Psychological recovery in the aftermath of patient violence: The case of psychiatric workers

Josianne Lamothe, MSW, PhD(c), Richard Boyer, PhD & Stéphane Guay, PhD
Université de Montréal – Centre de recherche de l'Institut Universitaire en Santé Mentale de Montréal

Introduction: According to a meta-analysis of 35 studies, one in five patients admitted to an inpatient acute psychiatric ward will become physically violent either towards staff or another patient during their stay (1). Unsurprisingly, this statistic places psychiatric workers at greater risk for all types of violence (e.g., psychological and physical violence) than their colleagues in other specialties (2). In a review of the impact of workplace violence on healthcare professionals, previous authors have found that a range of 5–32% of workers affected by workplace violence met all of the criteria for PTSD (3). Patient violence has also been linked to intentions to leave (3), worker reassignment, duty changes (4), and increased sick leaves (5). Because of the nature of the work, the risk of patient violence in psychiatric settings will probably never be eliminated; consequently, organizations need more information on how these professionals cope and how to best support them.

Hypotheses

1.Levels of psychological distress will be high immediately after the event but will improve over time;
2. Some predictors will be associated with recovery (self-efficacy, perceived organizational support) while others will be associated with persisting distress (acute stress disorder, cumulative exposure);
3. The impact of these factors will be the same for women and men.

Methods: The current study used a longitudinal design. Self-reporting questionnaires were administered at four different time points (less than one month after the event, two months, six months, and twelve months). Data collection began in January 2013 and ended with a final follow-up in April 2015. In the end, 81 professionals were included in this study accounting for 74% of all known eligible participants.

Psychological distress. The K6 is a widely used six-item questionnaire designed to assess general psychological distress in adults. A score of 13 or higher indicates the possibility of a serious mental illness (6)(a = .829).
Acute Stress Disorder. Acute Stress Disorder was measured using the Acute Stress Disorder Scale (7)(a = .927).
Perceived Organizational Support. Researchers created a shorter version of the Survey of Perceived Organizational Support (8) to this concept (POS - items 1, 4, 8, 9, 10, 20, 27, 35 - a = .941).
Self-Efficacy. The confidence in coping with patient violence inventory (9) is a 10-item instrument wherein clinicians rate their level of confidence on an 11-point Likert scale (a =.956).
Cumulative exposure. Participants were asked to recall how many other physical assaults they had sustained over the last year (M=3.85).

Analysis: Mixed modeling was used to assess K6 scores over time. All assumptions of mixed modeling were met or corrected (i.e., independence of residuals). Attrition was manageable with only 10% of participants having dropped from the study. The BIC, AIC and -2 R. Log indicators were used to assess model fit, all of which favored a linear model with an unstructured covariance matrix. Bootstrap resampling (M=1000) was used to test the indirect effect of cumulative exposure on POS and distress.

Sample description	N	%
Men	35	43,2
Women	46	56,8
Nurses	25	30,9
Physicians/Psychologists	3	3,7
Admin. personnel	3	3,7
Medical orderlies	29	35,8
Educators	11	13,6
Incident control officers	7	8,6
Other	3	3,7
Witness to an assault	6	7,4
Threats of harm/death	7	8,6
Physical assault	68	84,0

Rates of severe distress (K6 >13)				
	N=81 3 weeks	N=71 11 weeks	N=67 27 weeks	N=73 52 weeks
Men	11,4	15,2	12,5	17,6
Women	34,8	39,5	28,6	12,8
Total	24,7	24,7	17,3	13,6

	Coefficients	Estimation	S.E.	df	t
Model 1					
Intercept	1.40	0.258	133.126	5.43	0
Sex	0.29	0.12	73.6	2.37	0.02
Nurse	-0.001	0.03	73.7	-0.02	0.98
ASD	0.02	0.004	74.9	6.44	<0.001
Cumulative	0.03	0.02	95.1	2.24	0.03
Time	-0.09	0.03	78.4	-2.70	0.009
POS	-0.09	0.05	201.4	-1.85	0.07
Model 2					
Intercept	1.55	0.25	129.965	6.118	0
Sex	0.32	0.12	75.32	2.59	0.01
Nurse	0.01	0.03	75.31	0.33	0.74
ASD	0.02	0.004	76.35	6.21	<0.001
Time	-0.09	0.03	78.11	-2.76	0.007
POS	-0.12	0.05	203.30	-2.39	0.02

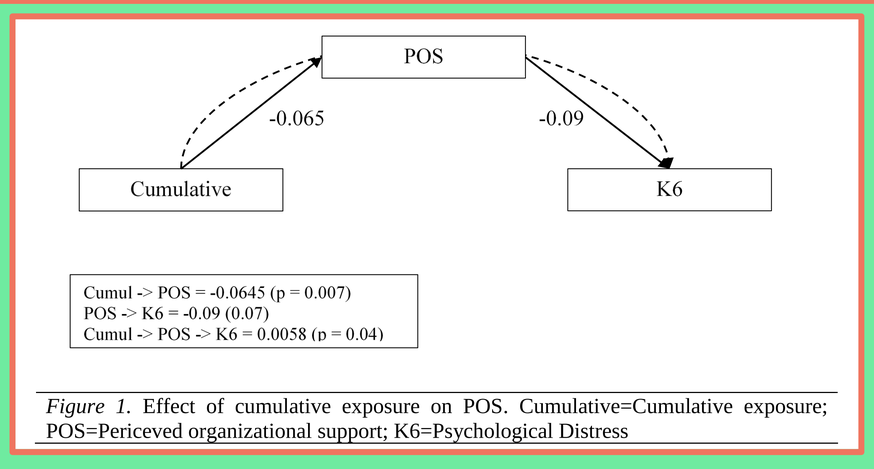

Figure 1. Effect of cumulative exposure on POS. Cumulative=Cumulative exposure; POS=Pericived organizational support; K6=Psychological Distress

Discussion

This study revealed that professionals were still significantly distressed more than 6 to 12 months after experiencing violence. ASD at Time 1 was the best predictor of distress scores over time. Women found themselves just below the severe distress threshold, while men experienced moderate but nonetheless persistent symptoms all year. POS was found to have a protective effect against distress. This protective influence, however, dissipated in the face of cumulative exposure. One possible explanation for this suppression effect could be that healthcare workers interpret cumulative exposure as a sign that their organization is unconcerned with their safety and this perceived lack of support in turn increases distress. Employers should consider investing in psychological first aid programs to mitigate any serious psychological sequalae among assaulted staff; such programs are usually appreciated by staff and have been proven to be cost-effective (10).

References

1. Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & De Girolamo, G. (2015). Prevalence and risk factors of violence by psychiatric acute inpatients: a systematic review and meta-analysis. PloS one, 10 (6), e0128536.
2. Chen, W. C., Hwu, H. G., Kung, S. M., Chiu, H. J., & Wang, J. D. (2008). Prevalence and determinants of workplace violence of health care workers in a psychiatric hospital in Taiwan. Journal of Occupational Health, 50 (3), 288–293.
3. Lamothe, J., & Guay, S. (2017). Workplace violence and the meaning of work in healthcare workers: A phenomenological study. Work, 56 (2), 185–197.
4. Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H. E., Nachreiner, N. M., Geisser, M. S., ... & Watt, G. D. (2004). An epidemiological study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. Occupational and environmental medicine, 61 (6), 495–503.
5. Lanctôt, N., & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. Violence and violent behavior, 19 (5), 492–501.
6. Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., ... & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. Archives of general psychiatry, 60 (2), 184–189.
7. Bryant, R. A., Moulds, M. L., & Guthrie, R. M. (2000). Acute Stress Disorder Scale: a self-report measure of acute stress disorder. *Psychological assessment*, *12* (1), 61.
8. Eisenberger, R., Huntington, R. H., & Sowa, S. (1986). Perceived Organisational Support. *Journal of Applied Psychology*, *71* (31): 500–507
9. Thackrey, M. (1987). Clinician confidence in coping with patient violence: Assessment and enhancement. Professional Psychology: Research and Practice, 18 (1), 57.
10. Flannery, R. B., Juliano, J., Cronin, S., & Walker, A. P. (2006). Characteristics of assaultive psychiatric patients: fifteen-year analysis of the Assaulted Staff Action Program (ASAP). *Psychiatric quarterly*, *77*(3), 239-249.