The Reciprocal Influence Between Nurse Burnout and Patient Violence

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Purpose
• To examine the influence that both nurse burnout and patient violence have on each other.

Design/Methods
• Narrative literature review

Setting
• Emergency departments

Subjects
• Registered nurses, full or part time, regular and frequent contact with patients, families and visitors.

Reciprocal Influence Theory

Leader Words/Behavior Nurse Words/Behavior
Influence & Modify Influence & Modify

Subordinate Words/Behavior Patient Words/Behavior

Reciprocal Influence in Nurse-Patient Relationships

Jean Watson on Human Caring
• Transpersonal, mutual, inter-subjective, reciprocal
• Central to nursing’s responsibility, role, moral foundation
• Nurse’s caring consciousness influences the patient’s health/healing as well as her/his own experience in the moment
• Caring and non-caring consciousness is communicated to the patient and informs future experiences of the practitioner and the patient

Janice Morse, et al and Comforting Interaction
• Relationship develops and changes with every interaction
• Mutually satisfying quickly, or negotiated over time, with ultimate goal being patient’s comfort
• Nurse’s personality reflected in the style of care (comfort strategies used)
• Style can change rapidly in a single interaction in response to changing patient signals of distress
• Nurse control = style of care to respond to the patient
• Reciprocally, patient control = negotiating, relinquishing or accepting care based on evaluation of the nurse and level of trust in him/her

Risk Factors for Burnout Syndrome

Seriously Ill Patients Demanding Patients
Violent Patients Abusive Patients

A shift in the life of an ER Nurse...

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Energetic Occupational Hazards of Caring
Nurses openly engaging with patients experience:

• Energetic absorption of patients’ fear and pain.
• Resonating patients’ frustration and anger.
• Patients’ may sap nurses’ energy to replenish their own.
• Possible identification with patients’ expressed hurt, spiritual desperation, depression
• Danger if not consciously aware of such energy exchange or if unprepared to respond in a way that nurtures both the patient and the self.

(Gaut&Tyler & Leininger, p. 56-7, Swanson, 1993)

Environmental: The Stress of Violence
Stressors = events that threaten an organism's well-being. ER nurses high targets for patient/family/visitor violence including:
• Verbal - Swearing, racial slurs, threats, insults, sexual innuendo and harassment
• Physical – Pushed, slapped, hit, kicked, spat upon, bitten, pinched, objects thrown

Gacki-Smith et al 2009: 3,465 ER Nurses surveyed; from all 50 states; >50% experienced physical violence, 70% or more experienced verbal violence.
Some ER's - 100% nurses report experiencing verbal violence regularly


Personal Characteristics associated with burn-out
• Under age 30-40 and early in one’s career
• Gender is unclear: males tend to score higher in cynicism
• Unmarried, especially men
• Singles more than divorced
• Higher level of education (possibly unmet job expectations)

(Maslach et al 2001)
Impact of Violence Associated with Burn-out
Short and long term maladaptive coping strategies

- Emotional: anxious, helpless, angry, shock, apathy, self-blame
- Social: fear of patients, difficulty returning to work, avoidance
- Biophysical: Startle, insomnia, headaches, soreness
- Cognitive: Denial, preoccupation, never "safe" PTSD-nightmares/flashbacks
  - Suppress feelings, fear reporting violence, embarrassment
  - Surface and Deep acting to display professional demeanor despite emotional exhaustion/apathy


Impact of Violence Associated with Burn-out
- Role Conflict—Needs of patients vs. own needs as victim
- Victim blaming by other staff—especially female victims
  - "Just World"—Bad things don't happen to good people
- Habituation—No longer recognize violence; unreported
- Effort/Reward Imbalance—Chronic High Investment/Low Return (Violence)/Ingratitude = exhaustion
- Disparities in Institutional reporting or support mechanisms Accepted as "part of the job"


Therapeutic Gap in Burn-out
Lack of empathy, indifference

Defensive Vulnerable

Therapeutic Connection
Patient (Values, etc.)
Nurse (Values, etc.)

Therapeutic Effort
Empathy

Adapted from Holmes 2012

Therapeutic Connection
Patient Violence
- "Aggression is programmed into the biological beast in all of us...Violent aggression, however, is not endemic to the human experience." (Brendtro & Long, 1995)


Factors Associated with Patient Violence
- Single most distinguishing commonality across the lifespan "person-environment relationship": 1. Violent individuals view themselves as weak; no control 2. View others as powerful and controlling 3. Vulnerable to loss of control to others 4. Most stressors = cause for panic 5. Low levels of family/external support
- Violence escalates as people cannot disengage from confrontation
- Also: History of violence, mental illness/pyschosis, or paranoid state, alcohol, recreational drugs, involuntary admission, dementia, poor impulse control (neurobiological deficits), access to firearms, gangs

(McAdams & Foster 1999)
Triggers of Violence

Patient Perception:
- Linguistic
  - "Nurse has an attitude"
  - Being rushed or ignored
  - Told to 'shut up'/disrespect
  - Nurse uncaring, insensitive, nurse aggressiveness, abrupt
  - Nurse belittling, putdowns
  - Lack of update on care plan
  - Anomalous toward patient
  - Restrictive limit setting without options

Nurse Perception:
- Linguistic
  - "Stale," inappropriate, negative nurse attitude, imitated by newer nurses
  - Poor communication to pt.
  - Patient misunderstands nurse behavior (laughter)
  - Pt. visitors lack understanding of triage prioritizing
  - Patient/visitor perceive staff as uncaring

Triggers of Violence

Patient Perception:
- Behavioral
  - "Treated like a prisoner."
  - "Try to lock us up."
  - Physical limit setting
  - Negative behavior based on cultural stereotyping
  - Staff dysfunction

Nurse Perception:
- Behavioral
  - Physical limit setting
  - Lack of control or privacy

Environmental
- Loud, uncomfortable waits
- Overcrowding
- Understaffing
- Law security coverage
- Easy department access
- Lack of staff training and policies to manage violence

Implications

- Winstanley and Whittington (2002) propose a cyclical model that elevated levels of burnout from all sources might do the following:
  - Increase vulnerability to victimization
  - Increase emotional exhaustion
  - Lead directly to increased depersonalization coping
  - This manifests as a negative behavior change toward patients
  - Renders staff more vulnerable to further aggression

Conclusion

- Quantitative and qualitative studies indicate reciprocal influence exists between nurse burnout and patient violence.
- More research needed on the effect of multipronged approaches designed to support psychological/emotional needs of nurses, and reduce patient violence.
- Fair, consistent administrative procedures, and a "culture of support," not punishment, for victims are critical.
- Future research is needed on the benefits of in-hospital violence management teams, nurse-nurse mentor systems across specialty areas and "clinical experts" in building and maintaining clinical cultures of support.

Reference List Reciprocal Influence Between Nurse Burnout and Patient Violence


