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Emergency Department Workers' Perceived Support and Emotional Impact Following Workplace Violence

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Abstract

Introduction. Workplace violence (WPV) is a common experience among healthcare workers in the United States. While WPV may affect workers physically, WPV also can affect workers' mental health. Emergency department workers perceptions of available and necessary WPV support have not been previously reported.

Methods. A cross-sectional survey design was used to examine emergency department workers' perceived level of WPV support and emotional impact that WPV causes them. This study was conducted at six Midwestern U.S. emergency departments. Respondents confidentially completed an adapted version of the Survey of Violence Experienced by Staff. Data analysis included descriptive statistics, *t*-test, and Kruskal-Wallis test.

Results. Respondents (N=206) who experienced WPV served as the analytical sample. Respondents predominantly agreed or strongly agreed that support was available following WPV (n=129, 63.2%). The predominant source of support after WPV was another colleague from the department (n=127, 62.3%). Less than half of respondents (n=96, 47.1%) indicated they agreed/strongly agreed that managers were supportive following verbal abuse but 63.6% (n=126) indicated that managers were supportive following physical assault. There was no statistical difference between the emotional impact of verbal abuse compared to threats/assaults.

Discussion. Forensic nurses and emergency nurses with forensic nursing training are situated to combine their expertise in trauma-informed care, evidence collection, and expert testimony to

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support victimized ED workers. Timely support should be offered regardless of the category of WPV experienced. Insight into why support is perceived as available and accessible but may not be used warrants further study.

Keywords

workplace aggression; mental health; verbal abuse; assaults; forensic nursing

Workplace violence (WPV) is a common experience among healthcare workers in the United States (U.S.) (Gilmartin & Saver, 2024). It includes verbal abuse, threats, and assaults enacted by patients and their visitors. Prior studies have examined WPV risk assessment, prevention, education, injury, support, and reporting (Registered Nurses Association of Ontario Best Practice Guideline Development and Research Team & Registered Nurses' Association of Ontario Best Practice Guideline Expert Panel, 2019). However, employees' perceptions of available and necessary WPV support have not been previously reported. This study evaluated the perceived support emergency department (ED) workers received following WPV by a patient or visitor as well as the emotional impact of WPV.

Background

Occupational injury and illness can occur in all sectors of employment. However, the U.S. Bureau of Labor Statistics (2020) found that 73% of all nonfatal violent acts of workplace injuries and illnesses are experienced by healthcare workers. Violent acts against healthcare workers are threatening and may consist of aggression, abuse, and assault (e.g., verbal, sexual, and/or physical). While WPV may lead to physical injuries, WPV also can impact workers' mental health (Öztas et al., 2023).

Healthcare workers in EDs operate in high-stress work environments that are fast-paced and often unpredictable (Wright-Brown et al., 2016). The primary focus of ED workers should be the health and safety of their patients. The emotional toll and mental stress caused by WPV can affect the efficiency and quality of their patient care delivery. The healthcare organization can incur financial burdens from employee injury, turnover, short staffing, and patient dissatisfaction when WPV is prevalent (Geoffrion et al., 2020). However, organizations may not be aware of its prevalence given that many healthcare workers do not report incidents of WPV for several reasons (Gilmartin & Saver, 2024). Predominantly, many workers believe WPV is expected and that no positive actions would be taken (Gilmartin & Saver, 2024; Powell et al., 2023; Spencer et al., 2023). Additionally, healthcare workers believe that some patient aggression is unintentional and/or completing a WPV incident report is time-consuming (Spencer et al., 2023). Some workers have questioned the usefulness of reporting due to the belief that nothing changes (e.g., learned helplessness), and employers show no concern (Spencer et al., 2023). Equally concerning is the perception that if WPV occurs, administrators may believe the worker failed to adequately perform their duties of providing a safe environment—essentially blaming the employee for being victimized (Spencer et al., 2023). These allowances for WPV promote tolerance of ongoing

WPV, potentially leaving employees without the emotional support they need and may put other employees at risk for being victimized by WPV (Powell et al., 2023).

Regardless of whether an employee reports WPV, support after WPV is paramount in effectively preventing sequelae of the incident. The emotional and physical injury experienced by healthcare workers from WPV can affect quality of patient care delivered, performance confidence, and job satisfaction, all integral in providing a safe and effective healthcare environment (Liu et al., 2019; Wright-Brown et al., 2016). WPV support can come from the healthcare organization and forensic nurse program managers through policies and procedures, or through individuals including colleagues, supervisors, hospital management, or family and friends. Understanding how workers perceive WPV support is vital for healthcare organizations and forensic nurse program managers to ensure appropriate responses to WPV incidents.

Methods

A cross-sectional survey design was used to examine ED workers' perceived level of WPV support and emotional affects that WPV causes them. This design allowed for examination of the perceived support from managers, colleagues, family, and friends following verbal abuse, threats, and physical assaults. The study procedures were approved by the affiliated university and hospital Institutional Review Boards. This study was part of a mixed methods research study focused on assessing the prevalence of WPV against ED workers. The research conduct, interpretation and dissemination of findings was not influenced by the study's funders. Reporting guidelines from the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) were used for the reporting of this study (von Elm et al., 2007).

Settings and Sample

The study was conducted at six Midwestern U.S. EDs. Three settings served a general population: one urban teaching hospital, one suburban hospital, and one rural free-standing ED. An additional three sites included an adult-focused teaching hospital, a pediatric ED within an urban teaching hospital, and a pediatric ED within a suburban free-standing ED. Approximately 900 ED workers were employed across the six study sites. The study used convenience and snowball sampling methods to recruit up to 50 respondents per site. Non-physician, adult employees who had been employed full-time, part-time, or per diem in the ED for at least six months were eligible for recruitment into this study. Traveling/temporary or other persons who were not permanent employees of the ED were excluded from participation.

Procedures

Following in-person recruitment at the start of their shift, participants signed an informed consent document. They then were provided a paper version of the survey packet, which they completed during break periods. At the end of their shift, the survey packets were collected.

Instrumentation

Respondents confidentially completed an adapted version of the Survey of Violence Experienced by Staff to measure the prevalence and impact of verbal abuse, threats, and assaults (Hahn et al., 2011). Panel experts from the European Violence in Psychiatry Research Group determined content validity and the internal consistency reliability of the tool to be 0.87–0.91 (Hahn et al., 2011). The survey included items on the prevalence of WPV (Gillespie et al., 2017), emotional impact of WPV, perceived support following WPV, and demographic information.

Respondents rated the emotional impact of a WPV incident from 0 (no impact) to 100 (significant negative impact) based on the worst WPV incident they experienced per category (verbal abuse, threat, assault). Emotional impact was managed using two strategies. First, emotional impact was dichotomized as (a) verbal abuse only and (b) any threat or assault (with or without verbal abuse). Second, emotional impact was limited to cases where respondents experienced all three categories of WPV: verbal abuse, threat, and assault.

Respondents rated the need for support following WPV and their perceived satisfaction of support following WPV using a Likert scale. Support was classified as available/unavailable, discussed/not discussed, needed/not needed, and supportive/unsupportive. Each item was scored using a 5-point Likert-scale ranging from strongly agree to strongly disagree. Support provided was further defined as support from managers, colleagues, family/friends, or others. Participants responded ‘yes’ or ‘no’ to indicate whether they had used each support person/category.

Data Analysis

Data analysis included descriptive statistics, *t*-test, and Kendall’s test. An independent-samples *t*-test was computed to compare the emotional impact of verbal abuse to threats/assaults. A Kendall’s test was computed to compare correlations in mean rank. Alpha was set at 0.05.

Results

Of 280 respondents in the parent study, 206 respondents reported having experienced at least one incident of WPV. Data from these 206 respondents served as the analytical sample. The majority of respondents self-reported as White ($n=186$, 90.7%), female ($n=156$, 75.7%), registered nurse ($n=122$, 59.8%), and full-time employee ($n=163$, 79.9%). The primary work shifts of respondents were day shift ($n=76$, 43.4%) and night shift ($n=64$, 36.6%). Most of the respondents experienced WPV in the 30 days prior to participation ($n=198$, 97.1%).

Availability of and Need for Support

Respondents predominantly agreed or strongly agreed that support was available following WPV ($n=129$, 63.2%) when needed (see Table 1). For example, 95.1% ($n=196$) of respondents believed support was needed following a physical assault, whereas 81.0% ($n=166$) of respondents believed support was needed for people who were verbally abused, and 88.8% ($n=183$) of respondents believed support was needed following threats. However,

the need for support varied by category of WPV. For example, more than half ($n=121$, 59.6%) of respondents believed the support varied based on the type of WPV (verbal abuse, threats, or assault).

Use of Support

Respondents proactively sought support from a variety of sources after experiencing WPV, and for some incidents they sought support from multiple persons (see Table 2). The predominant source of support was another colleague from the department ($n=127$, 62.3%). In comparison, only 30.4% ($n=62$) of respondents used supervisors and 44.1% ($n=90$) used partners/family members as a source of support. Some respondents ($n=36$, 17.6%) reported not seeking any support person after WPV.

Perceptions of Support Provided

Respondents' perceptions of who provided support following WPV varied depending on the category of WPV. For example, 47.1% ($n=96$) of respondents indicated they agreed/strongly agreed that managers were supportive following verbal abuse, and 63.6% ($n=126$) indicated that managers were supportive following assault. About 75% ($n=154$) of respondents indicated they disagreed/strongly disagreed that colleagues were unsupportive after verbal abuse, and 85.1% ($n=171$) disagreed/strongly disagreed that their colleagues were unsupportive after assaults. Additional findings of perceived support following WPV are provided in Table 3.

Emotional Impact of WPV

The emotional impact of verbal abuse and threats/physical assaults was similar. The mean score for the emotional impact of verbal abuse was 33.5 ($SD=29.1$, $n=89$) with a range from 0 to 100. The mean score for the emotional impact for threats/assaults was 34.1 ($SD=31.0$, $n=117$) with a range from 0 to 100. The mean scores for the emotional impact of verbal abuse and threats/assaults were not statistically different, $t(204) = -.135$, $p = 0.893$. See Figure 1 for a distribution of the emotional impact scores. There were 46 respondents who experienced all three categories of WPV. When comparing the correlations in mean rank for the emotional impact of verbal abuse (mean rank = 1.91), threat (mean rank = 1.92), and assault (mean rank = 2.16), no statistical correlations were found ($W = .034$, $p = 0.212$).

Discussion

Although registered nurses were the primary respondents in this study, many healthcare workers in the ED experienced WPV. While it is well known that healthcare workers are at substantial risk of experiencing WPV, the present study goes further, exploring the need, availability, and use of supports for those who experience WPV in addition to gauging the emotional impact of this WPV.

Support following incidents of WPV is important for addressing the physical and emotional impacts of WPV (Park & Song, 2023). Discrepancies exist between needed support, available support, and use of support. Similar to other research (Gillespie & Berry, 2023; Öztas et al., 2023), the respondents in the current study reported the need for support

following verbal abuse, threats, and assaults. Their responses suggest that ED workers desire support following WPV events to manage the emotional impact, which could lead to a mental health stress disorder. Yet, support was inconsistently used. This lack of use by some individuals warrants further investigation. Forensic nurses and emergency nurses with forensic nursing training can leverage and partner with their ED co-workers to prompt administrators to provide options for increased emotional support such as cognitive behavioral therapy, group therapy, exercise, and mindfulness-based practices (Price & Maquire, 2016).

Most respondents did not discuss their WPV experiences with close friends, partners, or family members even though they were identified as a significant source of support. This discrepancy between recognition of family and friends as potential supporters and the actual use of family and friends as supporters raises additional questions. First, ED workers may not want their friend and family members to know how dangerous their work environment is due to concern that their support persons may encourage them to quit the ED setting. Second, some ED workers may be concerned of violating patient privacy should they describe the incident in such detail that the aggressor becomes known. Given that some of the respondents worked in smaller communities, a future confrontation could occur at the grocery store or local school event between the aggressor and friend/family member who is advocating on behalf of the victimized worker.

In addition to family and friends, respondents also identified colleagues and supervisors as sources of support with 62.3% discussing WPV incidents with colleagues, but only 30.4% of respondents discussing WPV with a supervisor. Seeking support from colleagues is intuitive when assistance is immediately needed to mitigate physical WPV (Gillespie & Berry, 2023). Managers may not be sought due to their limited work schedule, typically working day shift Monday through Friday. By the time victimized workers see their manager, they may not want to discuss the event further or they may be concerned about reprisal or being blamed for the incident (Spencer et al., 2023). Overall, managers were reported to be supportive of staff following WPV, with assaults having the highest perception of support. Colleagues were reported as significant support after WPV. Wright-Brown et al. (2016) previously reported that ED colleagues described having a strong connection with their ED coworkers, which reflects teamwork in trauma situations. Colleagues often have the lived experience of witnessing WPV and have developed their own ways of coping with WPV (Öztas et al., 2023). ED workers, especially registered nurses, rely upon and value the experiences and advice of veteran colleagues and other healthcare workers.

Consistent with the literature (Gillespie & Berry, 2023), more support was received following physical assaults compared to verbal abuse. This is problematic given the emotional impact of physical violence was not significantly different than that of verbal abuse. However, with assaults, people may be more inclined to ask “Are you okay? Do you need help?” due to the risk for physical injuries. This questioning is likely perceived as emotional support. However, when the WPV is verbal abuse, ED workers may be less likely to receive similar support as noted in our findings. Although the emotional impact is slightly less for verbal abuse, the need for support is not eliminated. All workers need emotional support to be offered after WPV. The employee should be given the opportunity to

accept or decline that support. Forensic nurses and emergency nurses with forensic nursing training can be integral in applying trauma-informed care to victimized workers and making referrals to professional mental health counselors such as employee assistance programs.

Implications for Clinical Forensic Nursing Practice

Forensic nurses practice in a variety of settings including hospitals, EDs, long-term care, prisons, and industry (Forensic Nursing Scope and Standards Task Force, 2017). Unfortunately, not every practice setting will be able to employ a full-time, specially trained forensic nurse. In some EDs, the forensic nurse's primary employment role may be that of an emergency nurse. Whether their primary role is forensic nurse or emergency nurse, they need to understand the "the scope of practice, roles, and responsibilities of forensic nursing in the emergency setting including proper identification, collection, and preservation of forensic evidence" (Navarroli, 2023, p. 2). These skills can be employed particularly following a physical assault to be used with reporting to local law enforcement. They also need to "be educated in trauma-informed care in order to provide appropriate care to all patients who experience intentional or unintentional violence" (Navarroli, 2023, p. 2). Price and Maguire (2016) further explained that forensic nurses may work in industrial settings such as the ED and have a responsibility for risk management, injury prevention, and investigations. This expertise will allow the nurse to transition from role of emergency nurse providing care of patients to forensic nurse addressing the aftermath of a violent incident including trauma-informed care to victimized ED coworkers.

Forensic nurses and emergency nurses with forensic nursing training are situated to combine their expertise in trauma-informed care, evidence collection, and expert testimony to support victimized ED workers. Forensic nurses can explain to victimized ED workers that anger and crying can be a normal manifestation of the emotional impact of WPV (Demirci & Uğurluoğlu, 2020). Support for victimized workers can be demonstrated by colleagues covering their assignment while they take a break to recover (Gillespie & Palazzo, 2022). In addition, forensic nurses and emergency nurses with forensic nursing training can collaborate with employers to provide a safe, quiet room where workers can reflect and/or cry as needed. Not all workers will show their symptoms of stress following WPV. As a result, forensic nurses and emergency nurses with forensic nursing training along with charge nurses and managers can purposefully round the department to inquire how ED workers are doing following incidents of WPV. They also can offer personal support and referrals for professional counseling to ED workers who experienced WPV as well as those workers who witnessed the event (Gillespie et al., 2019; International Association of Forensic Nurses, 2023; Powell et al., 2023). For some workers, witnessing WPV may be as traumatic as being the target of WPV. The need for trauma-informed care/support should not be limited to WPV involving threats and/or assaults; verbal abuse can have a significant emotional impact and thus warrants support being offered. It is possible that some ED workers may not ask for support, because they believe their colleagues will not know how to provide emotional support to them. This perceived lack of effective emotional support could be mitigated through training sessions with ED workers led by forensic nurses and emergency nurses with forensic nursing training (Graham, 2017).

Forensic nurses and emergency nurses with forensic nursing training can leverage their expertise to partner with an interprofessional team of ED workers, security personnel, and risk management to design a violence prevention, management, and recovery program (Demirci & Uğurluoğlu, 2020; International Association of Forensic Nurses, 2023). This program can include training in interpersonal relations to prevent interpersonal violence, conflict resolution, and self-defense strategies (Demirci & Uğurluoğlu, 2020). Navarroli (2023) recommended that workers receive training on evidence collection and preservation, which will be particularly beneficial for documenting physical injuries due to WPV. Photos should be taken over the course of several days, because the visualization of the injury can evolve (Adams et al., 2023). The training also can include information on how to file a police report and testify in legal proceedings should victimized workers choose to press charges against the patient/visitor offenders (Navarroli, 2023; Powell et al., 2023).

Limitations

There were three key limitations for this study. First, the study design was cross-sectional, which limited the ability to determine cause and effect between WPV and emotional impact. Second, the details of WPV incidents were not explored, which could have explained why some incidents of verbal abuse were rated as higher than some incidents of threats and assaults when rated by the same ED worker. Third, sexual abuse was not measured. This limited the ability to realize the full scope of potential WPV enacted by patients and visitors in ED settings.

Conclusion

Respondents agreed on the need for support after experiencing WPV. However, many ED workers who experienced WPV did not use the support available to them after personally experiencing WPV. For those who sought emotional support, colleagues were their primary source. Given that no difference was found between the emotional impact of verbal abuse and assaults, support should be offered to all ED workers regardless of the category of WPV they experience. Forensic nurses and emergency nurses with forensic nursing training can lead the design and implementation of a trauma-informed care approach to support victimized workers, prevent and manage future incidents, and train ED workers on pressing charges and testifying. Further research is needed on the deficiency in support mechanisms at the organizational level and the ED workers' perception of effective tactics in WPV support. Insight into why support is perceived as available and even accessible but not used by all warrants further study.

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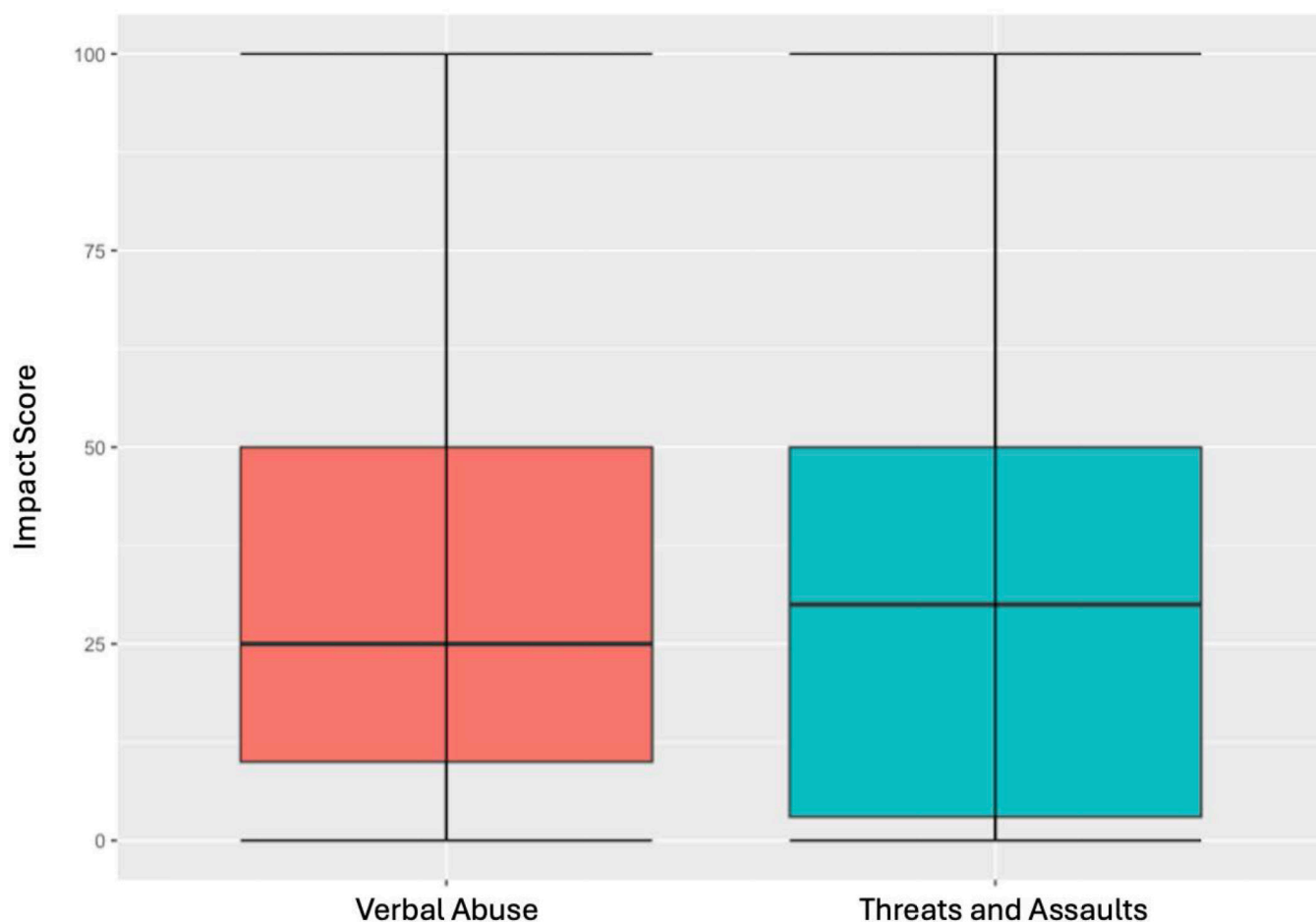


Figure 1.
A Comparison of the Impact of Workplace Violence Experienced by Verbal Only and Threat/Assault

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Table 1
Availability of and Need for Emotional Support Following Workplace Violence.

	Disagree or strongly disagree		Neutral		Agree or strongly agree	
	n	%	n	%	n	%
Support available to me when needed	23	11.2	52	25.5	129	63.2
Staff verbally abused need support	12	5.9	27	13.2	166	81.0
Staff threatened need support	4	2.0	19	9.2	183	88.8
Staff physically assaulted need support	3	1.5	7	3.4	196	95.1
Verbal abuse, threats, and physical assault require different supports	30	14.8	52	25.6	121	59.6
It is difficult to access appropriate supports when necessary	85	42.5	77	38.5	38	19.0

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Table 2

Use of Support Person Following Workplace Violence.

Support used	n	%
Colleague	127	62.3
Supervisor	62	30.4
Partner/family member	90	44.1
Close friend	57	27.9
Other	5	2.5
None	36	17.6

Table 3
Perceptions of Emotional Support Provided Based on Category of Workplace Violence (i.e., verbal abuse, threats, assaults).

	Disagree or strongly disagree		Neutral		Agree or strongly agree	
	n	%	n	%	n	%
Managers are supportive following workplace violence						
Verbal abuse	57	27.9	51	25.0	96	47.1
Threats	43	21.4	48	23.9	110	54.7
Assaults	35	17.7	37	18.7	126	63.6
Staff are reluctant to discuss workplace violence with family/friends						
Verbal abuse	102	50.2	50	24.6	51	25.1
Threats	105	52.2	50	24.9	46	22.9
Assaults	109	53.2	52	25.4	38	18.5
Colleagues are generally unsupportive after workplace violence						
Verbal abuse	154	74.8	34	16.5	18	8.7
Threats	163	79.1	28	13.6	15	7.2
Assaults	171	85.1	20	10.0	10	5.0
Families/friends are significant source of support after workplace violence						
Verbal abuse	21	10.3	42	20.6	141	69.1
Threats	22	10.9	38	18.8	142	70.3
Assaults	18	9.0	36	18.1	145	72.9
Staff are generally satisfied with organizational support after workplace violence						
Verbal abuse	71	35.1	68	33.7	63	31.2
Threats	63	32.1	67	34.2	66	33.7
Assaults	60	31.1	68	35.2	65	33.7