 1988; Lenehan, 1991 in Hurlebaus & Link, 1995; Zernike & Sharpe, 1998) is an additional difficulty pertinent to this investigation. It is necessary to explore and critique the culture and ethos of nursing to gain an understanding as to why there is a reluctance to report aggressive incidents (Farrell, 1997; Lawler, 1991; Poster & Randall, 1993).

In the present investigation, given that social support has been proposed as providing a potential moderating influence by several authors (Caplan, 1974; Cobb, 1976; House, 1981), it was decided to test an exploratory model hypothesising the moderating effect of institutional social support on work-related aggression as it impacts upon perceived professional competence of registered nurses.

1.3 Outline of the significance of work-related aggression and stress

The terms aggression, assault, violence, abuse, disturbed behaviour, threatening or challenging behaviour are all euphemisms to describe a certain genre of behaviour indicating an action or intent to act toward something or someone in a harmful manner. Aggression occurs in many areas of human involvement in the community at large–in criminal acts, group violence, some forms of sport, and in specific situational reactions to threat or frustration, e.g. road rage or air rage. It is considered endemic in certain institutions, for instance in prisons.

Certain occupational groups are exposed to aggressive behaviour in their workplace and, as a consequence, experience varying degrees of work-related stress. Health care is one such occupation, as confirmed by the study of Leppanen and

Olkinuora (1987). These researchers examined the effects of work stressors on health care personnel, and concluded that aggression was a central and growing cause of work-related stress in that sector. A report by Perrone (1999) for the Australian Institute of Criminology (AIC), showed the health industry as the most violent industry in Australia. Registered nurses recorded the second highest number of violence-related workers compensation claims in 1995/96, ranking higher than prison and police officers.

Since the early 1990s, there has been an increasing interest in the Western world in occupational health and safety of employees and an increasing recognition that work-related stress problems and other psychological conditions are among the most prevalent work-related conditions (Ganster & Schaubroeck, 1991; Hurlebaus & Link, 1995; Levi, 1990; Miller, 1990; Williams, & Robertson, 1997). Reasons for the interest in work-related, stress-related problems have included the financial implications to the individual, the work organisation and society as a whole. For example, work-related stress has been linked to serious medical conditions such as cardiovascular disease (Johnson, Hall & Theorell, 1989; Melamed, Kushmir & Shirom, 1992; Uehata, 1991) and emotional states such as decreased job satisfaction (Guppy & Rick, 1996; Jain, Lall, McLaughlin & Johnson, 1996; Jansen, Kerkstra, Abusaad & Vanderzee, 1996; Leong, Furnham & Cooper, 1996; Locker, 1996). Workers experiencing stress also tend to be less productive than other employees (Caldwell & Ihrke, 1994; Hatfield, 1990; Kompier & Di Martino, 1995). It has also been shown, from a sociological perspective, that work-related stress has impacted negatively on the family of the employee (Adams, King & King, 1996; Doby & Caplan, 1995; Kinnunen, Gerris & Vermulst, 1996; Leiter & Durup, 1996; Rout, 1996; Rout, Cooper & Rout, 1996).

The effectiveness of organisations has been disrupted as a consequence of work-related stress. For example, a relationship between stress and absenteeism has been frequently reported (Cooper & Bramwell, 1992; Donaldson, 1993; Geurts, Buunk & Schaufeli, 1994; Harvey & Burns, 1994; Heaney & Clemans, 1995; Kohler & Mathieu, 1993; Kompier & Di Martino, 1995; Ramanathan, 1992; Saxton, Phillips & Blakeney, 1991). A relationship between stress and absenteeism has been specifically found among nurses (Parker & Kulik, 1995).

Employees experiencing work-related stress have been reported to have had more accidents at work (Carter, Cooper & Barron, 1996; Lowenstein, 1991; Rundo, 1995; Sutherland, 1993), to have been more likely to terminate their employment than other employees (Blix, Cruise, Mitchell & Blix, 1994; Hochwater, Perrewe & Kent, 1993; Hromo, Lyons & Nikkel, 1995; Huebner, 1992; Parker & Kulik, 1995; Rahim & Psenicka, 1996; Sager, 1994; Saxton, Phillips & Blakeney, 1991) and to have been more likely to take early retirement, which resulted in significant financial burden to the organisation (White, Olson & Knowles, 1981).

1.4 The risk of work-related aggression for nurses: The need for research

The nursing profession and its professional and industrial organisations have expressed concern that nurses are increasingly subjected to acts of aggression in their workplace (Campbell, Stuart, & Sutherland, 1989; Convey, 1986; Croker & Cummings, 1995; Lechky, 1994; Orr, Rowden, Gooch, Bolger & Brewer, 1988; Rogers & Salvage, 1988; Wykes, 1994; Whittington, 1997).

These concerns have been well represented in professional journal publications. In the United Kingdom, a study showed that nearly one third of all nurses had been violently attacked or abused at work by patients or patient's friends and relatives (Trades Union Congress, 1999). The American Association of Colleges of Nursing,

(in Sullivan, 1999a) issued a position paper delineating violence toward nurses as a public health problem and recommended a set of competencies for students in nursing education programs. These competencies include acknowledging the scope of violence and its sequelae. In the United Kingdom, Beech (1999:610), publishing in the journal Nurse Education Today, featured an article entitled "Sign of the times or the shape of things to come? A 3-day unit of instruction on aggression and violence in health care settings for all students during pre-registration nurse training". Sullivan (1999b:259), in an editorial in the Journal of Professional Nursing, made the following claim: "in spite of the prevalence of violence in contemporary society and nurses' ongoing contact with the results of violence, scant information about violence can be found in nursing educational programs or professional publications".

1.5 Theoretical perspectives and antecedents of aggression

Blackburn (1993) drew attention to some of the variations in theories encountered when trying to obtain a clear picture of aggression. For example, some theories focus upon the antecedents of aggression rather than aggression itself. These variations are dependent upon assumptions held about whether the components of aggression are learned or unlearned, whether aggression is determined by internal or external factors, or whether processes of aggression are affective or cognitive in nature (Siann, 1985). Blackburn stated that "[theories] differ in how they address the critical questions of how aggressive tendencies are acquired, maintained, and regulated" (1993:216).

The theoretical perspectives summarised below provide a helpful background to understanding the context of the rationale for the present investigation. These perspectives draw mainly upon two discipline fields, namely psychology and nursing. They also draw from the discipline fields of sociology, biochemistry and law.

1.5.1 Evolutionary and psychological perspectives on aggression

Lorenz (1966) suggested that aggression is a fundamental component of the evolutionary process of all animals, and that human beings, like other species, are born with a predisposition toward violence. Lorenz saw aggression as a necessary innate instinct of being human, which is essential for human survival in competition with other species for food and shelter. According to this view, aggression assists human beings to respond effectively to external stimuli. As a source of energy, it is spontaneously produced at a constant rate and is either released in response to some external stimuli or is accumulated internally awaiting some future release. Aggressive behaviour is more likely to occur if the accumulated energy is elevated and there is an accompanying strong aggression-releasing stimulus. Lorenz suggested that in modern human civilisation, the energy associated with aggressive instincts must be redirected into more acceptable outlets, including sport and recreational activities.

In early writings, Freud (in Strachey, 1990) also viewed aggression as instinctive behaviour that emerges from the life instinct (libido) whose energy is directed toward the sustenance of life. Aggression arises because energy associated with the libido becomes obstructed or frustrated. In Freud's later writings, he proposed the existence of a second instinct, Thanatos, the energy of which is directed toward the destruction of human life (in Strachey, 1990). The two instincts were seen as in a constant state of interaction and tension, forming a basis for all human experience and behaviour. Freud hypothesised that the energy from the destructive instinct of Thanatos was often channelled away from the self, through mental defence mechanisms such as displacement, on to external sources that are perceived to be relatively non-threatening, giving rise to aggressive behaviour toward others.

Psychoanalytical theories have developed this concept in great detail. For example, the frustration-aggression hypothesis (Dollard, 1939), stating that frustration tends to lead to aggression, is a proposal that was experimentally investigated and demonstrated.

1.5.2 Biological perspectives on aggression

Theories have been proposed that explain aggression as a result of neurochemical transmitters which stimulate specific groups of neurones resulting in aggressive behaviour (Moyer, 1980, in Brain & Benton, 1981). Cholinergic and catecholaminergic mechanisms seem to be involved in the induction and enhancement of predatory aggression, whereas serotonergic systems and γ-aminobutyric acid (GABA) seem to inhibit such behaviour. The catecholaminergic and serotonergic systems evidently modulate affective aggression. Dopamine seems to facilitate aggression, whereas norepinephrine and serotonin appear to inhibit it (Kaplan & Sadock, 1997, pp. 158-159).

There have been many substances linked to aggressive behaviour in animals. These include testerone, progesterone, luteinizing hormone, renin, β-endorphin, prolactin, melatonin, norepinephrine, dopamine, epinephrine, acetycholine, serotonin, 5-hydroxyindoleacetic acid (5-HIAA) and phenylacetic acid. Research has also shown that small doses of alcohol inhibit aggression and large doses facilitate it. Barbiturate and solvent effects are similar to alcohol. Anxiolytics generally inhibit aggression whereas opiod dependence, stimulants, cocaine, hallucinogens, and, in some cases, variable doses of marijuana stimulate aggression (Kaplan & Sadock, 1997, pp. 158-159).

1.5.3 Behavioural perspectives on aggression

The behavioural perspective holds that aggression, like most other social behaviours, has been learned and maintained by reinforcement and punishment schedules throughout social life. According to Bandura (1982) and Schaffer (1979), people engage in assaultive behaviour because they have learned aggressive responses through past interpersonal experience; they expect that some form of reward for being aggressive results from specific social or environmental conditions. The social learning perspective suggests that the antecedents of aggressive behaviour involve the aggressor's past experience, learning and a wide range of external situational factors.

Like the psychoanalytical perspective, behavioural theory has proposed that one of the most significant factors that contribute to aggression is frustration (Berkowitz, 1988). Frustration can be defined as a negative emotional state that occurs when one is prevented from reaching a goal (Coon, 1998). Anger, which results from this frustration, can increase aggression, the expression of which often reduces frustration. The implication here is that both interpersonal and environmental factors are operating to activate behaviour.

External and personal obstacles of many kinds can cause frustration. These obstacles prevent an individual from reaching a desired goal. There is little doubt that becoming ill, and/or becoming an inpatient in a hospital severely restricts one from reaching desired goals. Many previously held goals are suspended and superseded by a goal to achieve improved health.

1.5.4 Sociological perspectives on aggression

Advocates of the sociological perspective have argued that aggression can only be understood if examined within the social context in which it takes place. Alienation was developed as a social construct by sociologists including Marx and

Durkheim (in Kanungo, 1979). Marx (in Kanungo, 1979:1) noted that "violent behaviour, such as threats and physical assault, occurs in every society, growing out of the social order, and can therefore be understood only in a social context".

Durkheim (1964) saw alienation as a condition of anomie that arises when people experience the lack or loss of acceptable norms to guide their efforts to achieve socially prescribed goals. Merton (1939:672) argued that "certain social structures exert a definite pressure upon certain persons in the society to engage in nonconformist rather than conformist conduct". He postulated an imbalance between individual goal-directed aspirations and the social structures that regulate and control modes of achieving these goals. Seeman (1959, 1971) identified five variants of the concept of alienation, namely powerlessness, meaningless, normlessness, isolation and self-estrangement. Aggression was seen to be an example of aberrant behaviour, exhibited as a result of the tension and conflict created by alienation of various forms.

Wolfgang and Ferracutti (1967) postulated that a subculture of violence based on masculine gender characteristics, and consisting of the values of excitement, status, toughness, provides the basis for aggressive behaviour in society.

Tedeschi (1980, in Green & Donnerstein, 1983) hypothesised exchange theory, which argues that coercive power or aggression, is used by individuals to maintain status, self-image and authority, in the face of cost-benefits of addressing the inequitable social forces that maintain class division. In exchange theory, influential and powerful people can decide upon the balance between the extent of harm perpetrated upon the victim of aggressive behaviour and the degree of retribution or retaliation that was warranted.

1.6 Rationale for the present investigation

Examination of the literature suggested that whilst some studies have identified important physical, psychological and emotional aspects of how nurses respond to work-related aggression, the most significant gap in the research literature was the absence of empirical studies that investigated professional outcomes. Instead there was a complete absence of reported empirical studies investigating the relationships between work-related aggression, reporting behaviours of registered nurses, supporting behaviours of colleagues and senior staff within the institution (institutional social support), and the specific outcome of registered nurses' perceived professional competence. The most obvious omission from the research literature concerned the role of social support in moderating the impact of work-related aggression on perceived professional competence of professional registered nurses. One study (Quine, 1999), conducted on health workers in England, found that a supportive work environment can protect people from some of the harmful effects of bullying. It was considered imperative that the role of institutional social support within the health industry be studied and clarified, in order to generate recommendations for policies and procedures that deal with future acts of aggressive behaviour toward nurses, aggression of whatever type and from whichever source.

There was a need for researchers investigating nurses' responses to work-related aggression to include an operational definition of aggression that was acceptable to both generalist researchers in the field of aggression research and to researchers who focus on the phenomenon in nursing. There was also a clear need to identify and describe key concepts including reporting behaviours, supporting behaviours and perceived professional competence. Further, there was a need to explore the subjective experiences of nurses in the context of their perceived professional

competence. These needs were addressed in the present investigation by the researcher conducting semi-structured in-depth interviews, asking questions based on data obtained from a preliminary analysis of survey data. In other words, a triangulated research design was developed, with quantitative and qualitative components, exploring the role of social support provided by the institution and its impact on perceived professional competence.

1.6.1 Aims of the present investigation

The purpose of the present investigation was thus to investigate and identify the incidence, type and sources of work-related aggression and further explore and describe ways in which registered nurses in the State of Victoria, respond to and cope with its stressful consequences. It was anticipated that this research process would raise awareness among nurses at all levels, thereby alerting the profession to the severity of the problem.

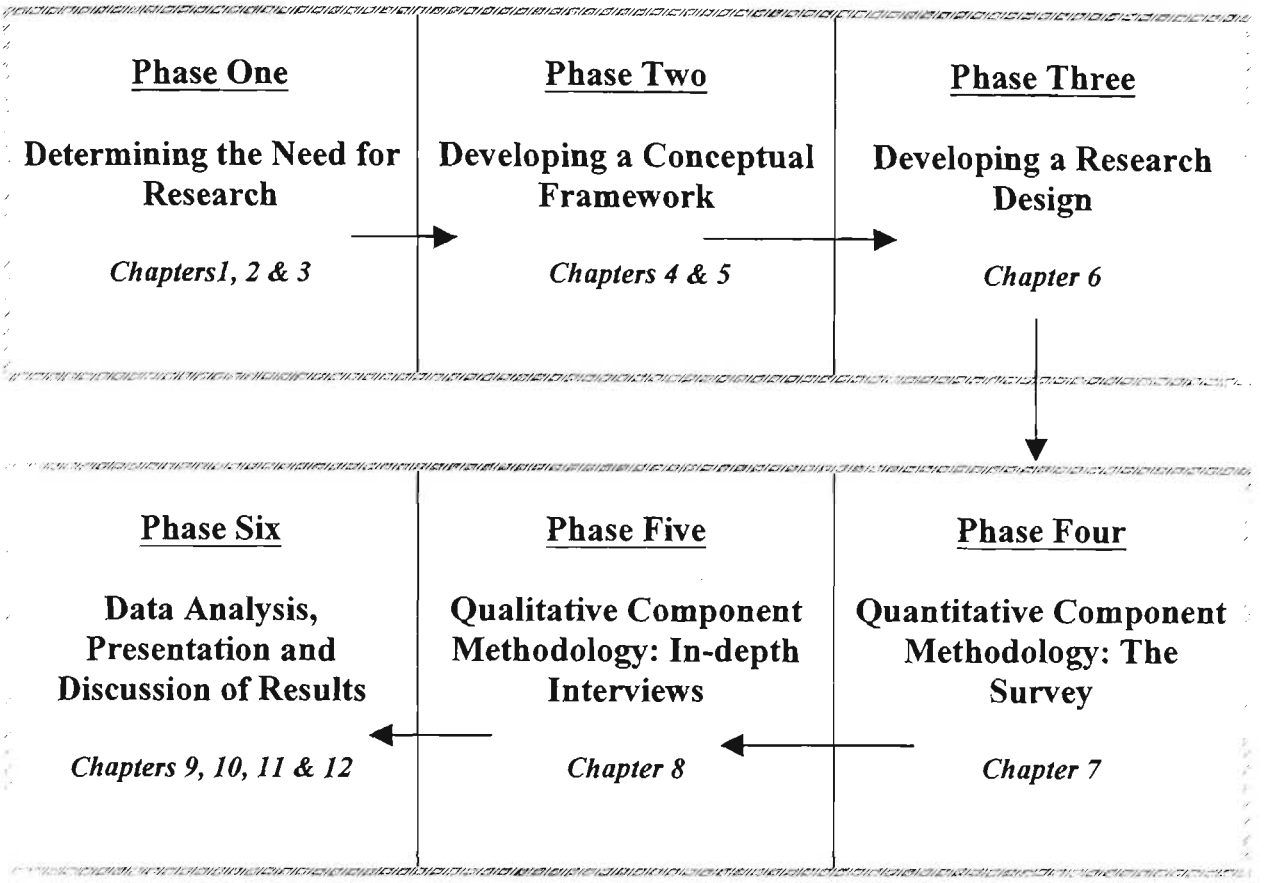
A second aim was to determine if any interventions, especially those related to social support, had been experienced as ameliorating the impact of aggressive behaviour. The study specifically tested an exploratory model postulating the role of institutional social support as a moderator on the relationship between work-related aggression and perceived professional competence.

Lastly, possible solutions to the problem of work-related aggression could be proposed.

1.6.2 Overview of the investigation and the thesis

The investigation was conducted in six phases which are represented across the 12 chapters of the thesis, as depicted in Figure 1 below.

Figure 1 Organisation of the thesis in terms of the phases of the research project



Phase One involved determining the need for research, specifically exploring the problem for nurses of work-related aggression. Previous research on work-related aggression is presented in the thesis and a broad definition of aggression is offered that encompasses behaviours that nurses perceive to be aggressive. The role of nursing culture is discussed, together with arguments as to why it contributes to under-reporting of aggressive behaviour by nurses. Competency is proposed both as a psychological construct and as a standard utilised in nursing for measuring nursing performance. Limitations and gaps identified in the research literature are presented and discussed.

In Phase Two the conceptual framework for the present investigation was developed, exploring the theoretical underpinning of the key concepts of stress, cognitive appraisal, coping and social support. A rationale is provided for the proposed moderator model which was utilised to examine the role of institutional

social support in the relationship between work-related aggression and perceived professional competence.

Phase Three of the study identified the need to combine quantitative and qualitative methodologies in a single research design and provided justification for sequential methodological triangulation.

Phase Four involved the stages of developing a survey questionnaire. These are presented, followed by an explanation of sample selection and distribution of the questionnaire. The questionnaire entailed both quantitative and qualitative components.

In Phase Five, a semi-structured in-depth interview schedule was developed and used to further explore nurses' subjective experiences to work-related aggression. The development of the interview schedule is described and the procedures for identifying and accessing the sample for interviews are outlined.

Phase Six, the final part of the investigation, involved data analysis and interpretation of the findings. It concluded with recommendations for the profession of nursing and for further research in the area.

CHAPTER TWO

NURSES' EXPERIENCES OF WORK-RELATED AGGRESSION

2.1 Nurses' experiences of work-related aggression

This chapter summarises a comprehensive literature review of relevant research on the topic of nurses' experiences of work-related aggression. Strengths and weaknesses of various definitions of aggression and more specifically, occupational aggression, which are frequently drawn from either the narrow exclusive categories of physical aggression and/or from the all embracing inclusive definitions, are considered. Although aggression may be viewed as a common experience across individuals and health disciplines, nurses appear to experience aggression differently from other health workers and members of society. Different experiences of aggression caused by type of setting or nursing speciality are introduced.

Individual and groups of responses by nurses to aggression are discussed, including a full range of negative emotional reactions that have the potential to impact upon the perceived professional competence of nurses.

2.2 Scope of research on work-related aggression experienced by nurses

The major focus of previously reported studies investigating work-related aggression has been on physical aggression initiated by psychiatric patients, toward psychiatric nurses (Benjaminsen & Kjaerbo, 1997). The most common settings for these studies has been within psychiatric agencies and the most likely outcome reported physical injury (Katz, & Kirkland, 1990). Reports of these studies often concluded with recommendations about the subsequent nursing management of such patients (Arnetz; Arnetz & Soderman, 1998; Beech, 1999; Cameron, 1998; Zernike & Sharpe, 1998; Whittington & Wykes, 1994).

Other specialist settings, including accident and emergency departments (Drury, 1997; Hoag-Apel,1998; Keep, 1995; Levin, Hewitt, & Misner, 1998; Mahoney,1991), nursing homes (Fiesta, 1996; Fisher, 1994; Malone, Thompson & Goodwin, 1993; Vinton & Mazza, 1994) and peri-operative settings (Michael & Jenkins, 2001) have also been identified as clinical areas of potential risk for nurse exposure to aggressive behaviour. A report by the United Kingdom Industrial Relations Service (1979, in Zernike & Sharpe, 1998) found that nurses, especially those in casualty departments, were ranked highest among workers most at risk of assault. Almost two decades later, Williams and Robertson (1997) claimed that workplace violence had reached epidemic proportions in critical care units and that critical care nurses needed to acknowledge its boundaries, its prevalence, and preventive strategies in order to make hospitals safe for their patients, visitors, and themselves.

According to Whittington, Shuttleworth and Hill (1996:326), "whilst extensive efforts have been made to understand the processes involved in violence in psychiatric settings, relatively few attempts have been made to examine the problem in general health care settings".

To date, very little literature has been available in the Australian context as well as elsewhere, about sources and types of aggressive behaviour experienced by nurses working in non-specialist areas of general hospitals.

2.3 Arriving at a definition of aggression

As noted in Chapter One above, the difficulties in deciding upon an operational definition of aggression have been well documented in this field.

2.3.1 A range of definitions

The meaning of aggression in every day language has not altered significantly since Johnson (1755, cited in Farrell, 1996:15) published his dictionary, in which aggression was defined as "the first act of injury; commencement of a quarrel; commencement of a quarrel by some act of iniquity."

The term lends itself to many usages and is frequently interchanged for more pejorative words such as assault, abuse, hostility, challenging or threatening behaviour and violence. Although these words are generally perceived with negative connotations, on other occasions aggression is viewed in a more positive light, for example in complimenting some valued characteristics of a male sales manager or sporting hero. Tutt (1976, in Australian Institute of Criminology Report, National Committee on Violence, 1988:3) stated that "the community may be more inclined to view physical aggression on a sporting field involving punching and kicking as acceptable, whereas if these actions occurred in the street they would be condemned and their perpetrators liable to criminal prosecution".

Webster's New World Dictionary of American English (1994:1490), defined violence as "physical force used to injure, damage, or destroy" and indeed most definitions utilised in the nursing field are consistent with that of Webster and focus on three aspects of aggression. The physical aspect of aggression which results in physical injuries (Rosenberg, O'Carroll & Powell, 1992). The second aspect is the means of communicating that the perpetrator's point of view is correct (Harper-Jacques, & Rimmer, 1992). The final aspect is the threatened or actual abuse of power against individuals, groups or communities (Foege, Rosenberg & Mercy, 1995).

An important limitation with the definition offered by Webster's New World Dictionary (1994) is that it implies a simplistic distinction in responses to aggression,

based upon severity and effects of aggression. Specifically, the intensity or severity of the aggressive behaviour and subsequent physical injuries sustained by the victim, or property damage inflicted upon the organization, are the usual parameters. This is an important issue for researchers in this field, as not only does it affect any meaning ascribed to comparisons of the incidence of aggressive behaviour, but it also has relevance to the consequences for nurses who have been victims. For example, such an approach disallows proper consideration of the impact of episodic physical aggression, compared to the cumulative effects of exposure to prolonged verbal aggression or to a single episode of sexual aggression. Such issues have been neglected in the research literature.

Kelly (1986, in Hoskins, Leach & Sideleau, 1987) proposed a broader view of the concept by including moral force or power, whilst Elliot (1997) introduced a cultural and environmental dimension to definitions of aggression, thereby taking into account individual perceptions and recognising a verbal component. These varied definitions demonstrate that violence can be seen as both physical acts and a range of other unacceptable behaviours.

Aggression can thus take on many forms. Physical violence is defined by the Centers for Disease Control and Prevention (CDC, 1996) as the intentional use of physical force with the potential for causing death, injury, or harm. Sexual violence, according to CDC, includes the use of physical force to compel a person to engage in a sexual act against his or her will. Psychological violence is defined as abuse, often verbal, that is intended to control another individual through degradation, humiliation, and fear (Brygger, Matricciani, Tulonen & Campbell, 1995, in Bowie, 2000).

Examination of the literature shows that researchers in the field of aggression toward nurses have often failed to distinguish between types and consequences of aggression:

(a) in terms of the method of exhibiting aggressive behaviour toward nurses, ie physical, verbal or sexual; or

(b) with regard to the source, ie. the identity or role of the perpetrator, ie patients, doctors or colleagues; or

(c) with regard to coping strategies utilised by nurses, and

(d) taking account of the impact of aggressive behaviour upon the professional role of nurses.

In psychology, definitions of aggression have entailed the same complexities. They have, however, attempted to identify features characteristic of aggressive behaviour. For example, Archer (1977) has drawn attention to three main features. The aggressor must have intended harm or injury; the aggressive behaviour must include actions that either cause physical damage or signal the intent to do so; finally, the aggression must be accompanied by an emotional state.

Within psychiatry, Morrison (1990:33), used the definition of aggression given by the American Psychiatric Association in 1974, namely "verbal, non-verbal or physical behaviour which was threatening to persons (self or others) or actually harmed or injured people, or damaged property".

In the nursing literature, definitions of aggression are equally complex. Levy and Horticollis (1976:430) indicated that they viewed aggression as "behaviour between two or more persons [which] produced at least minor physical injury (including scratches and bruises) or destruction of property". This definition excludes verbal threatening behaviour and many other types of less obvious forms of aggression, such as passive aggression. Lanza (1983:241), one of the most prominent authorities on nurses' experience of aggression, defined assault "by the victim's

perception that the patient hit, scratched, punched (etc.) another person with some part of his body and/or some object. Hence the evaluation is of a physical and not verbal assault". Although this definition is limited to physical assault by patients, it is important because it introduces into the discussion behaviour which is defined *'by the victim's perception'*.

Farrell and Gray (1992), two experienced researchers in the field of nursing workplace aggression, acknowledged that aggression is a difficult concept to define. They viewed aggressive behaviour as the infliction of harm, or threat of harm or injury, either physical or psychological, upon another. Farrell and Gray stated that this definition encompasses, firstly, physical aggression, also known as assault, battery or violence, and secondly, passive aggression such as sarcasm and racism. They considered that this definition of aggression "is in keeping with nursing's use of the term... [which] invariably has negative connotations" (p. 2).

Mason and Chandley (1999), on the other hand, defined violence and aggression as distinct. Violence was defined by them as "the harmful and unlawful use of force or strength, of or caused by physical assault, while aggression refers more to a disposition to show hostility towards becoming violent, but clearly can also involve assault itself" (Mason & Chandley, 1999:6). They did however, agree with Farrell and Gray (1992) in that the context of aggression toward nurses is an "extreme negative tendency towards becoming assaultive" (Mason & Chandley, 1999:7).

A comprehensive review of the nursing literature by Haller and Deluty (1988:175) indicated that "unless otherwise specified, assaults refer to all violent, personal attacks, either physical or verbal (e.g. biting, kicking, punching, threatening to do bodily harm)".

Among other writers, Fleming (1987:186) offered a legal perspective, defining aggression as a group of offences which requires either "intentionally creating in another person an apprehension of imminent harmful or offensive contact (assault), and/or actual physical contact with intent to harm the recipient (battery)".

The definitions elucidated above can be seen as variations on a theme. They either assume that the meaning of aggression is well understood, or that the problem of aggression is, to some variable degree, a subset of the legal meaning of aggression, which includes assault, assault and battery and aggravated assault.

The lack of consistent operational definitions of aggression has been a serious and continuing limitation in this area of research. It is difficult to know whether researchers are comparing the same or similar behaviours when they present statistics on the prevalence of aggression in their research reports. Some studies have employed differing definitions of physical assault without injuries, for example Hunter and Carmel (1992), while others have emphasised injuries sustained as a criterion for definition, (Lanza, 1983, 1984a). Other researchers have defined aggression from their professional perspective (Hanson & Balk, 1992), whilst some have offered no rationale for their definition (Whittington, 1997). Others have added sexual assault as a category to be examined (Carlson, 1988, Kaye, 1996), but no reported study appears to integrate threatening and actual physical, sexual and verbal experiences of aggression in a single operational definition. Without a common definition of aggression, research on relevant topics and the collection of meaningful and comparable statistics is extremely difficult.

2.3.2 Toward an operational definition of work-related aggression

The literature reported in the previous section examined aggression as a psychological construct and was found to have as many definitions as there are proponents of definitions. There is a need to determine whether the definitions used in the professional and general literature are compatible with definitions provided specifically for the workplace. It would appear that those who investigate workplace aggression experience the same difficulties, for there is little agreement concerning an operational definition of work-related aggression. Perrone (1999:18) pointed to the potential difficulties created by continuing ambiguity of the term.

> If the definitional parameters of violence are drawn too narrowly, there is a risk of over concentrating on what are essentially sensational, though rarely enacted forms of occupational violence. There is, therefore, the potential to overlook more prevalent, though insidious manifestations, which may have longer lasting effects, and which represent more of a financial drain on our health system and our economy generally. On the contrary, if the term violence is defined too broadly, then it is important to question the value of treating violence in the workplace as a phenomenon separate from the larger universe of violence.

An example of a definition from the narrow range of the spectrum has been provided by Gates (1995:40), who operationally defined workplace aggression as "violent acts, including physical assaults and threats of assault directed toward persons at work or on duty".

A broader operational definition was articulated by Elliot (1997:40), who viewed work-related aggression as "any incident in which employers, self-employed people, and employees are abused, threatened, or assaulted in circumstances arising out of, or in the course of, the work undertaken".

An operational definition that appears to take a middle course was provided by the Health Services Advisory Committee (1987) report on violence to staff, in which occupational assault was defined as:

> ...the application of force, serious abuse or severe threat by members of the public towards people arising out of the course of their work whether or not they are on duty...including severe verbal abuse or threat where this is judged likely to turn into actual violence, serious or persistent harassment (including sexual or racial harassment), threat with a weapon, major or minor injuries, fatalities... (cited in Howard, 1989:218).

The obvious limitation of the definition cited above is its restriction of perpetrators to 'members of the public' thereby ignoring other potential aggressors.

At the more inclusive end of the continuum of definitions, a useful one for nursing was offered by Campbell and Landenburger (1996:732) as "those nonaccidental acts, interpersonal or intrapersonal, that result in physical or psychological injury to one or more persons". This operational definition encapsulates some important aspects of workplace aggression which may be argued as being different from other experiences of aggression. Firstly, it takes into account intentionality in that aggression can injure other workers who were not the intended victim. An example of an accidental act of aggression would be where a patient threw a basin at the door which hit a nurse as she was entering the ward and injured her. The general meaning of aggression required 'intention to cause physical harm' as a pre-requisite for aggression. Secondly, Campbell and Landenburger's definition focuses on the relationships between people involved in aggression. This may include the different roles and power relationships people have within the organisation. Finally, it considers both physical and psychological outcomes for victims.

In Australia, the Commonwealth Accident Compensation Commission (ACC) has had the responsibility for maintaining aggregated statistical records of labour force injury since 1985, therefore it is sourced by Australian researchers as providing authoritative statistics on the incidence of work-related aggression. The ACC operational definition, however, belongs within the range of the most narrow

definitions as discussed by Perrone (1999), relying upon the victim sustaining physical injuries. The definition used by the ACC has been based on the International Labour Organisation: World Health Organisation classification. These internationally recognised bodies have included in their reports injuries caused by other persons in the "*Classification of Type of Accident*, as a subset of Division 2: Stepping on, Striking against, or Struck by an object-Subdivision 25: Assault by other person or persons, and further describe the *Classification of Agency of Injury* as Division 6: Other Agency-Subdivision 639-Human Body" (Victorian Occupational Health and Safety Department, 1991:21).

The clear implication of this category of injury is that physical injury has taken place as a result of some force emanating from a person to the victim. The 'pure' statistical aggregate form of these descriptions used by statutory national and international bodies lose detail in their production, which limits their usefulness to hospitals in developing an understanding of the problem and devising strategies to deal with the problem.

It is thus evident that there is considerable divergence in the way aggression is interpreted and defined by researchers both in general terms and in operational terms. This inconsistency presents a major difficulty for researchers in providing valid and reliable information for investigating comparisons between victims' responses at the individual, ward or hospital/organisational level, and between countries at the international level. It would therefore seem to be essential that researchers who wish to investigate the phenomenon of aggression, specifically work-related aggression, utilise a standardised operational definition, thereby enabling valid comparisons to be made. Smith-Pittman and McKoy (1999:7) highlighted this issue and appeal for uniformity when they stated that "there is a need to formulate a standard definition to

ascertain the scope of the problem and its effects on individuals, families, and society". To date, no such standardised operational definition has evolved in this field. Given this situation regarding definitions, the task for this investigation is to arrive at a satisfactory definition for the purpose of this research. Therefore a broad comprehensive definition is adopted, as discussed below in Section 7.2.1.1.

2.4 Incidence of aggressive behaviour toward health professionals

A 1987 survey of 3000 hospital and community staff from a variety of specialties, conducted in the United Kingdom by the Health Services Advisory Committee (HSAC) revealed that 11% had received minor injuries from assault at work in the previous twelve months. According to the estimates of the HSAC (1987), over 100,000 National Health Service employees are assaulted every year and about 9% of staff in general hospitals had received physical injury from patient assault over a twelve month period. Although this study was instrumental in bringing the risk of work-related aggression and its sequelae of physical injuries to the attention of the Government, there was no attempt to investigate professional consequences to victims of aggression.

The Industrial Relations Services of the United Kingdom (in Zernike & Sharpe, 1998) ranked health care workers as the group of employees most at risk of assault. This fact is supported by literature that details assaults to health care workers as disproportionately high in comparison to that of other occupations (Bowie, 2000, 1989). Bowie (1989) reported that health care workers have been cited as being 26 times more likely to be seriously injured by assault than the general public.

2.5 Incidence of aggression toward nurses: A unique experience

According to the Australian Institute of Health and Welfare's Biennial Report to the Minister of Health (1998, in Bowie, 2000), 272,370 Australians were employed in

health occupations in 1997. Traditionally, nurses have been the single largest group of employees within the health sector. Data collected from the 1991 census noted that the largest group of health professionals was registered general nurses (139,380), 92 percent of whom were female. Bowie (1989) stated that amongst health care workers, nurses are the most frequent targets of patient assault.

Aggression as experienced by nurses within their workplace is different from aggression experienced by other health and non-health occupations, and from members of the general public. Most people have experienced aggression in their everyday life, and in a variety of social situations, and as a consequence of these experiences, have suffered similar physical and psychological responses as nurses. Work-related aggression as experienced by nurses, however, has different consequences, as nurses must continue to perform their duty of care and whilst so doing, maintain their professional competence while delivering health care to patients.

2.5.1 The professional position of the nurse

Mason and Chandley (1999) provided an explanation for some important differences when investigating nurses' responses to work-related aggression. According to these authors, nurse-patient relationships are more complex than other social relationships and even those of other health professional/patient relationships.

Firstly, the relationship is characterised by the extensive amount of personal contact, often intimate, that nurses have with patients. Nurses are the only health care providers that have 24 hour per day and seven day per week contact. This contact may also involve the conduct of painful and/or embarrassing intimate procedures on patients. In addition, the environment in which these interactions occur contains many of the interpersonal and situational factors that are often antecedents of aggression and, as such, are frequent precursors to human aggression (Berkowitz, 1990). These

antecedents include factors associated with high arousal such as pain from illness or treatment, anxiety, fear of negative outcomes from illness, disinhibition caused by alcohol, prescribed and non-prescribed medicines and drugs, reduced cognition, brought about by post-operative confusion or dementia, interpersonal issues, contributed to by invasion of privacy and personal space, and organisational issues emanating from high stress levels among patients and staff, varying skill levels of staff and cultural and communication issues resulting from different value systems.

Secondly, nurses and patients are attempting to establish and maintain a therapeutic relationship within a stressful environment that is often typified by the presence of pain, tension, fear of death or disability and anxiety about loss of control.

Thirdly, nurses are perceived to be and actually are more available than other health professionals. This puts them in a unique but difficult position as negotiators of health care, as they are frequently attempting to forge multiple channels of communications between doctors and other allied health professionals and patients. Whereas medical staff have most of the power when allocating resources to patients, it is inevitably nurses who must put into practice medical decisions often in an environment which has a lack of resources to fully implement prescribed treatments.

Other problems which indirectly impact upon aggressive behaviour toward nurses have been identified by Kasta (1990, in Lechky, 1994) who stated that nurses work in a patriarchal medical model that is characterised by poor communication between doctors and patients. Patients who are angry with the doctor are reluctant to abuse a dominant authority figure, often male, and consequently take their frustration out on the nurse who is usually female. Ruben, Wolken and Yamamoto (1980) claimed that aggression is related to arrogance, brusqueness and aloofness of professional staff coupled with issues of domination, power and coercion, rather than

other factors. Feminist writers have pointed to the marginalized position of nurses compared to other health workers (Ahsley, 1979; Lovell, 1981; Twaddle & Hessler, 1977). Marginalization can contribute to what has been called the submissive aggressive syndrome (Carmichael & Hamilton, 1967). The oppressed person, when able to feel aggressive against the oppressor, is not able to directly express it. Fanon (1963) has described the tendency of native groups to be in constant intergroup conflict, often spending most of their aggressive energy killing and maiming each other.

Duffy (1995:9) described horizontal violence, characterised by "overt and covert non-physical hostility, such as criticism, sabotage, undermining, infighting, scapegoating, and bickering". She suggested that "the nursing world is rife with aggressive and destructive behaviours inflicted by nurses on nurses".

Freire (1972) had earlier thought that horizontal violence was a characteristic of oppressed groups.

> Submerged in (the oppressor's) reality, the oppressed cannot perceive clearly the 'order' which serves the interests of the oppressors whose image they have internalised. Chafing under the restrictions of this order, they often manifest a type of horizontal violence, striking out at their own comrades for the pettiest reasons (Freire, 1972:48).

Strategies adapted by nurses are predictable responses to a system that has excluded them from the power structure (Short, Sharman & Sheedy, 1993; Skillings, 1993). Within this system nurses direct their aggression toward each other, toward themselves and toward those less powerful.

Kasta (1990, in Lechky, 1994), identified a further causative factor of aggression expressed towards nurses as ignorance on the part of the public about what health institutions can offer, given the severe constraints with which they are faced. Once again, nurses are in a unique position, compared to other health professionals, to

be likely to be on the receiving end of the complaints of a frustrated consumer of health care.

2.5.2 Health care settings and aggression

Another contributing factor which distinguishes nurses' experiences of aggression in the workplace has been identified by Mason and Chandley (1999), who claimed that those on the receiving end of aggression within health care settings are restricted in their responses to actions acceptable within professional codes of conduct. This limits the professional worker's behaviour in the moment of intense stress, adding a dimension to the dynamic of aggression.

Secondly, Mason and Chandley (1999:32) claimed that the first difference is countered by "a second feature, namely the anticipation of support".

It is clear from their writings that Mason and Chandley (1999) were specifically focusing on aggression and violence encountered by health workers in psychiatric settings. These settings are structured to produce what Mason and Chandley call medicalised or, more accurately, psychiatrised aggression, "where the disposal of the aggressor is ... transportation, according to legislation, to a place of residency for the application of treatments" (1999: 7). The fundamental principle underlying this process is protection of other members of society from harm (Bowers, Whittington, Almvik, Bergman, Oud, & Savo, 1999).

In the context of providing nursing care in non-psychiatric settings, there are different sets of expectations of relationships between the health care provider and the recipient of health care. The underlying principle underpinning in the provision of health care in the general setting is restoration of the 'sick' person to normal or near normal states of health (restoring homeostatic balance). In contrast to psychiatric settings, there is less expectation of aggression as part of every day encounters of

performing nursing duties. An expectation or anticipation of institutional social support would usually involve receiving appropriate responses from colleagues to managing critical incidents involving serious illness or death of patients.

When aggression occurs in the non-psychiatric setting it can often be explained as a response to some physiological or organic event such as a brain tumour or a disease process such as Alzheimer's disease. In these circumstances, there is a duty of care to protect patients from the consequences of self-inflicted aggression upon themselves. Nurses are aware of the potential for aggression amongst these patients, and implement nursing care plans based upon the risk of harm these vulnerable patients impose upon themselves and others.

Duxbury (1999) conducted a comparative study exploring nurses' experiences of patient aggression encountered in acute inpatient general and psychiatric health settings, reporting a main difference relating to nursing control over situations involving violent patients. Psychiatric nurses seemed to consistently take control of aggressive situations, whilst general nurses relied more heavily upon the input of others (medical staff, mental health teams and the police) when intervening.

These important differences in the experience of aggression between nurses and other members of the health care team, and other members of society, and within the profession between general and psychiatric nurses contributed to the necessity of conducting this study.

2.6 Aggression: Financial implications

Several authors have commented on the financial consequences of aggressive behaviour for organisations in general (Elliott, 1997; Yassi, 1994). Elliott (1997) estimated that in the United States of America, 25 million people are victimised by fear and violence in the workplace each year. A conservative cost estimate of this

violence is U.S. $4.3 billion annually which does not include hidden expenses from the emotional pain victims, witnesses and families suffer. Assaulted staff may take sick leave or pursue legal action (Hunter & Carmel, 1992; Ishimoto in Turner, 1984; Lanza & Milner, 1989; Lawson, 1992), or become less effective in performing their role (Rowett, 1986). Mason and Chandley (1999) claimed that the cost of injuries is difficult to determine as it is problematic to measure emotional, psychological, and physical impacts in financial terms.

Neither is the nature of the relationship between aggressive behaviour and staff sickness easily determined (Rix, 1987). Whereas preventing foreseeable physical injuries to staff has long been accepted as a responsibility of the employer, it has only recently been established by legal precedent that employers are also responsible for protecting employees from psychological trauma. Paterson, Leadbetter and Bowie (1999) reported on a watershed judgment in Britain, [Walker vs Northumberland County Council (1994) IRLR 35], which resulted in the award of £175,000 for the plaintiff, following judgment that the stress injury in question was foreseeable and consequently potentially preventable.

Grieco (1987) estimated that the cost of sexual harassment in the workplace to the United States Federal Government was 94 million U.S. dollars per year due to staff turnover, impaired productivity, absenteeism, and emotional distress.

In this context, the financial as well as the human cost of nurses' experience of workplace aggression underlines the significance of better understanding that experience.

2.7 Type and source of aggression

Wilson and Kneisl (1992) echoed the comments of Ryan and Poster (1989) in noting that there are relatively little detailed data or systematic descriptions of the frequency, types, or consequences of assaults on nursing personnel.

In addition to different settings impacting upon nurses' experience of aggression, there may also be different reactions depending upon the type and source of aggression. As already indicated in Section 2.3.2 above, work-related aggression towards nurses may take the form of verbal abuse, (Cameron, 1998) psychological bullying (Farrell, 1996), sexual assault (Dult, 1982; Grieco, 1985; Madison, 1997; Madison & Gates, 1996) or physical threats (Croker & Cummings, 1995). It can come from a variety of sources including patients and/or their relatives, doctors, administrators or colleagues (Binder & McNeil,1988, Carmel & Hunter 1991; Diaz & McMillin, 1991; Haffke & Reid, 1983; Holden, 1985).

In this section, work-related aggression is discussed from the perspective of its type and source. Having conducted an extensive literature review the researcher concluded that although there is a growing body of literature in the area of aggression, most reported research has focused on physical aggression perpetrated by psychiatric patients. There was a dearth of information on verbal and sexual aggression and an absence of any studies that investigated the phenomena of aggression using other non-traditional types of aggression, for example, passive aggression.

Sources of aggression have been restricted to those persons with whom nurses have most contact. These include doctors, nurse colleagues and patients. Restricting research to these three sources is justified, as it is unlikely that other groups have extensive contact with nurses in general hospital work-setting.

2.7.1 Types of aggression

Aggression in health care settings may be classified into different types. Unfortunately, perhaps the most common, yet most misleading, differentiation in clinical practice and research is made between major (synonymous with serious) and minor (synonymous with trivial) aggressive incidents. Degrees of seriousness have normally been assessed by the amount or severity of physical injuries sustained by a victim. This perspective has been perpetuated by nurse researchers and permeates throughout clinical practice. It is based upon a view that relatively trivial physical and non-physical aggressive incidents are inconsequential, and that research should focus on the occurrence of physical incidents which are regarded by the institution as serious (Haller & Deluty, 1988). Although the majority of aggressive incidents in health care settings do not result in serious physical injuries, the non-serious acts of aggression create a problem because they occur more frequently and tend to be overlooked as they are less visible.

2.7.1.1 Physical aggression

Physical aggression is a frequently reported type of aggression experienced by nurses (Whitehorn & Nowlan, 1997) and health professionals and less experienced nurses in particular have been found to be most at risk (Caldwell, 1998). A study by Whittington, Shuttleworth and Hill (1996) of aggression on 396 staff drawn from a single general hospital in England, found that nurses were physically assaulted, threatened and verbally abused at higher rates than other professionals. Interviews with an additional 53 staff found the prevalence of aggression toward staff at a surprisingly high rate of over 21%, even in those departments which are not normally considered to suffer from the problem of patient violence. They found the rate of assault was much higher than the 9% reported for general hospitals in the United

Kingdom by the 1987 Health Services Advisory Committee survey. A limitation of the Whittington et al. (1996) study was that subjects were asked to include the management of the patient during and after the assault, the underlying assumption being that nurses would only be experiencing patient-initiated aggression. They did, however, conclude that there is clearly a need for further investigation into this problem.

Cembrowicz and Shepard (1992) reported on trauma sustained in an accident and emergency department in which the majority of injuries result from being punched, kicked, grabbed, stabbed, scratched, slapped, head-butted, strangled and hair pulled, and by the use of furniture and fittings, knives, wheelchairs, broken bottles, broken glass, scaffold poles, planks, scissors, stretcher poles, syringes and needles. The focus of the Cembrowicz and Shepard study was on physical injuries. They concluded that physical aggression was an increasing concern for nurses employed in accident and emergency departments and that hospitals must develop strategies and policies that reduce the risk of nurses being injured.

Despite the concern expressed in the nursing literature about the increasing incidence of physical aggression toward nurses, and its potential impact upon the work of nurses, there has been little research undertaken to investigate the impact of work-related aggressive behaviour upon the assessment of perceived professional competence of nurses who have experienced it.

2.7.1.2 Verbal aggression

Verbal aggression initiated by patients is the most common form of work-related aggression experienced by nurses (Anderson & Clarke, 1996; Cameron, 1998; Cox, 1994, 1987; Farrell & Gray, 1992, Michael & Jenkins, 2001; Wondrak, 1997, in Turnbull & Paterson, 1999). Anderson and Clarke (1996) identified verbal abuse as

communication through words, tone, or manner that disparages, humiliates, intimidates, patronises, threatens, accuses, or is disrespectful toward another.

A high incidence of verbal aggression towards nurses has been found by several researchers (Cox, 1994; Farrell & Gray, 1992). A survey by Cameron (1998), investigating verbal aggression by patients or their family members, found that 52% of subjects reported that verbal aggression influenced job performance by causing increased errors, 51% reported decreased morale, 40% reported decreased productivity and 29% reported increased work-load for peers. She also found that 51% of nurses reported verbal aggression to their supervisors, subjects stating that it 'is part of the job', 'it doesn't matter', 'I handled it', 'didn't see the need' and 'it was the patient's usual behaviour'.

Manderino and Berkey (1997) found that 90% of a sample of registered nurses (n=130) reported that they had experienced at least one episode of verbal abuse during the past year. Manderino and Berkey concluded that verbal aggression had negative consequences on nurses' professional wellbeing although they were not specific on how these negative consequences were exhibited. Although there has been extensive publications exploring the issues of physical aggression, there has been little information about verbal aggression (Cox, 1987). There were no studies located that specifically investigated emotional or professional reactions to verbal assault.

2.7.1.3 Sexual aggression

Kaye (1996) claimed that nursing has dealt with sexual harassment since the era of Florence Nightingale. Nevertheless, only a limited number of studies on the characteristics and extent of sexual harassment in nursing can be found in the nursing literature. Two studies involved surveys of nursing students who volunteered to complete questionnaires on sexual harassment (Cholewinski & Burge, 1990; Dult,

1982). One study by Williams (1996) surveyed 346 nurses and found that 57% reported personal experience of some aspect of sexual harassment, with one third of this group reporting in addition that they had experienced physical assault.

When Dult (1982) conducted her study on 89 nursing students in North America, over 60% reported experiencing sexual harassment the previous year. Of these, more than half reported adverse effects. Distraction from nursing tasks was perceived to be the most serious, since clients' best interests and safety were in jeopardy. Twenty five percent reported being so upset they were unable to work normally and a few were so distracted that their ability to make sound decisions was impaired. Robbins, Bender and Finnis (1997) found that sexual harassment can have adverse effects on nurses' physical and psychological health as well as a direct impact on patient care.

Dult (1982:337) identified the typical harasser as "the physician or supervisor; the typical harassee tends to be the relatively powerless staff nurse, team leader, and charge or head nurse". Libbus and Bowman (1994) found that although nurses were prepared to confront patients when sexual harassment occurred, they were less likely to confront male co-workers.

A follow up to the Dult (1982) study was conducted by Greico (1987) with a random sample from a population of registered nurses in Missouri, USA. He received 496 questionnaires and found that 76% of respondents had experienced sexual harassment, most frequently perpetrated by patients (54%) compared with doctors, (31%) and co-workers (22%) and supervisors (3%). Greico also identified victims as being younger females with less nursing experience than nonvictims.

Also in North America, Donald and Merker (1993), found that one in three respondents had been the targets of sexual harassment. Once again the perpetrator was

often a medical doctor. In Britain, Finnis and Robbins (1994) found sexual harassment reported by over half of the nurses surveyed. The perpetrators were, most frequently, doctors or patients.

Only one study was located that specifically dealt with sexual harassment in the nursing profession in Queensland, Australia. Maddison (1995a, 1995b, 1997) surveyed 317 registered nurses and found that two out of three registered nurses experienced sexual harassment. The most frequent perpetrators were medical officers, co-workers and supervisors.

Most of the reported studies had major limitations. Only two studies were found that obtained representative samples of nurses (Cox, 1987 & Grieco, 1987). Neither the Dult (1982) nor Cholewinski and Burge (1994) studies, which used small non-random samples, indicated the size of the population from which the nursing students volunteered. Further, the validity of using nursing students for studies on work-related aggression can be questioned on two accounts. Firstly, nursing students are not considered to be employed by the health agency and therefore the agency may not perceive themselves to have any managerial responsibility toward this group. Secondly, nursing students are considered as novices (Benner, 1984), and have not yet developed the full range of interpersonal skills to interact with patients and staff. This may expose them to a higher risk of aggression compared to professional registered nurses. However, notwithstanding the limitations these results have important implications for investigating the impact of workplace aggression on perceived competence of nurses.

2.7.2 Sources of aggression

The sources of aggression toward nurses include patients and their relatives, medical staff and co-workers including senior nursing staff (Diaz & McMillin, 1991;

Farrell, 1999) and medical and nursing educators (Capen, 1997). In the first Australian study on workplace aggression, Holden (1985) revealed that, in a sample of 310 nurses from all levels of the nursing hierarchy, 86% (266 nurses) had experienced aggression from patients, 42% (130 nurses) had experienced aggression from visitors and 37% (96 nurses) reported verbal abuse by co-workers. Farrel, (1999:537), in a survey of 270 Australian nurses in Tasmania, found that, "approximately 41 percent of public sector respondents and 62 percent of private sector respondents indicated that 'aggression' caused them more distress at work, with aggression from colleagues being most commonly cited by both groups of respondents".

In an American study on the types and frequencies of nurse abuse, Diaz and McMillin (1991) reported that 64% of the nurses surveyed (N=164) said that they had experienced some form of verbal abuse from a physician at least once every 2 or 3 months. Diaz and McMillin (1991) reported that 30% of nurses experienced sexual abuse and 23% had at least one experience with a physician who had threatened their physical person in some way. In a recent Australian study investigating traumatic events experienced by peri-operative nurses in Perth, Michael and Jenkins (2001:22) found that the most common traumatic event experienced by 45% of subjects was abuse and 73% of this abuse was from doctor and that this resulted in a "lack of respect towards surgeons and anaesthetists...[and] poor work effectiveness and efficiency".

Doctors, who have been identified in the literature as the most frequent perpetrators of sexual aggression, (Donald & Merker, 1993; Finnis & Robbins, 1994; Maddison, 1995a; Maddison, 1995b) have a great deal of discretionary and perceived power, as well as a reputation for 'closing ranks' when there is a threat to their

professional status and image. Frequently, doctors are retained by hospitals as visitors or consultants with privileges without regular employee status, thereby making them less responsive or accountable to normal policies and procedures [providing they exist] for complaints (Llyod, 1994; Palmer & Short, 1989).

Duffy (1995) identified one specific source of aggression as nurse colleagues, an occurrence defined by Freire (1972) as horizontal violence. Duffy (1995) argued that, because nurses were dominated by a patriarchal system headed by doctors, male administrators and marginalised nurse leaders, nurses lower down the hierarchy resorted to aggression amongst themselves. In such a way nurses may adopt adaptive strategies of oppressed groups. Moore and McVey (1995) suggested that there is evidence of the Battered Staff Syndrome (BSS) among nurses. They further suggested that nurses who experience BSS use aggression toward each other as a coping mechanism, which protects impaired workers and enables marginally performing nurses to function more effectively in their workplace.

2.8 Responses to aggression

Human response to aggression is another dynamic within the complex interplay of factors that constitutes aggression in all health care settings. Episodes of work-related aggression can be experienced and interpreted as a significant emotional and/or physical trauma (Holden, 1985; Lanza, 1983; Lion, Snyder & Merril, 1981).

Aggressive behaviour toward nurses has been shown to have negative effects on individual nurses and on the nursing profession (Bowie, 1996; Bowie, 2000; Farrell 1997; Patterson, Leadbetter & Bowie, 1999).

There are so many variations in responses to stress that almost any sign or symptom may be construed as a stressful reaction. There are, however, a number of commonly observed types of response. Conn and Lion (1980, in Lion & Reid, 1983)

found that nurses who had experienced assault agreed that the emotional impact of having been attacked far exceeded the impact of physical injury. Resulting symptoms resembled those of post-traumatic stress disorder. This finding was supported by Walker (1990, in Diaz & McMillin 1991:98), who stated in a study of women who had been recipients of aggressive behaviour, that "these women also report feelings of low self-esteem, powerlessness, abuse, loneliness, fright, and humiliation and that psychological battering is often more damaging than physical abuse". Lanza (1986:321) reported that "the reaction of nurse victims to patient assault include emotional, cognitive, social, and biophysiological responses lasting up to one year and often beyond the time they return to work".

Janoff-Bulman (1989:120) suggested that being a victim of aggression has the potential to destroy one's perception of, and ability to function in, a stable and orderly world. Being a victim of a traumatic event can "shatter the assumptions that normally govern the person's sense of security, predictability and well-being within their work role". Consequently, when an aggressive incident occurs, the victim's professional and personal world no longer feels familiar. Lanza (1984a) found that one reaction to aggression was that many nurses perceived themselves to be 'unprofessional' or less professionally competent.

Bowie (1989) examined the incidence of violence experienced by human service workers both in Australia and overseas and concluded that:

> ...violence leaves not only physical scars but may also have a large emotional impact on workers in a variety of ways. Addiction, suicide, burnout and depression may all be responses by workers feeling trapped in a violence prone situation (Bowie,1989:13).

Lanza (1983, 1985; 1986; Lanza & Kayne, 1996) conducted a series of studies on the effects of physical aggression on psychiatric nurses over an eleven year period. In her early study of 40 assaulted nurses' reactions to trauma, Lanza (1983)

noted two major patterns. Firstly the reactions to assault can last much longer than the actual sick leave taken as a result of the assault. Secondly, however, assaulted staff frequently either reported no reaction to the trauma, or attempted to minimise their reactions. In a later study, Lanza (1985) drew attention to the particular problem of conflict with which nurses must deal when responding to aggression; being assaulted by a patient is a very disturbing experience for nurses resulting in intense reactions, which can result in conflict between the belief in professional goals of nursing and the need to protect oneself from physical and emotional harm.

Holden (1985), in an early Australian study, stated that nursing staff admit to feeling anxious, angry, helpless and resentful when at work. These emotional responses experienced by nurses conflict with their professional ethos and ideology. Holden warned of the inevitable induction of a state of cognitive dissonance within nurses following repeated exposure to aggressive behaviour in the workplace and she anticipated that this would contribute to staff wastage within the nursing profession.

The findings from the two 1985 studies by Lanza in America and Holden in Australia was subsequently supported by Lanza, Kayne, Pattison, Hicks and Islam, (1996) who found that 71% of nurses felt the victim would experience a fairly severe or very severe emotional reaction to the assault, while 72% felt the victim would experience a physical reaction of similar severity. Lanza's et al. 1996 findings further supported those of her 1985 study, which drew attention to the tension or conflict experienced by nurses between their professional responsibilities and their own wellbeing. Lanza et al. (1996) found that about half the nurses felt that they could not express their feelings about the assault because of their professional responsibilities, and more than a third considered it unprofessional to express their feelings. Lanza (1994) concluded that although nurses may experience intense reactions to being

assaulted, they may be reluctant to acknowledge them. In addition, they may perceive a role conflict between their experience of victims and nursing's professional goals. Despite wanting to talk to someone about being assaulted, many nurses felt unsupported by co-workers and hospital administration. Paton (1994) found that professionals who are repeatedly exposed to traumatic incidents such as work-related aggression, are often unable to draw upon their previous experience or access support to assist with their response to the incident and their reactions to it.

A number of hypotheses have been put forward to explain the basis of psychological trauma. Bowie (1996:34) proposed that, in common with the general population, health care workers may hold a series of assumptions about themselves:

> They may believe in their own invulnerability (it won't happen to me).
> They may hold a perception of the world as a meaningful and comprehensible place 'just a world' in which bad things don't happen to nice people (Lerner, 1980, in Bowie, 1996).
> They may have a positive self-image bolstered by the respect of others (Bowie, 1996).

The experience of assault can significantly undermine these basic assumptions and may have serious psychological consequences for the individuals involved (Whittington & Wykes, 1992; Wykes & Whittington, 1994). Although the majority of people who have been exposed to trauma will experience an acute episode of distress, they will not develop any long-term or prolonged pathological reaction. For some, however, there will be a progression into serious mental disturbance which may last for decades (Horowitz,1973, 1986).

Mason and Chandley (1999) identified individual differences in emotional distress by people who have experienced aggression. Differences emerged in the extent of: (a) the humiliation felt, (b) the personal insult incurred, (c) the loss of 'face', (d) the trust that is broken, (e) the injustice that is perceived and (f) the desire for retribution.

Tapsell (1990, in Lechky, 1994:739) stated that the emotional impact of assaults has all the features of post-traumatic stress syndrome. "Many assaulted nurses say it really affected their ability to cope on the job ... they found themselves questioning their judgement and feeling unsure of themselves, especially following an assault that wasn't acknowledged by the physician in charge or the hospital administration".

Ryan and Poster (1989) found that 82% (N= 61) of nursing staff who had been assaulted had felt that they had resolved the crisis caused by the assault within six weeks of the incident. More importantly, however, they found that these nurses had experienced a variety of physical and emotional responses when attempting to maintain therapeutic relationships with assaultive and other patients. Such reactions were not dependent upon the severity of the assault with some severe reactions associated with less severe assault.

Ryan and Poster (1989) also found that some assaulted staff continued to experience moderate to severe reactions at six and twelve months after the assault. They found that some of these respondents displayed chronic or delayed post-traumatic stress disorder (PTSD). Conn and Lion (1983, in Whittington and Wykes, 1992:481) in reporting anecdotal data from nurses who had been assaulted, noted anger at the aggressor, leading to conflict with the 'caring' role, guilt and self-doubt about the incident and their competency as a major finding. Anger was found to be nurses' main short-term emotional response following assaultive behaviour (Ryan & Poster, 1989; Poster & Ryan, 1994).

Furthermore, Lenehan and Turner (1981, in Turner, 1984) pointed to more pathological symptoms, including those of clinical depression, as being common following aggressive behaviour. They noted symptoms such as sadness and crying

spells, feeling of worthlessness and emptiness, lack of direction and motivation, fatigue and irritability, and sleep and eating disturbances. Becoming a recipient of aggressive behaviour from someone with whom there are mutual expectations of respect and trust could result in more damaging psychological consequences.

Croker and Cummings (1995) investigated the emotional, biophysiological and social reactions of 35 female non-psychiatric nurses who had been assaulted by their patients. Results showed that as nurses reported more assaults, they experienced more intense emotional, biophysiological and social reactions. They coped by learning to change their own behaviour. Croker and Cummings found that nurses were more likely to attribute blame to patients for aggression, a finding that runs contrary to the pattern of self-blame found in other studies (Bowie,1996; Bowie, 2000; Whittington & Wykes, 1992; Wykes & Whittington in Wykes & Mezey,1994).

Smith and Hart (1994) conducted a qualitative study using grounded theory, interviewing nine female nurses about their feelings and responses to an intense encounter with an angry patient. Their findings suggested that when nurses felt that threat to self was high, they managed the situation by disconnecting from the angry patient. This had the potential to compromise their perceptions of professional competence in meeting therapeutic goals. Whittington and Wykes (1994) found some evidence of association when they tested a model proposing that stress induced by exposure to aggression leads to impaired staff performance in a psychiatric setting.

As well as feelings of helplessness and frustration, anger toward administrators was experienced by emergency room nurses for what was perceived to be a lack of interest and support, was reported by Lenehan (1991, in Hurlebaus & Link, 1995). Engel and Marsh (1986, in Hurlebaus & Link, 1995) thought that more supportive measures were needed for the victims.

Mason and Chandley (1999) observed that emotional responses, such as anger, to injuries are particularly distressing and can last for long periods of time, far beyond of any physical damage. There can be feelings of shame, fear and disbelief, which can have a traumatising effect on the social functioning of the victim. Psychological responses to injuries are also damaging, as the victim's physical integrity has been threatened. Intense anger and helplessness can lead to worry and frustration. These are important observations as they point to the duality of responses to aggression. Physical and psychological reactions take on equal emphasis when studying nurses' responses to work-related aggression. Although many factors may contribute to the severity of the response, it is equally clear that it is nurses' perception of the aggression which has a major influence on how they respond.

2.8.1 Common characteristics in responses by nurses to work-related aggression

From a non-nursing perspective, Horowitz (1986) postulated that people exhibit a general response to stressors regardless of the type of situation that is encountered. Grouping symptoms together as a syndrome, Horowitz claimed that there are two phases to this general response. Phase one, which he labelled denial, includes perceptual symptoms such as attention deficits, inability to assess stimuli appropriately, forgetfulness and daydreaming. Denial also involves ideation-processing symptoms such as rigidity of thought and distortion of meanings. Emotional symptoms include flatness of responses, accompanied by somatic symptoms such as agitation. In severe reactions people may exhibit symptoms ranging from overactivity to total withdrawal.

Horowitz (1986) postulated that in phase two there may be attentional symptoms such as hypervigilance and disturbances of sleep. Consciousness may be affected by intrusion of unwanted or repetitive thoughts and obsessional behaviours.

There may be a tendency to overgeneralise, be preoccupied with specific issues, and to be confused and disorganised in daily functioning. These may be accompanied by emotional symptoms including sudden surges of emotions and somatic symptoms such as a sudden desire towards fight or flight responses.

Earlier work on the responses of nurses to aggression by Lanza (1983) contributed to the development of a categorisation of responses. These include short-term emotional reactions including anger, fear, anxiety, helplessness, resignation, sadness, guilt, depression, shock, apathy, empathy, disbelief and dependency. Long-term emotional reactions include anxiety, anger, and fear of the patient and sympathy for the patient. Short-term social reactions include changes in professional relationships with co-workers. Short-term biophysiological reactions include startle responses, disturbances to sleep patterns, soreness, aches and headaches. Long term biophysiological reactions include body tension and general soreness.

Wykes and Whittington (1993, in Wykes & Mezey, 1994) also provided a list of symptoms in responses to stressful incidents. This includes symptoms associated with anxiety, such as fears and phobias, cognitive effects, guilt and self-blame, and anger and morbid hatred. Nurses confronting aggressive behaviour and experiencing some of the symptoms previously mentioned, perhaps accompanied by physical injuries, may eventually develop what the literature has referred to as burnout. This concept has now been well documented in the literature in respect to health care workers.

2.8.2 Burnout

It is important to point out that 'burnout' may be offered as an alternative explanation to 'work-related aggression' for changes to perceived professional competence of nurses and that support may moderate the effect of burnout (Etzion,

1984). Many of the changes outlined below are similar to or the same as, changes hypothesised as brought on by work-related aggression. On the other hand, aggression may be regarded as a possible cause of burnout (Mason & Chandley, 1999; McKnight, & Glass, 1995).

There is some considerable debate in the literature over the validity of considering burnout as a discrete syndrome. Research has demonstrated that there is a relationship between "job-related subjective competence" and "the personal accomplishments at work component" of burnout (Warr, 1987:197). Examples of low personal accomplishment at work include cynicism to patients, low efficiency, and a lack of respect for patients, colleagues and a loss of idealism.

Maslach and Jackson (1981:3) defined burnout "as a combination of physical exhaustion and emotional exhaustion, in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients". This definition appears to suggest that burnout is the end result of prolonged exposure to stressors.

Interestingly, Cherniss (1980:18) defined burnout "as a process in which a previously committed professional disengages from his or her work in response to stress and strain experienced on the job". Burnout in this context could be viewed as a safety system, which protects committed professionals from further emotional and physical damage.

Edelwich and Brodsky (1980) pointed to organisational and/or structural factors, by defining burnout as a progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of the conditions of their work. This definition poses some serious questions about which conditions perpetuate aggression in the workplace for nurses.

Freudenberger and Richelson (1980:13) defined burnout as a "state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward". This definition is also appropriate for nursing, because many nurses have entered the profession with what may be called an idealistic, missionary zeal and a devotion to care for or administer to the sick (Potter & Perry, 1993). Such images have been promoted and sometimes exhalted by the profession. Florence Nightingale, perhaps the most influential figure in nursing history exemplified this selflessness and devotion to duty (Potter & Perry, 1993).

Although these definitions appear to offer different perspectives, Maslach (1982) suggested that there are common elements to the condition of burnout. Firstly, it affects the individual. Secondly, it is understood as an intrapsychic experience involving feelings, attitudes and motives. Thirdly, it is viewed as a negative experience with negative consequences. Starrin, Larsson and Styrborn (1990) added to Maslach's elements of burnout, physical or psychological exhaustion and a negative deterioration in interpersonal relationships, which could be characterised by a lack of respect for patients, colleagues and a loss of idealism. Most discussions of this latter dimension emphasise its "movement in a negative direction over time – a movement which is sometimes also characterised as a change, development or accumulation" (Starrin, Larsson & Styrborn, 1990:86).

There is substantial diversity and variation in signs and symptoms of burnout as they overlap considerably and are influenced by individual responses to stress. Although the major signs and symptoms of burnout are plentiful, the overall condition presents as a person whose personality style changes from positive, motivated and enthusiastic to negative, demotivated and unenthusiastic. A few of the individual symptoms include holding grudges, loss of interest, insensitivity to co-

workers, cynicism to patients, low efficiency, withdrawal from contact, dissatisfaction with job and dislike of line managers. Starrin, Larsson and Styrborn (1990) claimed that, despite the diversity of signs and symptoms of burnout, most staff working in the clinical area know burnout when it is encountered. The implications for nurses and the nursing profession are significant. In professional health care areas, "... burnout can not only jeopardise the person concerned, as the condition alters perception, slows reactions and reduces the capacity to deal with situations effectively... can also affect those other staff who must take on the added work and responsibility of someone who is not performing up to standard" (Braithwaite, 1992:36).

Conditions thought to induce burnout include lack of interest from managers, lack of supervision, lack of autonomy, scarce social support, lack of positive feedback, abuse from patients, possibility of assault and deliberating over whether actions will receive support (Mason & Chandley, 1999). One very common theme identified by Mason and Chandley (1999:235) was lack of support ... "whether this is peer group support or managerial support. A discrepancy between expectations and the ability to achieve fulfilment is another. Insufficient skills and knowledge to deal with aggressive patients is a third".

To summarise, burnout is a condition experienced by health professionals who have been subjected to repeated stressors. It has a number of responses that are significant to this study. These include cynicism to patients, low efficiency, and a lack of respect for patients, colleagues and a loss of idealism. There is also evidence to suggest that a common problem associated with these responses is a perceived lack of interest from managers, lack of supervision, lack of autonomy, scarce social

support, lack of positive feedback, and deliberating over whether actions will receive support.

2.9 Conclusion

Aggression has been an imprecise concept, thereby causing definitional problems to researchers in both the general area of aggression research and the specific area of occupational aggression research. Whilst it has been the focus of research in specialist areas of nursing, there have been limited studies on the impact of work-related aggression on nurses employed in general wards.

It was argued that nurses, because of their unique work situations, have different experiences of aggression compared to other health professionals. Work-related aggression as a stressor, therefore, has the potential to evoke a variety of responses in nurses, similar to reactions caused by other more recognisable stressors such as the death of a patient. These responses include physical, psychological, social, professional and emotional reactions. It is also worth noting that a group of responses may affect nurses' perceived professional competence has been identified; this group includes, disorganisation, self-blame, anger, and changes in professional relationships with co-workers and a conflict between fear of the patient and sympathy for the patient.

CHAPTER THREE

REPORTING AGGRESSION: NURSING CULTURE, SOCIAL SUPPORT AND COMPETENCE

3.1 Reporting aggression: Nursing culture, social support and competence

Chapter three examines the research literature on reporting behaviours of registered nurses who have experienced work-related aggression. Institutional social support is presented as a possible buffer to work-related aggression, as it may moderate the negative impact of workplace aggression on perceived professional competence of nurses. The culture of nursing itself is then considered as a potential obstacle to nurses seeking such support.

Competency is outlined both as a psychological construct and as an external measurement using prescribed professional standards. It is argued that nurses have internalised and consequently employ these standards as a subjective internal measurement to evaluate themselves when performing their nursing role.

3.2 Reporting aggression by nurses

Previous research has pointed to a reluctance by nurses to report aggressive behaviour to their colleagues and senior administrative personnel within the institution (Haller & Deluty, 1988; Lenehan, 1991 in Hurlebaus & Link, 1995; Zernike & Sharpe, 1998). As a result, there is little information about the reporting behaviours of nurses who have experienced aggressive behaviour, and subsequent supporting behaviours of hospital staff.

The reluctance to report aggression is compounded by the belief, commonly held by nurses, that being a victim of aggression is part of the job of being a nurse (Kohnke cited in Wondrak, 1989; Lanza, 1983). This assumption makes very difficult the conduct of any research on the effects of aggression on nurses. The reluctance of

nurses to report may be related to what McCue (1986, in Bowie, 1989) calls a 'conspiracy of silence' in which human service workers, who wish to project an image of professional integrity, are hesitant to acknowledge any difficulties in coping emotionally or with the day to day realities of the work situation.

In North America Donald and Merker (1993) found that 77% of registered nurses who had experienced sexual harassment, had not reported their complaints. Donald and Merker commented that it was a serious concern that the same percentage indicated that employers did not have formal policies in place.

The factor of non-reporting limits an accurate picture of the problem by reducing the available data that would assist researchers to more clearly understand the professional, psychological, physical, emotional and social impact that aggression has upon nurses.

A number of reasons for low levels of reporting aggressive behaviour have been found. These reasons include apathy, protracted administrative procedures, difficult access to documentation, poor response from managers, minor injuries becoming the accepted norm, the possibility that it may be perceived as performance failure, and the cultural expectations which sometimes belittle reporting such injuries.

A study by Zernike and Sharpe (1998) of general nursing staff at the Royal Brisbane Hospital (Australia) reported that nursing staff felt that they had become acclimatised to aggressive behaviour and accepted it as part of the nature of nursing work. Work-related aggression was therefore underreported. This underreporting may lead to underestimating the extent of the problem and consequently a lack of resourcing. The beauracratic, hierarchical structure, which continues to dominate the management of hospitals and the health care organisations, may also contribute to underreporting of sex-based aggression.

Levy and Hortocollis (1976) provided an explanation of how the problem of non-reporting may be understood in the nursing context. They claimed that when senior hospital personnel addressed patient violence, the nurse was often blamed. It was believed that the nurse's expectation of assault represented a self-fulfilling prophecy. Haller and Deluty (1988) made the important observation that reporting behaviours of health care staff are largely dependent upon perceived severity of physical injuries by the victim. Incidents resulting in minor physical injuries and no physical effects were not likely to be reported. The more severe the injury, the more likely staff were to report the incident. Haller and Deluty (1998:174) considered that this was linked to requirements for compensation policies as they applied to staff. The reasons offered by Haller and Deluty for such patterns included the observations that:

- the frequency of minor assaults is so high that staff become inured to them and, therefore, do not report all incidents;
- staff consider it too troublesome to fill out reports, especially when they see no change forthcoming as a result of reporting; and
- staff fear accusations of negligence and inadequate performance when nurses are assaulted.

Likewise, Rose (1997) conducted a study amongst accident and emergency nurses in Ireland and concluded that non-reporting was a major problem, whereas reporting aggression was often seen as an empty gesture because of a lack of institutional support for victims.

In brief, in the context that aggressive behaviour in the workplace has been found to be an underestimated problem, the reluctance to report is both a function of the culture of nursing and an actual antecedent to aggressive behaviour. Non reporting will continue to encourage aggressors to inflict their behaviours on victims. Working within a system that discourages nurses to report such behaviour contributes to an

inability of the profession, and individual organizations, to provide appropriate, timely and effective institutional social support.

3.3 Institutional social support of nurses

Before reviewing the literature pertaining to social support in the workplace, specifically as provided to nurses following work-related aggression, it is important to consider definitions of social support, the role it may play in buffering the negative effects of stress, and the concept of social support as a coping resource in response to stressful events in the non-work environment.

Social support in general has been defined as support which is "accessible to an individual through social ties to other individuals, groups, and the larger community" (Lin, Ensel, Simeone, & Kuo, 1979, in Terry, Neilson & Perchard, 1993:168). A more detailed definition was provided by House (1981:39), who viewed social support as an "interpersonal transaction involving one or more of the following:

(1) emotional concern (liking, love empathy),
(2) instrumental aid (goods or services),
(3) information (about the environment),
(4) appraisal (information relevant to self-evaluation)".

Researchers have suggested a model in which social support may moderate the effects of stress on health and wellbeing (Berkman, 1985; Cohen & Wills, 1985; Kessler & McLeod, 1985; Kessler, Price & Wortman, 1985; Turner, 1979; Wallston, Alagna, De Vellis, & De Vellis, 1984). This model, termed the buffering model, proposes that social support protects individuals against adverse effects of stress by helping them reappraise problems and providing a strategy for coping. The impact of stress is therefore reduced (Finney, Mitchell, Cronkite & Moos, 1984). According to the buffering model, the effects of social support are influenced by the stressfulness of the event and may have main or direct effects (Cohen & Wills, 1985). A main effect is where support on its own contributes to reducing stress, whereas a direct effect is

where support combine with other factors to produce a reduction in stress. It is also worth noting that stress is a subjective concept. What one person perceives as stressful may not be perceived as stressful by another or vice versa.

In the general stress research literature, social support has been the most frequently investigated external coping resource (Bartone, Ursano, Wright & Ingram, 1989; Bourmans & Landerweerd, 1992; Cummins, 1988; Daniels & Guppy, 1994; DeLongis, Lazarus & Folkman, 1988; Dunkel-Schetter, Folkman & Lazarus, 1987; Ensel & Lin, 1991; Florence, Lutzen & Alexius, 1994; Hobfell & Lerman, 1988; Hobfell, & Walfisch, 1984; Hockenberry, Kemp & , 1994; Jayarante, Himle, & Chess, 1988; LaRocco, House & French, 1980; Morrison, 1998; Morrison, Dunne, Fitzgerald & Cloghan, 1992; Pearlin, Lieberman, Menaghan & Mullan, 1981; Sarason, Levine, Basham & Sarason, 1983; Shinn, Rosario, Mørch & Chestnut, 1984; Tetzloff & Barrera, 1987; Veiel, 1987; Yang & Carayon, 1995).

This extensive body of knowledge has supported the proposition that social support had either a direct effect or an ameliorating indirect effect on psychological distress across a variety of contexts.

Studies conducted in the non-work environment have found positive effects of social support on children with cancer (Hockenberry, Kemp & DeLorio, 1994), women who were HIV-positive (Florence, Lutzen & Alexius, 1994), people with diabetes mellitus (Krause, 1995), and the elderly (Preston, 1995).

A great deal of attention has also been directed towards the role that social support plays in assisting people to cope with work-related stress. Seeking assistance from co-workers and family has been reported as producing more positive outcomes, thereby acting as a moderator of work stress. The positive effect of social support on coping with occupational stress has also been established by research.

Jayarante, Himle and Chess (1988) reported that, although existing organisational social support systems were used by social workers who benefited from their use, social support did not guarantee positive outcomes. Furthermore, it was demonstrated that workers were more likely to use social support systems if they perceived the work organisation to be supportive. Yang and Carayon (1995) found that office workers who experienced stress reported a greater reduction in stress when they were supported by their supervisor compared to being supported by their coworkers.

A sample of 234 mental health professionals reported using social support, self-control, confrontative coping and positive reappraisal equally, whereas distancing, accepting responsibility and escape-avoidance strategies were used less often for coping with stress (Thornton, 1992). A study of coping strategies utilised by 102 medical students demonstrated that problem solving was employed most frequently, followed closely by seeking social support and self-blame (Stern, Norman & Komm, 1993). A study by Shinn, Rosario, Mørch and Chestnut (1984) on human service workers concluded that individual coping efforts did not have a significant impact in work situations, whereas social support had a main role to play in ameliorating the negative effects of work stress.

Coyne and De Longis (1986) found that the perception of having available emotional support from close others appears to account for much of the effect of social support on stress. Those emotionally closest to the person experiencing stress were in the most favourable position to offer and provide effective support that reduced stress levels.

In a review of the literature on the effects of social support in the work context, Kahn and Byosiere (in Dunnette & Hough, 1992) concluded that the majority

(20 out of 22 studies) had found evidence of main effects of social support (from supervisor and co-workers), but that evidence for the buffering model was less convincing. Moreover, Kaufman and Beehr (1989) and Ganster, Fusiler and Mayes (1986) found evidence to suggest that the availability of social support may exacerbate rather than buffer the negative effects of work-related stress. To some extent, this contradicts previous findings of Coyne and De Longis (1986), who found that the perception of having available emotional support from close others appears to account for much of the effect of social support on stress. It would appear that 'closeness' may not be the important variable operating on support; rather, it may be the ability to provide 'understanding' as proposed by Cohen and Wills (1985).

Cohen and Wills (1985) argued that these conflicting results may be ascribed to lack of matching between the support requirements of the situation and the type of support under consideration.

In the nursing literature, Paterson, Leadbetter and Bowie (1999) stated that any attempt to provide formal support may need to overcome the attitude, historically prevalent in nursing, that to access support indicates a need for support which is interpreted as professional failure. In their 1996 study, Lanza, Kayne, Hicks and Islam linked the human responses experienced by nurses and the subsequent support they received from nurse managers. Ninety nine registered nurses were asked to read a vignette, which featured an incidence of patient-initiated aggression on a nurse. Fifty one percent of subjects reported that they felt the victim would receive no support or only slight support from co-workers, while 56% felt the victim would receive no support or only slight support from the hospital administration.

Interestingly, it has been found that nurses frequently express more anger toward management as a result of reporting and subsequent lack of support, than they

feel toward the assault itself or the perpetrator of the aggression (Deans, 1991). Victims were inclined to be reprimanded by management because they were perceived by management to have deficient technical or interpersonal skills, or had failed to follow policies, practices or procedures. Deans (1991) also found that many victims would have welcomed, but failed to receive, an inquiry as to how they had felt and/or how they were coping with the incident.

Most reported studies on the role of social support in the nursing work environment have relied on either anecdotal or very small qualitative investigations. Wallis (1987), however, developed a model for the study of stress in nursing that proposed social support as one of several moderators between the stressors and strain on staff. There were, however, no follow up studies that tested the model.

Whittington and Wykes (1992) attempted to measure levels of stress and social support for 24 staff in a major psychiatric institution who had experienced the trauma of being assaulted by a patient but had not suffered any physical injuries. They reported that although 16 (66%) of the subjects had been offered an opportunity to talk about their feelings regarding the incident, only eight subjects (33%) had an opportunity to talk about the assault with somebody of a higher grade. Subjects were not encouraged to go off duty immediately after the assault. Over half (54%) of the victims were dissatisfied with the support they had received. Whittington and Wykes concluded that a few subjects reacted with extreme negative emotions to 'so-called' physically insignificant incidents and that four subjects reported symptoms that would be consistent with a diagnosis of post-traumatic stress disorder. They found that social support provided for victims was on an informal basis. Usually it was provided in public places by workmates and that there was no formal system for providing staff

support. Thus although there may frequently be an attempt to offer well meaning informal support by peers, these attempts are not always successful.

Etizion (1984, in Whittington and Wykes, 1992) found that support at work was negatively correlated with work stress and burnout amongst Israeli managers and social service professionals.

Farrell (1997:503) conducted a qualitative study on a sample of 29 nurses. He reported that "respondents were most concerned both about the number of incidents of aggression that they had to face, and annoyed, that when incidents did occur, their fears and feelings about the event were almost totally ignored by their nurse managers".

Several writers have advocated that support must go beyond the immediate 'on the spot' informal discussions and that all victims of aggressive behaviour require debriefing and post-trauma counselling (Bolger, 1991; Hoff, 1989; Hume, 1993; Parkinson, 1997).

This process of seeking support may have positive or negative effects (Bowie, 1996), depending on the individual's appraisal of the aggressive behaviour (Lazarus & Folkman, 1984), including assessing who was to blame for the behaviour.

Although there is a preponderance of research literature on the benefits of social support on stress, very little attention has been paid to the role of social support from within the institution in reporting behaviors of nurses who have experienced work-related aggression. Nevertheless, the perceived availability of social support from significant others within the institution have consistently been demonstrated to moderate the effects of stress on subsequent physical and psychological distress (Kessler & McLeod, 1985; Wallston, Alagna, De Villis, & De Villis, 1984).

Most research undertaken on social support within the context of life stress has investigated support from non-professionals, including friends, family and neighbours. In these personal relationships, individuals are supposed to accept the other as a person, to be concerned with the wellbeing of the other, and to take care of the other without extrinsic rewards (Clark & Mills, 1979). However, the focus of research on social support and occupational support has been primarily on relationships with superiors and with colleagues. In such professional relationships, the perception of receiving more help than one can return may be accompanied by negative feelings, including the fear of appearing incompetent (Buunk, Doosje, Jans & Hopstaken, 1993). This may be a function of the fact that while friendships may develop and flourish at work, relationships at work are primarily exchange relationships, in which reciprocity is expected and required (Mills & Clark, 1982).

Although the perception of reciprocity may in general be important in relationships at work, there is probably an important difference in this respect between relationships with colleagues and those with superiors. In relationships with superiors, that is, those with a higher status, a certain degree of asymmetry might be considered normal, because the provision of help and support is expected from the superior. In contrast, in relationships with colleagues – those with equal status to oneself – individuals will probably aim at reciprocity and will avoid a state of indebtedness. After giving help to a colleague, an individual may expect that colleague to provide help and support in return, and after receiving help will be inclined to reciprocate. Thus, it is expected that perceived reciprocity will be more characteristic of relationships with colleagues, whereas feeling over-benefited will more often be prevalent in relationships with superiors. Ganster, Fusilier and Mayes (1986:482) found very weak evidence of such an effect, even though social support,

"especially from one's supervisor, shows a consistent relationship with a variety of affective and somatic outcomes". Once again, this points to a differentiation in the effectiveness of support by source of support. There is limited but nevertheless credible evidence to suggest that support from senior staff has the potential to reduce or minimise the effects of work-related aggression.

This is particularly relevant to the work environment of nurses who have many colleagues at an equal status, and many colleagues who occupy senior levels of management. This is also exacerbated by having other professional colleagues who are not in any senior line management position but do occupy positions with higher status.

Buunk, Doosje, Jans and Hopstaken (1993) studied 181 employees of a large psychiatric hospital in the Netherlands. They hypothesised that in relationships with colleagues a higher degree of reciprocity would be perceived than in relationships with superiors, and that in the latter relationships more often an imbalance in one's favour would prevail than in relationships with colleagues. The results very clearly supported these predictions. Of the sample, 21.5% felt they invested more in the relationship with their superior than they received in return, 57.7% perceived reciprocity in this relationship, whereas 20.2% felt they received more help and support from their supervisor than they provided. The situation with respect to the relationships with colleagues was, as expected, quite different. Most (77.6%) reported reciprocity, 15.2% felt they were the ones who invested more support than received, and only a few (6.7%) indicated that they received more support than they provided, a percentage that is much lower than in the relationship with the superior.

Buunk et al. (1993) concluded that the results were largely in line with their theoretical predictions and suggested that it is important to consider perceptions

regarding the mutual flow of support and help when examining the role of social support in reducing job stress. First, reciprocity was more often reported in relationships with colleagues than in relationships with superiors, and a feeling of being over-benefited was more prevalent in this last type of relationship than in relationships with colleagues. Remarkably, even in relationships with superiors, a substantial number of subjects felt they were providing more support to the other than they received in return. Nevertheless, these data suggest that exchange processes differ between relationships of equal and unequal status and that in relationships of equal status, there is a relatively strong tendency toward reciprocity.

Buunk et al.(1993) considered that their findings may be relevant for theories on social support as well as for the literature on equity and social exchange. To begin with, reciprocity was more often perceived in relationships with colleagues as compared with relationships with superiors, and feeling over-benefited was relatively more prevalent in the relationship with the superior. These findings suggest that exchange processes differ between relationships of equal status, in that there is a relatively strong tendency toward reciprocity. By illuminating the association between lack of perceived reciprocity and negative affect, Buunk et al. suggested that their findings may help explain why in many studies on job stress inconsistent results have been found and why social support often seems to have an adverse effect.

Moreover, Buunk et al. (1993) found that the perception of reciprocity is more important for some individuals than for others. Particularly for individuals high in exchange orientation or low in communal orientation, the feeling of receiving more support than they give seems to aggravate stress. From an applied point of view, their finding suggests that individual differences have to be taken into account when aiming at promoting social support at work. Some individuals may prefer not to

receive support at all, rather than to feel they receive more support than they are able or willing to return.

To summarise, Buunk et al. (1993) have provided some evidence that, with regard to stress at work, it is relevant to take into consideration the amount of support individuals perceive to receive in proportion to the amount of support they feel they give to others, thus contributing to the small literature examining reciprocity with regard to social support in naturally occurring exchanges. Furthermore, their work has underlined the importance of differentiating between various types of role relationships, suggesting that in relationships with peers there is a stronger tendency toward reciprocity than in relationships between individuals of unequal social status. Most importantly, their work has contributed to specifying some of the individual-difference characteristics that make the perception of reciprocity in relationships a relevant concern, and thus to outlining some of the conditions under which social exchange theories are more or less valid.

3.4 The culture of nursing: Explanations of aggression

Successful adaptation to acts of aggressive behaviour depends on the ability of nurses to cope with stressors and thereby diminish the distress experienced, without exhausting internal and external resources. Culturally based values and beliefs embedded in the nursing profession may, however, inhibit nurses from making optimal use of available coping resources, especially seeking institutional social support. Poster and Randell (1993) claimed that, in some areas of nursing practice, the dominant belief system may be that aggressive incidents are seen as going with the territory, and are therefore nothing about which staff should be alarmed or distressed. Clearly, such attitudes and values embedded within the culture of nursing may

drastically mitigate against the ability of the employing institution and the profession to provide support for victims.

Johnstone (1999, in Harulow, 2000:28) commented that she "is convinced that a culture of silence towards occupational violence exists within the nursing profession...comes with the territory".

A disturbing feature revealed in the literature is that victims of aggression are often either directly or indirectly blamed by other colleagues, co-workers and hospital administrators for provoking the aggressive incident (Bowie & Malcolm, 1989; Lanza & Kayne, 1996; Lanza & Carfio, 1991). Jannoff-Bulman (1992:150) illustrates this phenomenon:

> Non-victims are motivated to blame victims so that they may continue to maintain their core assumptions about the nature of the world and themselves...a secondary benefit of such blame is the minimisation of any responsibility and any need they have to help.

Bowie and Malcolm (1989) suggested that blaming the victim assists other staff members to distance themselves from the possibility that they too may become a victim of abuse and to retain the belief that they are better nurses or have superior interpersonal skills. This motivation by other staff, colleagues and managers, to protect their own feelings of insecurity and vulnerability decreases their capacity to offer and provide support to victims. Decreased capacity, in turn, contributes to the effect of one of the principal cognitive responses to trauma, that of self-blame and the resulting performance guilt. When nurses feel they may be blamed by their colleagues or employers, or may even lose their positions, they are understandably reluctant to report their experiences of aggression to significant personnel within the institution.

Fisher et al. (1995:25) claimed that "it was little wonder nurses said that their experiences when reporting violence to their employer had made them reticent about

reporting future incidents. Fear of being blamed or made to feel incompetent contributed to a reluctance by nurses to formally report workplace aggression".

Lawler (1991) described a traditional view held by nurses and the nursing profession concerning characteristics of nurses. One common notion is that a 'good' nurse has the ability to hide emotional reactions and to cultivate an air of detachment or professional distance in clinical work. Others describe guilt being experienced by nurses who have felt anger when aggression has been directed toward them (Davidhizar & Farabaugh, 1987; Dult, 1982). These experiences have been compared to the experiences of women who are subjected to harassment in other workplaces (Reakes, 1986, in Wondrak, 1989; Walker, 1989, in Diaz & McMillin, 1991). A self blaming attitude may contribute to self doubting about professional competence in the nursing role and about individual self image (Lanza, 1983).

Handy (1986, in Dewe, 1989:318) stated that it is "all too often ... the individual rather than the organisation who has to assume responsibility, with the result that intervention strategies often ignore the relative powerlessness of individuals within large organisations and allow maladaptive organisational practices to remain unchallenged". Dewe concluded "that simply identifying and changing demanding aspects of the job is not necessarily the same as providing supportive and positive structures through which nurses can grow and develop" (p. 319).

Linder-Perz, Pierce and Minslow (1990, in Willis 1992:19), in an Australian study of occupational stress in nursing, claimed that situational factors such as social support influence stress levels more than the nature of the work. They linked stress to individuals' self-worth, ability to thrive under pressure, degree of satisfaction with support systems, and feelings of ill health. According to Cartledge (2000, in Harulow, 2000:28), "the institutional support mechanisms for nurse victims of occupational

violence are often non-existent...after the syringe incident (stabbed by a patient with a used syringe), there was no de-briefing, no hospital counseling, not even a formal acknowledgment of the incident report".

Many studies report institutional responses in which blame for the aggressive incident is either directly or indirectly attributed to the victim. There is a failure by such institutions to recognise the psychological impact of aggressive behaviour on the victim, which thereby reinforces and intensifies the impact of aggression (Bowie, 1996; Crane, 1986; Rowett, 1986).

Paterson, Leadbetter and Bowie (1999) suggested that the nature of the organisational response to the traumatised staff member can therefore play a pivotal role in the process of recovery and, where the organisational response fails to understand or consider the needs of the victim, can constitute a source of secondary injury or trauma.

There may also be an additional problem in situations where horizontal violence occurs, in that where peers and supervisors may be perceived as the sources of work-related aggression, they are unlikely to be called upon for support. The following portion of an editorial written by Dunn (1979:1), who although not a nurse, came in contact with many nurses through her job as editor of a national nursing journal:

> Of the many things that puzzled me when I first explored nursing and nurses, two (sic) remain a mystery. One is how horrible nurses are to one another - in the form of seniors victimising juniors, or of a mutual refusal to acknowledge stress, or an intolerance of colleagues who crack physically or mentally.

3.5 The concept of competency

Competency is a concept familiar to most nurses who have been introduced to it from their first day of education as a nurse. To a large extent it becomes symbolic of academic and clinical achievement and can become enshrined as a professional ideal

to which nurses must aspire. All clinical components of nurse education programs in Australia are based on a set of agreed competencies referred to as Australian Nursing Council Incorporated (ANCI, 1998) competencies. To be competent is linked with those skills and techniques associated with manual dexterity and often fails to include those psychosocial components of nursing, for example interpersonal skills.

An understanding of how competency is applied to nursing in terms of standards is enhanced by consideration of competency as a psychological construct.

3.5.1 Competency as a psychological construct

In the general research literature, the construct of competency has been evaluated through indirect measurement of related concepts. For example, a large number of measures of job-related affective wellbeing have been developed and utilised by researchers. These include job satisfaction, alienation from work, job attachment, job tension, depression, burnout and job morale (Cook, Hepworth, Wall & Warr, 1981; Diener, 1984; Goldberg, 1972). Competence is therefore implied through measuring other constructs. For example, in addition to job-related affective well-being, high or low mental health is also exhibited through the behaviour of employees. One important example here has been in the work of Warr (1987), who measured competence through measuring job-related mental health. It is important to note that a perceived lack of competence at work is not, in itself, an indication of poor mental health. Rather, job-related competence may predict mental health only if failure to cope with job demands influences the individual's affective well-being (Warr, 1987).

Competence has been widely discussed in the psychological literature (Smith, 1965, in Sells, 1968) in terms of environmental mastery (Jahoda, 1958), ability to cope with difficulties (Bradburn, 1969) and self-efficacy or expectations of mastery (Bandura, 1977). A competent person, according to Warr (1990:197), "is one who has

adequate psychological resources to deal with experienced difficulties". Warr pointed to a distinction between context-free competence and domain-specific competence, and the separate measurement of the two forms by either subjective or independent assessments. In this investigation the research topic of work-related aggression clearly places competence in the domain-specific category and will be measured by subjective self-report in the questionnaire. Warr stated that there are no instruments available to measure job-related competence. For example, he argued that the personal accomplishment component of burnout provides an index of job-related subjective competence.

3.5.2 Competency as applied in the nursing profession

As outlined in previous sections, nurses' responses to aggression can include a perception of themselves as less professionally competent, which may be linked with nursing culture expectations that aggression is prevalent and is to be tolerated and not reported. Competency is an important construct in professional training and registration in nursing. Potter and Perry (1993:327) defined competency in this context as the "overall perceptions of nurses regarding quality of functioning in delivering effective, direct patient care". The significance of this definition lies in the use of the words 'perceptions of nurses' as it clearly moves the assessment of competence from an external source to the internal, subjective domain, in agreement with Warr's (1987) reference to "psychological resources to deal with experienced difficulties." This definition is also not far removed from other notions of effective coping as expounded by Lazarus and Folkman (1984).

However, generally speaking, the emphasis on competency in nursing is on the so-called objective assessment of performance against agreed standards by external

measurements. In other words, competency as a standard is frequently assessed by others who are observing nurses perform nursing care.

Notwithstanding the abundance of literature on competency as a standard against which we assess nursing performance, Bradshaw (1998, in Australian Nursing Council Incorporated (ANCI, 1998) stated that nursing competency is only vaguely and broadly defined, and assessment of competency is haphazard and unstructured. In view of Warr's (1990) domain-specific category, the researcher considered it necessary to clearly link the construct of competency to the domains of nursing.

A major premise of the role and function of the nurse is the concept of caring which is the nurse "having positive regard for other people ... and respecting them as individuals" (Potter & Perry, 1993:327). In nursing, competence is linked to the quality and quantity of interventions and interactions that nurses' implement on a regular basis with patients. Professional competence may be self assessed by nurses reflecting on the amount and quality of time spent with patients, the nature and level of their communications with patients and colleagues, their ability to trust and respect patients and colleagues and the level of satisfaction they receive from their perceptions of how these interactions have been beneficial to patients. These components of competence are similar to those outlined by Warr (1987) as job-related subjective competence.

The ability to care is dependent on attitudes and feelings held by nurses toward people with whom they work as well as toward the people for whom they care. This ability is in turn nurtured by the physical and psychological environment in which nurses work. Nurses who have been recipients of aggressive behaviour may experience the negative emotion of anger, which will have to be reconciled with caring and hence competence. An inability to cope with the negative consequences of

aggression may impact upon nurses' perception of their ability to care, which will raise doubts regarding self-assessment of their professional competence. Professional competence, in the context of experiencing an aggressive incident, is therefore largely dependent upon nurses' perceptions of how they feel about the quality of their functioning within their role as a professional nurse.

3.5.3 Competency as a nursing standard

Slee (1992, in Australian Nursing Council Incorporated (ANCI, 1998) competencies), chairperson of the National Training Board (NTB), contended that competency standards developed by industrial and academic parties and subsequently endorsed by the NTB would form the keystone of the Australian vocational nursing education and training system. McGovern (1991:10), Assistant Secretary of the Australian National Office of Overseas Skills Recognition (NOOSR), stated that "nursing is the profession most advanced in developing competency standards". Accordingly all registered nurses are assessed along the accepted set of ANCI competencies.

ANCI defines competency as "the combination of skills, knowledge, attitudes, values and abilities that underpin effective/or superior performance in a profession/occupational area" (ANCI, 1998:28). In addition, "a registered nurse ... assumes accountability and responsibility for his/her own actions ... [and] practises independently and interdependently in accordance with professional standards" (p. 26).

The second edition (1998) of the ANCI competencies has as one of its purposes: to assess qualified nurses who are required to show that they can demonstrate the minimum level of competence for continuing practice. One of the four domains for nursing practice is 'enabling' which is described by ANCI as,

> [containing] those competencies essential for establishing and sustaining the nurse/patient relationship. This integrates the maintenance of safety, skills in interpersonal and therapeutic relationships, and communication and the organisational skills to ensure the provision of care. It also includes those interactions with other members of the health care team (p. 3).

A second domain described by ANCI is "reflection on practice, feelings and beliefs and the consequences of these for clients".

Each domain has a number of 'cues', defined by ANCI as "key generic examples of competent performance... [used] ... in assessing nursing practice" (p. 28). These cues spell out the standards to which professional nurses aspire. Once practising, each nurse carries internalised criteria which relate to ANCI standards. Competency, as "one who has adequate psychological resources to deal with experienced difficulties," as defined by (Warr, 1990:197), also implies within the nursing context the ability to meet standards of performance which have been prescribed by the profession and internalised by individual nurses. Although there is a major element of independent external assessment, nurses can also subjectively assess their own performance against the standards established by the profession. Obstacles, which prevent the attainment of these standards, have the potential to impact negatively upon their perception of professional competence.

The importance of competence is demonstrated in a study by Shinn, Rosario, Mørch and Chestnut (1984) on human service workers, including nurses. They reported that one third of their sample attended workshops and conferences in an attempt to build competence as a way of dealing with stress at work. Another third of the sample used the strategy of changing their approach to the job, using cognitive or emotional strategies, such as self-blame, anger or positive reinterpretation, when dealing with stress. It was also concluded in this study that individual coping efforts

did not have a significant impact in work situations, whereas social support had a main role to play in ameliorating the negative effects of work stress.

3.6 Research linking the relationships between work-related aggression, institutional social support and perceived professional competence

Lazarus and Folkman (1984) described the moderational effects of social support on the appraisal of the stressor with its potentially damaging effects on coping processes. To date there have been no empirical studies conducted in nursing which have tested the moderational effect of social support in the context of work-related aggression as a stressor. Wallis (1987) developed a model for the study of stress in nursing, which proposes social support as one of several moderators of the consequences of being assaulted. He did not, however, report on any research that tested this model. Nor has any research been identified which specifically focuses on institutional support as opposed to support from family members or non-work friends or associates.

Ganster and Victor (1988:22), having reviewed the evidence for the buffering effect of social support, concluded that "although there is evidence of a causal effect of such support on general wellbeing, very few specific conclusions can be reached regarding the impact of particular forms of social support".

3.7 Summary of Phase One of the study

The ability of professional nurses to function competently as effective health practitioners is clearly linked to how they address difficult experiences encountered in their workplaces. The resources available to them, both external as obtained through the availability of supportive staff, or internal, through the subjective feeling of competency, will either assist or provide barriers to their effective functioning. The nursing profession sets both the standards upon which feelings of competency are based, but also, through its own culture, limits the ability of nurses to make use of

available resources. Hence, there is a paradox for nurses who experience work-related aggression. On the one hand they should resort to the profession for support to deal with their negative experiences, whilst on the other hand, they are fearful that they be judged by their professional colleagues to have fallen short of the prescribed standards. The problem of aggressive behaviour toward nurses is therefore exacerbated by a culture within the nursing profession that leads recipients of aggression to cope with it at an individual level.

CHAPTER FOUR

PHASE TWO: A CONCEPTUAL FRAMEWORK, AGGRESSION, STRESS, COPING AND SOCIAL SUPPORT

4.1 Phase two: A conceptual framework, Aggression, stress, coping and social support

Professional nurses working in an environment already perceived to be stressful, featuring both the accepted stressors of high workloads, pain, anxiety and death, the potential for acts of aggression, may experience a state of heightened stress-based anxiety, with unfavourable physical, psychological and professional consequences. If those nurses who experience these unfavourable consequences do not obtain relief from stress through their own efforts, or by the efforts of the employer organisation, they are possibly victims of deficiencies of the organisation, rather than victims of aggression.

This chapter first explores the concept of stress and goes on to discuss the relationship between stress caused by work-related aggression, the concept of coping and the concept of social support as a contributor to coping in the context of exchange theories.

The stress model of cognitive appraisal is then integrated with a conceptual framework based on the notion of institutional social support as a moderating influence on the relationship between nurses' experience of work-related aggression and their perceived professional competence.

4.2 The concept of stress

The concept of stress was first used in the area of engineering, to refer to pressure applied to metal or other materials. Relating this notion of stress to human beings, some stress theorists have defined stress as the pressure placed on a person to adjust. Selye (1976), however, used the term to refer to the body's response to any

demand originating within or without the organism. The demand, which may take the form of aggression or hostility, upsets physiological and psychological homeostasis and activates a predictable stress response. Selye referred to these demands as stressors.

Lazarus and Folkman (1984:21; Lazarus, 1966) took the concept of stress further, to mean "the relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being". Thus, in this process-oriented or transactional scheme, the judgement that a particular person-environment relationship is stressful hinges on cognitive appraisal by the individual.

In this scheme, stress is viewed as having two components, stressors and the stress response and two intermediate stages of appraisal, namely, primary and secondary appraisal. The stress model can be easily presented diagrammatically as in Figure 2. Stressors in the area under investigation here are the actual incidents of aggression experienced by nurses in their workplace, which require some form of adaptation or adjustment to reduce the outcome of stress. According to Lazarus and Folkman (1984), these stressors stimulate a relatively fixed set of responses, which are collectively known as the stress response. The stress response consists of physiological, cognitive, emotional and behavioural responses in a complicated pattern.

Lazarus and Folkman (1984) have identified two stages of stress response. Acute stress occurs when the act of aggression is taking place and an immediate response is warranted. Acute stress may be very intense and lasts for the duration of the aggressive behaviour. Chronic stress, on the other hand, may be completely unnoticed by the person as it is often below awareness.

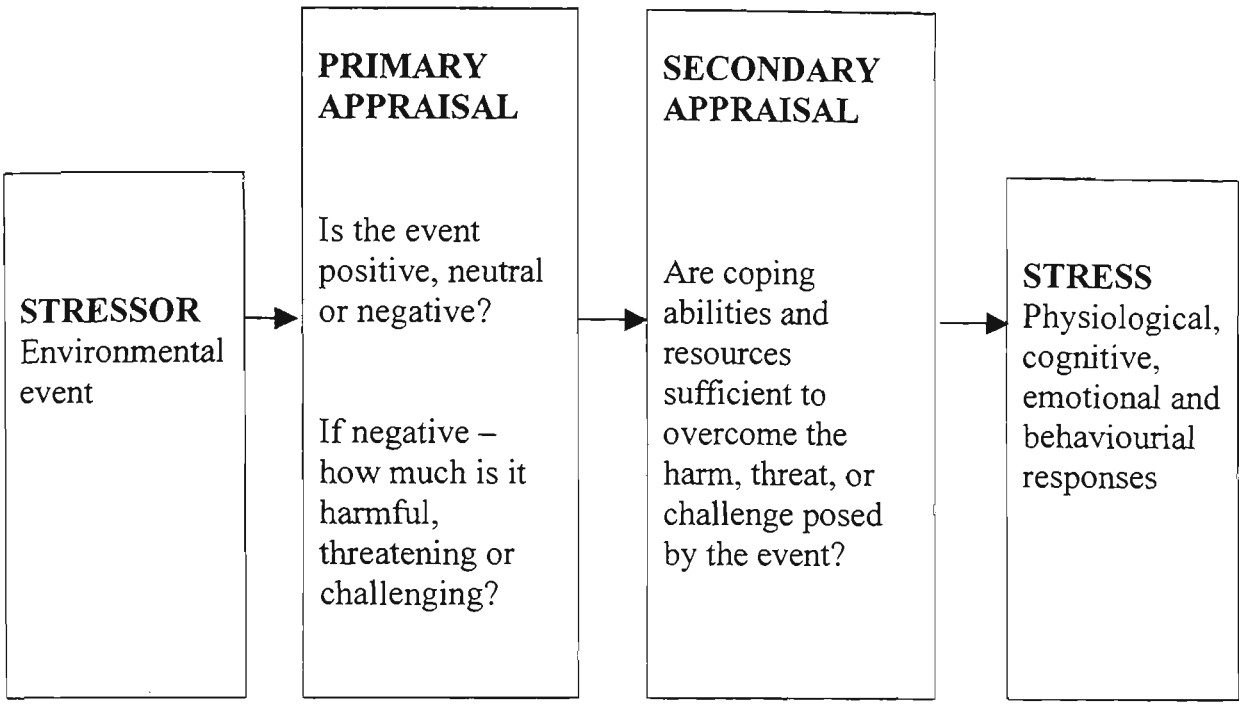


Figure 2. The experience of stress: From Billings and Moos, (1981:145)

A single outburst of aggressive behaviour may be stressful and place immediate demands upon a nurse who has the necessary resources and strategies to cope, thereby resulting in experiencing acute stress that will be reduced. Repeated aggressive behaviours, on the other hand, may appear unrelenting and exhaust coping resources and strategies and contribute to chronic stress.

4.3 Cognitive appraisal of stress

The proposition that cognitive processes moderate the individual's responses to the environment has been widely accepted in the stress literature (Croyle, 1992; Dewe, 1991, 1992; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Folkman, Lazarus, Gruen, & DeLongis, 1986; Gadzella, Ginther, Tomcala, & Bryant, 1991; Larsson, Kempe, & Starrin, 1988; Ptacek, Smith, & Zanas, 1992).

Lazarus and Folkman (1984:314) have stated that "the degree of stress a person experiences depends on how much of a stake he or she has in the outcome of an encounter". They further elaborated:

> If the encounter seems to have no relevance for the person's well-being, then the primary appraisal will be that it poses no threats, has done no harm, or offers no prospects of gain. On the other hand, if the person has something at stake in the outcome, the primary appraisal will be that the encounter does pose a potential threat, harm or challenge, depending on the coping resources and options (p. 315).

According to Gazzaniga (1988:996), threat has more to do with the idea of control "...people can't, or think they can't, control their immediate environment". DasCupta (1992:33) claimed that "in short a perceived lack of control is just as important as an actual lost of control in causing us to feel threatened". A person's sense of control in any situation also comes from believing that it is possible to reach desired goals. Bandura (1986:750) similarly observed, "it is threatening for a person to feel that he or she lacks competence to cope with a particular demand".

Secondary appraisal involves an evaluation of whether there can be something done to prevent or minimise the potential negative outcome. Reappraisal refers to a changed appraisal based on new information from the environment and/or person (Lazarus & Folkman, 1984). Thus, in the present context, while primary appraisal involves the level of threat perceived by the nurse, secondary appraisal involves the nurse's assessment of his or her own resources for dealing with the incident. This not only involves immediate resources such as maintaining physical safety, but appraisal of the impact of the incident on the ability to remain in control and maintain professional competence within the nursing discipline itself and within the employing organisation. To a large extent this secondary appraisal will be influenced by such factors as the perceived support available from significant others within and outside the institution.

Such a view is supported by Lazarus and Folkman's (1984) suggestion that we must ask the person to tell us in some way what is at stake and how much it matters to him or her personally. Questions about what the person felt, thought and did to cope

with the various demands of a specific encounter should be asked. The essence of Lazarus and Folkman's appeal is that a phenomenological approach is required when investigating the experiences of human beings subjected to stressful or aversive stimuli.

4.4 Stress as threat and/or challenge

An important distinction between a threat, with its potential negative outcomes of harm and loss, and a challenge, with potential positive outcomes of growth and gain, was made by Lazarus and Folkman (1984). Aggression might indeed be viewed as a challenge by nurses in the workplace as it affords an opportunity to develop, improve and utilise skills and professional knowledge that may result in improvements in perceived competence. This view was supported by Finnema, Dassen and Halfens (1994), who claimed that, despite the fact that on the whole the general public have a negative view of aggression, nurses in their study acknowledged positive as well as negative aspects of aggressive behaviour of patients.

According to Lazarus and Folkman (1984), threat and challenge are separate but related stimuli that may occur simultaneously and both call for mobilisation of coping efforts. Individuals who appraise the situation as a challenge are likely to function more effectively as they feel more confident, less emotionally overwhelmed, and more capable of drawing on available resources. Challenge appraisals are more likely to occur when the person has a sense of control over the troubled person-environment relationship. Lazarus and Folkman (1984:65) stated that "the extent to which people feel confident of their powers of mastery over the environment or, alternatively, feel great vulnerability to harm ... affects whether an encounter will produce threat or challenge behaviours". It is clear that this feeling of mastery over their environment as proposed by Lazarus and Folkman (1984) is akin to the

subjective job-related competence discussed by Warr (1987). Perceptions of either threats or challenges may be dependent upon who initiated the aggression. Nurses may feel more in control with patient initiated aggression but quite powerless with either nurse or doctor initiated aggression.

Feinstein and Dolan (1991) investigated whether the extent of actual severity of the threat produced symptoms of stress in the longer term and showed that the initial reaction to the assault had the greatest influence on the end result. Feinstein and Dolan also developed a model of stress as a result of violence in the workplace setting. In their model, there was a focus on the type of violence that takes place rather than the outcome or consequences for the victim. However, conceptualising these dimensions to be distinguishable from each other is flawed in certain respects, as seen from a psychological viewpoint. Two other workers in this area have produced a body of literature that has not only incisively criticised existing models, but has also developed a practical model of staff appraisal of violent situations in the health care workplace (Whittington & Patterson 1995; Whittington, Shuttleworth & Hill 1996; Whittington & Wykes 1994a, b, unpublished work 1995; Wykes & Whittington, in Wykes & Mezey, 1994).

4.5 The concept of coping

"People are rarely passive in the face of what happens to them; they seek to change the things they can, and when they cannot they use cognitive modes of coping by which they change the meaning of the situation" (Pearlin & Schooler, 1978:248). Researchers have therefore increasingly investigated coping responses as a way of understanding individual variability in response to stress. How individuals appraise problems, whether they initiate problem-focused strategies, and how they deal with

adverse emotional consequences of a stressful situation influences psychological wellbeing (Folkman & Lazarus, 1980; Pearlin & Schooler, 1978).

Both the coping responses that individuals use and the supportive (or nonsupportive) responses they receive from significant others in their employing institution influence vulnerability to stress. By coping, Pearlin and Schooler (1978) referred to the things that people do to avoid being harmed. One of the factors that may influence a nurse's interpretation of an aggressive incident is how much she/he is able to cope with it.

Researchers have claimed that coping facilitates the management of tension effectively, and that it has both cognitive and behavioural elements (Billings & Moos, 1981; Matheny, 1983). Lazarus and Folkman (1984:325), in their transactional model, viewed the person and the environment as being in a "mutually reciprocal, bi-directional relationship," and suggested that "separate person and environment elements join together to form new meanings through appraisal" (p. 326).

The transactional model treats individual differences and environmental factors as part of the one global construct, rather than as separate entities. Other models have been proposed that view outcomes between individual differences and environment as being moderated by other independent factors, including personality characteristics, coping styles, or the psychosocial environment. This structural model can be found in the writings of Billings and Moos (1981).

Lazarus and Folkman (1984:141) have defined coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that one appraises as taxing or exceeding the resources of the person". This definition was further developed to include the internal and external demands of the person-environment transaction (Folkman, Lazarus, Gruen & DeLongis, 1986). It took into

account the context in which coping takes place, rather than attempting to make predictions about how the individual might behave across a variety of situations in the future. Lazarus and Folkman (1984:142) continued to clarify the concept of coping as having three main features:

> Firstly, observations and assessment are concerned with what the person *actually* thinks or does, in contrast to what the person usually does, would do, or should do.
>
> Secondly, what the person actually thinks or does is examined within a *specific context.* To understand coping, and to evaluate it, we need to know what the person is coping with. The more narrowly defined the context, the easier it is to link a particular coping thought or act to a contextual demand.
>
> Thirdly, to speak of a coping process means speaking of *change* in coping thoughts and acts as a stressful encounter unfolds (p. 142).

The definition of coping provided by Lazarus and Folkman (1984) does not imply successful outcomes; rather, it denotes the maximising of efforts to manage the situation regardless of outcomes. Lazarus and Folkman (1984) took pains not to confound coping with adaptational success or the process of coping with the outcome of coping. They pointed out the importance of defining coping independently of outcome, adding that the study of coping behaviour should include failures as well as successes: "the concept of coping is defined by the behaviours subsumed under it, not by the success of those behaviours. It may be even more profitable to concentrate upon those behaviours which are intended to cope with stress but which fail to do so" (p. 144).

Lazarus and Folkman (1984:139) emphasized that coping is not mastery over person-environment problems; rather, "coping processes that are used to tolerate such difficulties, or to minimise, accept, or ignore them, are just as important in the persons' armamentarium as problem-solving strategies that aim to master the environment". They also pointed out an important methodological issue when

measuring responses to stress. They stated that it is difficult to see how the unfolding nature of stressful encounters, and the concomitant changes in coping, could be adequately described by a *static* measure of a general trait or personality disposition.

Coping, therefore, may be viewed as "constantly changing efforts to manage stressful demands" regardless of outcomes (Lazarus & Folkman, 1984:139). It may be influenced not only by the nature of the stressful event, but also by the intraindividual and environmental resources available to the person concerned (Moos & Billings, 1982; Rosenbaum, in Rosenbaum, Franks & Jaffe, 1983; Roskies & Lazarus, in Davidson & Davidson, 1980).

Pearlin and Schooler (1978) elaborated useful distinctions between social resources and psychological resources. They stated that resources refer not to what people do, but to what is available to them in developing their coping repertoires. Social resources are therefore represented in the interpersonal networks of which people are a part and which are a potential source of crucial support. Psychological resources are internal personality characteristics, for example self-esteem, that people draw upon to help them withstand threats posed by events and objects in their environment. An important contribution was also made by Pearlin and Schooler (1978:6) when they pointed to 'positive comparisons', which are characterised by such idioms as "count your blessings" or "we're all in the same boat". Conditions which may appear to be very difficult to an outsider may be assessed as less difficult, or no more difficult, than those faced by their significant others.

4.6 Dimensions of coping

Lazarus and Folkman (1984) have identified two broad dimensions of coping, namely problem-focused and emotion-focused coping. Problem-focused coping involves taking direct action to solve the problem or seeking information that will be

relevant to the solution. Problem-focused forms of coping are more likely to be used when such conditions are appraised as amenable to change (Lazarus & Folkman, 1984:150). Emotion-focused coping, on the other hand, constitute efforts to reduce the emotional reactions to stress. Emotion-focused forms of coping are more likely to occur when there has been an appraisal that nothing can be done to modify harmful, threatening, or challenging environmental conditions. In a review of relevant literature, Greenglass (1995) concluded that men and women differ in the coping strategies they utilise. She suggested that the differences resulted from an unequal distribution of power and control, stereotypes and occupational gender segregation.

In the nursing response to workplace aggression, emotion-focused coping could be reflected by the nurse victim's reluctance to report aggressive incidents to senior personnel. As Dewe (1989:316) indicated, "in many situations the selection of a coping strategy is in part determined by the physical, social and psychological resources that the nurse perceives are available to her".

This would imply that if nurses in general health care settings are limited in the amount of control they have to manage aggression, they are more reliant on other key staff to provide support during or following aggressive behaviour.

Hospitals impose bureaucratic policies, practices and procedures upon employees, thereby formalising and prescribing how nurses at different levels of the hierarchy can actually cope with stressful situations. Nurses may not have a choice, or at least perceive that they have limited choices, in what type of coping strategy they can utilise in dealing with aggressive behaviour. It is important, therefore, to distinguish between coping resources and coping strategies. Dewe (1989) pointed out that due to restrictions or limitations on nurses' choice of problem-solving strategies, emotion-focused strategies should be valued and given higher recognition. If nurses

are to rely upon emotion-focused strategies, then it is important that work structures be more sympathetic to these strategies and provide a support climate where nurses can constructively release and deal with their emotions.

Results of Billings and Moos' (1981) study showed that the relationship between social resources and coping is very complex and contradictory. Billings and Moos suggested that it may not be possible to identify positive or negative types of coping because of this complex relationship between coping, social support and the event to be dealt with. They did, however, note that more reliance on active attempts to deal with the event, and fewer attempts to avoid dealing with it, were associated with less stress.

The effectiveness of individual coping strategies has been explored in a sample of married couples (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). They demonstrated that stressful encounters ending with a satisfactory outcome, as rated by the participants, were characterised by the use of problem-solving and positive appraisal. Stressful events with unsatisfactory outcomes were characterised by the use of confrontative coping and distancing.

It has been contended that the coping responses of coping and venting emotions, behavioural and mental disengagement were less useful and may be dysfunctional (Carver, Scheirer, & Weintraub, 1989). These contentions were not supported by Stockdale (1998:533), who found that "contrary to conventional wisdom, individuals who experienced frequent sexual harassment and who use confrontive coping strategies tended to experience worse job outcomes than did others". Other studies, however, found the reverse. For example, Cairns and Wilson (1984) discovered that people in Northern Ireland who realistically perceived that the

level of violence was threatening experienced more stress than people who used denial to inaccurately perceive the level of violence in the environment.

Whatever the detail, the Lazarus and Folkman (1984) framework suggests that stress experienced by nurses as a result of aggressive behaviour is a consequence of their individual judgement about whether their personal resources can meet the demands of the environment, including its social and political structures.

4.7 The concept of social support and coping

Caplan's (1974) first definition of support provided pioneering direction when he noted that those persons who coped most adaptively with stress were those for whom the environment provided consistent feedback about their behaviour and performance, as well as information about assistance and help with tasks. He concluded that the term social support consisted of three elements:

> Others (who) help the individual mobilise his psychological resources and master his emotional burdens; they share his tasks; and they provide him with extra supplies of money, materials, tools, skills, and cognitive guidance...(p. 6).

Cobb's (1976) definition of social support suggested that individuals' relations to their social environments influence their health. He defined social support as information leading to the belief that one is cared for, loved, esteemed, valued, and part of a network of communication and mutual obligation. Cobb omitted tangible aid such as materials and money as social support. Kahn and Antonucci (1979, in Baltes & Brom, 1980) conceived social support as interpersonal transactions containing one or more of the following: affect (love, liking, respect, and admiration), affirmation (agreement, acknowledgment of appropriateness or rightness of another's behaviour), and aid (direct service of giving of material supplies). Schaefer, Coyne and Lazarus (1981) defined social support as being comprised of three subconcepts of emotional, informational, and tangible support.

House (1981:22) made an important contribution to the definition of social support in two ways. First, he structured the definition issue as, "who gives what to whom regarding which problems". Second, he noted agreement among the many definitions of social support that emotional support is important in buffering stress and facilitating health. Schaefer et al. (1981) distinguished three types of social support, namely emotional support, contributing to the feeling that one is cared about, tangible support, involving direct material assistance in the form of money or services, and informational support, providing helpful information or offering feedback. According to House and Kahn's (1984, in Cohen & Syme, 1985) review of social support instruments commonly used in the social-psychological literature, priority should be given to measurement of emotional support. Another important dimension of social support important to the area of nurses' responses to workplace aggression, is its potential for either positive or negative outcomes. Reciprocally stressed networks within complex institutions such as health agencies, inter and intra discipline conflict, role ambiguity, and strain between individual staff members, may all result in negative 'supportive' behaviours.

Lazarus and Folkman (1984:250) expanded on the concept by declaring the basic assumption underlying social support to be "other things being equal, people will have better morale and health, and function better, if they receive or believe that they will receive social support when it is needed". Lazarus and Folkman (1984) made the point that the way people cope is determined in part by their resources. These resources include health and energy, existential or religious beliefs, general beliefs about control, commitments prompting motivation to sustain coping, problem solving skills, material resources and social support itself.

Lazarus and Folkman (1984) described the moderational effects of social support on the appraisal of the stressor with its potentially damaging effects and coping processes. Personal and situational factors applicable to individual nurses will influences how they appraise work-related aggression.

A supportive work environment has been proposed as a coping strategy or moderator, buffering the individual from the damaging effects of work stressors such as work-related aggression (Payne, 1978, in Mackay & Cox, 1979). In the health industry, however, the work environment is not necessarily supportive. Nurses' interactions with the environment must take account of the social and political implications of the hierarchical structure and the factors of gender, status, class, race and personality that impinge upon that structure. Victims of aggression may be encouraged to not report or discuss aggressive incidents, thereby closing off possible sources of support, and, as a consequence, suffer more intensely.

Stewart (1989) also made an important point when she distinguished between perceived support as potentially available from the social network, and received (actually provided) support. Perceived social support is the cognitive appraisal of being reliably connected to others. It refers to the subjective evaluations, especially to their supportiveness, of the interactions occurring in social relationships (Sarason, Levine, Basham & Sarason, 1983, in Lazarus & Folkman, 1984).

Similarly, Dean and Lin (1977) wrote that since so much of the research on social support entails subjective perceptions by people of what kind of help they were given, we may essentially be studying differences in perception and not differences in amount or type of help. Those who believe that benefit can be derived from peers will nurture and utilise such relations, while those not possessing positive expectations will not make this kind of investment.

If nurses in general settings are limited in the amount of control they have to manage aggression, they are more reliant on other key staff, for example medical staff and senior nurse administrators, to provide support during or following aggressive behaviour. An added factor here is that the support potentially available from staff following aggression may not be actually provided, as those very same staff members may have instigated the aggression.

Further, culturally based values and beliefs embedded in the nursing profession may inhibit nurses from making optimal use of available coping resources. Although nurse colleagues and management may quickly rally around nurses who experience stressful but predictable critical incidents, such as a death of a patient, to provide support, they may be less supportive in response to unpredictable stressful situations that arouse feelings of discomfort, such as work-related aggressive behaviours. Thus the nurse may feel inhibited about communicating assertively with a doctor or senior nurse administrator because of power imbalances.

Yet another issue for nurses in coping with work-related aggression is that their work-environment is bi-directional, both the source of aggression, it also paradoxically, has the potential to provide social support, which will assist nurses' to cope. Whittington, Shuttleworth and Hill (1996) warn that it is possible that the relationship between staff stress and patient aggression is more complex as stress in staff may contribute to dysfunctional nurse-patient interactions, resulting in patient initiated aggression. Poyner and Warne (cited in Whittington, Shuttleworth and Hill, 1996:332) identify that "staff stress can lead to misinterpretations and lower tolerance of offensive behaviour and thus acts as a cause of workplace violence as well as being an effect".

The social environment, then, through its rules, regulates relationships and influences individuals' psychological, emotional and professional responses. Reciprocally, individuals also influence the social environment. As now demonstrated, a significant theme of the theoretical literature on social support is that it acts as a buffer between stress and health by either reducing negative consequences or providing valuable resources when stress does occur.

4.7.1 Timing of social support

The model of ecological congruence (Hobfoll, 1985), which relates to the fit of individuals' perceptions, values, and resources to the circumstances of the stressor event, suggests that time elapsed since the occurrence of the event is a central factor in determining the social support requirements. Studies on social support need to consider this key variable, which has been underutilized in this area of research.

The failure to take into account time since the stressful event may have confounded the study of the stress buffering effect in particular. For example, by say ten months after an event emotional support has waned, other resources have had time to come into play, and instrumental support may no longer be congruent with needs. Individuals who differ in the amount of stress in their lives may be differentially affected by social support, but such a process is more likely at an earlier stage.

Immediately following a stressful event, those who have supportive networks might be expected to receive a flood of instrumental assistance, information, love and affection, and direct attempts by social network members to help them solve their problems or prevent a chain of related life events (Wilcox in Thoits, 1983). They would also at this time be able to apply other resources – personal, financial, constitutional – to battle the negative consequences of the event.

For similar reasons, examining individuals who experience a common single event and not an aggregate of many different events may allow for clearer analysis of the buffering effect in particular and the social support process in general (Hobfoll & Walfisch, 1984). Events which are less likely to be related to personal variables, may also be chosen to limit the confounding effect discussed earlier. Such designs also limit the possibility of mixing different types of events which require different resources – some actually being incongruent with social support (Hobfoll, 1985). In fact, the buffering hypothesis has intuitive appeal because it has been assumed that during stressful periods, persons with social networks that have certain qualities receive supportive efforts from their networks (Caplan, 1974; Cobb, 1976; Dean & Lin, 1977).

4.7.2 Social support and exchange theories

As indicated above in Section 3.3, reciprocity in social support relationships appears to be important in understanding the dynamics of nurses' experience of work-related aggression. It can hence be assumed to be important in how the Lazarus and Folkman transactional model may be applied. Social exchange theories or models share a common assumption that social support should be examined within the context of social influence processes entailing obligations and rewards (Kasi & Wells, in Cohen & Syme, 1985). Such models suggest that support can involve benefits and costs for both recipients and providers, where costs are the perception of effort expended and debts incurred.

Most exchange theorists assume that relationships are in general more satisfying and stable when reciprocity is perceived, and when the rewards for each partner are perceived to be more or less equal (Adams, 1963; LaGaipa, 1977; Thibaut & Kelley, 1959). In particular, equity theorists have argued that being overbenefited

as well as being underbenefited in a relationship is accompanied by negative feelings and this applies to many types of relationships, including helping relationships (Walster, Walster & Bersscheid, 1978).

For example, Hatfield and Sprecher (in Fisher, Nadler & DePaulo, 1983) have presented evidence that receiving help may induce feelings of inequity when persons are not willing or able to reciprocate the helping behaviour or when they obtain a more favourable rate of outcomes than the help giver. According to Hatfield and Sprecher, help may be experienced as particularly negative when someone fears that the other might expect costly benefits in return. In a similar vein, Greenberg and Westcott (1982, in Fisher, Nadler & DePaulo, 1983) were concerned with indebtedness as a negative affective consequence of receiving help and have shown that this state is aversive because of feelings of obligation and owing, fear of being unable to repay the debt, and uncertainty about if, when, and how the debt can be repaid.

The social exchange model identifies a lack of reciprocity of social support from colleagues as a contributor to stress at work (Buunk, Doosje, Jans & Hopstaken, 1993). In this type of stress modelling, the support relationships between peers and managers have been considered to be a major influence on the production of stress-related negative symptoms (LaGaipa 1977). Walster, Walster and Berscheid (1978) suggested that in different types of helping relationships, the extent to which a person considers themselves to be undersupported, will dictate the level of perceived stress. In a similar vein, Greenberg and Westcott (in Fisher, Nadler & DePaulo, 1983) postulated a 'degree of indebtedness,' which has a negative affective consequence of being in a position to receive help, and argued that this contributed to the production of stress owing to the fear of being unable to repay such a debt.

4.8 A proposed conceptual model

A conceptual framework considered potentially helpful in understanding possible associations between nurses' experience of work-related aggression, institutional social support and nurses' self-perception of professional competence involves the notion of moderating relationships between these experiences.

Barron and Kenny (1986:1173) described a moderator as a "function of third variables, which partitions a focal independent variable into subgroups that establish domains of maximal effectiveness in regard to a given dependent variable". Similarly, Lindley and Walker (1993) claimed that a moderator is a third variable that influences the relationship between a predictor variable and an outcome variable. The moderator variable may be either a categorical or continuous variable. The moderator effect can be described as an interaction between a predictor variable and a moderator variable. A moderator, therefore, affects the direction and/or strength of the relationship between an independent and a dependent variable, the implication being that the causal relation between two variables changes as a function of the moderator variable.

Cohen and Cohen (1983) explained that an interaction effect occurs when two variables, in their accounting for variance in the outcome variable, have a joint effect over and above any additive combination of their separate effects.

In the conceptualised model developed and proposed here, institutional social support was categorised into different levels and further sub-categorised into different sources. Levels and sources of support would interact with type and sources of workplace aggressive behaviour and bring about alterations to perceptions of professional competence. The proposed moderating relationship between work-related

aggression, institutional social support and perceived competence is represented in Figure 3 as a path diagram.

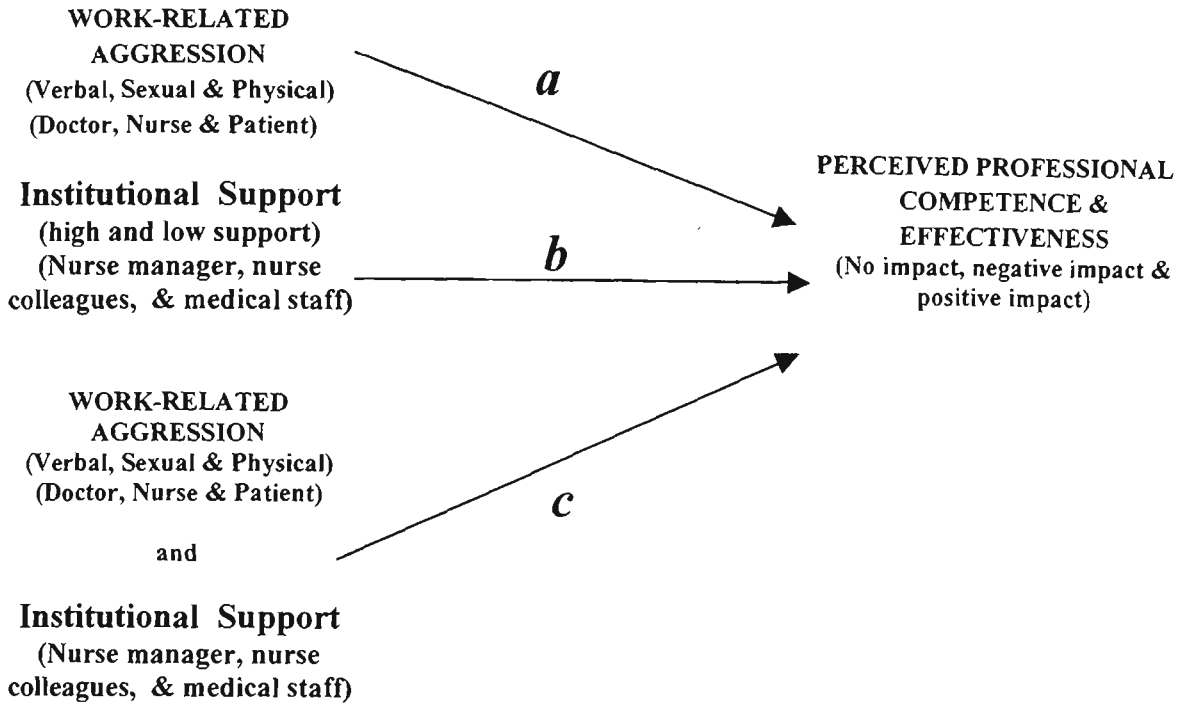


FIGURE 3 **Model of the moderating effect of institutional support on work-related aggression and perceived changes to professional competence**

4.8.1 Institutional social support as a moderator

Moderator effects here can be represented as an interaction between work-related aggression and institutional social support, providing appropriate conditions for institutional support are specified. The appropriate conditions would include institutional social support being available, having significant personnel within the institution to care for and be supportive toward victims of aggression.

The model diagrammed in Figure 3 has three causal paths that feed into the outcome variable of perceived professional competence. The impact of work-related aggression as a predictor (Path *a*), the impact of institutional social support as a moderator (Path *b*), and the interaction or product of these two (Path *c*). The moderator hypothesis is supported if the interaction (Path *c*) is significant. There may also be significant main effects for the predictor and the moderator

(Paths *a* and *b*), but these are not directly relevant conceptually to testing the moderator hypothesis. According to Barron and Kenny (1986), it is desirable that the moderator variable be uncorrelated with both the independent and dependent variable to provide a clearly interpretable interactional term.

An important point is the fact that very few psychological phenomena have single causes. A variety of causes have been postulated as contributing to changes to perceived professional competence of registered nurses. Therefore, it is unlikely that moderators such as institutional social support would result in zero correlations. Nevertheless, the relationship would be significantly reduced indicating the absence of institutional social support as a single dominant moderator and the presence of multiple moderating factors. These may also include non-institutional social support from family and friends, and use of other stress reducing strategies, personality characteristics, coping styles or the psychosocial environment.

4.9 Rationale for the moderational model

The proposed conceptual model is grounded in the relationship between the person's primary and secondary appraisal of stressors and the available resources, influenced by the support received or not received (Lazarus & Folkman, 1984), and the impact of this relationship on perceived professional competence (Bandura, 1986; Gazzaniga, 1988). The theoretical underpinnings of coping, cognitive appraisal, social support and competency have been presented in the current chapter and have been supported empirically in Chapters Two and Three (Billings & Moos, 1984; Buunk, in Stroebe & Hewstone, 1990; Caplan, 1974; Cobb, 1976; Cohen & Wills, 1985; Lazarus & Folkman, 1984; Maslach & Jackson, 1981; Pearlin & Schooler, 1978). Mason and Chandley (1999) and Duxberry (1999) referred to an anticipation of support which is germane to this thesis and forms the basis for postulating the central

hypothesis, that institutional social support should make a difference to how nurses who experience aggression in their workplace perceive their own professional competence.

4.10 Summary

Chapter four presented the conceptual framework for the investigation. This framework is dependent upon establishing a basis for proposing the moderating effect of institutional social support. More specifically it establishes the basis for hypothesising that the adverse effects of work-related aggression on perceived professional competence will be moderated by the perceived availability of institutional support.

The first part of chapter four details the concept of stress and concludes that work-related aggression has the potential to be considered an adverse event that may be perceived by nurses as a challenge or a threat. The impact of this effect would be on those aspects of job-related competency that were considered to be domain-specific competence.

The concept of cognitive appraisal was presented with an explanation that work-related aggression as a stressor had the ability to bring about changes in victims as a result of their actual or perceived loss of control. It was previously argued in an earlier section that competence was akin to control and mastery over one's environment. Therefore, a relationship appears to exist between work-related aggression and perceived competence.

The concept of coping as described by Lazarus and Folkman (1984) was the foundation for proposing that social support could be considered as a buffer to stress. The element that was of most interest to the current investigation was how nurses perceived the availability of social support from key people within the institution. The

researcher argued that one element of support was the willingness or unwillingness of nurse victims to access support. Reporting therefore is an integral component of institutional support. An environment conducive to supporting victims of aggression will facilitate reporting of aggressive incidents whilst an environment which is perceived by nurses to be non-supportive will not only inhibit reporting, but will also exacerbate the situation. Either way, there is a real potential to have either positive or negative effects on perceived competence.

There was a constant theme which has a significant impact upon the methodology selected for this study. Lazarus and Folkman (1984) point to the need to consider the context that influences coping. They appeal to researchers to adopt a phenomenological perspective when conducting research.

The final section of chapter four presented other theories that appear to have relevance for this investigation. Exchange theory would appear to explain the nature of different responses by recipients of support. Exchange theory would argue that supportive relationships were based on reciprocity and that there were essential differences in seeking and obtaining support from people who were considered equal in ranking and those who were considered of senior ranking.

CHAPTER FIVE

CONCEPTUALISATION OF THE PRESENT INVESTIGATION

5.1 Conceptualisation of the present investigation

As clearly emerges from the empirical literature in this field, there is a need to firstly investigate the frequency, type and sources of aggression and the reporting behaviours of nurses who have been victims of aggressive behaviour in the workplace. Secondly, there is a need to identify the perceived presence or absence of institutional social support for nurses when they report aggressive behaviours. Thirdly, there is a need to elucidate the effect of institutional support in moderating the potential negative impact of workplace aggressive behaviour on perceived professional competence. Finally, there is a need for research studies which explore and describe in greater depth the experiences of nurses who have been victims of aggression in their workplace.

In order to meet these research needs, it has been necessary to combine two methods of data collection. The first approach was to survey a systematic random sample of registered nurses whose names were obtained from the Nurses Board of the state of Victoria.

The purpose of this survey was two-fold. Firstly, the questionnaire was used to collect quantitative data concerning the frequency, types and sources of work-related aggression experienced by professional nurses in Victoria. Other data deemed to be essential to the investigation were the reporting behaviours of nurses and the subsequent supporting behaviours of key staff from within the institution as perceived by the nurses. Finally, data relating to perceived professional competence of nurses in response to their experience of work-related aggression would be obtained.

Secondly, the questionnaire elicited qualitative data exploring the location of aggressive behaviour, circumstances leading up to aggression and means by which aggression was managed by participants.

A further aim of the questionnaire was to recruit a number of participants who had reported that they had experienced work-related aggression and were willing to have continuing involvement in the investigation. In essence, they consented to be contacted by the researcher to discuss the possibility of being interviewed about their experiences.

The second approach to data collection, then, was the conduct of in-depth interviews with participants who had experienced workplace aggression and agreed to further involvement in the investigation. The purpose of in-depth interviews was to elicit qualitative data in the form of participants' own narratives about their experiences of workplace aggression. These narratives were analysed to identify common responses of nurses to their experiences of work-related aggression. This approach recognised the significance of Lazarus and Folkman's (1984) appeal to integrate a phenomenological approach into investigation into their model.

5.2 Research aims

Overall, the study aimed to provide empirical data essential to assist the nursing profession to more effectively support nurses who have been victims of work-related aggression.

The primary aim of the investigation was to develop and evaluate the proposed conceptual model outlined in Chapter Four. The model identifies relationships between stressors associated with work-related aggressive behaviour, perceived institutional social support of registered nurses, and nurses' perception of changes to professional competence. The second aim was to identify in some depth the

professional and emotional reactions and responses of registered nurses to work-related aggression.

A third aim was to recommend strategies and policies to health administrators, nurse administrators and educators, which either prevent and/or minimise the traumatic effects that work-related aggressive behaviour directed toward nurses has on their perceived professional competence.

5.3 Research questions

This study would therefore address the following research questions:

1. What is the frequency of work-related aggressive behaviour experienced by nurses?

2. What are the sources and types of work-related aggressive behaviour experienced by nurses?

3. What are the reporting behaviours of nurses in response to work-related aggression?

4. What institutional social support is expected and received from staff within the organisation by nurses who have experienced work-related aggression?

5. What is the impact of work-related aggression on nurses' perceptions of institutional support and professional competence?

6. What effect has work-related aggression on the professional and emotional wellbeing of nurses?

and

7. Does perceived institutional social support moderate the negative effects of work-related aggression on registered nurses' perceptions of professional competence?

5.4 Research objectives

The above questions generated specific research objectives as set out below.

Objectives (i), to (v) are relevant to the quantitative aspects of the project, while objective (vi) is relevant to the qualitative aspects.

(i) Develop a valid and reliable instrument which will assist with the description of key concepts of work-related aggression, perceived institutional social support, and perceived professional competence of registered nurses;

(ii) Identify the frequency, type and sources of work-related aggressive behaviour experienced by registered nurses;

(iii) Identify nurses' reporting behaviours following acts of aggression;

(iv) Identify nurses' expectations and perceptions of the availability of and their utilisation of institutional social support following their experiences of acts of work-related aggression;

(v) Identify and describe associations between work-related aggression, institutional social support and perceived professional competence; including testing of the possible moderation function of perceived institutional social support on work-related aggression as it impacts upon nurse's perception of professional competence;

and

(vi) Explore and describe nurses' responses to work-related aggression in some depth.

5.5 Research hypotheses

In the current investigation perceived institutional social support was hypothesised to function as a moderater on the relationship between work-related aggression and perceived professional competence. Based on the testing of this hypothesis in a moderational model (Barron & Kenny, 1986), it was expected that when institutional social support was controlled statistically, the magnitude of the relationship between work-related aggression and perceived professional competence would decrease.

Two hypotheses relevant to objective (v) were to be tested:

(i) Work-related aggression is experienced as having a negative impact on nurses' perceptions of supporting behaviours of key staff from within the institution;

and

(ii) Work-related aggression is experienced as having a negative impact on perceived professional competence;

5.6 Expected outcomes of the investigation

On the basis of the results of this study, it was planned to make recommendations to nurse administrators regarding the management of nurses who have experienced work-related aggression. Information would be provided to relevant agencies and institutions, as well as to the field in general, to assist in the development of educational programs, in both inservice staff development and undergraduate tertiary courses.

There is clearly a need for the nursing profession, through a combination of in-service, staff development, undergraduate and post-graduate education programs to raise the overall level of awareness to the problem of work-related aggression within its members.

In summary, the study was intended to provide the nursing profession in general and more specifically to nursing educators, administrators and clinical nurses, knowledge that will assist nurses who have experienced stressors associated with work-related aggressive behaviour, to develop and utilise adaptive coping strategies that will contribute to their professional competence. It will also contribute to improving knowledge of nursing culture and decrease the existing gap in the research literature in the area of work-related aggression, perceived professional competence and institutional social support.

CHAPTER SIX

PHASE THREE: DEVELOPING A RESEARCH DESIGN

6.1 Phase Three: Developing a research design

This chapter highlights the difficulties encountered by researchers in selecting appropriate research designs for studies involving negative human phenomena such as aggression. These difficulties include the inability to manipulate an independent variable and randomly assign subjects to groups. To overcome some of these difficulties the researcher elected to utilise complementary quantitative and qualitative methodologies in a single research design.

The design selected was sequential methodological triangulation, which commenced with a survey (Phase Four) to collect primarily quantitative data on the extent, source, type and some situational factors relating to workplace aggression. Justification for sequential methodological triangulation was the need to test the model that outlined the moderator relationship between work-related aggression, perceived institutional social support and perceived professional competence.

The study went on to conduct in-depth interviews (Phase Five) to collect qualitative data. Phenomenology was the preferred qualitative approach for the design. A brief historical overview of phenomenology is provided, together with an explanation of its usefulness in studies that require researchers to gain insights into the lived experiences of participants.

The final section of the chapter provides an overview of Phase Four, Five and Six of the investigation.

6.2 Complementary quantitative and qualitative methodologies

Lanza (1986) raised a methodological question as to the best way to study nurses' experiences of patient assault, noting that ethical considerations prevent the

actual staging of an assault situation. Experimental manipulation of the independent variable, a control group, and random assignment of subjects - all requirements of an experimental design - are not ethically possible. It would be necessary to explore the research questions by drawing upon the retrospective experience reported by nurses.

The rationale for conducting a two-phase investigation into work-related aggression utilising both quantitative and qualitative methodologies was as follows. The extent, source and type of aggressive behaviour experienced by general nurses in general health care settings are relatively unknown in Australia. Small sample sizes, non-random selection of samples and the use of instruments that have been untested for reliability and validity have contributed to a patchy picture of the problem.

The researcher was unable to locate any empirical research which specifically investigated reporting behaviours of nurses and supportive behaviours of staff following work-related aggression. Most of the literature contained anecdotal comments about the absence of reporting or the underreporting of aggression by nurses, and these comments were usually reported within the context of psychiatric rather than general or other settings. Further, the researcher was unable to find any evidence, other than his own previous study, identifying nurses' expectation and subsequent receiving of social support from key personnel within the institution. Although a model for the moderating effect of support in the nursing context was postulated by Wallis (1987:481), no study testing this was conducted.

Therefore, based on theoretical and research information contained in the literature, the researcher developed a context-specific research instrument to measure perceived institutional social support (Stewart, 1989) reported by registered nurses experiencing work-related aggression. The social networks relevant to the current study are confined to the healthcare institution. Therefore, the newly developed

instrument contained items pertinent to only nurse colleagues, doctors and nurse managers. Support for this approach comes from Norbeck (1988), who pointed to the promising strategy of using situation specific measures in clinically focused social support studies and the feasibility of including situation specific measures in existing instruments. Further support comes from Stewart (1989:273) who stated: "Surely situation and population specific measures are a valid focus of nurse investigators expanded efforts to develop and modify measuring instruments".

The researcher hypothesised, based on theories of coping and cognitive, primary and secondary appraisal (Lazarus and Folkman, 1984), that work-related aggression actually has a direct effect on perceived institutional social support. That is, variations in work-related aggression significantly account for variations in perceived institutional social support.

It was also hypothesised that variations in perceived institutional social support significantly account for variations in perceived professional competence. A limited number of studies have been identified which have specifically investigated psychological, emotional and social trauma to nurse victims of aggression. These, however, have been conducted in North America or the United Kingdom and no Australian data have been available. Most studies have focused on physical trauma, inflicted by patients and classified as serious. The researcher was unable to locate any studies that specifically investigated the impact of work-related aggression on perceived professional competence. No studies have been identified which used a random sampling technique to assist with representativeness of findings.

Lazarus and Folkman (1984:46) have reminded us that "appraisal rests, on the individual's subjective interpretation of a transaction, it is phenomenological". They further comment that:

> First, appraisal is a private, subjective process that has an uncertain relationship to the objective environment; second, ... because in order to predict the emotional or adaptational outcome we must ask the person how he or she construes events; in turn, the subjective appraisal itself can only be verified by reference to the very outcome we want to predict.

This study was therefore designed to collect both quantitative and qualitative data from a postal survey of randomly selected nurses, and qualitative data from semi-structured in-depth interviews from a sub-sample. This approach involved what has been termed sequential methodological triangulation. The use of multiple methods and sources of data collection, sometimes referred to as triangulation was selected for this study.

6.3 Sequential methodological triangulation

Research studies often choose triangulation as a research strategy to assure completeness of findings or confirm findings (Campbell & Fiske, 1959; Miles & Huberman, 1989; Patton,1983). Completeness provides breadth and depth to an investigation, offering researchers a more accurate picture of the phenomenon (Denzin & Lincoln, 1994). Combining different methods of data collection assisted in describing the research problem. Blaike (1988, cited in Minichiello, Aroni, Timewell & Alexander, 1990:222) referred to these multiple strategies as triangulation which he claimed has the advantage that "it can be used to overcome the problems from studies relying on a single theory, a single method, single set of data and single investigation."

Streubert and Carpenter (1999) identified different types of triangulation, referring to "methods triangulation" as most often combining quantitative methods with qualitative methods in the study design. An instance of such triangulation is

sequential implementation, involving the use of quantitative method first, then planning and based on the findings, implement the qualitative technique second. According to Streubert and Carpenter (1999:302):

> If substantial theory has already been generated about the phenomenon, if the researchers can identify testable hypotheses, or if the nature of the phenomenon is amenable to objective study, the investigation would begin with a quantitative technique.

They added that "when combining research methods, it is essential that investigators meet standards of rigour for each method" (p. 304).

Begley (1996) suggested that it is not easy to use triangulation methods, as they are often more time consuming and expensive to complete a study. The study design is more complicated, complex, and difficult to implement, and imprecise use may actually increase error and enhance the weaknesses of each method, rather than compensate for weaknesses (Fielding & Fielding, 1989; Morse, 1991).

There has been, however, increasing recognition and acceptance that the two paradigms can complement each other (Lakomski, 1992; Salomon, 1991), and growing support for the use of triangulation to increase validity of studies (Burgess, 1994, Howe, 1985; Lather, 1986). Archer and Browne (1989) observed that studies on aggression had to achieve a balance between two distinct but complementary approaches.

In the present investigation, in order to identify the problem of work-related aggression toward nurses and the moderating effect of institutional social support on their self-perceptions of professional competence, a quantitative methodology was first implemented, involving descriptive correlational techniques, followed by testing the hypothesised model. This methodology provided data that described the relationship between nurses' perceptions of professional competence and work-related aggression. It also tested the proposed model of the moderating effect of institutional

social support from significant others on the perceptions of registered nurses on their professional competence following work-related aggression.

The second aim of the study was to provide deeper insights into how nurses respond to aggressive behaviour in their workplace. These insights would extend and enrich the quantitative data collected and would complete and enhance the picture of nurses' subjective experiences of work-related aggression. This aim was achieved through qualitative methodology. It was therefore necessary to conduct an investigation that was rigorous, descriptive and analytical to unearth subjective life experiences of nurses.

6.3.1 Quantitative approach

The first, quantitative approach is generally regarded as the logical positivist approach which attempts to control variables and eliminate or reduce threats to internal and external validity. This approach can offer the opportunity for researchers and clinicians to generalise findings from randomly selected samples to populations and thereby extend knowledge to practice situations across many health settings. Many members of the scientific community still hold the view that "hard science is more rigorous, more objective, and hence more worthy of being done than so-called soft research" (Tinkle & Beaton, 1983:27). When Berger and Luckman (1966) claimed that reality is socially constructed, "the scientific discipline was piqued, spawning both vitriol from the old guard and a rich body of theory and research on a new front" (Holstein & Gubrium, cited in Denzin & Lincoln, 1994:85). One of the limitations (or a strength, depending upon which paradigm you are viewing from) of the logical positivist approach is that it removes the subject of the study from his or her social and historical context, thereby diminishing its relevance to clinical practitioners.

6.3.2 Qualitative approach

The second, qualitative approach, often referred to as naturalistic inquiry, takes into consideration the subjective realities of subjects who have experienced the phenomenon under investigation, by engaging in a dialogue with them that takes account of their social and historical context. Lincoln and Guba (1985:37) stated that the axioms of the naturalistic paradigm include assumptions that:

> Realities are multiple, constructed, and holistic; knower and known are interactive, inseparable; only time and context-bound working hypotheses are possible; all entities are in a state of simultaneous shaping, so that it is impossible to distinguish causes from effects; and, inquiry is value bound.

Munhall and Oiler (1993:67) stated that "the world is perceived as the first reality [therefore] people and the world can be understood only through an account that discloses their contacts with the real world". Similarly, Leininger (1985:340) proposed that qualitative approaches are effective means of obtaining extremely rich and comprehensive data that reveal the "real world, truths, and lifeways of people".

The qualitative approach, although appealing to practitioners, loses some ability to draw conclusions about cause and effect relationships and is not generalizable to populations. Consequently there is growing support to design research utilising triangulation, including both quantitative and qualitative approaches, as complementary in the conduct of research (Field & Morse, 1985).

It is contended that both approaches were justified in this investigation to assist in answering quantitative questions about the nature, extent, type and source of work-related aggression and the function of institutional social support on registered nurses' perceptions of professional competence, and qualitative questions on the impact of this aggression on the lived experience of nurses who have been victims of work-related aggression.

6.4 Phenomenology as a philosophy and qualitative method of enquiry

Qualitative research is a field of inquiry in its own right which "...cuts across disciplines, fields, and subject matter" (Denzin & Lincoln, 1998:2).

After an extensive review of the possible qualitative approaches, the researcher selected phenomenology as the preferred philosophical foundation and appropriate methodological strategy. An overview of the origins of phenomenology as a research philosophy and method, encompassing its historical development as an accepted alternative to the logical positivistic method of obtaining knowledge, is considered to be helpful at this point.

Phenomenology is a philosophical approach to the study of phenomena (appearances) and human experience. It has served as a basis for qualitative research particularly in the areas of health and illness (Benner, 1984; Munhall & Oiler (1993; Streubert & Carpenter, 1995); and in psychology (Giorgi, 1985; Vallé & King, 1978).

Phenomenology has been described by Spiegelberg (1975:3), the best known historian of the phenomenological movement, as:

> The name for a philosophical movement whose primary objective is the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions.

Husserl (1857-1938) and his colleagues Heidegger (1889-1976) and Schutz (1899-1959) have been acknowledged as the leaders of the phenomenological movement that began in Germany in the first decade of the 20th Century (Streubert & Carpenter, 1995). Schutz has been credited with developing a social phenomenology extending Husserl's (1970) more philosophical phenomenology (Holstein & Gubrium, 1991, cited in Denzin & Lincoln, 1994).

Phenomenology underwent further development in France in the early 21st Century by Marcel (1889-1973), Satre (1905-1980) and Merlau-Ponty (1905-1980)

(in Rice & Ezzy, 1999). Merlau-Ponty (1962) and Spiegelberg (1975) described phenomenology as both a philosophy and a method. It has been used extensively in the nursing literature where it has been described "as a philosophy, a perspective, and an approach to practice and research" (Munhall, 1994:14).

Becker (1992:7) put it simply: "phenomenologists study situations in the everyday world from the viewpoint of the experiencing person." Schutz (1970:320) described the world of every day life as the "total sphere of experiences of an individual which is circumscribed by the objects, persons, and events encountered in the pursuit of the pragmatic objectives of living". This attention to the individual's construction of his or her life-world can be contrasted with ethnography which has as its central focus an emphasis on groups or sub-groups who form a culture. It can also be contrasted with the logical positivist's view of the world as principally "out there," separate and distinct from any act of perception or interpretation (Schutz, 1970). Ainlay (in Hunter & Ainlay, 1986:43) stated that "taken together, the whole of people's unquestioned, subjective experience of their biological worlds can be termed their 'life-world' (or Lebenswelt)". Each individual's life-world is different, and individual actions can be understood by situating them within the life-world of the actor (Rice & Ezzy, 1999).

The phenomenology paradigm has had its critics. According to Carey (1989), the positivist resistance to qualitative research goes beyond the ever-present desire to maintain a distinction between hard science and soft scholarship. He went on to say that the positivists sciences (physics, chemistry, economics, and psychology) often see themselves as the crowning achievements of Western civilisation, and that in their practice it is assumed that truth can transcend opinion and personal bias. Qualitative research is seen by them as an assault on this tradition (Carey,1989).

Phenomenology features several central concepts which originate from different philosophers. The concept of intentionality, first developed by Brentano, (1838-1917) is integral to Husserl's (Brentano's student) phenomenology. Moustakas (1994:28) described intentionality as referring to consciousness, "to the internal experience of being conscious of something". Husserl (1970, in Streubert & Carpenter, 1995) argued that the relationship between perception and its objects is not passive, and human consciousness actively constitutes the objects of experience. Crotty (1996) explained intentionality as the individual's reaching out to something beyond their own human experience toward the object of experience. Berger and Luckman (1966) similarly considered human consciousness as always being intentional because it is always directed toward objects.

The importance of intentionality is that from the phenomenologist perspective the dichotomy between object (for example, aggressive behaviour), and subject (for example, the nurse who experiences aggressive behaviour) is non-existent, and experiences are real if they are described by the subject. This view obviously has important significance for the present investigation as nurses were being asked to recall and describe their experience of aggression and social support. The definition of aggression, therefore, was what nurses perceive it to be, and therefore real. The underlying assumption is that from a phenomenological perspective the lived experience can be recalled.

Another central concept of phenomenology is provided by Schutz (1971, in Denzin & Lincoln, 1994) who argued that the social sciences should focus on the ways that the life-world, that is the experiential world every person takes for granted, is produced and experienced by members. In other words, researchers who wish to study and understand human action have to understand the meaning individuals give

to their actions. Heidegger (1962) used the German term "Dasein" (being there) to refer to the person, emphasising that people are beings in the world and refuting the Cartesian understanding of the person as isolated self-consciousness. "To separate person and world is false; to be a person is to be in a world" (Becker, 1992:13). According to Heidegger (1969, in Holloway, 1997), people's existence is always connected with the world in which they live. The two cannot exist without each other, and a continuous dialogue goes on between the person and the meaning attributed to his or her world.

A third central concept of phenomenology is the sharing of such meanings between individuals. Moustakas (1994) claimed that the aim of phenomenological studies is to determine what an experience means for the persons who have had the experience and who are able to provide a comprehensive description of it. There are of course shared meanings which Schutz (1971, in Denzin & Lincoln, 1994) referred to as a stock of knowledge composed of common sense constructs and categories that are social in origin. Shared meaning, however, produces a familiar world which is typified under fewer constructs and categories, making it possible to identify, understand and explain experiences as belonging to a particular type. Because we continually interact with each other, shared meanings are taken for granted and lead us to believe that each person who has experienced a phenomenon (for example aggression) has experienced it in a fundamentally similar way. Husserl and his students referred to this as intersubjectivity as every person is endowed with the sense of 'the Other' and has access to the experience of others through his or her personal experience (Holloway, 1997:118). Holstein and Gubrium (1978, in Denzin & Lincoln, 1994:263) summarized the impact of shared meanings as "an assumption that others

experience the world basically in the way we do, and that we can therefore understand one another in our dealings in and with the world."

Although the world may be familiar, shared meaning can always be extended by the interpretive application of a category to the concrete particulars of a situation. In the present investigation it was expected that there would be found shared meanings of aggressive behaviour, shaped by a unique professional culture (discipline of nursing) and institutional structures (hospitals and health care settings). It was expected, however, that these shared meanings could be advanced and clarified by applying interpretive analysis to how nurses report their own experiences of aggressive behaviour.

Beck (1994) argued that phenomenology affords nursing new ways to interpret the nature of consciousness of the world. Streubert and Carpenter (1999) similarly claimed that because professional nursing practice is enmeshed in people's life experiences, phenomenology as a research method is well suited to the investigation of phenomena important to nursing.

As one of the aims of this study was to explore and describe the experience of nurses who had experienced work-related aggression (objective vi), phenomenology therefore was ideally suited to examine the meanings and shared meanings of nurses who had experienced such behaviour. Further, phenomenology would be appropriate because its philosophical and methodological foundations are specifically linked to subjective experiences, thereby, assisting the researcher to discover and interpret experiences of workplace aggression in greater depth. How the phenomenological approach was implemented in the design of the in-depth interview schedule used for this investigation is discussed in detail in Chapter Eight.

6.5 Overview of the research design of the investigation

As outlined in Figure 1 in Chapter One, Phases Four and Five of the present study provided for quantitative and qualitative data collection and adopted sequential methodological triangulation in which Phase Four was the survey and involved the following three stages.

Stage 1 Development of the research instrument for the survey. The survey was used to collect both quantitative and qualitative data. The survey was further used to identify participants for involvement in Phase Five of the study and to construct an interview schedule from preliminary analysis of qualitative data.

Stage 2 Identification of and selection of sample for survey.

Stage 3 Mail out of questionnaire.

Phase Five focused on the qualitative components of the study, and comprised a semi-structured in-depth interview method. It was conducted in the following three stages.

Stage 1 Development of an interview schedule.

Stage 2 Identification of a sample for interviews.

Stage 3 Conducting interviews.

Phase Six involved the data analysis, presentation of results and discussion of results in terms of the conceptual framework, comprising the following five stages.

Stage 1 Presentation of descriptive data and results.

Stage 2 Presentation of correlational data and results.

Stage 3 Presentation of model testing data and results.

Stage 4 Presentation of phenomenological data and results.

Stage 5 Discussion of results

CHAPTER SEVEN

PHASE FOUR: METHODOLOGY, QUANTITATIVE COMPONENT

7.1 Phase Four: Methodology, Quantitative component

In the absence of a suitable existing tool it was necessary to develop a reliable and valid research instrument that collected data on key variables under investigation. This chapter begins by documenting the process for developing a valid and reliable research instrument. Firstly, the variables under study were operationally defined. Secondly, a pilot version of a questionnaire was subjected to a convenience sample of registered nurses. Thirdly, content validity was established by submitting the preliminary questionnaire to a panel of six experts and constructing a content validity index (CVI). The operational definitions underlying the questionnaire, results of the pilot study and content validity check are presented. All items in the questionnaire were subjected to principal component analysis, which identified several discrete components of the key variables of perceived institutional support and perceived professional competence.

The second part of Chapter Seven deals with identifying and conducting a systematic random sample of nurses obtained from the registration authorities in Victoria, Australia. This is followed by a description of how the questionnaire was distributed.

7.2 Phase Four: Stage 1: Development of the survey questionnaire

The first objective for this study was to develop a valid and reliable instrument to investigate key concepts of work-related aggression, perceived institutional social support, and perceived professional competence of registered nurses.

7.2.1 Design of pilot questionnaire

A letter of explanation along with a pilot questionnaire (presented as Appendix A) was developed, to tap the variables of interest presented in the research aims, questions, objectives and hypotheses outlined in Sections 5.2, 5.3, 5.4 and 5.5 above. Construct validity was explored by checking that the questions contained in the pilot questionnaire were accurately aimed toward examining the theoretical foundations of the research problem. Abstract concepts of work-related aggression, perceived institutional social support and perceived professional competence were converted into valid measures on the research questionnaire.

7.2.1.1 Measuring work-related aggression

The second research objective was to identify the frequency, type and sources of work-related aggressive behaviour experienced by nurses. In this study work-related aggression was defined operationally as non-accidental, verbal, physical and/or sexual assault, including threatening, intimidating, manipulative, passive-aggressive or demanding behaviour that results in a nurse reporting such behaviour to the researcher as aggressive. Stating it simply, aggressive behaviour is behaviour perceived by nurses as injurious to themselves.

This broad definition is used because researchers have demonstrated that an individual's perception of an event is a critical factor in the intensity and duration of responses to that event (Folkman,1984; Folkman, Lazarus, Dunkel-Schetter, Delongis & Gruen, 1986).

The definition used in this study belongs to the broadest range of the continuum as discussed by Perrone (1999). As a consequence the researcher may lose some ability to make comparisons with research conducted within the general field of aggression research. Failure to use the broadest definition of aggression, however,

may result in a failure to identify some important behaviour experienced by nurses' that may not be regarded as aggressive in the general literature. The combining of a research instrument and methodologies which both outlines behaviours described in the current literature as aggressive and also seeks to explore through open ended questions other types of aggressive behaviours provided the opportunity to more clearly define work-related aggression as it pertains to nurses.

In this investigation, the term aggression is confined to a number of factors which have been identified in the research literature as being relevant (Diaz & McMillin, 1991; Farrell, 1997; Mason & Chandley, 1999). These factors have been operationalised in the research instrument to collect both quantitative and qualitative data.

The first of these was victim characteristics, identified in the questionnaire by items eliciting age, gender, place of employment, level of appointment, years of experience, length of time in current position, nursing and tertiary qualifications.

The second factor was aggressor characteristics, limited in this study to three sources, namely patients and/or their relative, doctors and nurse colleagues. Data elicited from these three sources was presented in three sections with doctor initiated aggression in section 1, nurse colleague initiated aggression in section 2 and patient or their relative initiated aggression in section 3. The pilot questionnaire contained 12 scaled-response questions for each source of aggression in each section. The 12 questions were presented as three types of aggression, namely, verbal, sexual and physical aggression.

Type of aggression was measured by three broad categories; verbal, sexual and physical. These three categories were each measured in four sub-categories. Verbal aggression was measured by, 'verbally threatened you'; 'verbally insulted

you'; 'called you a derogatory name' and 'yelled at you'. Sexual aggression was measured by 'sexually threatened you'; 'sexually insulted you'; 'made sexual suggestions to you' and 'sexually touched you'. The final area, physical aggression was measured by, 'physically threatened you'; 'slapped you'; 'threw an object at you' and 'hit you with an object'.

The first three sections of the pilot questionnaire contained a total of 36 questions which had four scaled-response categories ranging from their experience of aggression from 'never', 'sometimes', 'often' and 'frequently'.

The researcher chose to omit consideration of the severity of injury from this study as it has been problematic in the current literature and has generally been used to limit studies to what is frequently referred to as major physical injuries. This decision also accorded with the view expressed by Lanza (1984b) that aggression is something which is defined by the perceptions of those victims who have experienced it. Consequently, aggression is viewed according to nurses' perceptions of the incident/s and the impact upon their professional competence. This approach is likewise consistent with the conceptual and theoretical model adopted here in which 'microstressors' or 'daily hassles' are emphasised (Lazarus & Folkman, 1984). The Lazarus and Folkman model holds that comparisons of the stress experienced as a result of major life events with that experienced as a result of daily hassles, shows that the latter are more likely to precede psychological and somatic symptoms.

7.2.1.2 Measuring reporting behaviours

The second research objective was to identify nurses' reporting behaviours following acts of aggression. Nurses may choose not to make any report or they may choose to make a formal report or an informal report. In nursing, reporting behaviours

are described according to how the report is made and the expected consequences resulting from reporting the incident.

Formal reporting implies that the recipient of aggressive behaviour has provided written documentation of the incident, either on a specified form used by the health agency for that purpose or in a personal account submitted to a senior person in the organisation. It does not include documentation of aggressive behaviour on medical or nursing records, a process aimed at identifying some medical or nursing intervention to manage the aggressive behaviour. Formal reporting of the aggressive behaviour would usually lead to an investigation of the incident by a senior member of the institution with appropriate follow up and feedback to the victim. In contrast informal reporting implies that the recipient verbally reported the incident to another member of staff, not necessarily a senior member, without any expectation of an official investigation or follow up and feedback.

Three groupings of institutional staff were included in the study as representative of targets for reporting of aggressive incidents. These were the nurse manager, the person immediately senior to the recipient of aggressive behaviour, other nurse colleagues, including nurses working within the same clinical environment and at the same or lower level, and medical staff.

Reporting behaviours of nurses were investigated in section four of the pilot questionnaire. The researcher incorporated three factors which are inherently linked to nurses' perceptions of supportive behaviours, by having six questions asking participants whether they had either formally or informally reported aggressive behaviour, six questions asking whether they had expected to receive support following reporting, and six questions asking whether they had received support

following reporting. Two nominal response categories, namely, "yes" or "no", were used in this section of the pilot questionnaire.

7.2.1.3 Measuring perceived institutional social support

The third research objective was to identify nurses' expectations and perceptions of the availability of and their utilisation of institutional social support. As discussed in Chapter Three, institutional social support is a complex phenomenon that has been defined and described in various ways by different theorists.

In the present investigation, the theoretical construct of institutional social support was defined by the researcher as the degree of access, care, support and interest that key staff within the institution showed for the victim following the experience of an incident of work-related aggression. This definition was extended to include confidence in reporting aggressive behaviour to these key people at the time of the incident and in the future. Key staff refers to senior nursing administrators, nursing colleagues and medical staff. Institutional social support from these three groups of staff was considered by the researcher to be the most appropriate resource to ameliorate the problem of work-related aggression as it comprises people who were more likely to understand the situation compared to family support or support from friends.

Support was classified as either official institutional support when the organisation implements some course of action, which alters nurses' working conditions in an attempt to alleviate further stress, or unofficial institutional support. Changing nurses' work schedule, sending them home or counselling recipients of aggressive behaviour are examples of official institutional support. Unofficial support implies the support received from a variety of sources that enable nurses to continue working in the same or similar situation where they have experienced work-related

aggression. Talking and listening to nurses, comforting and reassuring them and other offers of encouragement were considered as unofficial institutional support. Nurses may have received either, none, or both types of support.

Section five of the pilot questionnaire contained 18 questions which explored supporting behaviours from 'nurse managers', 'other nurse colleagues' and 'medical staff' following aggression. Each of these three categories of staff were sub-divided into six sub-categories of support, namely, 'how accessible were they to support you'; 'how much did they make you feel they cared for you'; 'how actively supportive were they'; 'how much interest in you did they have'; 'how confident are you now in reporting aggressive behaviour to these people' and 'how confident are you in reporting aggressive behaviour to these people in the future'. Participants were asked to report on how they perceived the incident/s of aggressive behaviour/s impacted upon their perception of supporting behaviours. Supporting behaviours were measured by utilising a four-point response-scale: 'not at all'; 'slightly'; 'moderately' and 'very'.

7.2.1.4 Measuring perceived professional competence

Research has demonstrated that there is a relationship between "job-related subjective competence" and "the personal accomplishments at work component" of burnout (Warr, 1987:197). Examples of low personal accomplishment at work include cynicism to patients, low efficiency, and a lack of respect for patients, colleagues and a loss of idealism. These factors are extremely relevant in this study and were utilised by the researcher to inform the construction of the pilot questionnaire, in measuring the key dependent variable of nurses' perceptions of professional competence. This study does not, therefore, attempt to rate or rank competence levels of one nurse compared to another, or against a prescribed standard as per Australian Nursing

Council Incorporated (ANCI, 1998) competencies. It merely asks nurses to subjectively assess the impact of work-related aggression on their own perceptions of professional competency against domains and cues outlined in ANCI (1998) and described in Section 3.5.3 above.

Section six of the pilot questionnaire contained questions asking participants the degree to which their experience of work-related aggressive behaviour had impacted upon 20 areas of professional competence selected from the ANCI domains and cues. Response categories were, 'not at all', 'negatively' and 'positively'.

7.2.2 Pilot study: Testing the pilot questionnaire

To test the content validity and reliability of the pilot questionnaire, a study was conducted utilising a convenience sample of 56 registered general nurses employed in three local hospitals who were attending a course of study at a tertiary institution. The Content Validity Index is based on the degree of agreement by participants in the pilot study on the relevance of questions to adequately represent the phenomenon under investigation (Parahoo, 1997).

Each participant in the pilot sample was given a questionnaire and a three page content validity index (CVI) checklist with directions on how to use it (presented as Appendix B). The CVI checklist requested information about the appropriateness and clarity of questions in each section of the pilot questionnaire, the length of time it took to complete the questionnaire, and their opinion about the relevance of each question to the topic of workplace aggression. Participants in the pilot study were asked to indicate on the checklist whether a question should be retained unaltered, retained but required to be amended, or discarded from the questionnaire altogether.

Content validity was also investigated by distributing the pilot questionnaire to six identified experts. These included two clinical psychologists who were also the

principal and associate supervisor, two statisticians from two universities in Victoria and two senior nurses who had experience in the area of work-related aggression. One of the latter was the Occupational Health and Safety Officer of a large regional health service and the other was a member of psychiatric services staff who conducted programs on managing patient aggression. Comments from this panel of experts assisted with question construction by selection, refinement and/or elimination of ambiguous questions and combined with the pilot study assisted in operationalizing the measurement of each variable.

In an attempt to identify the major dimensions of perceived institutional support and perceived competence, a number of exploratory principal component analyses were conducted on the 18 questions of the supporting behaviours section and 20 questions on perceived professional competence section. Principal component analysis is used when the objective is to summarise most of the original information in a minimum number of factors for prediction purposes (Hair, Anderson, Tatham & Black, 1995).

7.2.3 Results of the pilot study: Refining the pilot questionnaire

Selection for inclusion of questions in the second draft of the pilot questionnaire was made on the basis that there was over 90% agreement by participants in the pilot study that questions should be retained. For example, if 53 from 56 participants agreed that the question, "During your career as a registered nurse, has any doctor ever verbally threatened you?"; should be retained, constituting a 94% CVI; therefore, this question was retained. On this basis, of the 36 questions on work-related aggression, 27 were retained for the final questionnaire. Nine questions with CVI ranging from 68% to 86% were discarded.

Feedback from the panel of experts resulted in two key changes to the questionnaire. The first was to integrate six open-ended questions into the final questionnaire to elicit qualitative data concerning a particular aggressive situation. that existed at the time of the aggressive incident. These were:

- Briefly describe the worst aggressive behaviour you have experienced.
- Where did it happen?
- What were the circumstances?
- How did you deal with it?

These four questions were incorporated in Sections one, two and three of the final questionnaire and the following two questions were added as Section seven.

- What was the one most significant factor that prevented you from coping effectively with aggressive behaviour? and;
- What was the one most significant factor that has most helped you to cope effectively with aggressive behaviour?

The rationale for including these questions was that they would assist in the selection of a sub-sample of participants for in-depth interview for Phase Five of the study.

Although open-ended questions are generally not well received by participants (Minichiello, Sullivan, Greenwood & Axford, 1999), the panel of experts considered that this format would yield qualitative information which would contribute to a further selection of participants to engage in in-depth interviews during the qualitative phase of the investigation.

The second change suggested by the panel of experts was to alter four existing response categories from 'never', 'sometimes', 'often' and 'frequently', as these were considered to be totally subjective. Five response categories were substituted, namely, 'never', 'less than once per year', 'about once per year', 'about once per month', 'about once per week'. These were considered to improve objectivity and therefore more likely to produce a consistent response.

All 18 questions on supporting behaviours and perceived professional competence were retained with some minor refinements to wording. The 20 questions in the pilot questionnaire on perceived professional competence were retained.

7.2.4 Principal component analysis of key variables

In order to identify the major dimensions of supporting behaviours and perceived professional competence, a number of exploratory principal component analyses were conducted on the 18 questions on supporting behaviours and 20 questions on professional competence. For interpretation purposes, the cutoff point of social support was defined as all loadings greater than .4. The Kaiser-Meyer-Olkin measure of sampling adequacy was .80 and Bartlett's test of sphericity was significant at .001.

By conducting principal component analysis together with orthogonal (varimax) rotation (eigenvalues greater than 1), three components of institutional support were identified and are shown in Table 1.

It is not surprising that these three components mirrored the categories of professional staff, namely nurse manager, other nurse colleagues and medical staff.

The first component, which could be labelled 'nurse colleagues' refers to 6 questions specifically referring to how nurse colleagues are supportive and explained 44.5% of the total variance. This component exhibited significant loadings on all 6 aspects of support from nurse colleagues. These were, access (.71), care (.81), support (.79), interest (.81), confidence in reporting (.62) and future reporting (.60).

A second component, labelled 'nurse manager', loaded significantly on all 6 aspects of perceived support and explained 13.8% of the total variance. These were access (.79), care (.86), support (.84), interest (.82), confidence in reporting (.49) and future reporting (.42).

Table 1

Major dimensions of 'Institutional Social Support'

Items	Components		
Following aggressive behaviour:	Component 1	Component 2	Component 3
How accessible were the following people			
nurse manager	.221	.794	.205
other nurse colleagues	.716	.184	.116
medical staff	2.878E-02	.226	.750
How much did the following people make you feel they cared about you			
nurse manager	.182	.865	.241
other nurse colleagues	.848	.132	.137
medical staff	.126	.206	.860
How actively supportive were the following people			
nurse manager	.262	.842	.280
other nurse colleagues	.794	.259	.175
medical staff	.150	.208	.881
How much interest in your own did you receive from the following people			
nurse manager	.267	.820	.261
other nurse colleagues	.813	.292	.140
medical staff	.176	.216	.814
How confident are you **now** in reporting aggressive behaviour to the following people			
medical staff	.196	.494	.114
other nurse colleagues	.628	.129	4.116E-02
medical staff	2.394E-02	4.017E-02	.467
How confident are you **in the future** of reporting aggressive behaviour to the following people			
medical staff	.177	.420	4.135E-02
other nurse colleagues	.602	8.384E-03	7.147E-02
medical staff	8.051E-03	1.450E-02	.407

The third component, labelled 'medical staff', also loaded significantly on 6 aspects of professional support and explained 11.3% of total variance. These were, access (.75), care (.86), support (.88), interest (.81), confidence in reporting (.46), and future reporting (.40).

A further factor analysis was conducted on 6 subsets of support. Each subset was constructed from 6 single questions representing support and include, access, care, actively supportive, interested, confident now and in the future. Two components were identified as shown in Table 2.

The first component, which could be labelled 'immediate support' consisted of four subsets, access (.77), care (.88), immediate support (.91) and interest (.87). This component explained 68.5% of variance.

The second component, labelled 'confidence to report' has two sub-sets, confidence now in reporting (.89) and confidence in the future to report (.93). This component explained 16.9% of the variance.

Table 2

Timing of 'Institutional Social Support'

	Component 1	Component 2
How accessible ?	**.771**	**.358**
How caring?	**.880**	**.299**
How actively supportive?	**.917**	**.193**
How interested in you?	**.875**	**.242**
How confident in reporting now?	**.339**	**.894**
How confident in reporting in the future?	**.221**	**.938**

An important implication of these results for the design of the final questionnaire is the relationship between immediate and future reporting of aggressive incidents. To a large extent this was consistent with the model of ecological congruence which relates to the fit of individuals' perceptions, values, and resources to the timing and circumstances of the stressor event (Hobfoll, 1985).

7.2.5 Outcomes, perceptions of professional competence, reactions and responses to work-related aggression

Section six of the pilot questionnaire collected data on perceived changes to professional competence. Participants in the pilot study were asked to report on how they perceived the incident/s of aggressive behaviour/s impacted upon their level of competence as professional nurses by utilising a three point scale: 'impacted not at all', 'impacted negatively', or 'impacted positively'. The latter two response sets are consistent with the theoretical foundations postulated by Lazarus and Folkman (1984) who make an important distinction between a threat, with its potential negative

outcomes of harm and loss, and a challenge, with potential positive outcomes of growth and gain.

In an attempt to identify the major dimensions of professional competence, a number of exploratory principal component analyses were conducted on the responses to the 20 questions on perceived professional competence. By conducting principal components analysis together with orthogonal (varimax) rotation (eigenvalues greater than 1), three components of professional competence were identified and shown in Table 3.

Table 3

Perceived professional competence

Items on perceived professional competence	Component 1	Component 2	Component 3
Your professional relationships with patients	.398	.175	.723
The amount of time spent with patients	.450	.151	.669
Your ability to respect patients	.237	.223	.796
Your ability to trust patients	-2.971E-02	1.077E-02	.728
Your interpersonal relationship with patients	.314	.321	.237
Your confidence in working as a team member	.350	.591	.316
Your professional relationship with colleagues	.406	.629	.133
Your ability to trust professional colleagues	.196	.866	.102
Your ability to respect professional colleagues	.173	.833	.102
Your interpersonal relationship with colleagues	.268	.279	.298
How you perceive your role as a professional nurse	.531	.297	.419
Your feeling of being in control of your work environment	.502	.327	.284
Your satisfaction with nursing	.231	.291	.265
Your professional autonomy	.546	.380	.267
How you perceive yourself as a professional nurse	.788	.194	.185
Your ability to make good clinical decisions at work	.863	.206	.149
How you perceive your level of clinical skill as a nurse	.860	.235	.111
The standard of care you practice	.816	.246	.199
How you compare yourself with other nurses	.239	.216	.214
Your decision to remain in nursing	.529	.388	.319

The Kaiser-Meyer-Olkin measure of sampling adequacy was .80 and Bartlett's test of sphericity was significant at .001. The cutoff point for interpretation purposes for professional competence was all loadings greater than .5. According to Hair, Anderson, Tatham and Black, (1995:385) this is a conservatively high cut-off but as sixteen questions had loadings fall substantially above this threshold, interpretation

was relatively simple. Responses to 4 questions, however, fell substantially below the cut-off point.

The first component, which could be labelled 'role competence' refers to aspects of professional nursing which have been identified in the nursing literature as being important aspects to performing the professional nursing role and explained 48% of the total variance. This component exhibited significant loadings on eight aspects of perceived professional competence. These were, 'perception of professional role' (.53), 'being in control of work environment' (.50), 'professional autonomy' (.54), 'perception of yourself as a competent nurse' (.78), 'ability to make good clinical decisions' (.86), 'level of clinical skill' (.86), 'standard of nursing care practiced' (.81) and 'decision to remain in nursing' (.52).

A second component, labelled 'professional relationships', refers to a professional competence to work interdependently with other key health personnel and explained 18% of the total variance. It loaded significantly on four aspects of perceived competence including, 'ability to trust professional colleagues' (.86), 'ability to respect professional colleagues' (.83), 'professional relationships with colleagues' (.62) and 'confidence in working as a team member' (.59).

The third component, labelled 'nurse-patient relationships', refers to the ability of nurses' to form effective therapeutic relationships with patients and explained 13% of the total variance.. It loaded significantly on four aspects of perceived competence. These were, 'amount of time spent with patients' (.73), 'respect for patients' (.79) 'ability to trust patients' (.72) and 'professional relationships with patients' (.72).

Four questions failed to load at the cut-off point and were omitted from the second draft of the questionnaire. These were 'your interpersonal relationship with colleagues' (.31), 'your interpersonal relationship with patients' (.29), 'your

satisfaction with nursing' (.29) and 'how you compare yourself with other nurses' (.23).

7.2.6 Reliability and validity of the second draft of the pilot questionnaire

A second draft of the pilot questionnaire was distributed to a convenience sample of 36 registered nurses obtained from nurses who had enrolled at a university course for upgrading from a certificate to a Bachelor of Nursing degree. The data from the second draft of the questionnaire which excluded discarded questions from the first draft and included open-ended questions proposed by the panel of experts, was subjected to split-half reliability tests for work-related aggression. Reliability scores ranged from Alpha = .64 for nine questions of doctor initiated aggression; .74 for nine questions of nurse initiated aggression and .89 for nine questions of patient initiated aggression. When all twenty seven questions were combined for work-related aggression and tested an Alpha score of .83 was found.

For the combined eighteen questions on 'institutional social support' an Alpha score of .92 was found, and for the combined sixteen questions on 'perceived professional competence', an Alpha score of .92 was found. When perceived professional competence was tested for its three individual components, 4 questions for relationships with patients (Nurse-Patient Relationships Competence) achieved an Alpha score of .74; 4 questions for relationships with colleagues (Professional Relationships Competence) achieved an Alpha score of .83, and 8 questions for intrinsic qualities of competence (Role Competence) achieved an Alpha score of .91.

As a final check for reliability the second draft of the questionnaire was subjected to a test-retest reliability test. This was achieved by administering the second draft questionnaire on a second occasion three weeks apart, to the same group of 36 participants.

A total of 31 participants completed the second draft questionnaires on both occasions. The test-retest reliability score ranged from 72.3 for social support to 96.2 for patient initiated aggression. The mean test-retest score was 83.64 which was acceptable. The open-ended questions remained unaltered.

7.2.7 Final questionnaire

As a result of reliability testing, the second draft questionnaire was adopted as the final questionnaire (presented as Appendix C). The final questionnaire is an eight page instrument with a front page for demographic information and six sections presented on six separate pages. A short section 7 has two open-ended questions which were previously discussed. Section 1 contains nine scaled-response questions on verbal, sexual and physical behaviour from a doctor, followed by four open-ended questions relating to describing the worst incident of aggressive behaviour experienced, where did it happen, what were the circumstances and how did you deal with it?

Section 2 and 3 follow the same format as section 1 with the focus in section 2 on aggressive behaviour from nurse colleagues, and the focus in section 3 on aggressive behaviour from a patient or their relative. Sections 2 and 3 are followed by the same four open-ended questions relating to describing the worst incident of aggressive behaviour experienced, where did it happen, what were the circumstances and how did you deal with it?

Section 4, once again on a separate page, elicits information on reporting behaviours of nurses who have experienced aggressive behaviour. An explanation of what is meant by reporting formally and informally is provided at the beginning of the section. Six closed-ended questions, three for formal reporting and three for informal reporting, are presented for each of the three potential sources of aggression, namely,

doctor, nurse colleague and patient or relative. These questions are, did you ever formally report the worst incident of aggressive behaviour you have experienced from any doctor, did you expect support and did you receive support? These three questions were repeated for informal reporting and all six questions were repeated for nurse colleague and patient or relative.

Section 5 contains 18 scaled response questions, sub-divided into six categories of type of support, namely, accessible, caring, actively supportive, interested in wellbeing, confident in reporting now and in the future. Each of these six categories has three questions about source of support, namely, nurse manager, other nurse colleagues and medical staff.

Section 6 contains 16 questions on perceived changes to professional competence. Although not indicated on the final questionnaire, the 16 questions are grouped into three sub categories with four questions (questions 1-4), relating to the component of 'nurse-patient relationships', four questions (questions 5-8), relating to the component of 'professional relationships', and the final eight questions (questions 9-16), relating to the component of 'role competence'.

The final questionnaire is completed by two open-ended questions eliciting information on 'the one most significant factor that prevented you from coping effectively with aggressive behaviour' and 'the one factor that most helped you to cope effectively'.

7.3 Phase Four: Stage 2: Identifying a systematic random sample from the target population of registered nurses

Stage two involved identifying and conducting a systematic random sample from the target population of nurses in Victoria. Systematic random sampling was possible through access to an established sampling frame, namely, a register of all

nurses (N= 50,413) held by the Victorian Nursing Council (Victorian Nursing Council Report, 1992). This register lists names of nurses in which they apply for and renew their registration.

The researcher utilised a Power Analysis procedure to estimate that a sample size of 504 (1% of the target population) nurses would be sufficient to conduct the survey phase of the project. Statistical power is determined by three factors, namely (a) effect size, estimated to be a mean difference of one standard deviation for this study, (b) Alpha, set at .05 for all statistical calculations in this study, and (c) sample size, calculated as 380 for this study. This would give a statistical power of 80%, which is acceptable to most authorities (Heiman, 1992).

Based on an expected response rate of 40%, a sample of 1,008 (2%) registered nurses in Victoria would be obtained. Systematic random sampling required the researcher to estimate a sample size and calculate the width. The formula is: number of nurses in the target population divided by number of nurses required in the sample. (50,413/1008 = 50). In systematic random sampling, the first nurse must be selected at random and then every 50^{th} nurse thereafter until 1,008 have been obtained.

For reasons of security and confidentiality the sample was identified on this basis by the Victorian Nursing Council (VNC) (now Nurses Board of Victoria (NBV), itself from a population of general registered nurses on Division 1 of the register of the VNC which is the statutory body for maintaining a register for all nurses practising in Victoria. Nurses in Victoria, through the VNC (1989) can register in any single or combination of registers. These include, Division 1, comprehensive nurses; Division 2, enrolled nurses; Division 3, psychiatric nurses; and Division 4, intellectual disability nurses. Division 3 and Division 4 of the register have been closed since 1996 although those who were registered prior to 1996 remain on the register. The

register is updated each year, as nurses are required to apply annually for a practising certificate. Division 1 nurses were selected, firstly, because they are the group which had largely been neglected in the research literature, secondly, they are the largest group of practising nurses in Victoria and finally, they had little or no educational preparation in managing aggressive behaviour compared to nurses in other Divisions. The process for selecting a sample for the survey included the following steps.

A letter was sent in April 1992, to Victorian Nursing Council (VNC) requesting permission to access a systematic random sample of nurses from Division 1 (registered general nurses) of the register. Permission was granted by the Chief Nursing Officer and a random sample of 1,008 nurses was obtained by the researcher.

At the commencement of this project in 1992, a total of 83,320 nurses held current annual practising certificates in Victoria (VNC, 1992). Of the 83,320 practising certificate holders 50,413 were enrolled on Division 1. Those remaining were enrolled in other Divisions of the register. Without the practising certificate, nurses are unable to be employed as a registered nurse in Victoria. The sample, therefore only contained the names of nurses who had applied in 1991 to be included on the 1992 VNC register.

Several factors relating to the registration list were expected to limit the response rate of the survey. It is important to note that this research was being proposed at a time of transition between the final years of the Victorian Nursing Council and the commencement of the Nurses Board of Victoria. The researcher was verbally informed by the Chief Nursing Officer of the VNC that there was a real potential that because of imminent changes to legislation and regulations, names and addresses of registered nurses were unlikely to be provided by the new organisation to external agencies.

Firstly, nurses are a mobile occupational group with many nurses changing their place of employment, moving interstate and overseas, and consequently changing their place of residence. It is worth noting that many (15%) nurses who returned completed questionnaires also were living interstate.

Secondly, the registration list was known to include nurses registered but no longer practising.

Nurses who are enrolled in a state registration are strongly motivated to retain their registration in their original state. There are two reasons for this. One, there is reciprocal recognition between states of each others registration, and two, failure to maintain registration will result in loss of registration. Nurses who are not currently practising will still retain their registration for a specified period of time and will undertake a refresher course before re-entering the workforce.

Despite these anticipated limitations, the systematic random selection of the sample was expected to contribute to representativeness across important demographic variables including age, gender, place of employment, employment status, nursing speciality areas, different levels from within the nursing hierarchy, number of years employed as a nurse, number of years employed in current position and nursing education qualifications.

7.4 Phase Four: Stage 3: Collecting quantitative and qualitative data through distributing the questionnaire

Mailed to each potential participant was the questionnaire, a reply-paid envelope and a letter of introduction and explanation for the study. At the conclusion of the questionnaire participants were thanked for completing the questionnaire and invited to provide their name, address and telephone number if they agreed to discuss the possibility of being interviewed about their experiences of aggressive behaviour.

The letter of introduction (presented as Appendix D) included the purpose of the study, how and why participants had been selected, and a statement explaining that anonymity was assured if the participant chose not to provide their name and contact number for further participation in the study. This was an important ethical issue. Participants were not asked to include their name for the purpose of having an interview, rather, they were consenting to the researcher making further contact with them to discuss the possibility of being interviewed. Participants would therefore be reassured that no further participation in the investigation was necessary until they had received a further explanation of the investigation and had signed a consent form to proceed. It would have been unethical to request consent at this first stage because the interview schedule had not been developed and, therefore had not been approved by the Human Research Ethics Committee.

A statement about confidentiality and security of data was also included. In this investigation, the Human Research Ethics Committee was concerned that participants may experience some psychological discomfort as they recalled and reflected upon their previous encounter/s with aggressive behaviour/s. Therefore, participants were alerted to the possibility that they could experience some psychological discomfort.

The names and contact telephone numbers of the researcher and the principal supervisor were also included in the introductory letter. All participants were told of their right to withdraw from the study at any time without penalty. Informed consent for this phase of the investigation was implied by the return of the completed or partially completed questionnaire.

CHAPTER EIGHT

PHASE FIVE: METHODOLOGY, QUALITATIVE COMPONENT

8.1 Phase Five: Methodology, Qualitative component

Chapter Eight describes the three stages of the qualitative component of the investigation. It commences with development of the in-depth interviews, identifying the sample for the interviews and consideration of conducting and analyzing the qualitative interview data. It is reasoned that although response to work-related aggression is a unique and individual experience, a core set of interview questions to elicit phenomenological experience was appropriate. Six open-ended questions from the questionnaire were further explored and incorporated into the interview schedule.

Three hundred and eighty seven completed questionnaires were returned. The responses within these were subjected to exploratory data analysis to determine the following two factors.

(i) What questions should be included in the interview schedule, and;

(ii) Which of the participants who indicated a willingness to discuss the possibility to participate in-depth semi-structured interviews should be approached?

The selection process of participants for interviews is presented along with justification for conducting semi-structured in-depth interviews. There is an examination of some of the specific ethical issues pertaining to conducting qualitative research. The chapter concludes with a description of the framework used for qualitative data analysis.

8.2 The value of in-depth interviews

As discussed in Chapter 6 above, the purpose of conducting semi-structured in-depth interviews was to provide a richer supply of information regarding nurses' professional reactions and responses to work-related aggression. Minichiello,

Madison, Hays, Courtney and St John (1999:396) stated that the goal of such interviews as to "collect detailed and richly textured person-centered information ... to sketch out the subjective nature of people's stories".

Taylor and Bogdan (1984:61) defined in-depth interviews as "face to face encounters between the researcher and informants directed toward understanding the informants' perspectives on their lives, experiences or situations in their own words."

Fontana and Frey (1998, in Denzin & Lincoln, 1998) have described semi-structured interviewing as a situation in which an interviewer asks each respondent a series of pre-established questions with a limited set of response categories. There is generally little room for variation in response except where an infrequent open-ended question may be used. The semi-structured interview was selected in preference to unstructured interviews as the format of the interview schedule closely followed the questions contained in the questionnaire and was primarily used to collect additional data, further exploring responses that had already been provided. Victoria University Human Ethics Committee approved the interview schedule.

Semi-structured interviewing can be useful for face-to-face interviews but is particularly appropriate for telephone interviews. Fontana and Frey (1998, in Denzin & Lincoln, 1998) claimed that semi-structured interviewing reduces the possibility of errors. Three sources of error can arise from semi-structured interviews. Interviewee errors in that participants provide socially desirable responses to please the interviewer or omit relevant information to hide something from the interviewer (Bradburn, in Rossi, Wright & Anderson, 1983). Instrument errors where the interview schedule or questionnaire contains badly phrased questions and thirdly, interviewer skill errors where an interview is flawed because of poor questioning techniques, or the interviewer changes the wording of the questions (Peneff, 1988).

An important point in the context of this study is made by Kahn and Cannell (1957). They stated that it is not enough to understand the mechanics of interviewing; it is also important to understand the respondent's world and forces that might stimulate or retard response. Understanding the respondent's world was particularly important in this investigation, as the forces that operate within the nursing profession are unique. An example of these different forces which partially explains why aggression is experienced differently by nurses compared to other health professionals and non-health employees is provided in Chapter 2. For several reasons the researcher in this study was ideally positioned to conduct interviews on registered nurses who have experienced work-related aggression.

Firstly, the researcher has had over thirty-three years experience as a nurse, and was, therefore, an 'insider' who understood the cultural mores of the profession and the organisational structures of health care settings. Secondly, he has had first hand experience of being a recipient of aggressive behaviour in a variety of settings. Thirdly, the researcher had conducted courses on the management of patient initiated aggressive behaviour. Fourthly, he had counselled nurses who have been recipients of aggressive behaviours. Finally, the researcher was an experienced interviewer having conducted clinical interviews with clients and colleagues.

On the other hand, the researcher's very familiarity with the topic presented the methodological challenge of bias.

According to Miles and Huberman (1984:320) there are three main sources of bias these being:

(1) the holistic fallacy: interpreting events as more patterned and congruent than they really are, lopping off the many loose ends of which social life is made;
(2) elite bias: over weighting data from articulate, well-informed, usually high status informants and under representing data from intractable, less articulate, lower-status ones;

(3) going native: losing one's perspective or one's "bracketing" ability, being co-opted into the perceptions and explanations of social informants.

Keeping these salient points in mind, the researcher began phenomenological reduction with the suspension of his own beliefs, assumptions, and biases about the phenomena under investigation. The researcher attempted to isolate pure phenomena, that which is revealed by participants, from what is already known through the researchers own knowledge and experience about the phenomena.

Such detachment was particularly difficult in this investigation as the researcher had collected and analysed data obtained from a survey conducted at an earlier phase of the study. These preliminary data were utilised to construct an interview schedule, therefore, data collected from in-depth interviews had already been influenced by previous knowledge. Consequently, information about work-related aggression obtained from the survey had the potential to bias findings from the qualitative component of the investigation.

To enable the researcher to 'discover' the participants' own worlds, and to understand these worlds as they are perceived and experienced by them, it is necessary to attempt to reduce the researcher's own biases regarding relevancy of data. This is important in phenomenological studies, as what is pertinent to observe or ask may not become apparent until after the study has commenced. Reducing bias is achieved through the cognitive process of bracketing.

Streubert and Carpenter (1999:21) describe bracketing as "putting aside one's beliefs, not making judgments about what one has observed or heard, and remaining open to data as they are revealed". Bracketing has been explored by various theorists (Giorgi, 1971; Van Kaam, 1969). Colaizzi (1978:52) asserts that the researcher must remain true to the phenomenon and develop an understanding of what is called "objectivity from the phenomenological perspective". Jasper (1994) suggests that the

ability to bracket facilitates thorough phenomenological analysis of the data because the researcher can listen to, and hear what the subject is saying, and in doing so, not merely interpret but elicit meaning from the data itself.

Merlau-Ponty, however, reassures us that complete isolation of pure phenomena may never be possible because of the intimate relationship individuals have with the world (Merleau-Ponty, 1956). Having identified some of his preconceived ideas, the researcher attempted to set aside previous knowledge or personal beliefs for the duration of the study.

In order to facilitate bracketing, and explore his own perspective, the researcher attended two sessions with a counselor who advised him to answer the research questions from his own experiences and prepare a reflective journal which reviewed the process.

8.3 Phase Five: Stage 1: Development of in-depth interview schedule

The focus of the qualitative component of the present investigation was to meet objective (vi) which was to explore and describe nurses' responses to work-related aggression. During development of the interview schedule the researcher was mindful of the need to get to the essence of phenomenological inquiry which is described by Crotty (1996:30) as "back to the things themselves or the objects of phenomenon".

The interview schedule and letter to the ethics committee (presented as Appendix E) therefore was developed from qualitative data provided by 387 participants in response to the six open-ended questions contained in the survey questionnaire. These questions asked about the worst aggressive behaviour experienced: 'where did it happen, what were the circumstances and how did you deal with it'? Two further questions, namely, 'what was the one most significant factor that prevented you from coping effectively with aggressive behaviour?' and 'what

was the one most significant factor that has most helped you to cope effectively with aggressive behaviour?' were included. All six open-ended questions were subjected to qualitative content analysis whereby qualitative data was refined and interview questions were generated through a process of repeated comparison as described by Corbin and Strauss (1990).

8.3.1 Design of interview schedule

The goal of data collection in Phase Five, stage 1, was to identify and describe the professional and emotional responses of participants to work-related aggression.

All interviews were preceded by the following verbal statement and request, 'thank you for completing the questionnaire and agreeing to be interviewed. I would like to follow-up on some of the responses you made to questions contained in the questionnaire'. Your completed questionnaire refers to the worst incident of aggression experienced from a doctor, a nurse, and a patient. Would you like to tell me some more about this (these) incident/s. This statement was followed by questions contained in the interview schedule and summarised in each applicant's contact summary sheet. The researcher did attempt, however, to facilitate interviewees to expand upon their comments freely, from their own points of view, taking time to maintain rapport and trust with participants. The researcher's status as a nurse academic appeared to have little effect on the participants' preparedness to provide information.

The conduct of this research, which has the potential to elicit very sensitive personal information about individual's experiences with work-related aggression, demands rigorous application to ethical principles and protocols. Most of the ethical concerns revolved around issues of harm, consent, deception, privacy, and confidentiality of data (Punch, 1996, in Denzin & Lincoln, 1998:89). As previously

reported, approval of the interview schedule was sought and granted from the Human Research and Ethics Committee, Victoria University, following conducting the survey and prior to conducting interviews.

8.3.2 Procedure for interview

It was anticipated that all interviews be conducted face-to-face, preceded by having the project explained to participants and having them record their verbal consent onto the audiotape. Audio taping was considered important, as commented by Taylor and Bogdan (1998, in Rice & Ezzy, 1999:63) to "provide a level of detail and accuracy .... allow for greater eye contact ... not obtainable from memory or by taking notes".

In both cases, it was extremely important in a study that asked participants to recall their responses to aggression to establish rapport and develop trust between participant and interviewer. According to Fontana and Frey (1998, in Denzin & Lincoln, 1998:60), "gaining and maintaining trust is subject to considerable fragility; any faux pas by the researcher may destroy days, weeks, or months of painstakingly gained trust".

In accordance with Bulmer (1996, in Denzin & Lincoln, 1998:89), "identities, locations of individuals and places are concealed in published results, data collected are held in anonymized form, and all data kept secure and confidential". There is also a need to consider issues of confidentiality when presenting results and findings. In this investigation all participants involved in interviews would be given a pseudonym to protect their identity in the results section. It would be also necessary to conceal the workplace location and other demographic data to further avoid identification. Security of data would be maintained by having all data stored in a locked filing cabinet in a locked and secure office at the researcher's place of employment. The

researcher would conduct the transcriptions of all data and audiotapes would be destroyed when data had been transcribed.

8.3.3 Contact summary sheet

An important element in phenomenological methodology is the concurrent analysis and data collection that takes place during the interview. This permits the researcher to revise original concepts in response to emerging information derived from the in-depth interview.

To assist in this process a contact summary form (presented in Appendix G) adapted from Miles and Huberman (1994:54-55) was utilized. Immediately following the interview, a brief summary of impressions of the participants' non-verbal communications was to be completed. The researcher was aware of the importance of recording non-verbal data as support of what was being communicated verbally when interviewing subjects about their feelings. The summary sheet could be partially completed prior to each interview and fully completed following each interview. The contact summary sheet is a single page with some focusing and summarising questions about experiences of individual participants. There were two main purposes for the contact summary sheet. The first purpose was to enable the researcher to summarise some of the qualitative comments made by participants in response to the six open-ended questions presented in the questionnaire, thus, facilitating establishing rapport with the participant and focusing on the main elements of their experiences of aggressive behaviour. This assisted the interviewer to focus the interview on key target questions from the interview schedule as a follow-up to the questionnaire. The second purpose was to assist the researcher to identify developing categories and themes from participants' responses. This process would also help the researcher to prepare for the next interview as issues and questions raised by responses from each

interviewed participant could be incorporated into the interview schedule of the next participant, thereby maintaining continuity with data collection and data analysis.

8.4 Phase Five: Stage 2: Identifying the sample for semi-structured interviews

Fifty-five (14%) participants who had experienced work-related aggression expressed a willingness in the questionnaire to discuss the possibility of being interviewed about their experiences of aggressive behaviour in more depth. The aim was to interview all of these participants.

8.5 Framework for qualitative data analysis

Data analysis in phenomenological research begins during data collection. Colaizzi (in Valle & King, 1978:52) suggests that the researcher who wishes to discover what a certain phenomenon may be should begin by "contacting the phenomenon as people experience it". Analysis of the data was therefore assisted by adapting the method described by Colaizzi (1973) and merging it with the interactive model proposed by Miles and Huberman, (1994). The latter involves three steps: data reduction, data display and conclusion: drawing/verifying. These are depicted in Figure 4. The interpreting and condensing of the data collected was achieved through a combination of computer and human techniques.

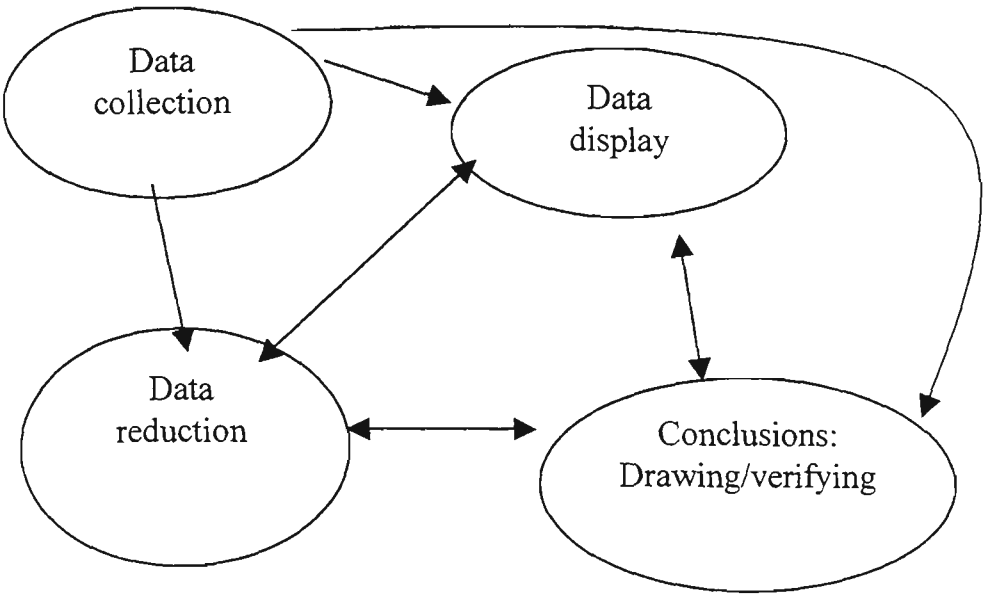


Figure 4: Components of Data Analysis: Interactive Model.
From Miles and Huberman, (1994:12)

8.5.1 Computer assisted qualitative data analysis

Data from the interviews were subjected to preliminary analysis utilising NUD•IST (Non-numerical Unstructured Data Indexing, Searching and Theorising) "a software system for managing and organising and supporting research in qualitative data analysis projects" (Richards, Richards, McGalliard & Sharrock, 1992:2). Miles and Huberman (1994) defined NUD•IST as a program which builds theory. Such programs:

> ...usually include code-and-retrieve capabilities, but also allow you to make connections between codes (categories of information); to develop higher order classifications and categories; to formulate propositions or assertions, implying a conceptual structure that fits the data; and/or to test such propositions to determine whether they apply.

NUD•IST was able to assist the researcher to conduct preliminary code-and-retrieve procedures on narrative data. Although NUD•IST has the facility to create and manipulate concepts and to store and explore emerging ideas, the researcher also used human data analysis to manually link ideas and concepts and to create insightful links between different data segments.

8.5.2 Human analysis of qualitative data

As previously stated, this study utilised a phenomenological approach to complement quantitative data collected and analysed in Phase Four of the investigation. Inherent in and consistent with this approach was a process for analysing qualitative data. The method of data analysis used in phase five of the study was a seven-step process outlined by Colaizzi (1973).

Initially, this involved the researcher transcribing participants' data (Step One), reading their descriptions and listening to their audio tapes to become familiar with participants own words (Step Two). Individual transcripts were then returned to participants who were asked to change any words or sentences they felt did not accurately reflect their experiences of work-related aggression. The researcher then returned to the participants' descriptions and focused on those statements that were most important for conveying nurses' responses to work-related aggression, thereby 'formulating meanings' (Step 3) (Colaizzi, 1973).

The researcher identified significant words and statements, emerging patterns and common themes. These were grouped on a thematic conceptual matrix (step 4), which the researcher intended to present in the qualitative results section of the thesis preceding each theme. This process of examining the data in the light of emerging themes was repeated until all participants narrative was accounted for.

Colaizzi (1973) called the fifth step 'exhaustive description'. The researcher conducted a detailed analytical description of participants' feelings and ideas contained in the themes. Data, clusters, tentative themes were reduced to merge into an overriding description of how work-related aggression impacted upon nurses (Step Six).

The last step consisted of a participant check, when the findings were once again returned to participants who were asked to add their own comments about the authenticity of the data. All subjects declined to make any comments.

Overall, the researcher considered that combining computer based analyses for preliminary coding and retrieving and human analysis for interpretation and developing themes produced a more insightful project. Some justification for this decision to combine both methods was given by Seidman (1991:85) who said that "a computer program cannot produce all the connections that a researcher makes while studying text". The researcher also agreed with comments by the developers of NUD•IST, Richards and Richards (1991) who stated that the computer method can have dramatic implications for the research process and outcomes, from unacceptable restrictions on analysis to unexpected opening out of possibilities. They also had previously raised their concerns about the impacts of computing techniques on method and the real dangers of software constraining and distorting research (Richards & Richards, 1991; Richards, Richards, McGalliard & Sharrock,1992).

8.5.3 Data reduction

Data reduction is the process of selecting, focusing, simplifying and transforming the raw data into field notes and short summaries. Miles and Huberman (1994:10) stated that "data reduction occurs continuously throughout the life of any qualitative project" and that "data reduction is part of [data] analysis".

Data reduction would be instigated following each interview as the researcher assigned 'codes' described by Miles and Huberman (1994:56-67) to the raw data. They describe codes as "labels for assigning units of meaning to the descriptive or inferential information compiled during a study....it is not the words themselves but their meaning that matters" (p. 56). A code is an abbreviation or symbol that is

applied to a segment of words in order to classify words in relation to their themes, hypotheses, speculations or concepts. Coding enabled the data to be retrieved or compared to other similar data quickly and accurately. The coding of data (data reduction) led to new ideas as to the content of a matrix (data display). To facilitate data display the researcher would utilize three types of code to assist with assembling and presenting data:

(i) Descriptive codes which classify words by the similarity of their meanings. These could be compared and contrasted with responses from each subsequent interview.

(ii) Interpretative codes in which words could be classified by the meanings as perceived by the researcher. As interviewing progressed, ideas would emerge regarding the participants' meanings.

(iii) Explanatory codes could be developed as classifications began to emerge and then used to attach inherent meanings to phenomena. Concepts and ideas, which were similar in nature, would be classified and classifications condensed to formulate themes.

8.5.4 Data display

On completion of data coding, a matrix could be compiled for each participant. This would enable the data to be displayed in a systematic condensed form that permitted the researcher to examine and compare several concepts, which assisted in preparing themes. Miles and Huberman (1994:11) defined a matrix display as "an organised, compressed assembly of information that permits conclusion drawing and action". The matrices are dependent on speculations, concepts, and hypotheses, which emerged from the data at the reduction stage. Once the data is displayed in this format the researcher can subject it to conclusion drawing and verification.

8.5.5 Conclusion drawing and verification

The third stream of analysis activity would entail the process of applying meaning to the data that has been collected and displayed. Conclusions could be identified using the clustering method, where understanding of a phenomenon is gained by grouping, then conceptualizing statements that have similar patterns. From the very outset of the interviews, the researcher would be noting regularities, patterns and explanations in the coded data. It would be important to engage in a data verification process continuously throughout the qualitative analysis. This was planned to be achieved by the researcher returning the raw data, interview transcripts, and display matrices back to the participants to gain a sense that the comments outlined in the analysis was truly reflective of participants' experiences.

8.5.6 Evaluation of the analysis process for validity and reliability

One of the final activities of the analysis of the data would be to evaluate the validity and reliability of the process. Wilson (1985) outlined some important concepts to be utilised as criteria to confirm the reliability of qualitative data analysis and promote the validity of the study.

The first concept is homogeneity, which is the degree of harmony between themes. The second concept is inclusiveness, wherein themes incorporate every aspect of the variable. The third concept is usefulness, which demands that each theme have a purpose, and meets the objectives of the study. Mutual exclusiveness is the fourth concept, described by Wilson (1985) as themes having independent and separate identities. If data can be coded to belong to more than one theme reliability of the coding is suspect. The final concept is clarity and specificity where themes are clear and stated in terms people can understand.

CHAPTER NINE

PHASE SIX: RESULTS OF PHASE FOUR: QUANTITATIVE COMPONENT

9.1 Phase Six: Results of Phase Four: Quantitative component

The results are presented in the context of the conceptual framework developed in Phase Two of the project and presented in Chapter Four, and follow the order of research objectives and hypotheses outlined in Chapter Five. Objectives (ii) to (iv) are met by descriptive statistical analysis of data obtained from Sections 1-6 in the survey questionnaire, including tests for associations between variables. Objective (v) and the testing of the two hypotheses flowing from it have been achieved by utilising the model-testing process pioneered by Barron and Kenny (1986) and by multiple regression analysis techniques. The results of these analyses are described in sequence and then summarized in Section 9.8.

The chapter concludes with presentation of the results of the small qualitative section of the survey questionnaire, which asked participants 'what was the one most significant factor that prevented you from coping effectively with aggressive behaviour'? and 'what was the one most significant factor that has most helped you to cope effectively with aggressive behaviour'?

9.2 The sample obtained

A total of 1,008 questionnaires were distributed to a random sample of Registered General Nurses of the Nurses Board of Victoria. One hundred and nineteen (11.8%) were returned unopened with "no longer at this address" stamped on each envelope. As these addresses on the register were no longer current, the researcher elected to disregard them as potential participants, as they were not accessible to participate in the investigation. A random systematic sample is dependent upon having a complete sampling frame containing all relevant information necessary for

selecting a sample; here, the complete sampling frame would constitute the accessible population of registered nurses in Victoria. The 119 returned unopened envelopes with the wrong addresses constituted an inaccessible sample.

Of the remaining 889 questionnaires, 387 completed questionnaires were returned. This represents 43.5% of the deliverable questionnaires, of the complete sampling frame.

The mean age of subjects was 39.18 (SD 10.61), range was 49, with the minimum age of 23 and the maximum age of 72. Thirty (7.9%) of subjects were males and 350 (92.1%) were females. The slightly low response from males is unrepresentative of the number of men in nursing which is approximately 10% (Victorian Nursing Council, 1989).

Two hundred and sixty three nurse participants (69.6%) were employed in urban facilities and 115 (30.4%) were employed in rural communities. The mean years of experience as a registered nurse was reported as 16 years (SD. 9.61), with a minimum of two and a maximum of 50 years. The mean length of time subjects had held their current positions was 5.25 years (SD. 4.42), with a minimum of one year and a maximum of 34 years.

Level of appointment data shows 250 participants (64.6%) coming from the lower level positions (1, 2, 3a and 3b) within nursing. Eighty-four (21.7%) were employed in levels 4a to level 7. Forty participants (10.3%) were currently unemployed; 13 (3.4%) missing values were recorded.

With regard to the tertiary and nursing qualifications held by the participants, 260 (68.9%) had no tertiary qualifications, while 117 (31.1%) had diplomas, bachelor degrees, graduate diplomas or masters degrees. These data were missing for ten participants.

9.3 Identification of frequency, type and sources of aggressive behaviours

Objective (ii): to identify the frequency, type and sources of work-related aggressive behaviour experienced by registered nurses.

This section reports results for frequency, types and sources of work related aggressive behaviour toward nurses as reported by participants in response to the survey questionnaire. Types of aggression included verbal, sexual and physical, whilst doctor, nurse and patient or relative represented sources.

Two levels of measuring aggression were used in this investigation. Firstly, frequency of aggression is measured by the number of responses made to each sub-category of type and source of work-related aggression. Twenty seven sub-categories were available and participants could respond to none or to all twenty seven. Frequency of aggression, therefore, does not mean actual number of aggressive incidents per se experienced by nurses, but rather the number of responses to sub-categories of aggression. This factor is explained more clearly by the following example. A participant could respond to one question in the questionnaire as being 'hit with an object', by a 'doctor' in the 'about once per week' category. Although recorded as a single response, it is clear that the participant had experienced more than one incident of aggression. The value of one allocated in this example would be the same as a value of one in response to a question in the questionnaire such as 'sexually touched you', 'by a patient' in the 'less than once per year category'.

From a total of 27 questions, 387 participants could report a maximum10,449 responses if they were to tick each question. In other words, a theoretical range of zero, if they had not experienced any type of aggression, to 10,449, if they had experienced all types and sources of aggressive behaviour was possible.

Secondly, work-related aggression was measured at the ordinal level of measurement by allocating values to each response set. The value of zero was allocated to the response of 'never', 1 was allocated to 'less than once per year', 2 was allocated to 'about once per year', 3 was allocated to 'about once per month' and 4 was allocated to 'about once per week'.

9.3.1 Frequency of responses to categories of aggressive behaviours

All 27 items from the questionnaire were grouped into three sub-categories, namely, verbal, sexual and physical type of aggression (9 items in each sub-category) and three sub-categories of source, namely doctor, nurse and patient initiated aggression (9 items in each sub-category). A single response, therefore, could indicate both verbal aggression (type) and patient aggression (source). The following summary reports two sets of percentages, the first percentage referring to percentage of the sample of nurses, and the second percentage to percentage of responses.

Three hundred and sixty one participants, 93% of the sample of 387 nurses, made a total of 2,755 responses, (26%) from a potential of 10,449 responses, to having experienced verbal, sexual and physical aggressive incidents from doctors, nurse colleagues and patients. These ranged in frequency categories from 'less than once per year' to 'about once per week' (see Table 4 below). This represented an average of 7.6 responses, from a potential of 27 responses, given by those nurses who indicated that they had experienced work-related aggression. Twenty-six participants, (7%) indicated that they had never experienced any type of work-related aggression from any source.

Fifty six percent of responses (1,544 of the 2,755) were of work-related aggression in the infrequent category 'less than once per year'; twenty six percent of

responses (707) were in the category of 'about once per year'; thirteen percent of responses (365) were in the category of 'about once per month' and five percent of responses (139) were in the most frequent category 'about once per week'.

Table 4
Number of responses made by nurses experiencing work-related aggression by frequency, type and source of aggression

	Type of aggression								
	Physical			Verbal			Sexual		
Source aggression	doctor	nurse	patient	doctor	nurse	patient	doctor	nurse	patient
Less than once per year	33	26	318	288	297	298	65	40	179
About once per year	2	5	151	125	68	260	9	12	75
About once per month	1	4	81	42	41	156	3	8	29
About once per week	0	0	28	8	25	77	0	0	1
Total responses	36	35	578	463	431	791	77	60	284

9.3.2 Types of aggressive behaviours

Three hundred and forty five nurses, 89% of the sample, made 1,685, (61%) of the total of 2,755 responses to having experienced verbal aggression. Of the possible categories of responses here, an average of 4.8 responses were made by each participant to verbal aggression (Table 4).

Two hundred and ninety eight nurses, 77% of the sample, made 649, (24%) of the total of 2,755 responses to having experienced physical aggression. This result represents an average of 2.1 responses per nurse in this category of type of aggression (Table 4).

One hundred and eighty three nurses, 47% of the sample, made 421, (15%) of the total of 2,755 responses to having experienced sexual aggression, thus representing an average of 2.3 responses per nurse in this category (Table 4).

9.3.2.1 Verbal aggression

Table 4 shows a total of 1,685 responses in the verbal aggression category, the most frequently endorsed sub-category with 281 responses, (16.6%) of the total 1,685 responses in the verbal category, to 'patient yelled at you'; followed by 268 responses, (15.9%) to 'patient verbally insulted you'; and 242 responses, (14.3%) to 'patient verbally threatened you'.

These three verbal sub-categories had the highest number of responses for all 27 sub-categories. The most frequently selected non-patient verbal sub-categories consisted of 209 responses, (12.4%) of the total 1,685 verbal responses to 'doctor yelled at you' and 190 responses, (11.2%) to 'doctor verbally insulted you'. Table 4 shows that verbal aggression was the most frequent type of aggression experienced by nurses, with 110 responses made to verbal aggression occurring 'about once per week'. Verbal aggression was also the most common response in the less frequent categories.

9.3.2.2 Physical aggression

Table 4 shows a total of 649 responses in the physical aggression category. The most frequently endorsed sub categories with 224 responses, 34.5% of the total of 649 responses in the physical aggression category to 'patient slapped or struck you' and 214 responses (33%) to 'patient physically threatened you'; followed by 140 responses (21.5%) to 'being hit with an object by a patient'.

Responses to the category of physical aggression from other sources were low, with five percent of responses emanating from doctors and five percent from nurse colleagues. Twenty-two participants (3.3%) responded to 'doctor hit you with an object' less than once per year as the most frequent non-patient initiated aggressive incident. Patient initiated aggressive behaviour was the most frequent type of

aggression, with 28 responses (4.3%) in the 'about once per week' category and no doctor or nurse colleague initiated physical aggression being reported in this category.

9.3.2.3 Sexual aggression

Table 4 shows a total of 421 responses in the sexual aggression category, the most frequent sub-category being 'patient sexually touched you' with 114 responses, (27%) of the total 421 responses. This was followed by 90, (21%) of total responses, to 'patient sexually insulted you' and 80 responses (19%) to 'patient sexually threatened you'.

Seventy-seven responses (18%) of the total 421 responses were made to sexual aggression initiated by a doctor and 60 responses (14%) were made to sexual aggression initiated by a nurse. The most frequent non-patient sub-category of sexual aggression was 44 responses (10.45%) to 'doctor sexually insulted you'. Sexual aggression was reported as an infrequent occurrence with only one response, 0.2% in the 'about once per week' category.

9.4 Sources of aggressive behaviour

Reference to Table 4 also reveals participants' responses to the three categories of sources of aggression explored. Two hundred and seventy four participants, 70.8% of the sample made 576 responses, (21%) of the total 2,755 responses to doctor initiated aggression. Of the possible categories of responses here, an average of 2.1 responses were made by participants to aggressive behaviour from doctors; 236 participants, (60.9%) made a total of 526 responses (19%) to nurse colleague initiated aggressive behaviour. Of the possible categories of responses here, an average of 2.2 responses were made by participants to aggressive behaviour from nurse colleagues and 343 participants (88.6%) made a total of 1,653 responses (60%) to aggressive behaviour from patients. Of the possible categories of responses here, an

average of 4.8 responses were made by participants to aggressive behaviour from patients. Sixty percent of responses indicate that patients were the main source of aggressive behaviour toward nurses, followed by 21% responses to doctor initiated aggression and 19% responses to nurse colleague initiated aggression.

9.4.1 Doctor initiated aggression

Table 4 shows a total of 576 responses, (21%) of the total 2755 responses in the doctor initiated aggression category. Thirty-one participants, (8%) of the sample of nurses made 36 responses, (1.3%) of the total 2,755 responses to physical aggression from doctors. The most common sub-category in doctor initiated physical aggression was 22, or .7% of total responses to 'being hit with an object'. Being 'slapped or struck by a doctor' or being 'physically threatened by a doctor' was an infrequent occurrence with seven responses in each sub-category.

A total of 60 participants (15.5%) made a total of 77 responses (2.8%) to sexual aggressive incidents from doctors. Sexually insulting behaviour by doctors was responded to 43 times (1.5%) by participants while 23 (·83%) of total responses were in the sub-category of 'being sexually touched by a doctor'. Responses to sexual aggressive behaviour from a doctor was made 65 times, 2.3% of total responses as occurring infrequently at 'less than once per year'.

Two hundred and sixty eight participants (69.2%) of the sample made 463 responses, (16.8%) of 2,755 responses to verbal aggressive behaviour from doctors. One hundred and ninety responses, (6.8%) were made to 'verbal insult' and 209 (7.5%) of total responses endorsed by participants to being 'being yelled at'.

9.4.2 Nurse initiated aggression

Two hundred and thirty six participants (60.9%) of the sample made 526 responses, (19%) to aggressive incidents from nurse colleagues. Twenty participants

(5.1%) of sample made 35 responses (1.2%) to physical aggression from nurse colleagues. These responses were evenly distributed between the three sub-categories of physical aggressive behaviour. Forty-one participants (10.5%) indicated 60 responses (2.1%) to sexual aggressive behaviour from nurse colleagues.

Table 4 shows 235 participants (60.7%) reported 431 responses (15.6%) to verbal aggressive behaviour from their nurse colleagues. Sixty-six responses (2.3%) of verbal aggression from nurse colleagues were reported as occurring about 'once per month' or 'once per week'. The two most common types of nurse initiated verbal aggression were 173 responses (6.2%) to 'verbally insulted' and 177 responses (6.4%) to being 'yelled at'. Being 'verbally threatened' received 81 responses, 2.9% of total responses.

9.4.3 Patient initiated aggression

Three hundred and forty three participants (88.6%) made 1,653 responses, (60%) to having experienced aggressive behaviour from patients. Two hundred and ninety participants (74.9%) made 578 responses (20.9%) to physical aggression from a patient. The most frequent responses were in the sub-category 'a patient had slapped or struck them' with 224 responses (18%), and 'a patient had physically threatened them' with 214 responses (7.7%). Being 'hit with an object by a patient' accounted for 140 responses (5%).

Being 'physically threatened' by a patient received 107 responses in the 'less than once per year' category, 57 responses were made in the 'once per year' category, 36 responses in the 'once per month' category and 14 responses in the 'about once per week' category. Being slapped by a patient had 127 responses as occurring 'less than once per year', with 55 responses to being slapped or struck by a patient 'once per year', 32 responses to 'once per month' and 10 responses to its occurrence in the

'about once per week' category. Eighty-four responses were made by nurses to being hit with an object by a patient as occurring 'less than once per year', 39 responses were in the 'about once per year' category, 13 responses in the 'about once per month' and 4 responses to being hit by an object 'about once per week' category.

One hundred and sixty one participants (41.6%) made 284 responses (10.3%) to sexual aggression from patients. The most common type of sexual aggression was 114 responses (4.1%) to being 'sexually touched by a patient', followed by 90 responses (3.2%) to being 'sexually insulted by a patient' and 80 responses (2.9%) to a 'patient had sexually threatened them'.

Three hundred and nineteen participants (82%) reported that they had experienced 791 responses (28.7%) to verbal aggression from a patient. Aggressive incidents were evenly distributed between the three types of verbally aggressive behaviour. Verbal aggressive incidents were more common and occurred more frequently than other sources of aggressive behaviour. Participants made two hundred and sixty eight responses (9.7%) to being 'verbally insulted by a patient', 242 responses (8.7%) to being 'verbally threatened by a patient' and 281 responses (10.1%) to 'being yelled at by a patient'.

9.5 Identification of reporting behaviours by nurses following aggression

Objective (iii): to identify nurses' reporting behaviours following acts of aggression.

Table 5 shows the number of participants who either formally (completing official written report with expectation of official follow-up) or informally (discussed incident with no expectation of official follow-up) reported the worst incident of aggressive behaviour experienced by them, from any doctor, any nurse colleague or from any patient or relative of a patient.

Thirty four participants (12.4%) of the 274 nurses in the sample who had indicated that they had experienced doctor initiated aggression formally reported a doctor, 39 participants (16.5%) of the 236 nurses in the sample who had indicated that they had experienced nurse colleague initiated aggression formally reported a nurse colleague, and 178 participants (51.8%) of the 343 nurses in the sample who had indicated that they had experienced patient initiated aggression formally reported a patient to senior institutional management. Two hundred and seven participants (75.5%) informally reported a doctor, 173 participants (73.3%) informally reported a nurse colleague and 275 participants (80.1%) informally reported a patient following the worst incident of aggressive behaviour they had experienced.

Table 5

Reporting, expectation of, and receiving institutional support following aggressive incidents

	Reporting		Expected support		Received support	
	reported incident	percent reported	expected support	percent expected support	received support	percent received support
Formally report doctor (n=274)	34	12%	32	94%	24	75%
Informally report doctor (n=274)	207	75%	178	86%	171	96%
Formally report nurse (n=236)	39	16%	36	92%	24	66%
Informally report nurse (n=236)	173	73%	156	90%	136	87%
Formally report patient (n=343)	178	52%	160	90%	117	73%
Informally report patient (n=343)	275	80%	254	92%	232	91%

When asked whether they expected to receive support when formally reporting their worst experience of aggressive behaviour, expectations ranged from 160

participants (89.8%) of the 178 nurses who had indicated that they had formally reported a patient, to 32 participants (94.1%) of the 34 nurses who had indicated that they had formally reported a doctor.

When asked whether they expected to receive support when informally reporting their worst experience of aggressive behaviour, expectations ranged from 178 participants (85.9%) of the 207 nurses who had indicated that they had informally reported a doctor to 36 participants (92.3%) of the 39 nurses who had indicated that they had informally reported a patient.

The question asking participants to indicate whether they had actually received support following their formal reporting of the worst incident revealed 24 participants (75%) of the 32 nurses who had indicated that they had expected to receive support, actually received support following the formal reporting of a doctor; 24 participants (66%) of the 36 nurses who had indicated that they had expected to receive support, actually received support following formal reporting of a nurse colleague and 117 participants (73%) of 160 nurses who had indicated that they had expected to receive support, actually received support following formal reporting of a patient. This compares to higher percentages of participants responding that they had actually received support following informal reporting of a doctor (96%), informal reporting of a nurse colleague (87%) and informal reporting of a patient (91%).

9.6 Identification of expectations and perceptions of institutional social support

Objective (iv): to identify nurses' expectations and perceptions of the availability of, and utilisation of institutional social support following their experiences of acts of work-related aggression.

Section 5 of the questionnaire elicited descriptions of specific supporting behaviours expected and experienced by nurses who had experienced aggressive behaviour. Nurses could characterise the institution as supportive 'not at all', 'slightly', 'moderately' or 'very'. For brevity and clarity, these four response

categories were collapsed into two categories of support, namely, 'not supportive' and 'supportive', hence, Table 6 shows two categories for each type of institutional supporting behaviour and the sources of institutional support. All original response categories are presented in Appendix H.

The data shown in Table 6 reveals differences in all aspects of institutional supporting behaviours. For example participants perceived that nurse colleagues were more accessible, caring, supportive and interested compared to nurse managers and doctors.

Table 6

Number and percentage of nurses perceiving fellow workers as supportive following aggressive behaviours

	doctor		manager		nurse colleague	
Supportive behaviours	N	%	N	%	N	%
Accessible following aggressive behaviour	227	(68%)	303	(88%)	348	(99%)
Not accessible following aggressive behaviour	108	(32%)	40	(12%)	3	(1%)
Cared about you	208	(63%)	290	(85%)	346	(98%)
Did not care about you	123	(37%)	52	(15%)	7	(2%)
Actively supportive	193	(58%)	282	(83%)	329	(95%)
Not actively supportive	139	(42%)	58	(17%)	19	(5%)
Interested in your wellbeing	181	(55%)	268	(79%)	321	(93%)
Not interested in your wellbeing	147	(45%)	70	(21%)	24	(7%)
Confident to report aggression now	263	(77%)	308	(90%)	336	(97%)
Not confident to report aggression now	78	(23%)	35	(10%)	11	(3%)
Confident to report aggression in future	273	(80%)	316	(92%)	336	(97%)
Not confident to report aggression in future	69	(20%)	26	(8%)	9	(3%)

N = number of nurses who experienced aggressive behaviour and responded to questions about supporting behaviours from three sources of institutional support.
% = percentage of nurses in each category of experiencing supportive and/or non-supportive behaviours

Doctors were clearly identified as 'not at all' supportive in all components of supportive behaviour with 139 participants (42%) of the 332 nurses who experienced aggression and had completed this question, reporting that doctors were 'not actively

supportive', and 147 participants (45%) of the 328 nurses reporting that doctors were 'not interested in their own [participants] wellbeing'. There was an overall perception by 70 participants (21%) of those who have experienced workplace aggression, that nurse managers were 'not interested in their own [participants] wellbeing', and 58 participants (17%) perceived managers as 'not actively supportive'.

9.7 Identification and description of associations between aggression, institutional social support and perceived professional competence

Objective (v): to identify and describe the associations between work-related aggression, institutional social support and perceived professional competence.

Prior to testing the proposed model it is important to estimate correlations between those variables which may be entered into a hierarchical or stepwise regression analysis. This would assist in determining which variable is the best predictor of perceived professional competence. The variable that 'is most closely correlated with the dependent variable should be entered first and would also identify any partial or semipartial correlations' (Hair, Anderson, Tatham & Black, 1995:135). Estimating correlations will also assist with identifying any multicollinearity which is when two or more variables are so closely associated or have near linear dependencies making it difficult to determine any single regressor on the response (Myers, 1990).

Table 7 shows the correlations between workplace aggression, institutional social support and perceived professional competence.

Role competence refers to intrinsic caring aspects of professional nursing. This component was negatively correlated significantly but not highly, with all sources of work-related aggressive behaviour and negatively correlated with verbal and sexual aggressive incidents. It was not correlated with physical aggressive behaviour.

Professional relationships was negatively correlated with aggressive behaviour from doctors and nurses but was not correlated with aggressive behaviour from

patients. This variable was also correlated with verbal and sexual aggressive behaviour but was not correlated with physical aggression.

Table 7

Pearson correlations between components of work-related aggression, institutional support and perceived professional competence

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Aggression from doctor	1.00										
2. Aggression from nurse	.36	1.00									
3. Aggression from patient	.18	.24	1.00								
4. Verbal aggression	.61	.65	.73	1.00							
5. Sexual aggression	.31	.43	.63	.47	1.00						
6. Physical aggression	.24	.29	.87	.63	.46	1.00					
7. Support from manager	-.24	-.14	.05	-.15	-.13	-.07	1.00				
8. Support from colleagues	-.17	.00	.09	-.01	.02	.09	.57	1.00			
9. Support from doctors	-.30	-.18	-.04	-.22	-.09	-.05	.56	.37	1.00		
10.Nurse-patient relationships	-.17	-.10	-.22	-.20	-.24	-.17	.13	.11	.14	1.00	
11.Professional relationships	-.16	-.18	-.00	-.11	-.12	-.00	.35	.25	.24	.42	1.00
12.Role competence	-.19	-.11	-.11	-.17	-.14	-.09	.15	.15	.19	.64	.66

Shaded area $p < .01$

Nurse-patient relationships was correlated on all aspects of aggression with the exception of aggressive behaviour from nurses.

Work-related aggression from a doctor was correlated with all three sources of institutional support, whereas nurse aggression was correlated with support from nurse manager and doctors. Patient initiated aggression was not correlated with any source of institutional support.

Verbal aggression was correlated with support from nurse managers and doctors but not for support from nurse colleagues, whilst sexual aggression was correlated with one source of institutional support, namely, nurse managers and physical aggression was not correlated with any source of institutional support.

All aspects of institutional support were correlated with all three components of perceived professional competence. As intended, this analysis provided the framework for the sequencing of the hierarchical, stepwise regression analysis reported in section 9.7.4.

9.7.1 The effect of work-related aggressive behaviour on perceived institutional social support

Hypothesis one: Work-related aggressive behaviour on nurses is experienced as having a negative impact on nurses' perceptions of supporting behaviours of staff from within the institution.

In Section 5 of the questionnaire, participants were asked to report how they perceived supporting behaviours of 'nurse manager', 'other nurse colleagues' and 'medical staff' from within the organisation following their experience of work-related aggression. Participants could respond that their perception of supporting behaviours could be 'not at all' (value = 0); 'slightly' (value = 1); 'moderately' (value = 2); or; 'very' (value = 3).

When all 18 items of perceived supporting behaviours were aggregated into an overall score for perceived support, a t test was conducted between two categories of high and low scores for the overall score for work-related aggression and aggregate score for supporting behaviours and individual scores for each source of support.

High and low scores for aggression were obtained by estimating the median score for aggression (Mdn = 37) and creating two groups. These were, those with an aggregate score below 37 who were given the value of 1. They were considered to have experienced aggression less frequently than those participants who had an aggregate score above 37 and assigned the value of 2. The result showed that there was a significant effect on the aggregate score and individual sources of perceived institutional support with support from nurse manager [$t(df=329) = 2.61$, $p < .009$)] and support from medical staff [$t(df=321) = 3.38$, $p < .001$)]. There was no significant difference in perceived support from other nurse colleagues. For the aggregate score of institutional support the result showed that there was a significant effect [$t(df = 313) = 2.54$, $p < .025$)], and that work-related aggression impacted negatively on perceptions of supporting behaviours of key institutional staff.

Thus the hypothesis that work-related aggressive behaviour on nurses is experienced as having a negative impact on nurses' perceptions of supporting behaviours of staff from within the institution was upheld.

9.7.2 The effect of work-related aggressive behaviour on perceived competence

Hypothesis two: Work-related aggressive behaviour on nurses is experienced as having a negative impact on nurses' perceptions of perceived professional competence.

Table 8 shows all 16 items of perceived professional competence. Items 1-4 were grouped by conducting principal component analysis into one category of responses, namely, 'nurse-patient competence'. Likewise, items 5-8 were grouped, using the same process, into a single category of 'professional colleague competence' and finally, items 9-16 were grouped into a single category of 'role competence'.

Table 8 indicates that a total of 386 participants (99.7%) of the sample completed this section of the questionnaire. A total of 6,174 responses was made by nurses with 1,215 responses (19.7%) of the total indicating that aggressive behaviours had a negative impact; 3,122 responses (50.6%) of the total indicated that aggressive behaviour had no impact at all and 1,837 responses (29.8%) of the total indicated that aggressive behaviours resulted in a positive outcome.

Table 8 shows individual items of professional competence with negative scores ranging from a low of 9.6% for 'the standard of nursing care practiced' to a high of 32.1% for 'being in control of your work environment'. Ninety (23.3%) participants responded that aggressive behaviour had negatively influenced their decision to remain in nursing as a career.

In section 6 of the questionnaire participants were asked to report how their experience of work-related aggression impacted upon aspects of their perceived professional competence. Participants could respond that their experience of

aggression had no impact on them by ticking 'positively' (value = 1); 'not at all' (value = 2); 'negatively' (value = 3).

Table 8

Impact of aggression on perceived professional competence N=386

	Questionnaire item	Responses		
	Nurse-patient competence	not at all	positively	negatively
1	Professional relationships with patients	227 (58.8%)	100 (25.9%)	59 (15.3%)
2	The amount of time spent with patients	254 (65.8%)	81 (21%)	51 (13.2%)
3	Your ability to respect patients	236 (61%)	87 (22.5%)	63 (16.3%)
4	Your ability to trust patients	211 (54.7%)	73 (18.9%)	102 (26.4%)
	Professional-colleague competence			
5	Confidence in working as a team member	200 (51.8%)	125 (32.4%)	61 (15.8%)
6	Your professional relationships with colleagues	172 (44.6%)	137 (35.5%)	77 (19.9%)
7	Your ability to trust professional colleagues	174 (45.1%)	108 (28%)	104 (26.9%)
8	Your ability to respect professional colleagues	163 (42.2%)	107 (27.7%)	116 (30.1%)
	Role-competence			
9	How you perceive your role as a professional nurse	180 (46.6%)	126 (32.6%)	80 (20.7%)
10	Being in control of your work environment	154 (39.9%)	108 (28%)	124 (32.1%)
11	Your professional autonomy as a nurse	189 (49%)	109 (28.2%)	88 (22.8%)
12	How you perceive yourself as a competent nurse	181 (46.9%)	142 (36.8%)	63 (16.3%)
13	Your ability to make good clinical decisions at work	194 (50.3%)	148 (38.3%)	44 (11.4%)
14	How you perceive your level of clinical skill	182 (47.4%)	146 (38%)	56 (14.6%)
15	The standard of nursing care you practice	201 (52.1%)	148 (38.3%)	37 (9.6%)
16	Your decision to remain in nursing as a career	204 (52.8%)	92 (23.8%)	90 (23.3%)
	N =	3122	1837	1215

N = number of nurses responding to each category; % = the percentage of nurses responding to each category

When all 16 items of perceived professional competence were aggregated, a t test was conducted between two categories of high and low scores for work-related

aggression on all components and aggregate score for perceived professional competence. The result showed that there was a significant effect on the aggregate score and individual components of perceived competence with nurse-patient competence [t(df = 384) = -2.42, p < .01)], professional-colleague competence [t(df = 384) = -2.21, p < .02)], and role competence [t(df = 382)= -2.91, p < .004)]. For overall competence the result was also negative [t(df=382)= -3.05, p < .002)]. Table 9 shows the group scores for all components of perceived professional competence.

Table 9

Components of perceived professional competence

categories	Nurse-Patient competence	Professional competence	Role competence
Not at all	928 (15%)	709 (11%)	1485 (24%)
Positively	341 (52%)	477 (7%)	1019 (16%)
Negatively	275 (5%)	358 (6%)	582 (10%)
Total	1544 (25%)	1544 (25%)	3086 (50%)

Thus, the results upheld the hypothesis that work-related aggressive behaviour on nurses is experienced as having a negative impact on nurses' perceptions of perceived professional competence.

9.7.3 Institutional social support as a moderator

Objective 5, Model testing hypothesis: that negative effects of work-related aggression on perceived professional competence will be moderated by perceived institutional social support.

The path diagram in Figure 5 presents a causal model involving the moderator function of institutional social support. The proposed model was tested by using multiple regression analysis. According to Baron and Kenny (1986), a moderator effect is present whenever the interaction (Path **c**) is significant. Effects in Paths **a** and/or **b** may or may not be significant and are not essential to establish moderation.

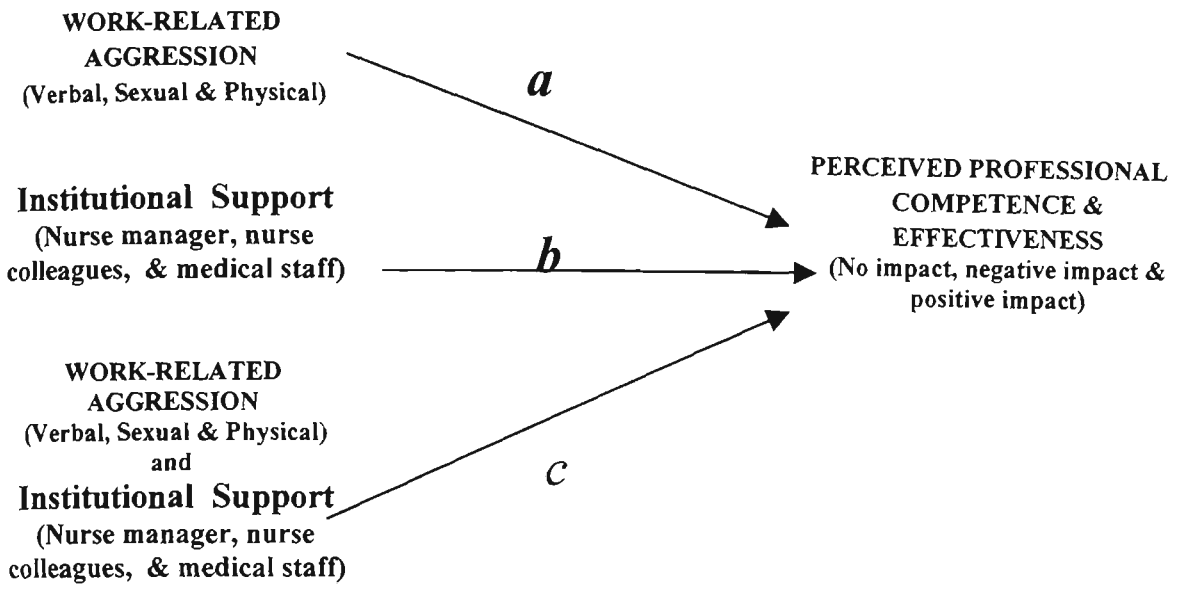


FIGURE 5 Model of the moderating effect of institutional support on aggression and perceived changes to professional competence

Barron and Kenny (1986) made some important comments about selecting appropriate analytic procedures to test moderation models. For the moderational hypothesis the statistical analysis must measure and test the differential effect of the independent variable on the dependent variable as a function of the moderator. The level of measurement of the independent variable and the moderator will influence the choice of statistical test. In this study the independent variable (work-related aggression) and the moderator variable (institutional social support) are continuous. In fact they are both measured at the interval level of measurement, which is treated by researchers as continuous.

Multiple regression analysis and descriptive statistical tests were used to explore the hypothesised moderational model. Regression analysis provides indications of the direction and strength of the individual relationships specified within the model as well as evaluating the quality of the measurements.

A series of three regression analyses, as specified by Baron and Kenny (1986:1177), were performed as follows:

1 The first equation regressed the moderator [institutional social support] on the independent variable [work-related aggression].

2 The second equation regressed the dependent variable [perceived professional competence] on the independent variable [work-related aggression].

3 The third equation regressed the dependent variable [perceived professional competence] on both the independent variable [work-related aggression] and the moderator [institutional social support].

To establish moderation the following conditions must hold:

(a) Work-related aggression must affect institutional social support in the predicted direction in the first equation.

(b) Work-related aggression must affect perceived professional competence in the predicted direction in the second equation.

(c) Institutional social support must affect perceived professional competence in the predicted direction in the third equation. Then, if these conditions are met, the effect of work-related aggression on perceived professional competence must be less in the third equation than in the second equation (Baron & Kenny, 1986:1177).

Data analysis involved a procedure for calculating centered predictor and moderator variables (Aiken & West, 1991). Centering of variables involves subtracting the sample mean of the variable from the variable, creating a new variable with a mean of zero. The use of centered variables in regression analysis greatly lessens the problem of high multicollinearity.

Table 10 shows the results of the regression analyses of the moderating effect of social support on the relation between work-related aggression and professional competence. Results show that there was significant social support and work related aggression interaction. This finding suggests that social support moderated the effect of aggression on professional competence.

Table 10

Summary of the moderational effect of perceived institutional social support on the aggression-perceived professional competence relationship

Variable	ΔR^2	*b*	β	*t*
Step 1				
Aggression		-.177	-.139	-2.54[b]
Support	.96[F(2,310)=16.50]	.264	.261	4.79[c]
Step 2				
Aggression X Support	.01[F(1,309)= 3.88]	1.13	.112	1.97[a]

b and β are unstandardised and standardised beta coefficients, respectively, from the final step of the regression equation. [a]$p < 0.05$; [b]$p < 0.01$; [c]$p < 0.000$.

Figure 6 shows the aggression and institutional support interaction. For this graph, the effects of institutional social support and work-related aggression on perceived professional competence were plotted at two points: high and low. High and low values for both institutional social support and work-related aggression were +1 *SD* and *–1 SD* of their centered mean of zero. For all slopes, the regression coefficients at high (+1 SD) and low (-1 SD) institutional social support, and the significance of these coefficients were also computed. The slope for high institutional social support was not significant [b = -0.02, t (df = 308) = 0.28, ns], while the slope for low institutional social support was significant [b = -0.26, t (df = 308) = -3.68, p <0.001]. As noted, the rate of effect of aggression on perceived professional competence is more at low institutional social support than high institutional social support. This suggests that institutional social support buffers the effect of work-related aggression on perceived professional competence.

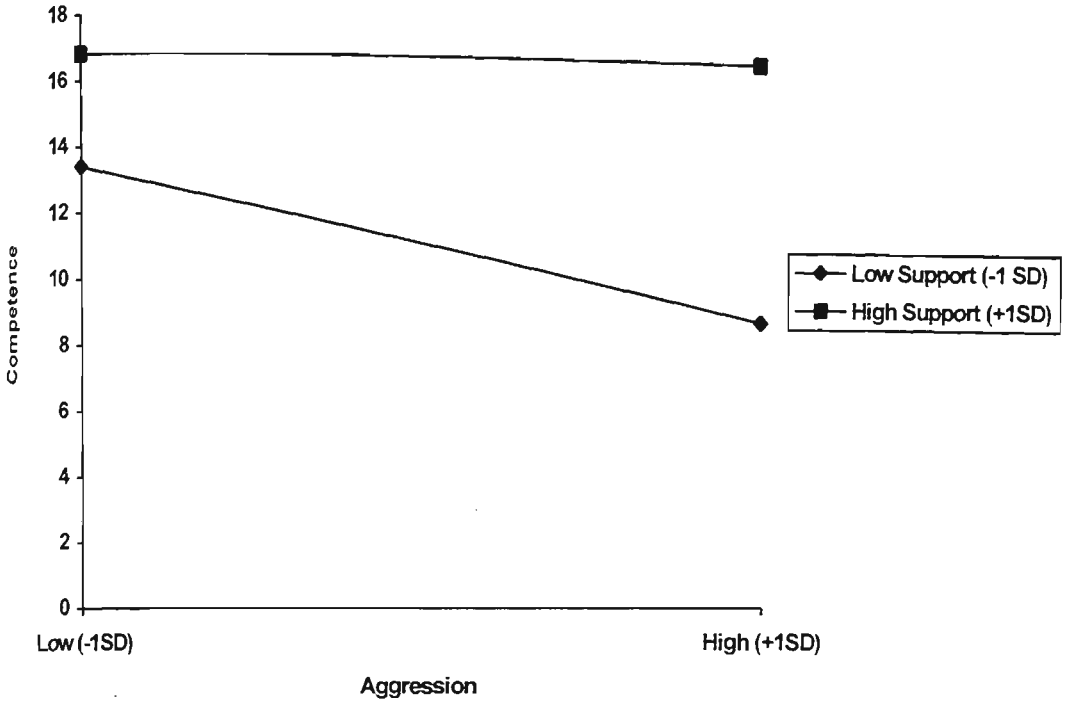


Figure 6. Institutional social support as a moderator of the relationship between work-related aggression and perceived professional competence

Overall, the data analysis demonstrated that the hypothesis that the negative effects of work-related aggression on perceived professional competence will be moderated by perceived institutional social support was upheld.

9.7.4 Stepwise regression among the variables

In order to examine the effect of work-related aggression on perceived professional competence, perceived professional competence was regressed on work-related aggression variables using stepwise regression analysis. A stepwise regression analysis was conducted to explore the best predictors (statistically) from components of work-related aggression by type and source (Table 11). In the first regression analysis, perceived professional competence was simultaneously regressed on the variables constituting type and source of work-related aggression. Table 11 shows that doctor and sexual aggression, contributed independently to perceived professional competence ($p = < .01$).

The selection criteria for inclusion in the model is the independent variable having the largest partial correlation with perceived professional competence, controlling for independent variables already in the regression model. In addition, a variable's partial regression coefficient must be significant at the .05 level and must exhibit at .01% of its variance independent of the other predictor variables in order to be selected.

Stepwise regression produced statistics for each stage of the procedure: selecting the variable with the greatest predictive ability out of those not yet selected each time.

Table 11

Summary of Stepwise regression analysis for variables predicting professional competence

Predictor variable	*F*	*β*	*R^2 Change attributed to each step*
Step 1			
Doctor aggression	16.41	-.203	.04 p= <.002
Sexual aggression	11.70	-.136	.02 p= <.01
Step 2			
Nurse aggression	8.80	-.150	.002 p= .4
Patient aggression	5.44	-.119	.001 p= .8
Step 3			
Verbal aggression	13.88	-.033	.003 p= .6
Physical aggression	3.90	-.101	.000 p= .2

9.8 Summary of quantitative data analysis results

Registered nurses frequently experience work-related aggression as they perform their role as professional nurses. Ninety three percent of the sample had experienced at least one incident of aggressive behaviour, with an average score of 7.6

responses to the incidents recorded. Fifty six percent of aggressive incidents were reported as occurring in the 'less than once per year' category, with five percent occurring in the 'less than once per week ' category.

9.8.1 Types and sources of work-related aggression

The six sub-categories with the highest number of responses, all above 200 responses, were all three sub-categories of verbal aggression from patients, followed by two sub-categories of physical aggression by patients and one sub-category of verbal aggression by a doctor. There were seven sub-categories with scores below 20 responses. These included all three sub-categories of physical aggression by nurses, two sub-categories of physical aggression by doctors and one sub-category each of sexual aggression by a doctor and a nurse.

Verbal aggression is the most frequent type of work related aggression with 89% of nurses in the sample making 61% of all responses, followed by 77% of nurses making 24% of total responses to having experienced physical aggression, and 47% making 15% of responses to having experienced sexual aggression at their work place. Almost seven percent of verbal aggression was reported as occurring 'about once per week'.

Patient initiated work-related aggression was the most common source of aggression, with 88% of nurses in the sample making 60% of all responses in this category. This was followed by 71% of nurses making 21% of responses from doctors, and 61% of nurses making 19% of responses from nurse colleagues.

The most frequent source of verbal aggression are patients, with almost 17% responses in the 'patient yelled at you' sub-category as the most frequent type of verbal aggressive behaviour. 'Doctor yelled at you' was the most frequent non-patient sub-category, followed closely by 'doctor verbally insulted you' also recording over 10% of responses.

Nurses with 649 or 23% of all responses frequently experienced physical-initiated aggression. The most frequent types of physical aggression were, 'patient

physically threatened you' and 'being hit with an object by a patient'. Doctors also were identified as hitting nurses with objects.

Sexual aggression also presents as a problem for nurses. Most types of sexually aggressive behaviour emanated from patients, followed by doctor initiated sexual aggression in the sub-category of 'doctor sexually insulted you' and nurse initiated sexual aggression in the sub-category of 'nurse sexually insulted you'.

9.8.2 Reporting behaviours of nurses following aggression

Very few nurses elected to formally report aggressive incidents. They were more likely to formally and informally report patients and less likely to formally report doctors and less likely to informally report nurse colleagues. It is clear that when nurses choose to report incidents of aggressive behaviour, they do expect to receive support; however, this expectation was not always translated into support received. They were more likely to receive support when informally reporting doctors, followed closely by receiving support when informally reporting patients. The least received support was in response to formally reporting a nurse colleague and formally reporting a patient.

9.8.3 Supporting behaviours of institutional staff

When institutional social support was received, it was provided mostly by nurse colleagues who were seen as very supportive and scored highest in all six sub-categories of institutional support. Doctors were generally considered to be either slightly or not at all supportive and scored lowest in all six sub-categories of institutional social support. In the main, managers scored in the middle ranges of slightly to moderately supportive in all sub-categories.

9.8.4 Relationships between variables

Results show relationships between sources of work-related aggression, institutional social support and perceived professional competence. Aggressive incidents from doctors were significantly negatively associated with all three components of perceived professional competence and overall total perceived

professional competence. Aggressive incidents from patients had a significant negative correlation with nurses-patient competence and with their role competence and overall total competence, but was not significantly associated with professional relationships competence. Aggressive incidents from nurses were not associated with nurse-patient competence but were significantly associated with role competence and professional competence.

Results also show a relationship between types of work-related aggression, institutional social support and perceived professional competence. Verbal and sexual aggression show significant negative correlations with all components of perceived professional competence. While physical aggression had a significant negative correlation with nurse-patient competence and overall total competence, this correlation was not significant with role competence and professional competence.

9.8.5 The effect of work-related aggression on perceived institutional social support and perceived professional competence

Both research hypotheses were supported in this investigation. It would appear that for nurses experiencing work-related aggression, there was a negative impact upon how they perceive supporting behaviours of nurse managers and medical staff. Work-related aggression also appeared to have a negative impact on the total score of perceived professional competence and on all three components of perceived professional competence.

9.8.6 Model testing the moderator effect of social support

Institutional support appeared to have a moderation function on the impact of workplace aggression on perceived professional competence. There was statistical support for the moderation effect of institutional support on the relationship between work-related aggression and perceived professional competence. When high levels of institutional social support were perceived by nurses, there was no impact of work-related aggression on professional competence; however, when low levels of

institutional social support were perceived, work-related aggression had a negative impact.

9.9 Results of qualitative component of questionnaire: Description of worst incident of aggression experienced and factors preventing effective coping

As previously stated, the researcher intended to utilise a phenomenological approach to conduct in-depth interviews with a number of participants who had indicated that they were willing to continue their involvement in the research project. To assist with this anticipated process, a content analysis was conducted on all 387 returned questionnaires to identify content categories of written responses provided by participants to the two open-ended questions presented in Section 7 of the questionnaire relating to factors that prevented nurses from coping effectively and factors that helped nurses to cope effectively with aggressive behaviour.

According to Lupton (1999, in Minichiello, Sullivan, Greenwood & Axford (1999:453) content analysis "is useful in that you can begin to make sense of a large mass of data through identifying patterns of representation".

Participants were requested to respond to two questions: 'what was the one most significant factor that prevented you from coping effectively with aggressive behaviour?' and 'what has been the one factor that has most helped you to cope effectively with aggressive behaviour?'

Qualitative content analysis of these particular data was conducted by a process involving counting the frequency of words or concepts and/or the number of instances of action or interaction (Tesch, 1990). Through this process, four categories of factors were identified which prevented nurses from coping. These were, in order of frequency, institutional deficits (n=245), psychological states (n=211), professional deficits (n=197) and negative emotions (n=190).

9.1 Institutional deficit factor

Institutional deficits were characterised by three subgroups of response, namely, lack of institutional support, lack of information on rights and obligations and characteristics of oppressed group behaviour.

Lack of support by nurse managers was identified by 161 participants as the major obstacle to coping with aggression. Twenty-six participants made comments about the organisational structure and/or political nature of the institution. Doctors were perceived to be in very powerful positions which were utilised to exhibit negative behaviours upon nurses. Ten responses used the word arrogance to describe the behaviour of doctors when interacting with nurses. This behaviour was often exacerbated by the display of disapproval by doctors of nurses in the presence of patients. One participant explained that the nursing staff "despised" the doctor for his repeated displays of arrogance. Other negative attitudes were reported in the questionnaire by 32 participants. Fifteen participants reported experiencing inferiority to doctors in carrying out their nursing role.

Illustration of responses indicating institutional deficits

Illustration 1: Participant 61

The following comment provides an example of non-supportive behaviour and also points to another type of aggression. She stated:

> The director of nursing in my present place of employment would really not want to know about aggression. If it were brought to her notice her reaction would be to blame the victim. This makes for a quicker resolution together with "under the carpet and let's forget it". By acknowledging a problem she may have to take some responsibility and try to resolve it. Is this not another form of violence?

Institutional deficits are characterised by structures, policies, and procedures that give rise to conflict and aggression. This is shown by the following comment:

Illustration 2: Participant 26

> I believe that aggressive behaviour is rife among nurses. This is caused by an undertone of resentment which may be presented in allocating some staff difficult patients and others relatively easy, or allowing some nurse colleagues to attend in-service education and not others, deciding what is appropriate or not appropriate for a nurse without consultation, the holding back of valuable information and knowledge and setting colleagues up to fail. These are just a few, and in my opinion cause low self-esteem, resentment towards the profession and loss of professionalism among other health workers.

Failure of the institution to recognise employee rights is contained in the following response by a nurse who stated:

Illustration 3: Participant 128

> Aggressive behaviour from patients, especially those in nursing homes, is put down to "they can't help it". Nurses are sometimes expected to be punching bags. The rights of the nurses are not always recognised. I have recently considered leaving my job as I am quite frankly fed up with being punched and hit with objects and accepting it as part of my job.

9.9.2 Psychological state factor

The psychological states group contained responses relating to participants experiencing a lack of confidence to cope with aggression and consequently to cope with nursing. Other related psychological states included low self-esteem, feelings of self-blame and guilt, a loss of trust and respect for patients and senior staff including medical staff, a sense of frustration and an overwhelming sense of injustice. There were expressions of wanting to exert revenge on individuals and on the institution.

Illustration of responses indicating psychological state

Psychological states can be detected in the comments of the following nurse who stated:

Illustration 1: Participant 173

> I found the aggression from staff more difficult to deal with, as it was both unexpected and unprofessional. The sexual harassment was both intrusive and demeaning and the unwarranted physical aggression, which came on both

occasions from female staff, made me very angry as they were in public. I find that verbal abuse has a more lasting impression on my confidence than physical abuse.

9.9.3 Professional deficit factor

Subgroups within professional deficits included both the participants' perceived lack of their own knowledge, skills and experience and a general criticism of their lack of professional preparation, training and education to respond to aggression. This lack of preparation was largely identified as a deficit in training related to assertiveness, communication skills training and management of aggression.

Illustration of responses indicating professional deficit factor

Illustration 1: Participant 116

> More knowledge in the area of aggressive behaviour should be given to nurses, either during their training or in graduate year, on how to deal with and report incidents involving medical staff, colleagues, patients and their relatives. Fear of repercussions or reprisals from senior staff is still a concern. Some institutions still hold medical staff beyond reproach, especially in private hospitals. My experience of aggression is that nurses are often not supportive to each other because they don't know how to be.

9.9.4 Negative emotion factor

Anger as a result of work-related aggression was a universal response in the negative emotion factor. Anger was often accompanied by fear, which was either a fear of physical or psychological injury or a fear of losing their employment. Intimidation was also expressed as a frequent experience and some participants pointed to their concern about working in small communities where everyone knew each other and their children shared the same schools as the children of perpetrators. Humiliation was also a common emotion accompanying the aggression experience. Some participants indicated that shyness and embarrassment prevented them from coping effectively with aggression. These comments from participants indicate that

there may be a relationship between emotional responses and deficits in professional training of nurses.

Illustration of responses indicating negative emotions

One nurse experienced negative emotions during the incident and continued to experience negative emotions several years later. This subject also would like to have her revenge. She stated:

Illustration 1:Participant 302

> I have been verbally abused by a radiographer. The feelings of unresolved aggression exists today, especially when recalling the incident. I feel the anger at once and a sense of revenge and how pathetic she was. Still is!

9.10 Results of qualitative component: Factors facilitating effective coping with aggression

Responses relating to factors which helped participants to cope effectively were grouped into four categories. These were, in order of frequency, institutional and peer support (n=265), education and training (n=230), psychological states (n=201) and nursing context (n=189).

9.10.1 Institutional and peer support factor

As may be expected as the corollary to institutional deficits, identified as the major barrier preventing nurses from coping effectively, peer support was the major facilitator in assisting nurses to cope effectively with work-related aggression. Very often peer support took the form of sitting down for a chat over a cup of tea or having an opportunity to talk about the situation. Finding time to talk, however, often presents a separate problem as nurses found some difficulty in getting quiet time to talk. Support from family and friends also assisted with coping, as did walking, swimming and jogging. Only one subject included support from a nurse manager.

Tangible support was listed in the form of ward orderlies providing restraint to aggressive patients or doctors ordering the appropriate medications for aggressive patients. Other tangible support was provided by the industrial union in the form of explaining employee rights of victims. Three subjects stated that what had best helped them to cope was to leave the hospital and in two instances, leave the profession.

Illustrations of responses indicating institutional and peer support

An example how an understanding of employee rights assisted is provided below: One nurse stated

Illustration 1: Participant 246

> The change in hospital policy to more actively report aggression from patients, ie, even to the police, has given recognition to the rights of staff by taking their grievance further and gaining some satisfaction.

9.10.2 Education and training factor

In the education and training category participants reported that they had attended additional courses on aggression management, communication and interpersonal skills. They commented on their experience and knowledge as key factors that assisted them to cope, being more aware of the potential for aggression and more confident in dealing with it.

Illustrations of response indicating education and training factor

Education and training are factors that assist with coping as demonstrated by the comment below:

Illustration 1: Participant 93

> I am able to cope with aggression because I have developed excellent interpersonal and communication skills. I have always operated on the premise that aggression can be prevented.

9.10.3 Psychological state factor

Once again there was a corollary to the psychological states described in the section which prevented nurses from coping. A picture was presented of nurses who are confident and have high self-esteem, considering themselves to be assertive and feeling in control of the situation. This is closely aligned with education and training.

Illustration of response indicating psychological state factor

A typical example from a nurse is shown below:

Illustration1: Participant 233

> I feel confident in my own personality and skills that I can deal with aggression towards me. I always view it as their problem and put it back to them. This doesn't always get through to them but it makes me feel better.

9.10.4 Nursing context factor

The final category in the 'helped to cope' question was nursing context. This term is used by the researcher to explain how nurses could rationalise aggressive behaviour as not being personally directed toward them. A patient with dementia, for example, was understood because he had a diagnosis which contributed towards aggressive behaviour; or a doctor was aggressive because he was experiencing a particularly stressful situation. In these circumstances nurses felt that no one was to blame.

Illustrations of responses for nursing context factor

The following two responses are exemplars of nursing context factors and involve patient initiated aggression and staff initiated aggression. One nurse sums up nursing context in the following comment when she refers to nursing elderly demented patients. She commented:

Illustration 1: Participant 49

> They have an astonishing talent for verbal abuse ... but even then it is tempered by the knowledge that they are demented.

The following comment also demonstrates the nursing context category and is from a nurse. She stated:

Illustration 2: Participant 287

> Due to staff shortages and lack of time, staff react aggressively to each other at times. With the number of ill patients and stressed staff trying to cope with the workload we need to communicate to each other and our patients if we want to prevent further hostilities and pain.

9.11 Summary of survey findings

This chapter has provided empirical evidence that work-related aggression is a major occupational health and safety issue for registered nurses in Victoria. There is clear support for the claim that nursing in the Australian health industry is a hazardous occupation (Perrone, 1999).

It is also evident from these results that a major source of aggressive behaviour is from nurses' own professional colleagues and, to a lesser extent, medical staff as well as from the more frequently reported patient source. Although patient initiated aggression is a frequent occurrence, it did not appear to have the same negative impact upon nurses' perceived professional competence as nurse or doctor initiated aggression.

An important and very clear finding is that, although nurses appear to be more comfortable in formally reporting patient initiated aggression, there is a reluctance to formally report aggressive behaviour from their own colleagues or medical staff. There is difficulty in conducting any meaningful analysis on the scant results obtained from the section in the questionnaire on reporting behaviours. The only significant conclusion to draw is that, although most nurses do attempt to gain support from their peers, they do not perceive any benefit in formally reporting nurse or doctor initiated aggression to administrative or managerial staff within the institution. Yet the results

show that, for the small number of nurses who do formally report work-related aggression, a significant proportion do in fact anticipate and consequently receive support.

It is also evident that when support is provided by the institution, the negative consequences on perceptions of professional competence caused by work-related aggression can be ameliorated.

The quantitative data obtained from the survey questionnaire was supported by qualitative data. There was a clear implication for the role of institutional support in either assisting nurses to cope with work-related aggression or preventing them from coping effectively. This finding was closely accompanied by nurses experiencing a full range of negative emotions and some skill deficits when responding to workplace aggression.

CHAPTER 10

RESULTS OF PHASE FIVE: QUALITATIVE COMPONENT

10.1 Results of Phase Five: Qualitative component

Phase Five of the study aimed to explore and describe the lived experiences of nurses who revealed themselves through the survey conducted in Phase Four to have experienced aggressive behaviour within their workplace, thus meeting objective (vi) of the study to explore and describe nurses' responses to work-related aggression in some depth. This chapter presents the results of the analysis of qualitative data obtained by in-depth, semi-structured interviews with a sub sample of registered nurses who responded to the survey questionnaire.

Discussion commences with a description of the sample obtained for the interviews, then proceeds to outline typical examples of the contexts of aggression experienced by the interviewees. This is followed by the presentation of five independent but closely related recurrent shared themes shared which emerged from the phenomenological analysis of the qualitative interview data. Two further potent themes revealed by a few participants are then described. Finally, interaction of the various themes identified is considered..

10.2 The sample obtained: Participants for in-depth interviews

As indicated in Section 8.4 above, 55 of the participants who responded to the survey questionnaire volunteered to discuss the possibility of being interviewed about their experiences of aggression. The selection criteria for participant inclusion in Phase Five were (i) provision of informed consent, (ii) belonging to one of five sub-groups described below and summarised in Table 12.

Although it was important to achieve a balance of participants who had formally and informally reported aggressive behaviour, and who had been identified

as having negative or positive perceptions to their professional competence, Phase Five of the study did not aim to achieve a representative sample of the overall sample.

Table 12

Summary of subgroups for in-depth interviews

Subgroup Number	Number of participants	Formal report	Informal report	Positive competence	Negative competence	Barriers to effective coping
1	5	✓	x	✓	x	no
2	7	✓	x	x	✓	yes
3	10	x	✓	✓	x	no
4	8	x	✓	x	✓	yes
5	3	x	x	x	x	yes/no
	33					

All 55 potential participants were contacted by telephone by the researcher and based on criteria for selection to subgroups and availability for interview, it was possible to organise interviews with 33 of these 55.

The 33 participants were allocated to subgroups to demonstrate that there was a full range of representation of nurses who had experienced aggressive behaviour in their workplace. From the 33 who consented to be interviewed, five nurses had reported aggressive behaviour to a significant other and had experienced no negative impact to their perception of professional competence. They reported no barriers to coping effectively and recorded what had helped them most to cope effectively. A further seven nurses had reported aggressive behaviour to a significant other and had experienced a negative impact to their perception of professional competence. In addition, they reported barriers to coping effectively.

The sample included ten nurses who had not reported aggressive behaviour to a significant other and had not experienced a negative impact to their perception of professional competence. They reported no barriers to coping effectively and recorded what had helped them most to cope effectively. A further eight nurses had not reported the aggressive behaviour to a significant other and had experienced a negative impact to their perception of professional competence. In addition, they reported barriers to coping effectively. Three nurses who did not fall neatly into the above categories were interviewed because they provided additional information about their perceptions of aggression and signaled that they would welcome the opportunity to further participate in the study. One of these subjects recorded neither formal nor informal reporting and experienced positive perceptions whilst two subjects recorded neither formal nor informal reporting and experienced negative perceptions of professional competence.

Twenty six face-to-face were conducted. Telephone interviews were conducted with participants who were interstate. It was decided to enhance the spread of the sample by also interviewing a number of participants resident interstate. Therefore, late in the research, it was decided to conduct seven interviews by telephone. These were not audio-recorded as it was decided not to delay the progress of the research by seeking University and police permission to audio-record the telephone conversations. In these cases participants were sent an introductory letter containing the interview schedule and consent form (presented as Appendix F). This was signed and returned to the researcher prior to contact for telephone interviews. Data obtained from telephone interviews was recorded by hand on the contact summary sheet (see Section 8.3.3, page 147 above).

Two telephone interviewees were in the Northern Terriority, two were in New South Wales, one was in Western Australia, one was in South Australia and one in Queensland.

Participants living in Victoria selected a venue suitable to them in which to conduct interviews. In fourteen cases face-to-face interviews were conducted in the participants' homes, nine took place in the work environment and three were conducted at a café/restaurant. Eighteen participants resided in Melbourne while eight resided in rural or regional Victoria. The mean length of face-to-face interviews was 65 minutes.

Telephone interviews were conducted from the office of the researcher, who is an academic at a Victorian university. Participants were contacted to arrange an appropriate time to be interviewed. The mean length of telephone interviews was 52 minutes. Three interstate subjects sent additional written information. They specifically expressed an inability to respond to their own experience of work-related aggression as the questionnaire did not include categories that encompassed their own experience of work-related aggression. These experiences required a broader definition of aggression to include aspects of 'intellectual property'. This information was incorporated into the qualitative data analysis.

10.3 Contexts of aggression experienced by interviewees

In order to provide a sense of context (Beck, 1994), to the responses to aggression explored in the interview, examples are provided of aggressive incidents typical of each type and source reported. Each of the nine subsets of type and source of aggression is preceded with a brief description of each participant in order to assist with the reader's ability to gain an overall perception of the difficulties encountered by nurses in the performance of their professional duties.

The nine typical incidents are as follows:

Verbal aggressive behaviour perpetrated by doctors (Participant 11)
27 year old female nurse, grade 3b, six years experience.

The doctor verbally abused me in front of other patients and staff for not telling him his patient had been transferred to another hospital even though the surgeon he referred his patient to had arranged the transfer due to the patients lack of private insurance and the two doctors had been in constant contact. The doctor in question yelled and verbally belittled me indicating that my place on staff could be in jeopardy.

Sexual aggressive behaviour perpetrated by doctors (Participant 5)
45 year old female nurse, grade 4a, 17 years experience.

I was backed up to a wall while gowning and gloving for a sterile operation in theatre. I was unable to escape. The doctor pressed up against me and rubbed his body against mine as I attempted to tie his gown. He made "smutty" sexual suggestions. I said nothing as he was a very important surgeon at the hospital and everyone was careful not to annoy him.

Physical aggressive behaviour perpetrated by doctors (Participant 13)
35 year old female nurse, grade 2a, 18 years experience.

A surgeon in the operating theatre kicked me to get my attention (he didn't know my name). I felt that this was very ignorant and rude and told him so. He then threw a soiled scalpel that landed point down, penetrating through the leather of my shoe and piercing my foot. I bled a small amount. I went to Accident and Emergency Department and had a checkup but nothing happened as a result of it. I didn't need to report it as everyone in theatre knew what had happened. I felt that they (doctors) could get away with murder.

Verbal aggressive behaviour perpetrated by nurses (Participant 22)
38 year old female nurse, level 3a, 20 years experience.

At a registered nurses meeting held in the unit, I was accused of being selfish and uncaring by five work "colleagues" when I was attempting to retain my night duty position which I had held for eight years. I was made to feel not part of the team and was ostracized for a couple of weeks. I was glad to get moved from that unit a few weeks later.

Sexual aggressive behaviour perpetrated by nurses (Participant 16)
24 year old female nurse, level 2a, 2 years experience.

A female colleague put her hand and left it on my knee as she talked in the ward office. I was sitting on one side and she was sitting about half a metre to my right at the desk. It really scared me as I had no one else near us and she was blocking my exit from the door. She behaved as if nothing was happening but I knew she was waiting for my reaction. I really felt confused.

Physical aggressive behaviour perpetrated by nurses (Participant 31)
23-year-old female nurse, about to complete her second rotation in the graduate year program.

> A ward sister threw a kidney dish at me because she had thought I was not quick enough to get her a new dressing pack when the first one was contaminated. It was my first day on the ward and I had been told about her before I was allocated to her ward. She didn't like new graduates from the university. The kidney dish hit me on the arm and clattered to the floor. The patient was more frightened than I was. I just picked the dish up and carried on my duties as if nothing had happened.

Verbal aggressive behaviour perpetrated by patients (Participant 28)
42 year old registered nurse who was working as a casual nurse in a medical ward.

> I was washing an elderly female patient who was loved by everyone in the ward when she suddenly called me all of the obscenities you could possibly imagine. I was really shocked. I reported it at the staff handover and everyone was surprised. They asked me what I had done to provoke it.

Sexual aggressive behaviour perpetrated by patients (Participant 9)
45-year-old female, level 4a with 22 years experience.

> I was standing talking to a nurse colleague when a male patient came up behind me and pinched my bum and fondled my breasts. He tried to lift my uniform and my colleague just laughed at him.

Physical aggressive behaviour perpetrated by patients (Participant 3)
35 year old female nurse, level 3, with 10 years experience.

> A patient in the Intensive Care Unit was somewhat confused and kicked me in the abdomen. I was two months pregnant at the time and was concerned about my pregnancy. I didn't blame the patient because I knew he didn't mean it.

10.4 The emergence of shared themes and their description

The process of phenomenological data analysis detailed in Chapter Eight (Section 8.4) resulted in the identification of a series of five shared themes, commonly emerging in the responses of the 33 interview participants. These themes, which encapsulate the meanings conveyed by the responses of the nurses to being victims of aggression in their workplace, have emerged from the verbatim data taken as a whole and analysed by combining computer assisted coding and retrieving with Colaizzi's (in Valle & King, 1978) method of qualitative data analysis, and Miles and

Huberman's (1994) model of data presentation. Each shared theme is presented below, in the following sequence, powerlessness, expectation to cope, emotional confusion, lack of institutional support and doubts about professional competency.

Although Colaizzi (in Valle & King, 1978) did not describe the use of verbatim data taken from original transcripts, it has been suggested (Beck, 1994) that the inclusion of such material not only enriches the description, but increases validity by contextualising the original data. Therefore, extracts of verbatim data, selected by the researcher as typical experiences revealing the underlying shared theme are presented immediately following the data display matrix. A pseudonym and participant number is used for each interviewee to ensure confidentiality of data.

Examples of descriptive codes, interpretative and explanatory codes utilized to transform the raw data through clustering into patterns have been presented in data display matrices (Miles & Huberman, 1994) preceding the verbatim descriptive data. These patterns were then grouped and conceptualized into themes.

Each matrix was constructed in the following way, using the particular scheme developed by Miles and Huberman (1994). For each shared theme, the actual key words used by participants to convey their experiences were classified then listed as descriptive codes, in the first column of each matrix. These descriptive codes have been taken verbatim from the transcripts of the interviews. Identifying interpretive codes was the next step, that is interpreting the full range of meanings indicated by the full range of the descriptive codes. Interpretive codes are presented in column two of each matrix. Finally, explanatory codes were assigned to encompass the classification of interpreted meanings into concepts and ideas relating to the shared underlying recurrent theme. Explanatory codes are presented in column of each matrix.

10.5 Theme 1: Powerlessness

Twenty-two out of the 33 participants reported that one of the most frightening experiences felt by them during and following aggression was a sense of powerlessness, usually experienced as a loss of control when performing their role as a professional nurse. The feeling usually commenced at the outset of the incident when the victim normally experienced shock and may continue for many days and sometimes weeks following the incident if resolution does not occur. Participants consistently reported that they needed someone to help them regain power by taking temporary control. In the first instance, immediately following the assault, participants turn to peer support from individuals or groups of nurses on the same shift. Narratives from Bonny, Helen and Louise are used as examples of three cases which demonstrate the theme of powerlessness explicated in Table 13 below.

Table 13

Data display matrix for powerlessness

Descriptive codes	Interpretive codes	Explanatory codes
Lack of responsibility Keep thinking about it Unsure/uncertain Unprepared/unable Not in control/failure Didn't know what to do Grovel/vulnerable Shock/stress/anxiety Take charge/advocate Not happening to me Couldn't talk/powerless	Seeking someone to take charge of the situation Using initiative but keep getting frustrated No one taking responsibility Frightened of consequences of incident Inability to make decisions/difficulty to focus on anything now Needs of medical staff/patients I didn't know what was happening	Nurses in powerless position Associated with control Need to contain situation Senior staff would need to empower nurse Need for reassurance about role, function and future employment

10.5.1 Illustrations for powerlessness.

Illustration 1: Participant 10

Bonny had been stabbed with a syringe containing some of a patient's blood by a drug addict who was attending Accident and Emergency Department. The drug addict had previously been diagnosed with AIDS (Auto-immune Deficiency Syndrome). She stated:

> I felt I was in danger and it was not because a gunman was going to shoot me. It was not knowing if I was going to live or die for several months. I didn't want to communicate with anyone about it. I couldn't even tell my partner that I had been jabbed with a needle with blood from a known drug addict who had AIDS. I was unable to function for four hours following the incident. I thought this couldn't possibly be happening to me.

Bonny then irrationally requested that doctor excise the part of her hand that had been stabbed. The initial feeling of being out of control continued for six months and was accompanied by a feeling of resentment toward those holding decision making power within the organisation. Bonny explained:

> For the next six months I lived in blind fear. I couldn't sleep. All I could think about was dying from AIDS. I used to wake up in the middle of the night in a cold sweat. When I talked it over with my partner we always argued. It was the worst time in my life. I just wanted things to go back to the way they were before the incident. There was no one there to advocate for me. I couldn't help feeling frustrated with the managers, those people sitting behind a desk, making decisions that will affect me. I was on my own.

Bonny sought assistance to deal with her problem from senior staff, including the doctor who was the on-call medical officer, the infection control officer, and the nurse in charge of the area. Her frustration at not getting assistance is demonstrated by the following excerpt:

> I had to ring the hospital at my own expense. This required me to hang about in a public phone box for thirty minutes on at least three occasions before I could get to talk to someone about the results of my HIV (Human Immuno-deficiency Virus) screen.

Bonny's attempt to regain control over her life was reflected in the following comment:

> I spoke to the Infections Control Officer about the long-term ongoing screen process for AIDS, but never the incident itself. I wanted to talk about relationships, because if I am going to be HIV positive it really is going to effect my relationship and I do recall thinking, do I become sexually inactive?, and how is my relationship going to stand up or should I terminate it now? I needed to get some answers to help put my life back together. My life would have gone down the drain if I didn't have a good partner.

Illustration 2: Participant 21

Helen had also been stabbed by a registered drug addict, a patient in the medical ward. She stated:

> I had to remind the nurse supervisor that I've got to go home and tell my husband that I may have been infected with AIDS. Nursing administration had forgotten about me and they were more concerned with the patient and his wife. There were times I felt like punching someone or something, like I was about to lose control, but then I would count to ten, breathe deeply, and get on with my job of being in control of everything, especially my emotions.

Illustration 3: Participant 5

Louise worked in an Accident and Emergency Department (A&E) and felt she was subjected to sexual harassment by co-workers. She stated:

> When I first came to A & E, I found that the male doctors and ambulance officers were often groping and embracing other female nurses. They would all expect an embrace from the nurse and I told them that I was uncomfortable with this and say, please don't do that and walk away. The Unit manager accused me of being prudish and that the behaviour was OK. One other nurse was encouraging a doctor to sit on my knee and when I asked him to stop the nurse called me a teaser. Another doctor pinched my bottom and I threatened to report him but no one else supported me. They stopped calling me a prude and now call me a lesbian. I feel that I have been doubly victimised and abused!

10.6 Theme 2: Expectation to Cope

All 33 participants directly or indirectly expressed that they were given inappropriate trivializing advice resulting in emotional turmoil to some degree. One of the most frequent attitudes by senior staff toward recipients of aggression reported by participants was the expectation that the victim should be able to cope. Suggestions were made to nurse victims that dealing with aggression is like getting back on your horse when you have fallen off, or getting into the car to drive when you have had an accident. These activities are presented as helpful coping strategies by management; however, they ignore the professional and emotional turmoil experienced by victims.

Narratives from Yvonne, Jim, Mary, Jan and Louise are used as examples of five cases which demonstrate the theme of expectation to cope as set out in Table 14 below.

Table 14

Data display matrix for expectation to cope

Descriptive codes	Interpretive codes	Explanatory codes
Irrational Intolerable Call for help What's the problem Didn't appreciate This is beyond me Impression/whingeing Completely forgotten Not even recorded Career security Because I'm a male That's a medical problem Have to take it In my day Branded as negative Over-reacting	Conflict between professional and personal needs Maintaining objectivity is a preferred way of coping Power struggle between medical/nursing administration/clinical nursing Coping is highly valued by nursing administration Coping is essential for job security Expected to cope Get on with the job	Underlying assumption that nurses will cope. Good nurses do not make a fuss Verbal aggression is more damaging than physical aggression Making complaints is considered irrational Male nurse perceive that they should cope better

10.6.1 Illustrations for expectation to cope.

Illustration 1: Participant 28

Yvonne is a 45-year-old nurse who was allocated a patient who had a history of being difficult to manage because of his alcohol abuse. Yvonne's comments illustrated that other staff in her workplace expected her to cope. She stated:

> When the patient assaulted me, the staff treated as if nothing had happened to me. I was told to go back to the same patient. He had continuously verbally abused me and had thrown equipment at me when I went into his room. Staff were more concerned that other patients would be upset, but what about me? It was as if I was expendable and should be able to cope with this shit. It really annoyed me. It was as if it had all been completely forgotten. It wasn't even recorded in the nursing notes. I hate coming to work now.

Illustration 2: Participant 12

A relative of a patient who was dying wrestled **Jim** to the ground following his explanation of the patient's serious condition. He described the frustration he felt when senior staff made little attempt to offer support. He explained:

> I would have liked more information spoon fed to me instead of me having to grovel around trying to get support and having the institution recognize that I have been assaulted. I got the impression that because I am a male I was expected to cope. The unit manager even went as far as to suggest that it was lucky it was a male as we should be able to deal with it much better.

Illustration 3: Participant 29

Mary, a unit manager, repeatedly went to medical and nursing administration staff to request support for the management of a very restless, agitated patient. She made the following comments about her feelings in response to the reactions she received., saying:

> I felt that nursing administration were saying what's the problem? You have got all the resources to cope with the situation. I felt that they thought I was over-reacting, that I wasn't experienced or competent to cope with the aggressive patient. This made me feel very disappointed in myself that I felt this way. I would say, 'this isn't on', I'm not going to put up with this any longer, and I want to do something. And then I would come back [from nursing administration] to the ward and feel that I had been made to feel irrational about it. We have to put up with it, don't we?

Illustration 4: Participant 8

In many cases, the recipients' peer groups did not provide the support that is required. **Jan** made the following comments about the reaction of staff around her following an incident in which she had been hit in the face by a patient. She commented:

> They said, oh, you will be alright, you can cope and that was about it. Carry on with what you are doing. I was completely devastated. These were my colleagues, how could they be so insensitive. After that I just hid in the toilet, crying until someone came and got me. Nothing more was said, I just finished my duties as if nothing had happened. I went home to my mum and cried.

Illustration 5: Participant 5

Louise also made the following comments which indicate the expectation to cope:

> My nursing colleagues wouldn't defend me when I challenged behaviour which I considered as sexual harassment. They just said that the behaviour of these men who were trying to kiss and hug me was perfectly normal; it was okay for them to do embrace and kiss me. I should just get on with my work and cope with their behaviour. I don't get any respect from colleagues for standing up for myself. Some staff think it is a joke that I should be upset.

10.7 Theme 3: Emotional confusion

The theme of emotional confusion reveals the wide range of emotions experienced by victims of work-related aggressive behaviour. The most obvious and frequently expressed was fear as a result of being physically, verbally or sexually assaulted. Fear was closely followed by anger, often intensified by non-supportive responses by senior staff and/or colleagues during and/or following the aggressive incident.

All 33 participants expressed some very powerful negative emotions following their experience of work-related aggression. A fundamental value of nursing is altruism (Potter & Perry, 1993). Since nurses are likely to hold altruistic attitudes towards the people they care for, they are prone to evaluate their own involvement in acts of aggression in a self critical and negative way. A range of emotions, including fear, anger, guilt, humiliation and embarrassment, were experienced by participants. The apparent difficulty in dealing with these emotions causes nurses discomfort and stress. They experienced doubts, confusion and conflict about their ability to function as competent professional nurses. Narratives from Muriel, Samantha, Clare, Maureen, Beverely, Eileen, Wendy and Roy are used as examples of nine cases which demonstrate a range of emotions experienced in a variety of contexts under the theme of emotional confusion, as set out in Table 15 below.

Table 15

Data display matrix for emotional confusion

Descriptive codes	Interpretive codes	Explanatory codes
Anger/displaced anger Rough treatment Resentment/hate Negative reaction to patient Crying/tearful/guilt It still hurts Hysterics/depressed It left its marks Consequences for patient care Good bitch about it Emotional crisis Humiliation Bottled up	Patient receives lower standard of nursing care Concern for future coping in similar situations Personal responses versus professional responses Concern for other nearby patients Concern for own health	Need for someone to counsel nurse Need permission to talk through feelings Need for early intervention Need for sensitive/knowledgeable staff Effecting work performance

10.7.1 Illustrations for emotional confusion.

Illustration 1: Participant 22

Muriel, is a 26-year-old nurse in her first year of nursing as a new graduate and was verbally abused by a colleague. Muriel illustrated the depth, intensity and focus of her emotions in the following comment:

> As a new nurse graduate, I was the only staff member in the unit with a tertiary qualification and I was made to feel awkward by other staff who had completed hospital based nursing courses the traditional way. It didn't matter how competent I was or how good a job I did; they would find fault with it. It seemed to me that they thought I couldn't be a good nurse with a degree. I was really confused because I loved the patients and hated the staff. It was a daily painful thing for me to go through.

Muriel's distress was exacerbated by her learning experiences in the wards. She said:

> You never forget when you are humiliated into learning how to do things the ward way as opposed to the university way. My off-campus coordinator insisted that I give an intra muscular injection to a male patient. I told her that I had never given an injection before and was anxious. She said that it was to bad as I was going to give one now. I asked her if I could practice first and she said to this man, "turn over and show her your backside". She embarrassed me in front of the patient and his family by saying that I had never given an injection before. "Look at her, she is 28 years old and trained at a university and never seen a patient's ass". I didn't want to go to work the next morning.

Illustration 2: Participant 1

Samantha's experiences as a new graduate were similar to those of Muriel. She stated:

> I was the only nurse there with a degree. There was only one nurse there who was helpful. The rest let me flounder and make mistakes and then rejoiced in my mistakes. They seem to trying to control me by keeping me in my place, that University training was not so good and that I was not a competent nurse. I was emotionally drained for the first few weeks as I experienced the joys of nursing and the terror of my colleagues.

The following four cases from Clare, Maureen, Beverly and Eileen demonstrate how these negative emotional reactions can in turn impact upon nurse-patient interactions and ultimately upon decisions on whether to remain in nursing.

Illustration 3: Participant 16

Clare described her sense of emotional confusion and its impact upon her nursing care when the unit supervisor sexually assaulted her. Interestingly, her account relates to an incident which occurred almost a year previously. She stated:

> When a nurse colleague sexually assaulted me, I wanted to give it (nursing) away. It still hurts. I am still upset. I don't think nurses care enough about each other. I still resent her (unit supervisor) and the hospital. In nursing you really need to be emotionally strong, like a pillar of strength through everything, no matter what is thrown at you. You get victimised for showing emotion, and you learn not to show how you feel. I just shut myself off now, from patients, from other staff. I avoid them if I can. I feel guilty about my caregiving, as it has become emotionally distant from patients. Seems I am protecting myself.

Illustration 4: Participant 30

Maureen explained her response to having been assaulted by a patient:

> Yeah, the anger was perpetuated by the inequities of the system. It was a diffuse anger. It wasn't focused against anybody at all. The medical officer received the butt of my anger, not directly, probably indirectly through my caustic remarks. That's only because the medical officer was handling the assault and since the system wasn't working, he became the system. I did all my raving to him. I wanted to take all my anger out on him, I wanted to tell him that he was an arrogant, pompous ass, but in the end I did what I always

do, bottled it up. But it was always there and I knew it was affecting the way I worked with patients.

Illustration 5: Participant 9

Beverley described her feelings:

> I think a lot of my anger is displaced towards the medical staff and nursing administration and perhaps some of the anger would then be put back towards the patient as well. I feel cold and unsympathetic when a patient tells me about their problems, and I can't be bothered listening to other staffs' problems. I think I am losing it and would be better off in another job.

Illustration 6: Participant 3

Another example of this was provided by **Eileen** who described her feelings when approaching a patient who had dementia and had a history for being aggressive toward staff:

> I would go in there (single bed ward) and it would always make me tense. And I would think, oh, you make me angry, why are you doing this to me? So I would have as little to do with him as possible. I would do the basic care for him and then just try and leave him alone.

On some occasions participants also expressed anger toward the perpetrator.

Illustration 7: Participant 11

Wendy an experienced unit manager comments:

> Probably the verbal abuse tended to get at you more because it was continuous and excessive. As a unit manager I found this totally intolerable for the staff to be put in that situation. I did say to this doctor that I don't get paid enough to put up with this from you. We were so sick and tired of all of this abuse; it just wore us down. You were trying to help him and restraining yourself from throttling him.

While all participants felt negative emotions as a result of aggression, there was also some concern about the approved management plan for the patient who was often not seen to be responsible for the aggression. These concerns produce conflict within the

nurse due to her expected role of carer and concern for self as a person. The nurse may indeed feel threatened but over-riding this is the need to be protective towards patients. This conflict and confusion between role expectations is illustrated by Eileen's (Participant 3) comments:

> This elderly fellow, who normally wouldn't hurt a fly, was as strong as an elephant and he had hit one of our nurses. We called security and two men came up and I just burst into tears when they took him away. They just grabbed this poor, little man, this poor little bloke, just literally dragging him and throwing him onto the bed. And I kept saying to them, you don't need to be so rough with him.

Illustration 8: Participant 19

Roy, who had experienced a physical attack, also expressed a different kind of emotional conflict as a result of an assault by a patient's relative:

> It was one of those things that as a male nurse, it is always difficult. Do you physically stand there and fight or do you turn and run? It was one of those situations I'd never felt comfortable in.

Roy described the fear that accompanied his confusion, and the conflict he felt between duty of care to patients and self-protection:

> I was very scared and backed off into the office where several other nurses had fled. They were quite hysterical at the time because they were rather shocked at this totally unexpected situation. I have been involved in aggressive incidents, on rugby league fields, hockey fields, all these sort of things, but I was not prepared for this. It has had a lasting impression on me. Its something I still feel uneasy about. It was a conflict between what legal aspects were involved. Am I legally allowed to step in and restrain the relative? Professionally nurses aren't seen to be fighting in corridors and wrestling with relatives. I still have that fear of what's going to happen next time. When I told my wife, she was shocked to find that, here I was, a nurse caring for someone and also fighting with his or her relatives.

10.8 Theme 4: Lack of institutional support

Feeling a lack of support from supervisors was a pervasive response among participants with 27 participants indicating that it was a source of resentment and anger. Following incidents when participants experience feelings of powerlessness,

being overwhelmed, blame, guilt, anger, despair, helplessness and alienation. Narratives from Tracy, Dot, Pamela, Julia, Margaret, Kathy, Carole and Judy are used as examples of nine cases under the theme of lack of support. The lack of institutional support category as demonstrated in Table 16 below was frequently accompanied by experiences of frustration.

Table 16

Data display matrix for lack of institutional support

Descriptive codes	Interpretive codes	Explanatory codes
Counselled/discussed Taking precautions Concern/impatient Remembered/forgotten Deeper concern Who's job Additional staff No one here Shouldn't be angry No feedback Didn't you/don't Interviewed Unprofessional Documented	Seeking out support from senior staff Dependent on extent of physical injury Dependent on sensitivity of others Dependent on who is to blame Responsibility unclear	Approval is highly desired by subjects Permission to feel anger/frustration Need for debriefing Need for a nurses advocate Need for immediate feedback

10.8.1 Illustrations for lack of institutional support

Illustration 1: Participant 18

Tracy is a 36-year-old nurse who was in charge of a busy ward in a large teaching hospital. Her comments illustrated the frustration she felt in trying to get additional support from nursing administration and medical staff. She stated:

> I often get the impression that nursing administration and medical staff think we are whingeing or we are just complaining about nothing. They do not seem to realise how difficult it is to give care to other acutely ill patients while you have this aggressive patient who has taken up so many nursing hours. I get very frustrated, especially with the medical staff. Time after time I would call them and say 'look what are you doing with this man? We can't put up with this much longer. He needs to be removed from here. This is not the facility to nurse him'. I don't know how many times a day I would go through that, and all I would get back was, 'we are still investigating'.

Illustration 2: Participant 25

Declaring similar feelings to those of Tracy, Dot stated:

> I needed more staff and nursing administration said, after a lot of begging from me, that they would provide more staff. But I felt that I really had to push for it. I felt that they were saying 'what's the problem?, go back and ask your medical staff'. When I said I was doing that, where else do I go, do I write a letter of complaint? I've had to do that before.

Whilst the above illustrations demonstrate seeking support of additional resources there was also discussed by participants another type of support required at a more personal level following an aggressive incident. If the nurse completed some form of written report about an aggressive incident involving a physical injury, there may be some follow up.

Illustration 3: Participant 13

Pamela, explained:

Researcher:	Did you talk to anyone about it afterwards?
Pamela:	I spoke to the hospital chaplain. She came to see me because she heard the story and I had already spoken to nursing administration and medical staff. I had to go over to the Accident and Emergency department after the incident form was completed because I had a bruise on my neck and my back was sore.
Researcher:	Did talking to nursing administration help?
Pamela:	They told me that I had done the right thing. When I had talked with them I went back to see the chaplain.
Researcher:	Did that help you?
Pamela:	Oh yes.
Researcher:	How was she particularly helpful?
Pamela:	Her concern was for me as a person. It

felt like she was interested in me.
It was for my wellbeing, my peace of mind. Sometimes the others are looking at the possibility of litigations and the image of the
hospital, and that's unfortunate because
the hospital is made up of people.

Illustration 4: Participant 6

Julia told of her experience when she made a mistake when caring for a patient. This example demonstrates the interconnectedness of experiencing 'lack of support' and feelings of 'powerlessness'. She stated:

> There was incredible stress in the Intensive Care Unit and we had a nurse unit manager who wasn't supportive and everybody felt like that she was us against them. I remember one particularly bad episode which was the most stressful night I have ever had since becoming a nurse.
>
> I had worked for six nights straight for 11 hours per night and I was just physically and emotionally exhausted. I had two critically ill patients who were intubated. I finished my shift at 8 o'clock in the morning. I was not sleeping very well through the day and I was almost 50 years old. I had made a major drug error that night and realised immediately that I had made a serious mistake. I felt devastated as I thought that I had almost killed a patient. I completed the incident form and the following morning I went to senior nurse on duty to inform her of the incident. I also told her that I was exhausted and I wasn't a safe practitioner working under these conditions. I asked her to change my shift to any other roster. She shouted at me that she wouldn't change me and I should be more careful in future.
>
> I was devastated and I got the impression that she just wanted me there and she didn't care who I was. To her I was just a nurse, a pair of hands, any nurse would do, but it had to be me. I told her I was handing in my two-week notice.
>
> That was the most powerless I had ever felt, sitting in the chair opposite her...and I realised that no one in that hospital knew what I did, other than the few nurses who worked with me that night and we appreciated each other. But I don't think we ever took the time to say that to each other. I don't think the situation would improve in that unit as long as she was the unit manager because she saw nurses as pairs of hands and not as people.

Illustration 5: Participant 33

Likewise, **Margaret** experienced a lack of support in carrying out her ethical duty of care. She stated:

> I remember a time when I had difficulty with my supervisors. I objected to giving an experimental drug one time because all the appropriate paperwork was not filled out and it was an experimental drug. I was instructed that I must give this drug even though I knew it was against all policy. I was taken into my supervisors office and told that I must give the drug. When I refused I was given another patient to care for. I didn't get any support from anyone and it was put down in my personal file as a reprimand and that I was not a cooperative team member.

Illustration 6: Participant 15

Kathy, a staff development officer, reflected on lack of administrative support in her educational role for nursing staff:

> I was staff development teacher and charge nurses would come into my classes and drag staff nurses out to clean up their sections, because they went to class and left their patient load without work being done. These staff nurses would say, 'We had three patients die on the same shift...We need just a half hour with you to debrief at the end of shift...will you sit with us'? And the Director of Nursing would tell me, 'That's what mothers are for; that's what husbands are for...that is not your job, stay out of it. I didn't have the power to say, no! [but] I won't stay out of it.

Illustration 7: Participant 31

Carole, who felt that support following assault would be available in difficult situations, reported that the atmosphere in her ward was conducive to giving and receiving such support. This illustration provides a more positive perspective, as Carole highlighted the importance of being able to discuss the incident:

> On ward x the charge will always make time to talk. I felt that it was all right to say that I don't feel comfortable with a patient. Following the incident the staff were very supportive. The charge nurse brought me back to the patient again and we talked about it. That helped me, as I don't think I could have faced that patient again.

Illustration 8: Participant 26

Judy provided some insight into why nurses are not always supportive to each other:

> Nurses are victims as they are at the bottom of the pecking order. They're employed by the hospital compared to doctors who have visiting rights. I don't feel like a victim and I don't want to be grouped in with all the other victims. All of a sudden you don't feel like one of those underdogs, you want to be at least equal to them and treated with respect. The next thing you know, you're being aggressive toward them, just like everybody else. How can you feel supportive to people who you despise as being victims?

10.9 Theme 5: Doubts about professional competency

A closely related theme to all previous themes revealed by 24 participants was the impact of work-related aggression on professional competency. The relationship between the participants' perceived competence, their emotional reactions, and the response to the reporting by the senior staff is interdependent. If an aggressive incident occurs involving a nurse and encouragement to report that incident formally is not given, participants interpret this as a form of criticism directed towards their competency. If nurses value themselves as competent practitioners in a caring profession they will experience a negative impact to their perceptions of competency when aggressive incidents occur and support from the institution is not provided. The most frequent concern of participants was that they had managed the situation to the satisfaction of themselves, their peers and nursing administration. Narratives from Susan, Kate, Roy, Eve, Charlotte, Maude, Samantha and Kerry are used as examples of eight cases under the theme of doubts about professional competency as set out in Table17 below. Within the theme of 'doubts about professional competence', there is a category wherein competency is linked with reporting behaviours of nurses.

Table 17

Data display matrix for doubts about professional competence

Descriptive codes	Interpretive codes	Explanatory codes
Devalued/incompetent/ uncertain They put the blame on you How will I manage next time Undermined What if this should happen again Good cry/useless I think I did something wrong I want to give it away	Self worth is dependent on senior staff. If you do not report, you do not look foolish. Nurses are unprepared for coping with anger. Nurses do not like to talk about dealing with anger. Lack of confidence Complaining	Professional competence is dependent on how the incident was managed. Professional competence is dependent on the sensitivity of senior staff and colleagues.

10.9.1 Illustrations for doubts about professional competency

Illustration 1: Participant 17

Susan, a 36-year-old nurse in charge of a busy ward in a large teaching hospital, explained her feelings after an aggressive incident which happened to one of her staff:

> No one reported the incident. I thought it was very shabby. I thought that someone should have put it in writing. It was as if nothing had happened. I felt that it was their way of putting the blame back on you, that I was inadequate or incompetent. Maybe I'm getting too old for this job. I can't keep up with the added pressure of being abused by doctors and administrators. I sometimes question myself whether I'm competent in my practice, as the nurse in charge I'm presumed to be the most competent and capable, and to set an example to others, but I'm not. Being abused just drains all my confidence

A frequent statement by participants was their belief that they did not like to make formal reports because it would be viewed by senior staff as complaining.

Illustration 2: Participant 14

Kate sat with her fists clenched and her voice raised:

> I felt they thought I was over reacting, you know, that's just Kate, and she'll over react to this because she's angry. I think they feel that I've caused the violent behaviour, that I had done something to bring it on, that it must be

> something to do with me not having good communication skills. By the time I leave their office (managers) I feel like a first year student who knows nothing. They have a way of making you feel incompetent.

When nursing administrators condone the nurses' behaviour, the nurse has a positive image of his/her abilities.

Illustration 3: Participant 19

Roy describes one incident in which he intervened to prevent a supervisor from being physically assaulted. He stated:

> I've spoken to the supervisor who was involved and everytime I have spoken to her she's said that she is glad that I did do what I did because she felt that he (patient's relative) was going to physically attack her. Her attitude really helped me. This really boosted my confidence and it was transferred into how I went about my work. I was valued, even though I was involved in an aggressive situation with a patient's relative. It was really reassuring, as otherwise I might have had some doubts about my ability to do my job.

Participants often referred to their reporting behaviours when discussing their feelings about competence. For example, a major factor in non-reporting is not wanting to be seen as incompetent.

Illustration 4: Participant 2

Eve explained a situation in which a patient hit her. She stated:

> I was reluctant to be seen as having done something wrong in that situation. Maybe I had done something wrong. I'm always scared that I will be caught in a situation that will result in some serious injury to other staff or myself. I might say the wrong thing and trigger an aggressive situation, which will get out of control. For me, it depends on the people I am working with. If I had a good rapport with supervisors, I would be more likely to report it or at least talk about it. But I didn't trust them. I felt that they would judge me in a negative way. It is very important to me to be regarded as a highly skilled nurse. That is why I completed all those courses. I couldn't bear it if they thought I was incompetent.

Another factor for not reporting the aggressive incident is the nurse's perception of the patient's intent to do harm. Feelings about patients intentions evoke mixed

emotions from nurses as they struggle with a duty of care to their patients and their own desire or need to be respected and cared for.

Illustration 5: Participant 27

Charlotte stated:

> I think that patients who are confused aren't really conscious of what they are doing. They are not deliberately trying to hurt anyone. It would be different if someone was trying to hurt you. On the other hand I often get angry about making excuses for these patients. All we ever do is care for them. I want some care too. We just give, give, and give. When will someone give to me? All we get is blame, blame, blame. Sometimes I just hate nursing. I resent it and then I feel guilty for feeling this way. It is a vicious circle and I can't see it getting any better.

In an aggressive incident where Maude was being choked by a patient who had thrown her across the bed, the nurse supervisor and security officers arrived on the scene.

Illustration 6: Participant 23

Maude described their reactions:

> They just fell over themselves in hysterics, laughing, and they were still laughing at me six weeks later. Every time I walked past them they made little comments. It left its marks. I remember every second of it still. It was embarrassing to be stuck with your bloody legs up in the air being bear hugged. I suppose the supervisor thought that I had got myself in the way and it 'serves you right'. My image as a professional nurse changed after that. I couldn't think of myself in the same way. It was if they did not take me seriously and my image of myself as a competent nurse was shot to pieces.

The attitude of colleagues in the ward can also have a major impact. **Samantha** described her experiences when she was a first year graduate on her first allocation to a ward and comments on the reaction of staff to her assault. She stated:

Illustration 7: Participant 1

> I felt that the nurses who were working with me shouldn't have had the attitude towards a new graduate. That really hurt me more than the blow to my face. They just sniggered and said that it was typical of new graduates, they shouldn't be here. They just do stupid things. They didn't offer any

> assistance or give you any hints on how to approach this difficult patient. I was made to feel it was my fault. I wasn't sure if my so-called incompetence was caused by my training (University), my age, or by my inexperience. No one made any allowances for me on that allocation.

Although she was a senior nurse manager, **Kerry** described similarly feeling a lack of competence in her performance. Kerry explained:

Illustration 8: Participant 24

> I see myself as a victim of a lot of violence. I feel that I am caught in the middle between a very, very authoritarian management structure above me that I have had to fit in with if I am going to get anywhere in management. I used to try to change things for the better but now I just subscribe unquestioningly to this structure...and yet when I look at all the nurses who are under me there is no one who has any respect for me. I feel like a victim. They (her juniors) think I am incompetent to get the results they want. I often wonder the same thing. Will my senior colleagues find me out? Have I been fooling them?

10.10 Further sources and types of aggression toward nurses

Comments considered to be relevant to the current study were made by three participants. Although these comments were infrequent and do not constitute shared themes in the data set, they nevertheless are considered by the researcher to be significant because they identify other sources and types of aggression.

10.10.1 Aggression in area of intellectual property

Comments were made by two interviewees that drew attention to a source of work-related aggression towards nurses not hitherto mentioned in the literature, and not addressed by the questionnaire in this study or prompted by explicit questions in the interviews. This concerned aggression in the area of violation of the nurse's ownership of intellectual property.

Illustration 1: Participant 7

Norma, a 62 year old retired nurse, was concerned that the definition of aggressive behaviour was limited. She felt that violation of ownership of intellectual property

was a more severe form of aggression than verbal, sexual or physical aggression. Norma had the following reflection:

> The professional, physical, psychological, social and emotional impact goes well beyond. [Referring to her time as professional nurse advisor in the Commonwealth Department of Health], she states: 'My work was removed from official department files or my name was removed so that credit was given to someone else. Others gained promotion on the basis of my work'.

Illustration 2: Participant 4

A similar problem was reported by **Carolyn,** who was research nurse attached to a research team led by a professor of medicine. She commented:

> I was required to write a substantial report which was to be supervised by the professor in the medical unit. I never received any comment from him and found it impossible to get any assistance from him. In fact I could not even get an appointment to meet him. When the deadline for the report arrived he submitted my work under his own name and did not acknowledge any contribution from me. I was so angry. I felt really cheated and used. I would be more careful now about getting involved in research projects.

The implications for researchers in aggression of these two statements are clear. There requires to be a definition of work-related aggression that goes beyond the traditional definitions currently used.

10.10.2 Aggression interpreted as invoked by nurses

A final comment was made by **Maria**, a 70-year-old who yearned for an era when nurses presented as dignified and devoted to duty. Her comment reveals a nostalgic perspective of nursing. Although Maria initially implied that aggression was not an issue when she was a nurse, she went on to reveal that she did experience sexual aggression. Even though sexual aggression has only recently been identified as a problem for nurses, Maria's comment demonstrates that the problem has been around for some time. Further, the aggression was reported to a significant other, the doctor in charge, who 'acted' on it (the report). This suggests that reporting and action were as necessary many years ago as it is today. It is also evident from Maria's

narrative that if nurses were sexually assaulted, they were thought to have contributed towards it by their manner of dress or appearance. This is similar to Norma's comment that "she did not dress or behave in a manner to encourage it". Clearly these comments, from very experienced female nurses, indicate that nurses experiencing sexual aggressive behaviour could not only expect to receive minimal support, they were likely to be blamed for inviting the behaviour. Norma stated:

Illustration 1: Participant 20

> During my years of active nursing practice, doctors and colleagues maintained a very high standard of conduct towards each other and over many years only once did a patient make a sexual threat, which was immediately reported to and acted on by the doctor in charge. Our professional standards were high, even if the nurse could not be [physically] admired, her uniform with cap and veil was respected, as was her devotion to duty and her patients. So much has been lost to technology and the labyrinth of knowledge that has taken over. If and when any abuse took place, personal dignity was capable of dealing with the situation. I am worried that aggressive situations do occur but I believe that health professionals should be polite, courteous, and sincere and have a sense of humour that can reverse any difficult situation.

10.11 Interactions of themes

Each of the shared themes derived from the data appears to overlap with another in some respect. Images presented in the narrative of nurses provide the reader with some insight into the context in which work-related aggression takes place. Problems which can arise when nurses have different expectations than senior staff and nurse administrators regarding their role and function when they have experienced work-related aggression are highlighted. How nurses view the role of senior staff and nurse administrators in the management of their experiences, and how these experiences impact upon nurses' images of themselves as individuals and professional nurses, is demonstrated in the narratives provided by participants.

The data also reveal the range of emotions, sometimes contradictory, that nurses feel at the time of the aggressive behaviour and, more significantly, continue to

feel twelve months or more following aggressive incidents. The incompatibility between senior staff's expectation that nurses should be able to cope and the nurses' need for support impacts on self-confidence in the enactment of professional nursing role. As a coping strategy, participants seek out individuals or groups whom they perceive will assist in reconciling conflicting needs. Senior staff or colleagues who were able to listen to them as people with personal needs as well as professional nurses were required.

CHAPTER ELEVEN

DISCUSSION OF THE FINDINGS

11.1 Discussion of the findings

This chapter commences with reflection upon the aims of the investigation and the means by which these were able to be achieved. The limitations of the study are then considered.

The chapter then proceeds to recall and discuss the significance of the main findings in light of the existing literature. The quantitative findings of the questionnaire survey are discussed under the headings of type and source of work-related aggression. The model which tested and found the role of institutional social support to be an important factor on the relationship between work-related aggression and perceived professional competence is discussed. The qualitative findings obtained from open-ended questions from the questionnaire and interviews are discussed under the headings of the five shared themes that emerged.

11.2 Aims of the investigation revisited

The prime aim of this investigation was to recommend strategies and policies to health administrators, nurse administrators and educators, which prevent and/or minimise the traumatic effects that work-related aggressive behaviour directed toward nurses has on their perceived professional competence. This aim is met in Chapter 12 below.

The second aim was to develop a questionnaire to identify frequency, type and sources of work-related aggression as experienced by nurses. Two other key variables namely, reporting behaviours and supporting behaviours are also presented for discussion.

The third aim was to develop and evaluate a model to identify and explain relationships between three factors. These were stressors associated with work-related aggressive behaviour, perceived institutional social support, and perception of changes to professional competence amongst nurses. The conceptual framework for the model was the transactional model of stress and cognitive appraisal as a coping strategy (Lazarus & Folkman, 1984). This framework holds that individuals who are confronted with a specific stressful encounter will appraise the situation as threatening or challenging and call on coping strategies, including seeking social support.

The fourth aim was to conduct a phenomenological study that would provide insights into the lived experiences of registered nurses who had experienced work-related aggression, thereby exploring in more depth the professional and emotional reactions and responses of registered nurses to work-related aggression. The first aim is brought to a conclusion in the final chapter where implications and recommendations for practice in the field, as well as for further research in this area, are drawn out. The findings of the study relating to the second, third and fourth aims are discussed in view of certain methodological limitations of the investigation.

11.3 Limitations of the study

Three particular limitations of the study need to be taken into account in considering the significance of the results. These are problems with defining work-related aggression, the validity of the questionnaire and the selection of the survey samples used.

11.3.1 Problems with defining work-related aggression

In the current study, work-related aggression was broadly defined by a number of characteristics associated with location and circumstances of the aggression and how the victim dealt with the aggression. Contributing factors, perpetrator and victim

characteristics and nurses' own perceptions of what they considered aggression to be were also important variables included in the definition. There is little doubt that studies of aggressive behaviour in the workplace must extend beyond the traditional settings which are the normal focus of investigation - for example psychiatric, accident and emergency and nursing home settings, and include those general areas where the majority of registered nurses are employed. Failure to examine the phenomenon in general settings will deny or underestimate the existence of a problem which is causing considerable emotional and professional discomfort to individual nurses and the profession as a whole.

It is also imperative that researchers into the phenomenon of work-related aggression broaden their scope to include all types of aggressive behaviour. The dominance of research based on definitions which are restricted to physical aggression with or without physical injuries has the potential to miss less obvious but equally important areas of aggression which may lead, not only to psychological and emotional trauma but of equal importance, professional trauma. Examples of behaviour regarded as aggressive were identified by in-depth interviews and were presented in Chapter Ten of this thesis. These other behaviours include belittling professional opinion, public professional humiliation and failure to give recognition and credit for work performed. While overt physical aggression may evoke a sympathetic response by hospital and nursing administrators as to its management, there are many subtle covert types of aggression, which through their cumulative effect may contribute to the hidden despair of many professional nurses. An example provided in the current study is the aggression implicit to plagiarism, often erroneously perceived to be within the exclusive domain of academic institutions in the context of intellectual property ownership. The use of other peoples' ideas in

hospitals is not as controlled as it is in tertiary academic institutions and there is an expectation that within multidisciplinary teams there would be a sharing of ideas and credit about the management of patient care, or the collection of data for research reports. When expectations for acknowledgment of contributions made have not been forthcoming, there is a resulting feeling of betrayal and future mistrust. Two participants in this study drew attention to the damaging professional impact this form of behaviour had on them.

Although broadening the definition of workplace aggression into areas not usually included in research will improve the validity of research in this area, it may paradoxically contribute to the confusion that currently exists in the research literature when researchers are reporting on its sources and frequency. To this extent the researcher agrees with Perrone (1999) who points to the potential difficulties created by the continuing ambiguity of the term workplace aggression when it is defined too broadly and its value is reduced to researchers.

11.3.2 Validity of the questionnaire

Firstly, although there is an attempt to clarify the concept of work-related aggression more broadly than has previously been evident in this field of research, the questionnaire was limited by a lack of consensus as to the precise nature of work-related aggression. When human beings interact with each other there is always a potential for conflict, tension and dispute. Investigating the topic of aggression, therefore, required the researcher to be mindful that aggression is something that each person has encountered in one form or another and has learned to cope with these encounters. These encounters may be influenced by whether the person has been a perpetrator, a target or an innocent victim of aggression.

In the present study nurse experienced aggressive behaviour was confined to patient, doctor and nurse colleagues and defined by nurses themselves, according to their perceptions. Although this definition was indeed inclusive of most behaviours deemed by nurses to be aggressive, it still failed to address many other non-traditional forms of behaviour that many nurses may regard as aggressive. Two participants, for example, stated that their most poignant examples of aggressive behaviour were in the general area of intellectual property and plagiarism, detailed in section 10.9. This information was obviously difficult to integrate within the quantitative sections of the questionnaire.

There is no doubt that further research needs to be conducted to create a comprehensive instrument that can both measure the range of work-related aggressive behaviours and its impact upon nurses. For example, the quantitative component of the current study has clearly demonstrated the importance of measuring perceived professional competence in response to work-related aggression in general and the specific impact of institutional social support as a moderator. An almost exclusive reliance by the vast majority of researchers on small non-random samples, or qualitative methodologies which have focused primarily on physical and emotional responses, would appear to be missing important aspects of professional responses to work-related aggression. To more fully clarify and improve validity on the effect of work-related aggression, researchers may consider utilising both quantitative and qualitative methodologies in their research.

Despite the limitation highlighted here, however, the questionnaire developed in the current study does appear to be an advancement on previously used instruments, as it attempts to measure aggression within specific work contexts of nurses and takes into consideration factors associated with the source of aggression as

well as key variables of reporting behaviours and supporting behaviours. The questionnaire also included the previously unknown factor, namely, professional responses to work-related aggression.

A second limitation of the questionnaire may result from the deliberate decision to avoid quantitative measurement of psychological trauma in this study. Responses to aggression are subjective in nature and difficult to measure in a questionnaire. The researcher rejected the use of psychometric tools to measure a cross-sectional sample of nurses' psychological responses choosing to triangulate methodology through phenomenological inquiry as an alternative. This approach was consistent with the views of Lazarus and Folkman (1984:139) who pointed out an important methodological issue when measuring coping responses. They state that "it is difficult to see how the unfolding nature of stressful encounters, and the concomitant changes in coping, could be adequately described by a *static* measure".

As there were no previous studies that had been conducted which measured psychological trauma in the context of nurses' experience of work-related aggression, an exploratory approach was considered appropriate and this limitation was tolerated.

11.3.3 Selection of survey sample

Selecting the sample for the survey phase of the investigation was discussed in Section 7.3. There is little doubt that the discrepancy in time between obtaining the sample and conducting the survey was problematic and had the potential to threaten the internal validity of the investigation by undermining the systematic random. selection of nurses. The use of the register for nurses in Victoria was considered by the researcher to be a robust sampling frame containing the up-to-date names and addresses of all registered nurses in Victoria. In the case of this investigation there was a fluid turnover of nurses which was not expected nor accounted for in research

planning. Nurses tend to move from agency to agency, and/or state to state, thereby necessitating a change of address which will not be noted by the registration authorities until the subsequent year when registration is renewed.

Although a larger response rate may have been forthcoming had this potential participant movement been taken into account, external validity was not threatened as a representative sample of participants was nevertheless obtained from the population of registered nurses in Victoria.

11.4 Identification of frequency, type and sources of work-related aggression

As the first aim of this study was to recommend strategies and policies which prevent and/or minimise the traumatic effects that work-related aggressive behaviour directed toward nurses has on their perceived professional competence, it was important to identify the frequency, type and sources of work-related aggression.

Examination of the literature indicated that previous research has focused heavily on anecdotal reports and qualitative studies conducted on either psychiatric or emergency room nurses or nursing students. Previous quantitative studies have had limited generalisability because small, non-representative samples had been the norm. Consequently, the incidence of type and source of work-related aggression had not been clearly demonstrated. There was also a failure by researchers to investigate the reporting behaviours of nurses and subsequent supporting behaviours of staff. Although previous studies had reported on the emotional and psychological impact of aggressive behaviour on nurses, there was a complete absence of any empirical study that investigated nurses' professional responses, specifically their perceived competence. Gaps also existed in identifying the role of institutional social support as moderator in reducing the impact on perceived competence in response to work related aggression.

The current study addressed these methodological issues and obvious gaps in the research literature. The survey phase revealed that physical, verbal and sexual work-related aggression, perpetrated by doctors, nurses and patients, was frequently experienced by registered nurses. For the purpose of discussing significant findings, three combinations of source and type of work-related aggression are presented in the following sections. These are patient initiated physical aggression, nurse colleague/doctor (staff) initiated verbal aggression and doctor/nurse/patient initiated sexual aggression. These combinations have been selected because they were revealed by the study to represent the most negative consequences for registered nurses who have experienced work-related aggression. Other combinations exist but because they occur infrequently with little apparent effect the researcher has elected to forego further discussion.

11.4.1 Patient initiated physical aggression

Patient initiated physical aggression was a prominent source and type of aggression and indeed almost all those nurses in the sample had at least one experience of patient initiated physical aggression. Physical aggression in this investigation was found to have a significant negative impact upon all components of perceived professional competence of nurses.

These findings raise some concern as there is a prevailing attitude among nurses, consistent with the literature, that acts of physical aggression initiated by patients is a job-related event and is an acceptable part of the role of being a nurse (Haller & Deluty, 1988; Lenehan, 1991, in Hurlebaus & Link, 1995; Zernike & Sharpe, 1998). Perhaps previous research pointing to the accepting nature of nursing to aggression only applies to patient initiated physical aggression without resulting injuries, as results from this study show that this source and type of aggression has the

same impact upon nurses' perceptions of professional competence as verbal and sexual aggression, and doctor and nurse initiated aggression. This is hardly surprising considering the frequency of its occurrence. An explanation for this apparent acceptance may rest with the fact that very few nurses could see beyond their duty of care to patients, who, for whatever reason, were in hospital to receive nursing care (Mason & Chandley, 1999). Patient aggressive behaviour, therefore, was more likely to be excused by nurses because of factors that were perceived by nurses to be beyond the control of patients. In the face of evidence pointing to the negative effects of physical aggression upon perceived professional competence, there is clearly a need to redress the prevailing nursing culture which mitigates against identifying the true nature and effect of physical aggression. Failure to do so will result in nurses continuing to be recipients of patient initiated physical aggression.

11.4.2 Nurse colleague and doctor initiated verbal aggression

Verbal aggression dominated all types of aggressive behaviour with the combined verbal abuse emanating from doctors and nurse colleagues exceeding that from patients. This paints an invidious scenario for nurses caught between physically abusive patients and verbally abusive staff. The impact of staff-initiated verbal aggression in the areas of 'role competence' and 'professional relationship competence' was significant.

At a superficial level, individual acts of verbal aggression did not appear to be serious, but the cumulative effect of frequently repeated episodes of rudeness, abruptness, abusive language, humiliation and so forth presented nurses with a demanding and demoralising work environment. There is little doubt that verbal aggression is rife in nursing and supports previous research (Duffy, 1995; Farrell, 1999; McCall, 1996) which describes the concept of horizontal violence and its

impact upon nurses. The concept of the Battered Staff Syndrome (BSS) among nurses described by Moore and McVey (1995) was also supported. Nurses have a documented propensity to be hurtful to each other (Lanza, 1984b; Mason & Chandley, 1999; Morrison, 1998; Paterson, Leadbetter & Bowie, 1999; Whittington & Wykes, 1992). Explanations have been offered to explain this phenomenon. The most common explanation, subscribed to by feminist writers (Ashley, 1979; Lovell, 1981; Twaddle & Hessler, 1977), is that the marginalised position of nurses in male dominated, bureaucratic, hierarchal structures which sees them at the bottom of the 'pecking order' in comparison to other health workers and leads to frustration. This oppressed state in nurses is said to promote horizontal violence as it is the sole remaining avenue for expression (Roberts, 1983).

Freire (1972) has pointed out that the major characteristics of oppressed behaviour stem from the ability of dominant groups to identify their own norms and values as the 'right' ones in the society and from their pervasive power to enforce them. This leads to what has been called the submissive aggressive syndrome (Carmichael & Hamilton, 1967). The oppressed person, while able to feel anger and aggression against the oppressor, may either lack the means of direct expression or is not able to directly express it. The aggression is therefore displaced. Fannon (1963) has described the tendency of native groups to be in constant intergroup conflict, often spending most of their aggressive energy killing and maiming each other.

The implication for nurses is that more senior nurses adopt the characteristics of the dominant professional grouping which in the health industry is male doctors. Nurses therefore become condescending, aloof and arrogant to those most immediately subordinate to them. The downward spiral of aggression is passed on from one generation of nurses to another in a similar fashion as domestic violence is

passed onto succeeding generations of perpetrators. Farrell (1996) showed that aggression among nurses is likely to be self-perpetuating. Nurses who had been victims of aggressive behaviour had a proclivity to act aggressively. According to Farrell (1996), this proclivity for aggression is likely to be assisted by organisational structures within health agencies that focus on accomplishing task orientated goals within specified timeframes.

11.4.3 Doctor, nurse and patient initiated sexual aggression

Although sexual aggression was the least frequent type of work-related aggression reported in this study, it produced a negative impact upon all components of professional competence. Sexual aggression creates a hostile and intimidating work environment where professional relationships can rapidly deteriorate especially in the areas of trust and respect for colleagues. These contribute negatively to the 'professional relationship competence' component of competence.

Patients were reported to be the main instigators of sexual aggression. This result is at odds with findings from previous studies (Dult, 1981, Grieco, 1987, Maddison, 1997) which found doctors to be the major contributors. Male doctors were, however, the main perpetrators of staff initiated sexual aggression. These contradictions in results may point to an important variable in the study of aggression research. Previous studies had focused on nursing students (Dult, 1981) or had been conducted in specialist areas, for example, operating theatres (Michael & Jenkins, 2001). Both these situations would result in an element of bias as nursing students are inexperienced in the health industry and lack skills and confidence to deal with aggression, whilst nurses in operating theatres are by necessity required to be in the continuous presence of powerful medical personnel.

Victims of sexual aggression reported that they felt helpless and powerless, and often withdrew or avoided all contact with the source of aggression, a behaviour which further reduced their perception of professional competence in performing the role of registered nurse. This finding supports previous research by the author which found that detachment was utilised by nurses to reduce emotional distress by avoiding potentially aggressive situations in the workplace (Deans, 1991). The consequence of detachment is that nurses make themselves more inaccessible and less effective when caring for patients.

It was interesting to note that although sexual aggression is a relatively new phenomenon demanding investigation, a 70 year old nurse, through personal correspondence to the researcher, having claimed that she had never experienced any aggression, went on to state that early in her career she had indeed experienced sexual aggression. Kaye (1996) claimed that nursing has dealt with sexual harassment since the era of Florence Nightingale. Results from this investigation support the writings of Dult (1982) and Grieco (1987) who found high frequencies of this behaviour to be experienced by nurses.

A problem for nurses is the status of doctors relative to nurses. Madison (1995a) pointed to the fact that many physicians are not actual employees of the hospital but conduct their business there due to their visiting rights. These visiting doctors represent an extremely important group of professionals in Australia, as most hospitals rely upon them exclusively through casemix funding, a formula utilised by the State Government of Victoria to provide funding to hospitals. The formula is based upon the number of patients treated per annum and the complexities of each case category (eg, patients needing surgery for gastric ulcers). As doctors are the only professional group that has admission rights to hospitals, health agencies are

dependent upon them for throughput, and consequently funding. A reluctance of hospital management to pursue medical staff who are accused of aggression toward nurses on the basis of a complaint from a nurse is therefore understandable. When this factor is coupled with the renowned ability of the medical profession to close ranks under pressure, and the equally renowned ability of nurses to proportion blame on each other, the reason for minimal reporting of aggression becomes clear.

11.4.4 Reporting of work-related aggression

It is important to recall that an important aim in this study was to identify and describe reporting behaviours of nurses who have been recipients of work-related aggression. Findings indicated that there was a reluctance by nurses to formally report their experience of work-related aggressive behaviour to staff within the institution. The present study showed the majority of participants were more likely to report all three sources of aggression at an informal rather than a formal level. With formal reporting, nurses were most likely to report aggression from patients and least likely to report aggression from a doctor. The literature contains references to the fact that nurses do not formally report aggressive incidents (Bowie, 2000; Farrell, 1996; Orr et al, 1988). The claim has been made that under-reporting may contribute to an under estimation of the number of incidents of patient assault (Paterson, Leadbetter & Bowie, 1999). Other reasons for non-reporting include guilt, self-blame and feelings of inadequacy (Dult, 1981; Lanza, 1986) or factors such as extent of injuries to patients or nurses. If the patient or nurse is not injured there is a tendency to not report the incident (Mason & Chandley, 1999).

The results of this study support previous studies that claim an under-reporting of the phenomenon (Kohnke, in Wondrak, 1989; Lanza, 1983; Lion, Snyder & Merril, 1981; McCue, in Bowie, 1989; Rose, 1997). This factor in turn contributes both to an

under estimation of the problem and an under resourcing of possible strategies to alleviate the problem.

It has already been established elsewhere in this thesis that the culture of nursing mitigates against nurses reporting (Farrell, 1996; Mason & Chandley, 1999). The author contends that a preparedness to report is an important indicator of perceived social support. If nurses perceive social support to be available from the institution, the nurse victims of aggression would be more likely to make a formal report of its occurrence in anticipation that they will indeed receive support. Likewise, the perception that social support is not available will result in non-reporting. Therefore, the finding that there is a positive relationship between social support and reporting behaviours has important implications. Nursing culture was found to contribute to both the problem of non-reporting and therefore, to the lack of access to people who were in the best position to offer support (Fisher, 1994; Pennebaker & O'Heron, 1984; Pennebaker & Susman, 1988).

Findings in the current study demonstrated that nurses interpreted work-related aggression as being threatening and stressful. The culture of nursing would appear to entail obstacles which prevent or inhibit nurses from sharing adverse experiences. Accordingly, nurses have to resort to alternative and less effective coping strategies and resources. Results showed that nurses infrequently used formal reporting to managers as a problem-focused coping strategy following their experience of work-related aggression. Their behaviour was more clearly categorised as emotion-focused coping through informal discussions with peers and colleagues. Emotion-focused coping constitutes efforts to reduce the emotional reactions to stress and is more likely to occur when there has been an appraisal that nothing can be done to modify harmful, threatening, or challenging environmental conditions (Lazarus & Folkman, 1984).

Nursing continues to be a predominantly female profession; nurses who are victims of aggressive behaviour are thereby predominantly female. Pearlin and Schooler (1978) found that the coping responses of women when compared to men were more likely to increase the experience of stress. They found that the perception of life events was strongly related to physical and psychological dysfunction for women. It would appear that women might experience more negative outcomes as a result of their emotion focused coping strategies. Sidle, Moos, Adams and Caddy (1969) reported that women seek to reduce tension through accessing information and sharing with others. Belle (1990, in Warren & Baker, 1992) reported that women, through their support of others, actually increased their own risk of stress.

Greenglass (1995) pointed out that men and women differ in the coping strategies they utilise. She suggested that the differences resulted from an unequal distribution of power and control, stereotypes and occupational gender segregation. In the nursing response to workplace aggression, emotion-focused coping could be reflected by the nurse victim's reluctance to report aggressive incidents to senior personnel. As Dewe (1989:316) indicated, "in many situations the selection of a coping strategy is in part determined by the physical, social and psychological resources that the nurse perceives are available to her (sic)". Hospitals impose bureaucratic policies, practices and procedures upon their employees, thereby formalising and prescribing how nurses at different levels of the hierarchy, can actually cope with stressful situations. Dewe (1989) further asserted that, due to restrictions or limitations on nurses' choice of problem-solving strategies, emotion-focused strategies should be valued and given higher recognition. If nurses are to rely upon emotion-focused strategies, it is important that work structures should be more sympathetic to these strategies and provide a supportive climate where nurses can

constructively release and deal with their emotions. The results of this study underline yet again the fact that institutional social support is a very positive contributor toward reducing the impact of work-related aggression on the perceived professional competence of nurses.

Nurses also must address emotional components that may accompany aggressive behaviours. Those nurses who fear embarrassment, disapproval or punishment experience an inability to report aggressive behaviour. This may also be explained within the context of perceived and real differences in status between doctors and nurses and may be related to oppressed group behaviour. Roberts (1983:27) commented, "that it is clear to most nurses that although there may be considerable complaining about physicians within the nursing group, rarely is there explicit complaint to the physician". Although this aspect of nursing behaviour is subtle, and difficult to substantiate, it may be evident in the divisiveness and lack of cohesiveness observed in nursing groups (Chinn & Wheeler, 1985; Roberts, 1983).

Another reason for non-reporting was suggested by Dult (1982). She claimed that the greater the nurses' distress, the greater the tendency not to report it. In addition, she asserts that "younger women think they can handle it but older women feel the opposite" (Dult, 1982:327). This is also not uncommon in the general literature where younger women have been reluctant or unwilling to report sexual harassment. Recall that findings from this study also point to more difficulty for younger nurses, with less experience, when coping with work-related aggression

11.5 Model testing findings

The third aim of this study was to test a model proposing a moderational effect of institutional social support on the relationship between work-related aggression and perceived professional competence. It was argued that although competency can

be viewed as an objective means of measuring nursing standards, there was an equally compelling need to measure competence from a subjective perspective.

11.5.1 Theoretical framework for model testing

In their pioneer work on the transactional model of coping, Lazarus and Folkman (1984) contended that individuals engaged in a cognitive process of appraisal which assists them to manage specific internal and external demands and therefore cope effectively with stressors. This model holds that when examining the impact of particular situations on individuals, cognitive appraisal and coping are important considerations (Croyle, 1992; Dewe, 1991, 1992; Folkman, Lazarus, Dunkel-Schetter, et al., 1986; Folkman, Lazarus, Gruen & De Longis, 1986; Gadzella et al., 1991; Larsson et al., 1988; Ptacek et al., 1992).

One important component of coping identified by Lazarus and Folkman is the use of social support, which is hypothesized to moderate stressful events and outcomes. In the exploratory model tested in this investigation, social support acted as a moderator upon nurses by transforming negative experiences of workplace aggression into subjective experiences of self-perceived competence. In other words, the internalised feelings of competence were altered as a result of feeling supported, or alternatively feeling unsupported. The researcher hypothesised that this internalising of perceived social support is facilitated by nurses being able to either verbally or in writing report their experience to key significant institutional staff. Reporting provides opportunities for victims of workplace aggression to translate potential negative experiences and emotions into an understandable medium of language, thereby facilitating the cognitive assimilation process. It is cognitive assimilation, an internal psychological process that explains the moderating effect of institutional social support in the exploratory model. This explanation finds some

support from Pennebaker, Colder and Sharp (1990:529) who stated that "requiring individuals to translate previously inhibited traumatic experiences into language, either through talking or writing, produces important physical and psychological effects" (p.530). They added that:

> A particularly efficient way to organize and ultimately understand events is to translate the experiences into language, which usually occurs in normal social interaction ... however ... people either are unable or unwilling to talk to others about upsetting experiences for fear of embarrassment, disapproval, or punishment. When this [fear of embarrassment, disapproval, or punishment] occurs, people must actively inhibit their desire to talk.

Other researchers have also found that a large percentage of people do not discuss major stressful experiences (Fisher, 1994; Pennebaker & O'Heron, 1984; Pennebaker & Susman, 1988).

11.5.2 Support for theoretical framework

Findings in this investigation as well as confirming Lazarus and Folkman's (1984) theoretical position, added to the existing evidence in support of the hypothesized relationship between work-related aggression and perceived professional competence. The impact of work-related aggression on perceived competence could be ameliorated through moderating processes, namely, by supportive behaviour of personnel within the organisation.

These findings are consistent with most of the other studies (Farrell, 1999; Lanza, 1983, 1984; Mason & Chandley, 1999; Morrison, 1987, 1998; Paterson, Leadbetter & Bowie, 1999; Whittington & Wykes, 1992) reporting consistently that nurses fail to receive support following work-related aggression.

The model-testing results of this study clearly imply that the provision of formal institutional social support may prevent, or at least reduce, a decrease in nurses' perceived professional competence following experience of work-related aggression. Differences were found between high and low levels of institutional social

support with high levels associated with higher levels of perceived professional competence and low levels associated with low levels of perceived professional competence indicating that institutional social support moderated the effect of work-related aggression. It is important to note that participants were reporting on perceptions of actual support received as a result of work-related aggression and not on a perception of the availability of support. Thus, the effects of institutional social support appear to be due to nurses feeling that they had real support from significant others from within the institution. This result adds weight to the theory that social support may protect people from the potentially damaging effect of exposure to stress through its effects on moderating appraisal and coping processes (Lazarus & Folkman, 1984). Nurses who perceived receiving social support from colleagues and senior staff following an incident of work-related aggression perceived themselves capable of coping more effectively than those nurses who did not receive such social support.

As a corollary, nurses who perceive the availability of support and/or receive social support are more likely to approach someone in the employing agency and report aggressive incidents. The availability of support may indeed be more relevant, considering the apparent lack of success that other individual coping strategies demonstrated (Pearlin & Schooler, 1978; Shinn et al., 1984).

Because the relationship between work-related aggression and perceived professional competence was statistically significant when controlling for institutional social support, it is obvious that other moderating variables operate in the relationship. In line with Barron and Kenny's (1986) arguments, if institutional social support were the single dominant moderator, the relationship between work-related aggression and perceived professional competence would no longer be statistically significant. Other

variables that may help to explain the relationship between work-related aggression and perceived professional competence need to be identified. These may include high levels of job control and personal dispositions such as hardiness, optimism or self efficacy. It is possible that other moderators will be more relevant to some groups of nurses than others (e.g. psychiatric nurses, community nurses, midwives etc.). For example, for registered general nurses as a whole, institutional social support is a moderate to strong moderator in the primary area of interest in this investigation, whereas for psychiatric nurses it may be stronger, as emphasis on support for colleagues who have experienced aggression is part of psychiatric nursing culture.

11.6 Qualitative findings: Insights into the lived experiences of nurses

The fourth aim was to conduct a phenomenological study that would provide insights into the lived experiences of registered nurses who had experienced work-related aggression, thereby exploring in depth the professional and emotional reactions and responses of registered nurses to work-related aggression.

Phenomenology was employed as a methodology to specifically focus on the single event of a nurse's worst experience of work-related aggression. From a phenomenological perspective there was no difficulty in having nurses recount their worst experience of work-related aggression and providing responses much later than the actual event and data analysis identified in the five shared themes of:

(1) powerlessness;
(2) expectation to cope;
(3) emotional confusion;
(4) lack of institutional support;
(5) doubts about professional competency.

The pervasiveness of these themes demonstrated that nurses had almost exclusively negative responses to their experience of work-related aggression. There was little variation in coping behaviour reported by the 33 nurses interviewed.

There were some differences in demographic variables in those nurses who had indicated on the questionnaire that they had been able to cope with aggressive behaviour and those who had indicated that they had not been able to cope. The major ones were associated with age and years of experience, with results showing that older, more experienced nurses were more likely to indicate that they could cope with work-related aggression. This result supported the findings of the qualitative component of the questionnaire, which asked open-ended questions about what was the one most significant thing that either helped or prevented the participant from coping with aggressive behaviour. The most frequent positive response was, gaining more experience, followed by talking it over with colleagues.

11.6.1 Theme 1: Powerlessness

A prominent image of a nurse, one commonly promoted by the nursing profession, is that of a person who is in control of what others would consider to be a chaotic situation. Many nurses themselves would also support the view that they remain in control even though others are experiencing crises. Being in control and exuding confidence is fundamental to allaying the fears and concerns that others may bring to tense and emotional scenarios characteristic of health impairment. Conveying control and confidence are therefore core nursing traits.

Being a competent nurse is synonymous with being a nurse who is in control of the clinical environment; therefore, the inability to prevent, contain or minimise aggression undermines perceptions of professional competence. Participants found themselves in situations they could not control and felt powerless and helpless. The learned inability to control a new situation or environment after having previously been in an uncontrollable event or environment is called "learned helplessness" (Seligman, 1975:45). In other words, nurses confronted with the reality of work-

related aggression described incidents in which they felt helpless due to their lack of control over the situation and environment. Loss and feeling out of control can cause shifts in the beliefs, expectations, and assumptions that nurses hold, subsequently triggering disturbing feelings with wide ranging consequences (Janoff-Bulman, 1992; MacCann & Pearlman, 1990).

Competence has been widely discussed in psychology (Smith, 1967, in Sells, 1968) in terms of environmental mastery (Jahoda, 1958), ability to cope with difficulties (Bradburn, 1969) and self-efficacy or expectations of mastery (Bandura, 1977). A competent person, according to Warr (1990:197), "is one who has adequate psychological resources to deal with experienced difficulties". Nurses who are victims of work-related aggression experience a sense of being overwhelmed by the events that are taking place. Some of these experiences are highlighted in the literature. For example, Whittington and Wykes (1992) identified disbelief and denial as part of the coping mechanisms used following assault. Powerlessness therefore involves the participants' inability to initiate or regain control of their own destiny.

The powerlessness theme has been identified in previous more general studies of nurses. Erlen and Frost (1991) found pervasive powerlessness in influencing decisions was described by nurses of all ages, educational levels, and years of nursing experience, while Bush (1988) found that powerlessness was a major cause of job dissatisfaction in hospital nurses. Nursing has traditionally been ambivalent toward the concept of power, perhaps because it has remained a woman's profession (Garant, 1981) in which power is perceived as something coercive (Carlson-Catalano, 1994) or unfeminine (Valentine, 1992).

Valentine (1992) found that nurses who fought for their rights were seen by their colleagues as uncaring and not having the qualities that nurses should have. The

essentially positive feelings of caring associated with nursing identity contrast sharply with the experiences of nurses in this theme. There is a feeling of disbelief and helplessness when they perceive themselves to be without power and authority. This is frequently associated with feelings that they are under pressure, facing insurmountable odds resulting in feelings of frustration.

Whittington and Wykes (1992) suggested that power can be a productive force when nurses aim to empower patients. Conversely, power can also mean a limitation for nurses, as managers and doctors within the organisation's management structure subject them to the assertion of power. While the aggressive attack may trigger negative emotions, these are frequently exacerbated by attitudes of senior staff or nurse colleagues who, from the perspective of participants, do not provide support and understanding.

Nurses in this study firmly expressed the need to be acknowledged as professionals who are accountable and responsible for their practice. Interestingly, however, the qualitative data suggested that nurses who experience work-related aggression do not perceive themselves to be autonomous. This lies in direct conflict with their perceptions as competent practitioners. People who have been through a threatening event in which they have lost control, experienced low self-esteem, and had their vision of the future severely taxed or shattered, may become vulnerable to similar perceptions in the future (Taylor, 1989).

The need to regain control as soon as possible appeared to be important, a mechanism facilitated by the interventions of significant others. When nurses are acknowledged by their senior managers as professionals, feelings about responsibility and accountability are positive, reinforcing their perceptions of professional competence.

11.6.2 Theme 2: Expectation to cope

Being expected to cope regardless of circumstances can be a devastating experience for victims as it has the potential to create and sustain negative emotions. When senior staff appeal to the victims to "carry on" because other nurses in similar situations have done so, nurse victims question their professional competence. Often they are unable to "carry on" or when they do attempt to do so, feelings of inadequacy or incompetence accompany their duties. A cycle is formed in which inability to cope further undermines their confidence as competent professional nurses. Ultimately lack of confidence leads nurses to question whether they belong to the profession, e.g. "Am I cut out to do this work?" or "Do I belong here"?

A typical response from a victim would be, "if others have coped in this situation, why am I unable to cope"? Confusion concerning the expectation to cope was highlighted by the following factors. None of the participants in this investigation went off duty because of the incident experienced even though there was often a high level of emotional distress. All of them stayed in the same area, sometimes reluctantly working with the perpetrator of the aggressive behaviour. Indeed, two of the participants allocated themselves to the same patient because they wanted to reaffirm their feelings of competence.

11.6.3 Theme 3: Emotional confusion

The qualitative data demonstrated that nurses experience a range of mixed emotions, including fear, anger and frustration, which are predominantly negative, in response to aggression in their workplace. When these are combined with reduced cognitive functioning of patients because of their illness or treatment, an environment that has the potential to become tense and possibly explosive is created.

Frustration leading to aggression is more likely to be found in hospitals because of the many aversive stimuli present in health care settings. Aversive stimuli, which produce discomfort or displeasure, can heighten hostility and aggression (Anderson, Anderson & Deuser, 1996; Berkowitz, 1990). Examples of aversive stimuli found in hospitals are pain, anxiety, distressing scenes, odours, high noise levels, and excess activity. These stimuli raise overall arousal levels so that people become more sensitive to aggression cues which are signals that are associated with aggression (Carlson, Marcus-Newhall, & Miller, 1990).

These negative emotions generally cause intrapersonal, interpersonal and professional conflict due to the need to reconcile their personal needs with those of the nursing profession and the needs of the institution. This conflict takes place within the context of a profession which appears to place a misguided value on nurses' ability to cope while neglecting to provide both educational preparation prior to incidents and the essential support for effective coping.

Nurses generally experience positive feelings associated with 'caring' and being a nurse. These feelings are reinforced by the nursing profession, which projects the predominant image of nurses as universally competent. This image may be seen by victims of aggression as a barrier to successful coping with the incident. Nurses may adopt a passive role as negative feelings of fear and anger are directed toward the organisation and/or senior staff. They may see themselves and patients as victims of organisational constraints and medical diagnoses. This reinforces nurses feelings of guilt and self-blame as they reflect upon their own contribution to workplace aggression.

Responses to anger by nurses could be partially explained by differences in gender role socialisation (Haynes & Feinleib, 1980; Thomas, 1989; Thomas &

Williams, 1991). Researchers have found that women who experience anger experience feelings of helplessness/powerlessness (Drake & Price, 1975; Munhall, 1993), somatic complaints (Munhall, 1993; Thomas, 1995), stress (Thomas & Donnellan, in Thomas, 1993), and low self-esteem (Saylor & Denham, in Thomas, 1993).

In the current study it would appear that participants lacked the ability to deal effectively with their own anger and were unable to cope when it was expressed toward them by doctors, colleagues and patients. Their anger was often displaced toward senior staff, for example, nursing administrators or medical staff, who were perceived by participants as not having provided sufficient support.

Positive reaction to the feelings and experiences of the participant is vitally important if conflicts are to be resolved. Binder and McNeil (1988:549) stated that "uncaring fellow nurses provided a source of frustration, hurt and disappointment."

Participants also used general terms like, "I was upset about what was happening,"; I can't trust her," and expressed concerns about their future in nursing. On occasions this extended into considering leaving nursing and in one situation the participant was in the process of resigning.

Anger in the nurse can exact a costly expenditure of energy and human resources. It is imperative for nurses to obtain a better understanding of the phenomenon of anger, especially its association with work-related aggression, and develop strategies for coping with it more effectively.

11.6.4 Theme 4: Lack of institutional support

Underpinning the need to seek institutional social support is the belief expressed by participants that when they experience a range of contradictory emotions, such as anger, concern, caring, ambivalence, hatred for the patient,

confusion about their role and competence, this results in their experiencing emotional discomfort and confusion. The standard of nursing care provided to patients is compromised due to the impact of these feelings. Participants felt that they were compelled to seek out senior staff to communicate their feelings and gain support. They had a need to talk to others, to gain approval or acceptance of their behaviour or emotions. If they are told that there is nothing to worry about, that all nurses have had similar experiences and have been able to cope with them, the result is escalation in negative feelings about themselves.

As indicated by the model testing findings of this study and again found in the in-depth interview narratives, responses from senior staff have the potential to assist, hinder or exacerbate the nurses' recovery from negative emotions. If opportunities are denied to nurses to resolve problems generated by their encounters with aggressive patients, doctors or colleagues, they may become disillusioned and dissatisfied with nursing. They may begin to displace their anger and hostility toward the source of their non-support. If senior staff, for example the nurse administrator or medical personnel, does not validate or give recognition to the behaviour and/or emotions of nurses who are victims of work-related aggression, the outcome may be a continuation of unresolved emotional conflicts, and a reduction of perceived or actual professional competence leading to compromises in delivering nursing care and perhaps eventually leaving the institution for another, or the nursing profession.

In most cases the first senior staff member to be approached for support is the team leader or the charge nurse. If the response is sensitive and reassuring, the participant may feel more at ease with the situation. If the participant is unable to get the required response, anger and criticism result. McClure (cited in Dult, 1981) reported a similar finding in her study. She found that a large portion of the

communication nurses describe as alienating comes from people in higher nursing service administration positions. There is ample evidence in the literature (Haller & Deluty, 1988; Lenehan, 1991, in Hurlebaus & Link, 1995; Zernike & Sharpe, 1998) that there is an overall, pervading sense by victims of work-related aggression, of management trivialising or minimising aggressive incidents unless they are accompanied by actual serious physical injury that requires immediate medical attention. There is often an apparent absence of concern by management for any professional or emotional difficulties experienced by victims (Hunter & Carmel, 1992; Ishimoto, in Turner, 1984; Lanza & Milner, 1989; Lawson, 1992). Results from the current study show that nurses were feeling alienated from the institution and senior management who were characterised by victims as uncaring and insensitive. Frequently these attitudes of victims were generalised to the wider profession so that it is nursing that is uncaring. This contributes to victims feeling alienated from the profession as a whole-an important component of their identity-which further intensifies their role conflict.

Miller (1990:57) stated that "the nurse as a victim is entitled to full support from colleagues, managers, the profession and her employer. Nurses who are treated with respect and empathy will be more able to carry out their duties effectively".

Nurses who are assaulted are frequently confronted by senior staff who criticise them for incompetent practice or irrational behaviour, creating a number of additional fundamental role conflict problems for nurses, which compound their feelings of guilt and incompetence. Participants who received a sympathetic hearing from an understanding senior staff member demonstrated an increased ability to resolve their conflicts. The experience was still traumatic, but they had fewer negative outcomes and less residual feelings of incompetence.

This result provides credence to Cohen and Wills's (1985) view that social support is best provided by personnel who are more likely to appreciate the problem. They found that non-work support had been demonstrated to be less effective. Family members and friends, although wanting to be supportive, are unlikely to fully understand health professionals' work environment and therefore may be unable to provide support. To some extent this contradicts previous findings of Coyne and De Longis (1986) who found that the perception of having available emotional support from close others appears to account for much of the effect of social support on stress. It would appear that 'closeness' may not be the important variable operating on support, rather it is the ability to provide 'understanding' as proposed by Cohen and Wills (1985).

From another angle, differences in the sources of supports finds credence in the literature on exchange theories, particularly the work by Buunk et al. (1993), who claimed that there is an important difference between relationships with colleagues and those with superiors. In relationships with superiors, that is, those with higher status, a certain degree of asymmetry might be considered normal, because the provision of help and support is expected from superiors. On the other hand there is a tendency to avoid seeking help and support from individuals at the same level because a debt would be incurred. Buunk et al. (1993) pointed out that in professional relationships, the perception of receiving more help than one can return may be accompanied by negative feelings, including the fear of appearing incompetent.

The degree of support requested was often related to the issues that were central to the aggressive incident. Participants identified two types of support. The first type is the professional support required to either prevent or at least ameliorate the incident, which may include providing extra medication, or allocating more staff

to assist with the management of an aggressive patient. The second type is the emotional support required to address personal needs of participants following incidents and involves someone "making the time" and being "prepared to listen" to them and "reassure them" by following up any concerns.

When participants felt that the aggressive behaviour of the patient could be managed by supportive interventions, they would request additional staff from nursing administration. This would generally lead to a discussion of resource management which frequently led to added feelings of guilt [taking staff away from other under resourced areas] or feelings of anger when reasonable requests were made [management don't really understand my problem]. Occasionally staff felt that the aggressive patient was inappropriately placed in their ward and sought interventions from medical staff to transfer the patient to a more appropriate environment. If this was not possible, they would then request medical staff to prescribe medications that would assist the patient to maintain control. There was an ongoing battle reported by participants between nurses and medical staff to share accountability for management of aggressive patients, and feelings of resentment by nurses who consider that doctors opt out of their responsibility.

Effective interaction between the nurse who has been a victim of assault and a senior staff member is essential to the nurse resolving concerns regarding future role, competence and function; standards of nursing care; and feelings of self worth, self esteem, guilt and anger. Interactions between nurses and senior staff, however, are influenced by the conflicting expectations that senior staff have regarding the nature, and implication of the aggressive incident.

11.6.5 Theme 5: Doubts about professional competency

There are both community and professional expectations that nurses approach nursing tasks as stalwart, stoic, capable, knowledgeable and resourceful individuals (Davidhizar & Wehlage, 1988; Thomas-Aasen, 1993). The importance of competence was demonstrated in a study by Shinn et al., (1984) on human service workers. She reported that one third of the sample attended workshops and conferences in an attempt to build competence as a way of dealing with stress at work.

When participants received approval they felt confident about their own abilities and were more able to resolve the emotional difficulties that accompany these incidents. The reverse was also true. If they did not gain approval, their negative feelings intensified and their confidence was further reduced. Janoff-Bulman (1992) argued that most people believe, either explicitly or implicitly, that the world is a benevolent and meaningful place and that the self is a worthwhile person. As a result of experiencing work-related aggression, nurses' beliefs of what constitutes quality nursing care may be undermined and this further shatters their idealized beliefs about their own and nursing's reality (Jannof-Bulman, 1992). Subsequently they reported a less trusting mode of interaction with others and a sense of hopelessness at the enormity of the situation (Michael & Jenkins, 2001). As witnesses of incompetence or inappropriate practice and the obvious frustration and helplessness attributable to the situation, nurses evidently undergo the dissolution of previously cherished concepts and views of the world and of human beings (Figley, 1986).

11.7 Overall conclusions

It is ironic that those who nurses are seeking to help or those professional colleagues with whom nurses are providing 'care', actually become those who inflict aggressive behaviours upon them - from frustrated patients who cannot attend to their

own activities of daily living, to stressed doctors making decisions in an environment lacking resources, to nursing colleagues attempting to calm a distraught parent waiting impatiently with a crying child at the accident and emergency department. Whatever the circumstances and reasons, the fact remains that patients, doctors and nurse colleagues are attempting or succeeding in inflicting physical, verbal and sexual assault on nurses at their workplace. While it is well documented that nursing is a stressful profession (Bargagliotti & Trygstad, 1987; Gowell & Boverie, 1992; Gray, Chapman, & Fisher, 1995; Lender, 1990; Lobb & Reid, 1987) and that hospitals are by their nature stressful work environments (Calhoun, 1980), the additional impact of physical, verbal and sexual aggression contributes to an unacceptable work culture for nurses.

It is also a concern that nurses' are reluctant to formally report aggressive behaviour, thereby denying themselves the opportunity to receive institutional support. This in turn impacts negatively upon their perceived competence.

By utilising triangulated methodology, data collected from quantitative and qualitative procedures have contributed to describing the phenomenon of work-related aggression. Whilst quantitative data has assisted in identifying the scope of the problem by addressing issues such as type and source of aggressive behaviour in the workplace, qualitative data was necessary to identify and describe the impact of aggression on those nurses who have experienced it.

CHAPTER 12

CONCLUSIONS AND RECOMMENDATIONS

12.1 Conclusions and recommendations

Nursing was presented earlier in the thesis as a unique occupation that had different sets of expectations in the relationships between nurses and patients than other health professionals and other social interactions (Mason & Chandley, 1999). These relationships play a prominent role in how nurses perceive themselves as competent professionals. This investigation explored the problem of work-related aggressive behaviour and its impact upon the perceived professional competence of nurses registered on Division One of the Nurses Board in the State of Victoria.

This final chapter presents the conclusions of the study and goes on to outline strategies and policies which have been identified and recommended to minimise the traumatic effects caused by work-related aggressive behaviour directed toward nurses.

12.2 Overview of conclusions of the study

In this sample of registered nurses, aggression was clearly a feature of the workplace. This aggression was predominantly physical in nature and mostly perpetrated by patients and, to a lesser extent, by nurse colleagues and doctors. Verbal aggression initiated by nurse colleagues and doctors was also a prominent feature of nurses' working environment. Less evident but nevertheless significant, was sexual aggression initiated by doctors. These findings heighten the responsibility of the nursing profession and health organisations for the welfare of nurses employed in general nursing settings.

It was also clear that there was a reluctance by nurses to formally report work-related aggression to senior staff within the organisation, with a preference for informal discussion with nurse colleagues of a similar status. Failure to report to

senior staff appeared to be linked to a culture of nursing that values professional competence as both an objective standard against which nurses are assessed by the profession and an internal subjective self evaluation by nurses on their own performance as professional nurses. Unfortunately, this lack of reporting denies nurses the opportunity to access and receive support from senior staff who are expected to understand the emotions and behaviours of nurse victims. Senior staff members were perceived as having the power to both provide understanding and support and legitimise nurses' actions. Junior members of staff and family members or friends are not in a position to perform this function. This motivation to seek support was directed toward the resolution or reduction of intrapersonal and interpersonal professional and emotional conflict and discomfort.

Unresolved negative emotions and conflicts interfered with the ability of nurses to function competently at their former level. The basis of the conflict is the need for professional nurses to competently perform their nursing duties and carry out their duty of care while simultaneously coping with personal needs which have been activated as a result of work-related aggression, and which require attention. These needs may be reconciled if nurses receive sensitive and appropriate institutional social support from senior staff and/or colleagues.

It was found that if nurses do not get the responses they desire from senior staff they attempt to get the necessary approval or understanding from family or personal friends, or indeed resort to maladaptive ways of coping. A process of questioning one's role and function as a nurse may begin. Nurses may become cynical about nursing, complaining that nurses do not care for their own colleagues. This is not an uncommon complaint in the nursing profession. The researcher suggests that

this is a major factor that may contribute to burnout, job dissatisfaction, low morale, absenteeism and high nursing turnover rates.

When institutional social support is not offered, or if it is inappropriate, nurses are likely to have on-going unresolved conflicts between their professional competence needs and personal needs. The conflict produces feelings of alienation in nurses toward the institution, particularly to the department of nursing administration.

From the findings of this study, there is no doubt that the provision of institutional support plays an important role in buffering the impact of work-related aggression on perceived professional competence, thereby giving further credence to the theory of cognitive appraisal as postulated by Lazarus and Folkman (1984). Conversely, the failure to receive appropriate institutional support can result in lowering nurses' professional competence levels causing a significant problem for the profession in that a reduction in professional competence has significant implications for patient care. Nurses who have been victims of aggression may become cynical about nursing, complaining about lack of collegial support from within the profession. They are reluctant to establish and maintain contact with aggressive patients and staff and thereby compromise the quality of care delivered to patients regardless of whether they are perpetrators or not.

Qualitative data demonstrated that nurses experience a range of negative emotions dominated by anger and fear resulting from lack of institutional social support. Whatever the cause of aggression, emotion focused ways of coping are predominantly negative and maladaptive. Importantly, they have the potential to impact negatively on the performance of professional nurses.

It is clear that nurses perceive work-related aggression as a threat and react accordingly. In very few instances was aggression perceived as a challenge. When

support was provided, nurses confirm that they are more competent in performing their role and functions. If, however, they did not receive support, they complain about the inadequacies and insensitivities of the organisation and its senior personnel. It is surmised that the results of this study demonstrate the importance of nurses' receiving professional and personal support. It is therefore important that nurses are not merely coping with work-related aggression but also recovering their professional competence. Nurses who have experienced work-related aggression should be provided with the opportunity to appraise these events to enable subsequent adjustment through the manageability, comprehensibility, and meaning of the aggressive incident. Cognitive restructuring that finds meaning in reactions to aggression, such as increased self-knowledge or a revision of priorities, is associated with positive adjustment and recovery (Lyons, 1991).

Another serious consequence of work-related aggression is the introduction of novice nurses into this work culture with an implied expectation that the strong will survive and the resultant devastation to the confidence and competence of new nurses when they experience their first episodes of patient and staff aggression.

12.3 Recommendations

It is unlikely that work-related aggression can be completely eliminated from the experiences of registered nurses. It is imperative, therefore, that both individual nurses and the nursing profession as a whole become more aware of this issue and its relevance for themselves, their colleagues and the profession. The conclusions of the present study lead to a range of recommendations for the nursing field to pursue this end.

The conclusions also lead to a number of implications for further research in this area, both in nurses' own experience and in how work-related aggression impacts upon other health professionals and upon patients.

12.3.1 Implications for education

The problem of work-related aggression must be tackled at several levels in education and ongoing professional development programs. While most of these programs suggested below would be directed toward nurses, there is clearly a need to focus on other perpetrators as well, namely patients and medical staff.

Building professional confidence

Opportunities should be made available through undergraduate programs to better prepare nurses for work-related aggression and its aftermath. Strategies should be designed to facilitate understanding the relationship between work-related aggression and stress reactions and to assist individual nurses to develop strategies of recovery and adjustment. Teaching nurses and assisting them to develop and appreciate a strong sense of team identity, perception of a job well done, and heightened appreciation of life and peers would contribute to reducing the impact of aggression.

Reducing frustration

One important aspect for education is assisting nurses to manage anger and frustration. There is an abundance of external obstacles found in hospitals that contribute toward frustration in patients and staff. Some obstacles may be perceived by patients as blocking the way to optimum health. These include rigid rules about doctor's rounds, unfamiliar and inappropriate meal times, restricted access to bathrooms and toilets, restricted access to bedpans and urinals, lack of privacy, lack of information or confusing information, infringement of intimate personal space and

curtailment of freedom because of physical attachment to technology such as intravenous cannula and infusion pumps.

It would be helpful for hospitals to review policies and procedures which could contribute to increasing frustration levels. This would include reviewing and improving communicating with patients, gaining consent prior to initiating procedures on patients, improving privacy, and introducing flexible meal, hygiene and sleep arrangements.

Personal characteristics of both staff and patients may also lead to frustration resulting in aggression. These may include lack of confidence, loss of status, personal shyness, poor body image, poor impulse control, physical deformity and low tolerance to discomfort and pain. Once again these issues should be featured in education programs for all health professionals, together with information concerning strategies for managing personal difficulties.

Educating patients

There is an obvious need to fully inform and educate patients about problems associated with delivering modern health services within restricted funding arrangements. Patients may have an opportunity to revise their expectations of a health service with increasing difficulties in responding to patient needs. Information booklets, pamphlets and preadmission education would all contribute to preparing patients for their stay in hospital, thereby reducing frustration levels of patients.

Teaching anger management

Unfortunately, a major consequence of work-related aggression for the nurse is inappropriate management of anger. Nurses are unprepared, both professionally and emotionally for aggression emanating from their patients, colleagues or doctors. While they generally recognise that aggression may occur, nurses believe that it will

not happen to them. An increasing awareness of their emotions and the opportunity to practice dealing with aggression and anger can ensure that nurses are more confident in dealing with aggression.

Tertiary education

Nursing curricula in tertiary education programs must systematically include content that prepares nurses to manage both aggressive behaviour and their own negative responses to aggressive behaviour. This may prove to be difficult. A survey of Canadian schools of nursing (Ross, Hoff & Coutu-Wakulczyk, 1998) found that although there was a sensitivity to the importance of including content of aggression in nursing, the approach to this content was largely incidental and heavily dependent on individual academics' interests.

A recent survey of 100 nurse educators by Woodti and Breslin (1997) found overwhelming agreement that nursing curricula do not adequately address aggression and that faculty are not prepared to teach aggression assessment and abuse reporting, despite agreement that it is a high-priority issue. There was no explanation for this omission to curricula. The introduction of relevant content in curricula may therefore present some difficulty.

In-service education

In-service and continuing education programs for registered nurses should also be implemented and evaluated. Staff development programs, using such strategies as role play, videotape playbacks, debriefing sessions and case management, would assist all clinical staff to become aware of how they can contribute to the overall coping strategies used by victims. As the incidence of aggression and its associated risks to professional competence have been demonstrated, there is a need to prepare students to deal both with aggression and with its aftermath.

Nurses must be educated through in-service or continuing education programs that admission to negative emotions is acceptable. Striving for an image of objective, controlled professional detachment is both unrealistic and potentially damaging. Nurses must also learn to deal effectively with patients' feelings of anger or frustration and develop coping strategies that assist with managing patient aggression. Courses on self-awareness, assessment, and diagnosis of aggressive or potentially aggressive patients and staff should be implemented.

Raising awareness

Perhaps the most important implication emanating from this investigation is that the profession as a whole should become aware of the extent of the problem and the role that nurse colleagues, nurse managers and medical staff play in its genesis. There is little doubt that many of the staff who have been implicated in this study as aggressors have little or no understanding of the effect of their behaviour on others. It is abundantly clear that nurse managers who themselves may well have been victims, are unaware of how to manage nurses who are recipients of work-related aggression. Education programs for nurse managers must include components addressing these issues.

Improving the culture

To address these matters there is an overriding need for improvement in a nursing culture that simultaneously fosters aggression amongst its members and blames its members for its causes and perpetuation. A cultural change is essential if nurses are going to have confidence in reporting aggressive incidents. To assist with this cultural change, there is a need to provide education content in both nursing curricula and throughout the broader health field that addresses medical and health politics, power relationships, assertiveness training and oppressed group behaviour.

12.3.2 Implications for management

Nursing administrators must make themselves more available to staff who have been victims of work related aggression. In was clear from the results in this study that nurse victims of work related aggression continued to experience negative emotions toward senior staff even though the aggressive incident occurred up to twelve months prior to the interview.

The current research demonstrated that nurses frequently experienced work-related aggression from patients, colleagues and doctors and frequently failed to report such incidents. There are some important implications for hospital managers, some of which are drawn out below. To implement the strategies suggested, changes in infrastructure and/or personnel may be required. For example, security or occupational health and safety staff may need to be appointed, professional educational programs may have to be established, policies regarding reporting and responding to aggressive incidents may need to be instituted or upgraded.

Primary prevention of aggression

Preventing, or at least reducing workplace aggression would appear to be a first priority for nursing administrators. Before this can be achieved there is a need by the profession to acknowledge and claim ownership of the psychological and professional injury experience by its members resulting from work-related aggression. Therefore a professional nursing culture that acknowledges its own contribution to the problem can contribute to individual and professional recovery.

It is uncertain whether senior nurse administrators are aware of the extent of the problem of workplace aggression and more importantly, aware of their own role in its perpetuation. Nursing administrators must become more aware of the personal needs of the victim as well as the needs of the organisation or the profession. They

should specifically consider the relationship between strategies utilised by managers for assisting new nurses to come to terms with aggressive behaviour from a variety of sources. Health agencies could be advised to consider displaying written warnings to potential aggressors in strategic locations in their buildings. These warnings may prohibit aggression toward staff and notify potential aggressors that abusive behaviours may result in prosecutions.

Secondary prevention of aggression

When work-related aggression does occur, all physical, verbal and sexual incidents should be reported and documented. A central register should be maintained in order to identify trends of work-related aggression. Spratlen (1997) suggested that an ombudsman can play a significant role in the continuing problem of aggression in the workplace. The role of the ombudsman would be as an independent objective person who would have the confidence of nurses and thereby facilitate the processing of complaints about workplace aggression.

Reporting of nurse and doctor initiated aggression should be encouraged regardless of whether or not physical injuries are sustained. It is suggested that support from senior personnel within the institution can significantly reduce the impact of aggression on nurses' perceived professional competence. Nurse administrators, educators, and clinical nurses must recognise the need to provide institutional support through formal and informal support groups. Further, there is a need to establish formal and informal debriefing sessions for nurses who have been assaulted. Brayley, Lange, Baggoley, Bond and Harvey (1994) suggested the establishment of a violence management team to manage patients who exhibit aggressive behaviour in the general hospital. These authors. proposed that an important consideration is the need to treat aggressive behaviour in patients as a

medical problem rather than a security problem. This proposal is at odds with the recommendations of other researchers who advocate the implementation of tighter security and legal measures into aggression management in psychiatric facilities (Mason & Chandley, 1995). These two recommendations are approaching the problem of work-related aggression from different perspectives and it may well be that a combination of these approaches would be optimally effective.

Tertiary prevention of aggression

State and territory occupational health and safety legislation is required to include protection of employees against acts of aggression in their workplace. From a legal perspective, hospitals and other health agencies may have to adopt policies that more vigorously assist nurses to pursue perpetrators of aggression through the legal system. This would significantly increase the visibility of the problem and provide encouragement to other nurse victims. Pursuing legal options may prove to have both symbolic value in sending out the message that aggression toward nursing staff is unacceptable and instrumental value by offering legal recourse as remediation for being assaulted.

Thus, comprehensive response strategies must include education and policy development, risk assessment, training needs analysis, training, as well as the capacity for a quick response during crisis situations, together with ongoing support for staff survivors of violence.

Providing support

Results from this investigation have heightened the importance of training nurses and nurse managers to provide social support to those nurses who have been victims of aggression. Nurse managers should receive comprehensive and carefully focused training in how to support the role of registered nurses, for example, by

encouraging and promoting professional autonomy, decision making and control over practice.

12.3.3 Implications for further research

The importance of ongoing research into work-related aggression has been highlighted by the emotional and professional costs borne by individual nurses, the hidden financial costs borne by the institution and the indirect costs borne by many thousands of patients who are subjected to a standard of nursing care inferior to that to which they are rightly entitled.

12.3.3.1 Methodological issues

The current research has highlighted a number of areas for future research. As has been mentioned, conducting research into work-related aggression presents researchers with several research design and methodological problems. These include those associated with random assignment of groups, manipulation of key variables, elimination of extraneous variables and having a control group. In order to investigate the issues highlighted here, it is necessary to overcome the methodological difficulties experienced when using experimental research designs. Until such methodological difficulties are addressed, the impact of specific work situations on nurses will not be adequately detailed, and the precise role of cognitive appraisal and social support in buffering the effects of work-related aggression will remain unknown. Some if not all of these problems could be eliminated by the use of creative research designs. It is evident that researchers investigating work-related aggression should include comparison groups and measurements of professional functioning into their designs.

Work-related aggression presents considerable methodological problems for researchers. A central difficulty is that of definition as no clear consensus exists to what constitutes workplace aggression. A definition is needed to standardise research

and establish an appropriate baseline upon which intervention policies and procedures can be created. It is also evident that researchers investigating work-related aggression should include operational definitions of aggression based upon nurses' experiences of aggression. More specifically, there is a need to further examine the nature of work-related aggression and the ways in which nurses' cope with it. This would require the utilisation of a reliable and valid research instrument that was subjected to the rigour associated with the development of the questionnaire used in the current study.

12.3.3.2 Issues for further investigation

The current research has highlighted the differential psychological and professional responses of nurses to work-related aggression. The ways in which nurses respond through cognitive appraisal and coping strategies, particularly social support, at least in part, influenced by age and level of experience. There was some differential responses of nurses to perceived professional competence to different sources of aggression. For example, whilst all types of work-related aggression were negatively associated with all components of professional competence, nurse initiated aggression was not significantly associated with nurse-patient competence. furthermore patient initiated aggression was not significantly associated with competence with colleagues. These differences should be further explored within the framework of cognitive appraisal to determine the relative strength of factors associated with work-related aggression as predictors of professional functioning of registered nurses. In order to provide appropriate and effective intervention strategies for nurses, particular work situations and/or specialist areas need to be investigated empirically to establish if these factors influence cognitive appraisal and coping strategies.

Given that nurses already are engaged in stressful work environments what, if any, additional stress does work-related aggression impose upon them? Given that those individuals with high stress levels are more susceptible to disease with a physiological basis, such as cardiovascular disease (Adler & Mathews, 1994), it is also important to explore the role cognitive appraisal plays in the initiation of psychophysiological arousal in nurses.

Likewise, institutional social support as a planned intervention could become a major focus of further empirical studies. There is a clear need for researchers to conduct empirical investigations into the moderating effect of social support on psychological and physiological responses of registered nurses. For example, it is important to understand the impact that work-related aggression has on nurses' levels of job-satisfaction, staff morale and self-esteem. Clearly, there is also a need to extend research into other groups of health professions.

The role of cognitive appraisal in work-related aggression should also be the focus of future research. Whereas the role of cognitive appraisal has been considered in many studies in the general stress literature, it has been totally neglected in the area of work-related aggression. The current study employed cognitive appraisal exclusively to focus on professional responses to work-related aggression. Future researchers should use the psychophysiological correlates of cognitive appraisal to focus on the impact of work-related aggression on the mental and/or physical wellbeing of nurses. There is also the potential for future researchers to utilise model testing research designs to further explore the complex relationships between variables that may be hypothesised as moderating/mediating variables and important areas of functioning for registered nurses.

Research investigating the causes and consequences of work-related aggression would assist health organisations in promoting and maintaining a healthy, productive work environment. It would also aid professional nursing organisations to develop strategies to counteract the existing damaging nursing culture. Perhaps most importantly, such research would benefit individual nurses who could work in an environment in which they were safe and free from the damaging effects of aggression and contribute to their providing optimal patient care.

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APPENDIX A

PILOT QUESTIONNAIRE AND INTRODUCTORY LETTER TO CONVENIENCE SAMPLE OF NURSES

interested in how registered nurses have perceived the value of either reporting or not reporting the incident. I am also interested in the support received from colleagues in the work setting.

I would be grateful if you would spend about 30 minutes of your time to complete the attached draft questionnaire which I am developing for the purpose of conducting a study on registered nurses in Victoria. The fully developed questionnaire will be distributed early next year. If you do decide to complete this questionnaire I am specifically interested in what you think about the questions. For example, are the instructions and questions clear? Are the questions relevant? I am also interested about the length of time it takes you to complete the draft questionnaire. In order to assist with the development of the questionnaire I have attached a two page checklist which I would like you to complete.

Thank you for your assistance with my research.

If you choose to participate, please return the completed questionnaire and checklist to me by the end of next week.

Cecil Deans

What is your age?

.....

Please tick the appropriate boxes.

What is your gender?

Male ☐
Female ☐

How would you classify your place of employment?

Urban ☐
Rural ☐

What is your current level of nursing appointment?

1	☐ 4a	☐
2	☐ 4b	☐
Clinical specialist	☐ 5	☐
3a	☐ 6	☐
3b	☐ 7	☐

If not currently employed as a nurse please tick the box. ☐

Other nursing position (please specify) .....

How many years of experience as a registered nurse have you had? .....

How long have you held your current position? .....

What nursing qualifications do you hold?

RN ☐
RPN ☐
RM ☐
SEN ☐
OTHER ☐

Please specify .....

What tertiary qualifications do you have?

Diploma ☐
Bachelor ☐
Grad.Dip. ☐
Masters ☐
PhD ☐
None ☐

PLEASE CONTINUE TO THE FOLLOWING SECTIONS:

Section 1 - Aggressive behaviour from any doctor
Section 2 - Aggressive behaviour from any nursing colleague
Section 3 - Aggressive behaviour from any patient or relative of a patient
Section 4 - Reporting incidents of aggressive behaviour
Section 5 - Supporting behaviours following aggressive behaviour
Section 6 - Perceived changes to professional competence

SECTION 1 : AGGRESSIVE BEHAVIOUR FROM ANY DOCTOR

During your career as a Registered Nurse, has any **doctor** (could be the same or different doctor/s) ever acted toward you in any of the following ways:

Please tick	**Never**	**Sometimes**	**Often**	**Frequently**
Verbally threatened you	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]
Called you derogatory names	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]
Made sexually suggestive comments	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]
Threw an object at you	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]

SECTION 2: AGGRESSIVE BEHAVIOUR FROM ANY NURSING COLLEAGUE

During your career as a Registered Nurse, has any **colleague/s** (could be the same or different colleague/s) ever acted toward you in any of the following ways:

Please tick	Never	Sometimes	Often	Frequently
Verbally threatened you	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]
Called you derogatory names	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]
Made sexually suggestive comments	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]
Threw an object at you	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]

SECTION 3 : AGGRESSIVE BEHAVIOUR FROM ANY PATIENT OR THEIR RELATIVE

During your career as a Registered Nurse, has any **patient** or **their relative** (could be the same or different patient and their relative) ever acted toward you in any of the following ways:

Please tick	Never	Sometimes	Often	Frequently
Verbally threatened you	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]
Called you derogatory names	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]
Made sexually suggestive comments	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]
Threw an object at you	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]

SECTION 4 : REPORTING INCIDENTS OF AGGRESSIVE BEHAVIOUR

Formally = Official written report of incident and expectation of follow up action.
Informally = Discussion of incident and no expectation of follow up action.

	Please tick	
QUESTION 1		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **doctor**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 2		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **doctor**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 3		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **colleague**?	**Yes** [ ]	**No** [ ]
Did your **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 4		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **colleague**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 5		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **patient or relative of a patient**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 6		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **patient or relative of a patient**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]

SECTION 5: SUPPORTING BEHAVIOURS FOLLOWING AGGRESSIVE BEHAVIOUR

Please tick appropriate boxes.	Not at all	Slightly	Moderately	Very
Following aggressive behaviour how accessible were the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how much did the following people make you feel they cared about you?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how actively supportive were the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how much interest in your own wellbeing did you receive from the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
How confident are you now in reporting aggressive behaviour to the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
How confident are you in the future of reporting aggressive behaviour to the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]

SECTION 6: PERCEIVED CHANGES TO PROFESSIONAL COMPETENCE

To what degree has your experience of work-related aggressive behaviour impacted upon:	Please tick		
	Not at all	Negatively	Positivel
1 Your professional relationships with patients?	[ ]	[ ]	[ ]
2 The amount of time you spend with patients?	[ ]	[ ]	[ ]
3 Your ability to respect patients?	[ ]	[ ]	[ ]
4 Your ability to trust patients?	[ ]	[ ]	[ ]
5 Your interpersonal relationships with patients?	[ ]	[ ]	[ ]
6 Your confidence in working as a team member?	[ ]	[ ]	[ ]
7 Your professional relationships with colleagues?	[ ]	[ ]	[ ]
8 Your ability to trust professional colleagues?	[ ]	[ ]	[ ]
9 Your interpersonal relationships with colleagues?	[ ]	[ ]	[ ]
10 Your ability to respect professional colleagues ?	[ ]	[ ]	[ ]
11 How you perceive your role as a professional nurse?	[ ]	[ ]	[ ]
12 Your feeling of being in control of your work environment?	[ ]	[ ]	[ ]
13 Your professional autonomy?	[ ]	[ ]	[ ]
14 Your satisfaction with work?	[ ]	[ ]	[ ]
15 How you perceive yourself as a competent nurse?	[ ]	[ ]	[ ]
16 Your ability to make good clinical decisions at work?	[ ]	[ ]	[ ]
17 How you perceive your level of clinical skill as a nurse?	[ ]	[ ]	[ ]
18 The standard of nursing care you practice?	[ ]	[ ]	[ ]
19 How you compare yourself with other nurse colleagues?	[ ]	[ ]	[ ]
20 Your decision to remain in nursing as a career?	[ ]	[ ]	[ ]

APPENDIX B

INSTRUCTIONS FOR COMPLETING CONTENT VALIDITY INDEX FOR PILOT STUDY

Sections 1, 2 and 3: Aggressive behaviours from doctor, nurse, patients

Instructions: Thank you for filling in the draft questionnaire. Would you now complete the following checklist by putting either 1 and/or 2 and/or 3 under the heading of retain, retain/amend, discard for each question. Retain means that you understood the question and that it is relevant for the area of work-related aggression. Retain/amend means that the question is relevant but requires some further clarification. Discard means that the either the question is unclear and/or that it was irrelevant to the study.

For Example

	doctor (1)	nurse (2)	patient (3)	retain	retain/amend	discard
Verbally threatened you				3	1	2

This would mean that you had decided to omit this question nurse initiated aggression, retained it for patient initiated aggression and wanted it retained but amended for doctor initiated aggression.

	doctor (1)	nurse (2)	patient (3)	retain	retain/amend	discard
Verbally threatened you						
Verbally insulted you						
Yelled at you						
Called you derogatory names						
Sexually threatened you						
Sexually insulted you						
Sexually touched you						
Made sexually suggestive comments						
Physically threatened you						
Slapped or struck you						
Threw an object at you						
Hit you with an object						

Section 5: Supporting behaviours following aggressive behaviour

	manager (1)	colleagues (2)	doctors (3)	retain	retain/ amend	discard
Accessible						
Cared						
Supportive						
Interested						
Confident now						
Confident future						

Section 6: Perceived changes to professional competence

Perceived changes to professional competence	retain	retain/ amend	discard
Your professional relationships with patients			
The amount of time spent with patients			
Your ability to respect patients			
Your ability to trust patients			
Your interpersonal relationships with patients?			
Your confidence in working as a team member			
Your professional relationships with colleagues			
Your ability to trust professional colleagues?			
Your interpersonal relationships with colleagues?			
Your ability to respect professional colleagues			
How you perceive your role as professional nurse			
Your feeling of being in control of your work environment			
Your professional autonomy			
How you perceive yourself as a competent nurse			
Your ability to make good clinical decisions at work			
How you perceive your level of clinical skill as a nurse			
The standard of nursing care you practice			
Your satisfaction with work?			
How you compare yourself with other nurse colleagues?			
Your decision to remain in nursing as a career			

How long did it take you to complete the questionnaire?

- ☐ 11-20 minutes
- ☐ 21-30 minutes
- ☐ 31-40 minutes
- ☐ 41-50 minutes
- ☐ 51-60 minutes

Did the opening page adequately introduce the study?

- ☐ Unclear
- ☐ Clear
- ☐ Very clear

Is the questionnaire too long?

- ☐ Yes
- ☐ No

Would you please add any other comments that would improve the questionnaire?

Thank you for your assistance

Cecil Deans

APPENDIX C

WORK-RELATED AGGRESSION

FINAL QUESTIONNAIRE

What is your age?

.....

Please tick the appropriate boxes.

What is your gender?

Male ☐
Female ☐

How would you classify your place of employment?

Urban ☐
Rural ☐

What is your current level of nursing appointment?

1	☐	4a	☐
2	☐	4b	☐
Clinical specialist	☐	5	☐
3a	☐	6	☐
3b	☐	7	☐

If not currently employed as a nurse please tick the box. ☐

Other nursing position (please specify) .....

How many years of experience as a registered nurse have you had? .....

How long have you held your current position? .....

What nursing qualifications do you hold?

RN ☐
RPN ☐
RM ☐
SEN ☐
OTHER ☐

Please specify .....

What tertiary qualifications do you have?

Diploma ☐
Bachelor ☐
Grad.Dip. ☐
Masters ☐
PhD ☐
None ☐

PLEASE CONTINUE TO THE FOLLOWING SECTIONS:

Section 1 - Aggressive behaviour from any doctor
Section 2 - Aggressive behaviour from any nursing colleague
Section 3 - Aggressive behaviour from any patient or relative of a patient
Section 4 - Reporting incidents of aggressive behaviour
Section 5 - Supporting behaviours following aggressive behaviour
Section 6 - Perceived changes to professional competence
Section 7 - Final comments

SECTION 1 : AGGRESSIVE BEHAVIOUR FROM ANY DOCTOR

During your career as a Registered Nurse, has any **doctor** (could be the same or different doctor/s) ever acted toward you in any of the following ways:

Please tick	Never	Less than once per year	About once per year	About once per month	About once week
Verbally threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]	[ ]

Briefly describe the **worst** aggressive behaviour you have experienced from a doctor:

.....

Where did it happen location)?.....

What were the circumstances? .....

How did you deal with it? .....

SECTION 2: AGGRESSIVE BEHAVIOUR FROM ANY NURSING COLLEAGUE

During your career as a Registered Nurse, has any **colleague/s** (could be the same or different colleague/s) ever acted toward you in any of the following ways:

Please tick	Never	Less than once per year	About once per year	About once per month	About once week
Verbally threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]	[ ]

Briefly describe the **worst** aggressive behaviour you have experienced from a nursing colleague:

.....

Where did it happen (location)? .....

What were the circumstances?.....

How did you deal with it? .....

SECTION 3 : AGGRESSIVE BEHAVIOUR FROM ANY PATIENT OR THEIR RELATIVE

During your career as a Registered Nurse, has any **patient** or **their relative** (could be the same or different patient and their relative) ever acted toward you in any of the following ways:

Please tick	Never	Less than once per year	About once per year	About once per month	About once week
Verbally threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Verbally insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Yelled at you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually insulted you	[ ]	[ ]	[ ]	[ ]	[ ]
Sexually touched you	[ ]	[ ]	[ ]	[ ]	[ ]
Physically threatened you	[ ]	[ ]	[ ]	[ ]	[ ]
Slapped or struck you	[ ]	[ ]	[ ]	[ ]	[ ]
Hit you with an object	[ ]	[ ]	[ ]	[ ]	[ ]

Briefly describe the **worst** aggressive behaviour you have experienced from a patient or relative of a patient:

Where did it happen (location)? .....

What were the circumstances? .....

How did you deal with it? .....

SECTION 4 : REPORTING INCIDENTS OF AGGRESSIVE BEHAVIOUR

Formally = Official written report of incident and expectation of follow up action.
Informally = Discussion of incident and no expectation of follow up action.

	Please tick	
QUESTION 1		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **doctor**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 2		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **doctor**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 3		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **colleague**?	**Yes** [ ]	**No** [ ]
Did your **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 4		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **colleague**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 5		
Did you ever **formally** report the worst incident of aggressive behaviour you have experienced from any **patient or relative of a patient**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]
QUESTION 6		
Did you ever **informally** discuss the worst incident of aggressive behaviour you have experienced from any **patient or relative of a patient**?	**Yes** [ ]	**No** [ ]
Did you **expect** to receive support ?	**Yes** [ ]	**No** [ ]
Did you **receive** support ?	**Yes** [ ]	**No** [ ]

SECTION 5: PERCEIVED SUPPORTING BEHAVIOURS FOLLOWING AGGRESSION

Please tick appropriate boxes.	Not at all	Slightly	Moderately	Very
Following aggressive behaviour how accessible were the following people perceived to be?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how much did the following people make you feel they cared about you?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how actively supportive were the following people perceived to be?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
Following aggressive behaviour, how much interest in your own wellbeing did you receive from the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
How confident are you now in reporting aggressive behaviour to the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]
How confident are you in the future of reporting aggressive behaviour to the following people?				
• Nurse Manager	[ ]	[ ]	[ ]	[ ]
• Other Nurse Colleagues	[ ]	[ ]	[ ]	[ ]
• Medical Staff	[ ]	[ ]	[ ]	[ ]

SECTION 6: PERCEIVED CHANGES TO PROFESSIONAL COMPETENCE

To what degree has your experience of the worst incident of work-related aggressive behaviour impacted upon perceptions of:	Please tick		
	Not at all	Negatively	Positiv
1 Your professional relationships with patients?	[ ]	[ ]	[ ]
2 The amount of time you spend with patients?	[ ]	[ ]	[ ]
3 Your ability to respect patients?	[ ]	[ ]	[ ]
4 Your ability to trust patients?	[ ]	[ ]	[ ]
5 Your confidence in working as a team member?	[ ]	[ ]	[ ]
6 Your professional relationships with colleagues?	[ ]	[ ]	[ ]
7 Your ability to trust professional colleagues?	[ ]	[ ]	[ ]
8 Your ability to respect professional colleagues ?	[ ]	[ ]	[ ]
9 How you perceive your role as a professional nurse?	[ ]	[ ]	[ ]
10 Your feeling of being in control of your work environment?	[ ]	[ ]	[ ]
11 Your professional autonomy?	[ ]	[ ]	[ ]
12 How you perceive yourself as a competent nurse?	[ ]	[ ]	[ ]
13 Your ability to make good clinical decisions at work?	[ ]	[ ]	[ ]
14 How you perceive your level of clinical skill as a nurse?	[ ]	[ ]	[ ]
15 The standard of nursing care you practice?	[ ]	[ ]	[ ]
16 Your decision to remain in nursing as a career?	[ ]	[ ]	[ ]

SECTION 7: FINAL COMMENTS

What was the one most significant factor that prevented you from coping effectively with aggressive behaviour?

.....

What has been the one factor that has most helped you to cope effectively with aggressive behaviour?

.....

IF YOU WISH YOUR PARTICIPATION IN THIS STUDY TO END HERE, SIMPLY PLACE THE COMPLETED QUESTIONNAIRE IN THE PRE-PAID REPLY ENVELOPE AND POST IT.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Cecil Deans Tel. 053 279666.

PTO

IF YOU AGREE TO DISCUSS THE POSSIBILITY OF BEING INTERVIEWED ABOUT YOUR EXPERIENCES OF AGGRESSIVE BEHAVIOUR IN MORE DEPTH, AND WOULD PREFER THAT I CONTACT YOU, PLEASE PROVIDE YOUR NAME, ADDRESS AND TELEPHONE NUMBER BELOW. I WILL CONTACT YOU WITHIN THE NEXT TWO MONTHS. IF YOU DECIDE TO HAVE A FOLLOW UP INTERVIEW PLEASE BE ASSURED THAT THE NATURE OF THE INTERVIEW WOULD BE FULLY EXPLAINED TO YOU AND YOUR WRITTEN CONSENT SOUGHT BEFORE COMMENCING THE INTERVIEW. YOU CAN CHOOSE TO WITHDRAW FROM THE STUDY AT ANY TIME IN THE FUTURE. PLEASE BE ASSURED THAT IF YOU SUPPLY YOUR NAME AND ADDRESS, I AM THE ONLY PERSON TO HAVE ACCESS TO THIS INFORMATION.

NAME.....

ADDRESS.....

.....

TELEPHONE (_____)_____

THANK YOU FOR AGREEING TO DISCUSS THE POSSIBILITY OF A FURTHER INTERVIEW.

Cecil Deans Tel. 053 279666.
survey/cd

APPENDIX D

LETTER OF INTRODUCTION TO THE STUDY

Dear Colleague,

Please let me introduce myself. I am a registered nurse and currently I am undertaking a PhD at Victoria University of Technology. I have twenty years experience in nurse education, and I also have many years of clinical experience as a general and psychiatric nurse both in Australia and the United Kingdom. I continue to practice as a nurse in a variety of psychiatric facilities, and I am involved as Chairperson of the Sexual Assault Centre in Ballarat.

Having conducted an initial study in the area of aggressive behaviour towards nurses as part of my Master of Nursing Studies degree, I am interested in discovering registered nurses' experiences regarding work-related aggression. You have been selected in a sample drawn from all nurses registered in 1993 with the Victorian Nursing Council.

While working as a Registered Nurse you may have come into contact with some people, including patients and their relatives, nursing colleagues and medical staff, whom you have perceived as being either physically, verbally or sexually aggressive toward you. I am gathering information regarding the impact of this aggressive behaviour upon nurses and how they have dealt with it, I am particularly interested in how registered nurses have perceived the value of either reporting or not reporting the incident. I am also interested in the support received from colleagues in the work setting.

I would be grateful if you could spend about 20 minutes of your time to complete the attached questionnaire. If you do decide to complete this questionnaire it is possible you may experience some psychological discomfort or mild distress as you reflect upon your experiences of aggressive behaviour. Please give this your full consideration before making your decision. I know your time is valuable but I believe the results of this study will raise nurses' awareness and assist the nursing profession to develop policies that will contribute to dealing with this problem.

If you choose to participate, please return the completed questionnaire in the reply paid envelope as soon as you can.

As a follow up to this questionnaire, it is extremely important that some nurses who have been recipients of aggressive behaviour are interviewed to discuss in more depth the professional, physical, psychological, social and emotional impact such incidents have upon them. Would you be prepared to discuss the possibility of a follow-up interview with me to further explore the impact of work-related aggression on nurses? Complete anonymity is assured unless you decide to provide your name at the completion of the questionnaire.

If you agree to discuss the possibility of such an interview with me please provide your name, address and telephone number in the section on the last page of the questionnaire so that I can contact you. I have enclosed a pre-paid return envelope. Please be assured that the only person to have access to this information is the researcher.

If you would like to discuss any aspect of my study or this questionnaire with me, please feel free to contact me on **(053) 27 9666 (WORK NUMBER)**.

Thank you for any assistance you may give me with this study.

Yours faithfully

Cecil Deans
Faculty of Arts
Victoria University

APPENDIX E

LETTER TO ETHICS COMMITTEE AND INTERVIEW SCHEDULE

Mr. Cecil Deans
120 Rathkeale Avenue
Mt Helen
Ballarat
Victoria 3350
Tel. (053) 279743

To: Dr. Beverly Blaskett
Office for Research
Attention of: Human Ethics Research Committee
Victoria University
6 Geelong Road
Melbourne

From: Cecil Deans, PhD student, Department of Psychology
(ID 9335778)

Re: Ethical Approval to conduct interviews

In May, 1994, I was granted ethical approval to conduct a study on 'Nurses' responses to work-related aggression'. **(HRETH 34/94)** The proposal provided to the Human Ethics Research Committee outlined that the study is to be conducted in two stages. Stage one was a survey with a mailed out questionnaire (approved by the Human Ethics Research Committee) to 1,000 nurses. Stage one has now been conducted. Quantitative data has been collected and analysed.

Stage two will involve conducting semi-structured interviews of a selected group of consenting participants. The purpose of the interviews is to collect qualitative data on their subjective experience of aggressive behaviour.
Dr. S. Dean from the Department of Psychology is my principal supervisor. She is currently on leave and Ann Graham who is my associate supervisor having discussed my progress agrees that I should begin stage two of the project. I therefore submit an Interview Schedule for approval by the Human Ethics Research Committee.

Thank you for giving this your consideration.

Cecil Deans

(A) In the questionnaire you stated that you had experienced (verbally, physically, sexually) behaviour:

Would you like to tell me more about the circumstances in which the (verbally, physically, sexually) behaviour occurred?

Would you like to tell me about your immediate (physical, emotional) responses?

In the questionnaire you indicated that you (Reported the incident, Did not report the incident):

What factors influenced your decision to : Report the incident, Did not report the incident.

Do you regret your decision to :Report the incident, not report the incident).

In the questionnaire you indicated that you expected/ did not expect to receive support if you reported the incident/ did not report the incident. Would you like to elaborate on your answer?

How did you feel about the level of support offered and/or received from your colleagues, managers, and family?

What do you consider was the most difficult aspect of this whole experience?

Do you think your experience of the incident itself impacted upon you in any way as a nurse performing your role as a registered nurse?

How did the incident impact upon you in performing your role as a registered nurse?

Do you think your experience of reporting/not reporting the incident impacted upon you in any way as a nurse performing your role as a registered nurse?

How did reporting/not reporting the incident impact upon you in performing your role as a registered nurse?

(B) In the questionnaire you stated that you had experienced aggressive behaviour from a (doctor, nurse, patient).

Would you like to tell me more about the relationship between you and the perpetrator?

Do you think that aggressive behaviour from one source has more serious consequences than others sources? If yes, please elaborate

Where your responses to aggressive behaviour influence by the status of the perpetrator ?

Looking back at the incident, why do you think you responded in the way you did?

Do you think you would respond differently if a similar incident occurred?

What circumstances, if any, have changed (within yourself, within the work environment) that would explain your different responses?

In the questionnaire you indicated that you (Reported the incident, Did not report the incident):

What factors influenced your decision to : Report the incident, not report the incident.

Do you regret your decision to :Report the incident, not report the incident).

In the questionnaire you indicated that you expected/ did not expect to receive support if you reported the incident/ did not report the incident. Would you like to elaborate on your answer?

How did you feel about the level of support offered and/or received from your colleagues, managers, and family?

What do you consider was the most difficult aspect of this whole experience?

Do you think your experience of the incident itself impacted upon you in any way as a nurse performing your role as a registered nurse?

How did the incident impact upon you in performing your role as a registered nurse?

Do you think your experience of reporting/not reporting the incident impacted upon you in any way as a nurse performing your role as a registered nurse?

How did reporting/not reporting the incident impact upon you in performing your role as a registered nurse?

(C) General Questions

In the questionnaire you stated that the one most significant factor that prevented you from coping effectively with aggressive behaviour was.....
.....

Would you please elaborate on this response?

In the questionnaire you stated that the one factor that has most helped you to cope effectively with aggressive behaviour
was.....
.....

Would you please elaborate on this response?

What changes, if any would you make to ensure that incidents of aggressive behaviour are managed differently:

By you as an individual?

By nursing as a profession?

By hospital administrators?

By professional organisations?

Thank you for your time.

APPENDIX F

CONSENT FOR INTERVIEW SCHEDULE FOR PROJECT ENTITLED: 'NURSES' RESPONSES TO WORK-RELATED AGGRESSION'.

Thank you for agreeing to be interviewed on audio tape by me, Cecil Deans, PhD student at Victoria University of Technology. The purpose of this interview is to follow up on some of the answers provided by you in the questionnaire you completed on your experiences of aggressive behaviour in the workplace. I will be asking questions directly related to your experience as a nurse of aggressive behaviour in your workplace. Before I begin I will need to get your written consent that you have had the purpose of the interview fully explained to you and that you have had the opportunity to ask questions about the study. I have also informed you that any information provided by you that may identify you would not be disclosed to any other person. You also understand that although the interview is for approximately one hour, you may terminate the interview at any time without any explanation provided by you. If you have any queries or concerns about the nature of this interview you can contact Dr. S. Dean, Faculty of Arts, Victoria University of Technology by telephone on **0393652397**.

I (Print) ....., have been fully informed of the purpose of this interview and consent to be interviewed by Cecil Deans on the topic of 'Nurses responses to work related aggression.' I fully understand that some questions on physical, sexual or verbal aggression may cause me some discomfort and that counselling, if required is available through the department of Psychology, Victoria University of Technology. I know that I can terminate the interview at any time without providing any explanation to Cecil Deans.

Name (Signature).....

Date.....

Name of interviewee.....

Thank you for agreeing to be interviewed.

APPENDIX G

PARTICIPANT CONTACT SUMMARY FORM

Contact type:

Interview

Phone

Site: medical ward

Date: 12/7/95

1 What were the main issues or themes that struck you in this contact?

The duration of anger. Incident occurred while on night duty 2 years ago but still very angry with supervisor. Lack of encouragement to report incident. Reluctance to talk about incident with husband. Felt like giving nursing away.

2 Summarise the information you got (or failed to get) on each of the target questions you had for this contact.

Question	Information
What people, events, or situations were Involved?	Unit manager and medical staff.
How did your feelings affect your ability to function	Resented coming to work for some time.

3 Anything else that struck you as salient, interesting, illuminating or important in this contact?

The impression that other nurses in the ward had similar experiences but were reluctant to talk about it. Wanted to leave nursing because of indifference shown by supervisor. The lack of security staff during night duty roster.

4 What new (or remaining) target questions do you have in considering the next contact?

Are the experiences of aggression different from day to night duty? How are security men used? Who employs them? Why are nurses reluctant to tell their partners?

Main issue: Fear for own personal welfare, now and in the future.
Suffering in private.
Intense emotional anger

APPENDIX H

TABLES SHOWING SUPPORTING BEHAVIOURS FROM KEY STAFF

Supporting behaviours from doctors following aggressive behaviours

	Accessible	Caring	Support	Interested	Confident now	Confident future
Not at all	108 (32.2%)	123 (37.2%)	139 (41.9%)	147 (44.8%)	78 (22.9%)	69 (20.2)
Slightly	103 (30.7%)	112 (33.8%)	99 (29.8%)	102 (31.1%)	85 (24.9%)	95 (27.8%)
Moderately	79 (23.6%)	60 (18.1%)	65 (19.6%)	50 (15.2%)	73 (21.4%)	70 (20.5%)
very	45 (13.4%)	36 (10.9%)	29 (8.7%)	29 (8.8%)	105 (30.8%)	108 (31.6%)

Supporting behaviours from managers following aggressive behaviours

	Accessible	Caring	Support	Interested	Confident now	Confident future
Not at all	40 (11.7%)	52 (15.2%)	58 (17.1%)	70 (20.7%)	35 (10.2%)	26 (7.6%)
Slightly	65 (19.0%)	71 (20.8%)	80 (23.5%)	72 (21.3%)	46 (13.4%)	47 (13.7%)
Moderately	90 (26.2%)	91 (26.6%)	81 (23.8%)	91 (26.9%)	79 (23.0%)	92 (26.9%)
very	148 (43.1%)	128 (37.8%)	121 (35.6%)	105 (31.1%)	183 (53.4%)	177 (51.8%)

Supporting behaviours from nurse colleagues following aggressive behaviours

	Accessible	Caring	Support	Interested	Confident now	Confident future
Not at all	3 (.9%)	7 (2.0%)	19 (5.5%)	24 (7.0%)	11 (3.2%)	9 (2.6%)
Slightly	30 (8.5%)	36 (10.2%)	44 (12.6%)	45 (13.0%)	27 (7.8%)	27 (7.8%)
Moderately	89 (25.5%)	100 (28.3%)	105 (30.2%)	112 (32.5%)	93 (26.8%)	101 (29.3%)
very	229 (65.2%)	210 (59.5%)	180 (51.7%)	164 (47.5%)	216 (62.2%)	208 (60.3%)