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Aspects of violence leading to distress and changed attitudes for physiotherapists: A qualitative investigation

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Abstract

Objective Physiotherapists are often the targets of workplace violence. We investigated how physiotherapists make sense of their exposure experiences, and what aspects of their experiences of workplace violence lead to negative reactions and changed attitudes towards the work organization.

Design Qualitative interview study.

Methods We conducted individual semi-structured interviews with 82 physiotherapists across a range of care settings. Interviews were recorded and transcribed. We then conducted an inductive content analysis of the transcribed interviews.

Results We found two themes representing meaningful characteristics of exposure incidents for determining reactions: attributions of intent to cause personal harm and acceptance of violence. We found three themes under changed attitudes: awareness of risk, adequacy of the organization's actions to prevent violence, and satisfaction with organizational support. Physiotherapists were more likely to experience psychological distress when they perceived that perpetrators intended to cause harm and were cognitively coherent. Following violence, physiotherapists were also more cognizant of risk in their profession. Changes in attitudes about the organization were driven by satisfaction with violence prevention measures and organizational support.

Conclusions Organizations should develop policies to prevent violence and provide victims with additional support, particularly when victims express that they believe that violence was committed intentionally and when the perpetrators are not cognitively impaired. Physiotherapists may be able to minimize the effects of violence exposure by reflecting on their exposure experiences and attributing the exposure to external factors.

Keywords: Physiotherapists; Workplace Violence; Incivility; Qualitative Research; Psychological Distress

Background

Physical (e.g., hitting, kicking) and nonphysical (e.g., insults, threats) violence is prevalent for healthcare workers [1–4] and exerts a heavy toll. Following an incident, victims report feeling stress, frustration, anger, and fear [5] and may develop anxiety [6], post-traumatic stress disorder (PTSD) [3], and depression [7]. Healthcare workers who suffer psychological injuries from a violent incident also take longer to return to work [8] and are more likely to leave the organization [3,5]. Depending on the role of the perpetrators, workplace violence can be categorized into four types. Healthcare workers most frequently experience Type 2 violence, perpetrated by patients/clients [5]. In response to violence exposure, victims may refrain from providing care to perpetrators [9,10]. They may also have diminished performance [7] and may develop negative attitudes towards their profession and organization [11]. Violence against healthcare workers is therefore costly not only in terms of victims' physical safety and psychological well-being, but also in the form of losses in work productivity, time, and diminished quality in patient care.

Studies on workplace violence in the healthcare setting

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have focused on nurses and/or physicians [1], but violence directed towards physiotherapists is also common. Physiotherapists provide care to increase patient mobility and reduce pain and often engage in hands-on techniques that may be uncomfortable or even painful, causing patients to lash out. Between 50% and 70% of physiotherapists report having been physically assaulted in their work [12–14]. After experiencing violence, physiotherapists are similarly likely to experience reduced well-being and job satisfaction [15].

Yet despite the detrimental effects of violence on workers, its costs to healthcare organizations, and the Joint Commission's standards for preventing workplace violence, healthcare workers continue to report that they see a degree of violence as "part of the job" [5]. For example, physiotherapists and other healthcare workers may view patients' violence as a means of emotionally "letting off steam" [16]. This reaction is concerning because it may lead physiotherapists to be less motivated to prevent type 2 violence. This normalization of violence could also make other types of violence (e.g., type 3 violence, perpetrated by coworkers) more common [5]. In order to understand these seemingly contradictory reactions to violence, researchers have questioned what violence may be tolerated and what healthcare organizations should do to protect employees [17].

Interestingly, little is known about what physiotherapists themselves find to be most distressing in their experiences with violence exposure. For example, there is some evidence that verbal aggression is linked to more negative reactions than physical violence [5]. Although violence results in deleterious health and behavioral outcomes [3], it is unclear what proximal causes may increase or reduce the likelihood that physiotherapists experience lasting negative effects. There may be important differences in how physiotherapists appraise their violence exposure experiences and the perpetrators of violence that drive their reactions. Greater knowledge of when violence exposure is more likely to lead to harm can provide a leverage point for organizations to intervene early and prevent worse outcomes for those at risk.

Relatedly, although researchers have examined various procedures for organizations to minimize conditions that lead to violence [18–20], as well as training for physiotherapists [21,22], it is not clear what physiotherapists *themselves* expect and desire from their organizations when they experience violence. Scholars have also solicited healthcare workers' opinions about what is needed to prevent violence, and workers have advocated for strategies such as training, increased staffing, and "zero tolerance" policies [21,23]. This indicates that they have clear opinions of what their organizations should do to prevent violence. However, it is less clear what prompts physiotherapist to change their attitudes following violence. For example, actual exposure to violence may not result in decreased estimations of the organization's violence prevention climate [24]. Understanding what factors prompt physiotherapists to change their attitudes about their organizations (either positively or negatively) following violence exposure can help organizations to better aid their employees, which may promote worker functioning and reduce the likelihood of maladaptive reactions (e.g., withholding care and turnover).

We conducted interviews with working physiotherapists in a variety of treatment settings to understand how physiotherapists evaluations of violent incidents relate to their emotional responses, as well as what leads them to revise their attitudes towards their organizations. Qualitative methods provide a greater depth of detail and are particularly relevant for uncovering the myriad reasons behind changed emotions and attitudes [25]. Our results hold implications for healthcare organizations and physiotherapists to minimize the nocuous effects of violence.

Method

Participant recruitment and interviews

Individuals were eligible to participate in the study if they were practicing physiotherapists who spoke English. The second author recruited physiotherapists for interviews through the assistance of managers in organizations employing physiotherapists. She visited organizations to speak and distribute information about the study and advertised the study through listservs and posts in forums for physiotherapists. We also used snowball sampling. Participants were encouraged to share recruitment materials with their colleagues. Interested physiotherapists contacted the second author to schedule an interview. We ended data collection when participants no longer raised new information in interviews, indicating that we had reached saturation.

Interviews

Interviews were conducted by the second author in 2010 over the phone. Interviews lasted approximately 45–60 min and participants were compensated with a $25 gift card. The interviews consisted of questions about participants' exposure to verbal and physical violence. For each form of violence that participants had experienced, they first provided a detailed description about the incident (e.g., who the perpetrator was, how, when, and where the incident occurred). They were then asked to discuss their emotional reactions and any changes in their feelings about their organization in reaction to each incident. Participants were able to provide this information, and these questions were kept for the entirety of the data collection process. At the conclusion of the interview, they provided demographic information. Interviews were audiotaped and transcribed

(with potentially identifying information removed) for analysis.

Qualitative analysis

Interview data were analyzed with an inductive content analysis [26,27] undertaken by the first author. This began by reading through transcripts and forming basic ideas about codes and themes based on literature and the research questions. For example, first-order codes included "emotional reactions" and "no emotional reactions" to violence. The first author then engaged in inductive open coding through close reading of the transcripts and generated an initial set of categories. The analysis was a recursive process; codes and categories were revised, and data recoded, throughout the analysis. Following open coding, the first author consolidated conceptually similar categories to generate higher order categories.

To enhance credibility of the analysis, the first author maintained an "audit-trail" [28] of analytic memos [29] tracking the analysis process. These memos recorded decisions made throughout the analysis (e.g., decisions to merge categories, reflections on ambiguous segments of text). Memos were also recorded to reflect upon any possible assumptions made and motivations in the analysis to maintain reflexivity throughout the analysis. Once a set of categories were identified, the first author sought out potentially dis-confirmatory ideas within the data to compare against the extant framework by searching for statements or examples that might contradict the established scheme. This strategy helped to minimize coder bias and refine codes. The analysis was facilitated by the software MAXQDA [30].

Results

Descriptive information on participants

The sample included 82 participants across 17 states. (Four participants had not experienced any forms of violence and are not included in analyses). Demographics are reported in Table 1. On average, participants had been working as physiotherapists for 15.7 years (*SD* = 10.01) and at their current organization for 7.8 years (*SD* = 7.2).

Qualitative findings

Participants commonly reported being the target of verbal and physical abuse in their work role. Participants most frequently reported that they had been yelled at (N = 53), insulted (N = 40), or subjected to a sexist remark (N = 31). Many had been pushed, grabbed, or shoved (N = 30), hit or slapped (N = 25), and/or kicked or punched (N = 21). Physiotherapists working in acute care were more likely to have experienced verbal (e.g., accounting for 49% of experiences of being yelled at) and physical (accounting for 56.7% of experiences of being pushed, grabbed, or shoved) abuse. Patients were the most common perpetrators of violence. Physiotherapists displayed a marked range in their emotional reactions and distress when exposed to violence: whereas some reported feeling anger and sadness, others were not affected. Physiotherapists in acute and outpatient care described feeling psychological distress somewhat more frequently. The analysis yielded five themes, represented in Table 2.

Table 1
Sample Demographics.

Characteristics	Percent of Sample (n = 65)
Gender	
Male	80% (n=52)
Female	20% (n=13)
Race/Ethnicity	
White	91% (n=59)
Black/African American	3% (n=2)
Hispanic/Latino	3% (n=2)
Asian	3% (n=2)
Age (years)	
21–30	21% (n=11)
31–40	34% (n=18)
41–50	23% (n=12)
51–60	23% (n=12)
Practice Setting	
Acute Care	45% (n=29)
Out-Patient	32% (n=21)
In-Patient Rehab	8% (n=5)
Home Health	6% (n=4)
Geriatrics	5% (n=3)
Pediatrics	5% (n=3)

Attributions of intent to cause harm

In discussing their experiences with violence and ensuing emotions, 79% of participants explicitly mentioned whether they perceived that the perpetrator intended to cause harm to them. In describing some incidents, physiotherapists attributed the cause of violence to external factors, such as the perpetrator's mental state making them unaware of their behavior, the influence of pain or strong emotions, or even their own ignorance (see Table 2). These external attributions helped physiotherapists dismiss the events more easily. When physiotherapists did not ascribe the intent to cause harm to a perpetrator, they tended to experience less distress. For example, participant 37 stated:

…if the person is cognitively intact it makes me feel outraged, but in this instance the patient had no idea, he had a severe brain injury. I would obviously not let it happen, but I would not take it to heart at all…

Physiotherapists were less likely to be affected when the perpetrators of violence had a behavioral disorder or dementia. Conversely, when they perceived that perpetrators were in full control of their actions, they were more

Table 2
Examples of Supporting Quotations for Study Themes.

Themes	Relevant quotation
Meaningful Characteristics of Incidents for Physiotherapists' Reactions	
Attributions of intent to cause personal harm	'You see why she is stressed, and why she is so upset, and probably that you are not the true target.' (P53). 'When I know a person is hurting, they don't always understand how this is going to help them and so they start yelling. They feel like they are losing the control and so they start yelling, they don't have the intention of hurting me or anything' (P36). 'I feel like this is just lack of knowledge. These patients say it like it's normal, but not maliciously. We don't belong to a very diverse area, so it doesn't help the situation' (P17). 'It's different because if you work with some patients with brain injuries they can be aggressive but it's not purposeful. It's done because they can't control themselves. Whereas, when I think of violence in the sense of I don't like when someone is going to consciously know they're going to hit you because of the intent of it. Whereas, this other guy was, I have to back up, I did see this one guy who was going to swing at some of the nurses and therapists. But he was so disoriented, that it was… He was so brain damaged he didn't know what was going on. So, I think you look at that separately.' (P2). 'I think he was more cognitively aware and made that choice. I was very frustrated that somebody would do that (P24).
Acceptance of Violence	'With the kids its almost accepted if it's not a behavioral thing where they're biting to hurt you, it's part of working with kids with disabilities.' (P12). 'we do what we can to minimize it and to set things up to minimize it, but we also at the same time understand that it is a part of the possibilities in this patient population.' (P82). 'Didn't bother me, it's just – it's part of what you expect sometimes working with these kinds of kids.' (P60).
Changed attitudes towards organization or profession	
Awareness of risk	'it just gives me an idea that the world is a place and it's not always safe. I think it makes me become more aware that yes, it's not super safe at the hospital I work at or anywhere you got to always watch what you're doing just to be careful.' (P18). 'It does me you feel like – it makes your job feel more dangerous than you would really expect it to be. You wouldn't think that – I mean you think of high risk– high risk jobs as being a police officer.' (P63). 'I realized that this home health thing is not always safe and I'm kind of at times putting myself at risk for what I love doing.' (P19). 'And in a school setting with autistic children or with behaviorally disordered kids there is a lot of, a lot more physical risk and so I sort of looked at it as, not par for the course but an inherent risk in the job, in that job setting.' (P46).
Adequacy of organization's actions to prevent violence	'Sometimes when we have a run of really inappropriate patients, it makes me feel like my admission department is more concerned about filling beds than they are about admitting people who are appropriate for rehab, for sure. Sometimes we will get a run on that type of patient when our capacity is low and then we will fill up. Not about my profession, just my organization.' (P33). 'I felt the organization didn't handle it correctly. They were not proactive. They didn't deal with this type of aggressive patient correctly.' (P34)
Satisfaction with organizational support	'I just felt like, again, there's no support here and, even when it's a problem that can be fixed and can be addressed when you bring it to the people's attention that have the authority and the ability to address it, it fell on deaf ears; they weren't interested in hearing what the problem was because they had no intentions of changing the way they do things.' (P47). 'it did change how I feel about some of our senior leadership because I did get some feedback from some of the senior leadership groups about how it was handled and they were very supportive and followed up to make sure things were going well.' (P14). 'I reported it to my supervisor who was a male and his reaction was you are not going back there. I will take over this patient, if he wants to kiss somebody, he can kiss me. The interesting thing was, I spoke to the nurse who was going in to take care of the patient as well…He did the same thing to her and she also told her supervisor…But her supervisor basically blew it off and said oh I think you're imagining it. So she felt very alone and non-supported where I felt extremely supported and a sense of relief.' (P46).

Note. Participant ID numbers are reported in parentheses following quotations.

strongly affected. Moreover, physiotherapists could, and did, reevaluate their attributions of the cause of violence. Attributions may be formed out of an active, effortful appraisal process, and external attributions may be a strategy to cope with violence exposure:

The first time, I thought "you jerk!". Of course I couldn't say that, so I just backed up. He wasn't trying to be a jerk, he just was losing his mental capacities. He had been powerful all throughout his life and so he was grappling with who he used to be and who he was. I had to consider that and what he was capable of cognitively and just let it go. (P33).

Attributions of intent were appraised, and could be reappraised, which would lead to redefined emotional reactions. Other participants discussed that they had learned over time to view patients' aggression as unintentional and recommended that other physiotherapists learn to do so as well. Participants also mentioned empathizing with patients to understand their situations, which helped them attribute the perpetrators' outbursts to external causes.

Acceptance of violence

In turn, some physiotherapists expressed that some violence was accepted and even expected. In fact, 45% of the participants stated, either verbatim or in other terms, that some degree of violence from patients was "part of the job". Mild harm from patients could even be seen as an indicator of proper work, making it something to exult in. As participant 78 stated, the workplace injuries that she had received were:
Just bruises, but nothing of real consequence. But if we didn't have bruises, we wouldn't think we worked that week…We wear our war wounds proudly.

Dovetailing with the previous theme, physiotherapists related that violence was an unavoidable condition of working with some patient populations. Specifically, they viewed violent encounters as a normal part of working with patients who may not be lucid or otherwise disinhibited due to a disorder. Participant 12 characterized violence in her work as:
[a] realistic part of the challenge of working with kids and families and middle and old adults too that have disabilities or challenges.

In these cases that physiotherapists expressed that they viewed a violent encounter as a part of the job, they tended to express fewer negative emotions. Along with the evaluation that violence may be expected from patients who are cognitively impaired, they often did not associate outbursts from these patients with the intention to cause them harm.

Awareness of risk

One outcome of violence, expressed by 48% of physiotherapists, was that they became more keenly aware of risk in their profession and day-to-day work, and more cautious as a result. Participants of different genders and races/ethnicities all appeared to express greater awareness of risk at equivalent rates. For some, this newfound understanding of potential threats even led them to reconsider their occupations. For instance, participant 65 expressed:

Yeah, I guess it did make me double think my job choice. Like, wow, this is violence here. What if he would've been stronger or actually hurt me.

Similarly, participant 41 outlined that an experience with violence influenced what settings they would work in:

it has affected how I practice today because it's almost like once bitten, twice shy. So I purposefully when I look for new employment do not want to go back into the situation where there's a private practice, PT-owned private practice.

Adequacy of organization's actions to prevent violence

Physiotherapists' experiences with violence also had ramifications for their attitudes towards their organizations. Of the 54% physiotherapists who expressed that their feelings about their organization had changed because of violence exposure, 34% discussed the importance of their organization's policies and actions for worker safety. Some experienced a positive increase in their evaluations of their organization, as highlighted by participant 21:

I was really happy with the way that they provided, and a task force was formed within 48 h on how to deal with threats in patients who are physically aggressive.

Alternatively, physiotherapists may come to feel more cynical about their organization following a perceived oversight in safety, as exemplified by participant 32:

I don't think enough was done at first to make sure that he was kept isolated from other people since he was at risk for harming others…it made me annoyed with our organization that nothing was done sooner to prevent this from happening.

Perceived safety failures may impact not only how physiotherapists felt about their own safety and security, but also about the extent to which they were valued by their organizations:

We felt like the Administration did not care about us as staff members, didn't care enough about us to ensure our safety in our workplace. (P47).

Satisfaction with organizational support

Of the physiotherapists who changed their attitude towards their organization following an experience with violence, 46% cited the importance of organizational support following an incident. The sense that their organization supported them (e.g., by listening to them, trusting their judgments, and providing assistance in managing difficult cases) could increase their evaluations of their organizations.

It actually made me feel very proud of my organization, because they didn't question what I said and just turned down the case, instead of sending another therapist to test it out. (P17).

On the other hand, when physiotherapists perceived that their organization and/or coworkers were not supportive after their experiences, they were more likely to come away feeling negatively. Having social support from their colleagues also helped physiotherapists to cope and feel safe, even following violent events. Participant 15 noted:

It makes it feel more secure. I feel good about this communication we have; I feel that we look out for each other. It's a very positive team feel.

Discussion

Physiotherapists routinely experience verbal and physical violence in their work roles [12–14]. Despite understanding that violence exposure may lead to negative outcomes [15], there is little insight regarding when physiotherapists are more likely to experience distress or change their attitudes towards their organization. This qualitative interview study was conducted to answer these questions.

A defining factor influencing whether physiotherapists were negatively affected by violence exposure was whether they perceived that a perpetrator intended to harm them. This finding is consistent with attribution theory, which contends with how people's inferences about the cause of behavior drive their responses. People commonly attribute the cause of an actor's behavior to factors that are internal or external to the actor, and these attributions inform their reactions [31]. External versus internal attributions provoke differing reactions, and people express greater anger towards and are more likely to retaliate against someone judged to be intentionally aggressive [31]. We found that violent incidents where physiotherapists believe the perpetrators are aware of their actions are more likely to cause psychological distress. On the other hand, for similar acts of violence, physiotherapists were less impacted when they perceived the perpetrators to be cognitively impaired, psychologically overwhelmed, or reacting to intense pain or emotions.

We also found that most perpetrators were patients and that physiotherapists viewed some violence as "part of the job"; both of these findings align with previous research [5]. However, physiotherapists were also less affected by violence that they construed as acceptable, which was often perpetrated by patients with a cognitive impairment (whose actions they attributed to this external cause rather than the intent to harm). In general, most perpetrators of violence against physiotherapists are patients with a cognitive impairment [1,32]. Considering our findings, this actually bodes somewhat positively as attacks from this population are less threatening and distressing.

Moreover, the perceived adequacy of the organization's actions to prevent violence and satisfaction with support drove changes in attitudes about one's organization. Studies have found that social support [33,34] and justice [35] shield workers from negative reactions after violence exposure. Organizational support may also have a larger role than coworker or family support in determining workers' health outcomes following violence, and those who lack organizational support are more likely to have worse health outcomes and to turnover [2]. Our results further indicate that the adequacy of organizational support may influence not only physiotherapists' health, but also their attitudes towards their organization. It is likely that such changed attitudes will in part drive turnover following violence [2].

Healthcare workers also hold preferences about strategies to prevent violence (e.g., de-escalation, medication) [5]; it follows that perceptions of the adequacy of extant strategies impact attitudes towards the organization. Finally, following violence exposure physiotherapists became more aware of the risk in their work. This heightened sense of vulnerability could lead some to consider changing their care setting or even profession.

Implications

Our results hold several important implications for healthcare providers. If organizations wish to avoid staff developing negative attitudes (which may lead to decreased performance and turnover), they should develop formal policies and implement procedures and practices to prevent violence. This may take the form of adequate staffing, strategies for detecting warning signs in patients, and de-escalation training for workers [32]. When violence occurs, physiotherapists evaluate their organization's safeguards to prevent violence, and if they are judged to be lacking, their assessment of their organization will become more negative.

Physiotherapists may also change their attitudes towards their organization based on the support provided after violence exposure. Organizations should adopt policies and norms for providing additional aid to those who have experienced violence. Examples of support include showing care through a follow-up call or visit, helping with

paperwork and getting medical assistance, and implementing further safeguards [2].

Physiotherapists may alternately expect relatively more innocuous violence from cognitively impaired patients. This may represent a unique type of workplace violence in healthcare that may have to be tolerated [17]. Physiotherapists were less negatively affected when they interpreted that violence was not intended to harm them personally. Because this cognitive appraisal was ongoing and deliberate, a strategy to curtail repeated victimization and negative health effects is for physiotherapists to reflect and attribute the cause of violence to external factors. This may be especially valuable for those who tend to interpret events negatively (e.g., due to higher trait negative affect) and may thus stand at a higher risk of falling into a cycle of impaired well-being and repeated victimization [36]. However, we certainly do not mean to suggest that the onus for preventing or coping with violence should fall on the shoulders of victims. Organizations and supervisors should also be ready to provide extra support when physiotherapists express that they view violence as intentional and/or the perpetrators are lucid.

Limitations and recommendations for future research

This study hosts several strengths. For one, we completed many interviews with physiotherapists across different care settings. However, physiotherapists had to contact the research team directly to schedule an interview, so there could be some bias in this sample. The sample was also mostly White and female. Although this represents the physiotherapist population [37], minority workers may have different reactions to some forms of violence. This is an area for further research. The nature and consequences of violence directed towards healthcare workers should continue to be studied within diverse samples.

Future research can investigate these topics by studying whether different forms of support or practices to reduce violence have a greater effect on attitudes toward the organization. Studies can also assess what impact increased awareness of risk has on physiotherapists' behavior and long-term perceptions of their profession. Finally, further research could be undertaken to investigate and design a cognitive intervention around external attributions to lessen the impact of violence.

Conclusion

Physiotherapists frequently experience violence, and this interview study explored what aspects of violence had a greater effect on their emotions and attitudes towards their organizations. Meaningful characteristics of events included: attributions of intent to cause harm and acceptance of violence, particularly from some populations. The theme of changed attitudes towards organization or profession included: awareness of risk, adequacy of the organization's actions to prevent violence, and satisfaction with organizational support. Workers may safeguard their well-being by attributing violence to external causes, and organizations should adopt thorough strategies to prevent violence and provide victims with support.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.physio.2022.08.005.

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