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Attitudes toward patient aggression amongst mental health nurses in the 'zero tolerance' era: associations with burnout and length of experience

RICHARD WHITTINGTON BA, PhD, CPsychol., AFBPsS
Senior Lecturer, Department of Nursing, University of Liverpool, Liverpool, UK

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Summary

• UK government policy now officially encourages an attitude of 'zero tolerance' towards aggression against health care staff.

• This study examines levels of such tolerance amongst a group of mental health care staff and associations between tolerance and other occupational and stress factors.

• Thirty-seven staff completed a Tolerance Scale (from the Perceptions of Aggression Scale) and the Maslach Burnout Inventory.

• Tolerance for aggression was higher amongst more experienced staff ($P < 0.01$) and high tolerance was associated with low emotional exhaustion, low depersonalization and high personal accomplishment ($P < 0.01$).

• Some staff endorse positive statements about patient aggression and a tolerant attitude may be linked to low burnout.

• Nurse attitudes to patient aggression therefore are complex and do not necessarily equate with an approach of 'zero tolerance'.

Keywords: burnout, health care, work-related aggression, zero tolerance.

Introduction

A commitment to tackling violence to health care staff is now well-established on the UK government's policy agenda for the National Health Service (NHS) (http://ww.nhs.zerotolerance) and violence is frequently condemned in policy statements as an abuse of the human and occupational rights of such staff. Exposure to violence is recognized as a significant factor in making the NHS an unhealthy and unattractive workplace that intensifies recruitment and retention problems (Department of Health, 1999). The government's approach to this problem is to exhort staff and their managers to adopt an attitude of 'zero tolerance' towards patient violence. Such violence is now expected to be viewed by clinical staff as unacceptable and liable to lead to sanctions of some sort against the perpetrator. Whilst it is true that there is scope for flexibility in applying this policy to mental health care settings, the general tone of the campaign still permeates these settings and may lead to reduced tolerance overall.

This shift in policy emphasis towards greater recognition of the problem of work-related aggression is an

Correspondence to: Richard Whittington, Department of Nursing, University of Liverpool, Liverpool L69 3GB, UK (tel.: 0151-794-5910; fax: 0151-794-5678; e-mail: whitting@liv.ac.uk).

improvement on the previous lack of policy in this area. There is certainly a serious issue to deal with (Budd, 1999) and it is laudable that the government is doing something about it. However the new policy is not without its problems. One of these is the lack of clarity in defining the problem behaviour of violence. Whilst the emphasis of government policy seems to be upon physical violence directed against staff, policy statements from other bodies include a much wider range of patient behaviours within their remit. The Royal College of Nursing (1999, p. 3), for instance, suggests that violence includes abuse, threats, the inducement of fear and the application of force. Research into the problem is also hampered by confusion of the term 'violence' with the more broad concept of 'aggression' and contradictory views on whether behaviour such as self-harm should be included (Whittington, 1994). For the purposes of this paper, the term 'aggression' will be used and defined as 'any form of behaviour directed towards the goal of harming or injuring another living being who is motivated to avoid such treatment' (Baron & Richardson, 1994, p. 7; Krahe, 2001, p. 11).

A second problem with adopting 'zero tolerance' policies is that it may disturb the subtle balance which needs to be struck in deciding what is acceptable staff and patient behaviour in any health care interaction. Government and management attitudes towards the problem of patient aggression had of course for many years been too lax, colluding with the widespread acceptance of the problem as 'just part of the job'. Now, however, there is a hardening of these attitudes to one of supposed 'zero tolerance' and it is possible to foresee that this could eventually lead to an abuse of patients' right to express appropriate annoyance and irritation with an inadequate service. It could raise the tension in staff–patient interactions so that the tone becomes one of confrontation rather than conciliation and thus aggression becomes more, not less, likely. Most importantly, zero tolerance could be seen as a government incursion into practitioners' right (and duty) to make clinical judgements about the therapeutic meaning and benefit of individual patient behaviour. This individual judgement is crucial to effective clinical decision-making. To put it another way, trained and experienced health care practitioners may have a wide range of views on aggression by a patient for whom they are caring, including perhaps awareness of possible positive aspects to such aggression. Such sophisticated views of aggression, if they exist, are being restricted under a blanket 'zero tolerance' policy.

Although a significant proportion of UK health care staff face work-related physical aggression (e.g. 5% of nurses, Budd, 1999), very little is known about how these staff view the problem. There is a quite appropriate emphasis in the literature on the negative physical and psychological outcomes amongst staff following exposure to physical aggression (Leather *et al.*, 1999), but the more general attitudes of staff to patient aggression have rarely been examined. If we take a step back, it is possible to see that such attitudes may include positive evaluations of patient aggression in certain circumstances. These might, for instance, include an evidence-based belief in the cathartic health benefits of expressing anger (Geen, 2001). Another situation is one in which an episode of patient aggression is appraised by the practitioner as justified assertion against a powerful oppressor (e.g. bullying by staff or other patients). It is likely that in both circumstances the aggression would have to result in low levels of harm for it to be positively evaluated. These attitudes are also worth exploring as they may to some extent predict staff behaviour in general or specifically during high-tension interactions with patients. Positive attitudes could be related to greater latitude being given to patients to express anger safely and to engage in low-level physical aggression in certain circumstances whilst negative attitudes could be associated with a more controlling approach.

'Zero tolerance' therefore is a neat slogan but it is unlikely to be an adequate summary of how trained and experienced mental health practitioners view, or should view, patient aggression. Tolerance is more likely to be an attitudinal dimension which distinguishes some practitioners from others and which may be associated with other attitudes and experiences. The aim of the exploratory study reported below was to begin examining this concept of 'tolerance' empirically amongst a group of mental health practitioners. Tolerance here is defined as the tendency to

- express awareness of the reasons for aggression by people in receipt of mental health care and/or to;
- endorse positive evaluations of such aggression.

It is proposed that such tolerance is an attitude as traditionally conceptualized by psychologists (e.g. Baron & Richardson, 1994) as a relatively stable positive or negative evaluation of a phenomenon involving cognitive, affective and behavioural components. It could be assessed in the general public or in patients themselves, but the focus here is on the attitudes of health care staff in particular, especially in the cognitive domain. Tolerance is measured in the study using a robust questionnaire developed in the Netherlands (Jansen *et al.*, 1997). The objective of the exploratory study therefore was to examine levels of tolerance amongst a small group of UK mental health staff using this scale, and to carry out a preliminary examination of how such tolerance varies according to some other demographic and occupational characteristics.

Of particular interest is the possible relationship between tolerance and occupational stress amongst mental health care staff. Burnout and exposure to previous physical aggression at work can both be seen as potential covariates with tolerance. Burnout is an occupational stress syndrome, sometimes developed by those in the caring professions which has been extensively studied and linked to a wide range of occupational factors, whether as cause, effect or covariate (Maslach *et al.*, 1996). An important theme of the burnout syndrome is reduced ability to empathize with clients and it is likely that such reduced empathy could be associated with reduced tolerance, as tolerance for someone's aversive behaviour must to some extent be based on an ability to empathize with the reasons for their behaviour. In addition, staff who have been recently assaulted may differ in their levels of tolerance for patient aggression. They may, as a result of being assaulted, be less tolerant of the behaviour in general or, alternatively and more speculatively, they may be more likely to be involved in an incident because they are less tolerant of the behaviour. Whatever the direction of causality, the association between these two factors is worth investigating. The study therefore set out to address two research questions:

1 Does tolerance for aggression vary amongst mental health practitioners, and, if so,
2 What occupational and stress factors are associated with a more tolerant attitude?

Method

DESIGN, SETTING AND SAMPLE

A cross-sectional survey design was adopted. A convenience sample was recruited from nursing staff working for a community mental health trust in the north-west of England. One hundred mental health staff were issued with the two questionnaires described below (Tolerance Scale and MBI) and 37 returned these completed (37% response rate).

MEASURES

Demographic and occupational information

Basic demographic information was requested from respondents, together with information on their current workplace, frequency of contact with detained patients, frequency of contact with violent patients, attendance at aggression management training and experience of physical assault in the preceding 12 months.

Tolerance Scale. The Perception of Aggression Scale (POAS) was initially developed in the Netherlands to assess attitudes towards patient aggression amongst mental health nurses (Jansen *et al.*, 1997). An analysis of the 32-item scale (Jansen, 2000) indicated that such attitudes load onto two main factors. One of these factors, 'aggression as a normal reaction', is the basis for the Tolerance Scale discussed below. This scale is made up of 12 items (see Fig. 1) relating to the concept of tolerance: eight items consist of neutral, non-condemnatory statements about patient aggression and four consist of positive statements. The scale is self-administered and elicits the degree of agreement or disagreement on a five-point range with each statement. All items are scored in the same direction, with no reverse scoring. Total scores can thus range from 12 to 60 and a high score indicates high tolerance for aggression as defined above. Jansen (2000) reported a mean score of 35.6 (SD = 7.6, range 12–53) and high internal consistency for this scale ($\alpha = 0.82$) based on a sample of 222 nurses from the UK, Republic of Ireland and Norway.

Maslach Burnout Inventory – Human Services Survey (MBI-HSS). This scale was developed by Maslach *et al.* (1996). It is a 22-item self-administered questionnaire widely used to measure the occupational stress syndrome known as burnout and yields scores on three subscales: emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA). Personal accomplishment is negatively correlated with the other two scales, and scores on each of the three subscales are usually reported in terms of high, medium or low categories. Respondents report the frequency with which they experience a range of negative work-related feelings from 'never' to 'every day'. The tool has robust psychometric properties but has been developed mainly using North American samples, who may score higher overall on all three factors (Maslach *et al.*, 1996). For comparison purposes, the inventory manual cites mean scores of 16.68 for EE, 5.94 for DP and 32.70 for PA from a large European (Dutch) sample of nurses (Schaufeli & Van Dierendonck, 1993).

PROCEDURE

Ethical and operational permission to proceed was obtained from the appropriate agencies. All staff on seven inpatient units within the trust were invited to take part in the study and those who agreed were given the questionnaire pack directly by a research assistant. They were asked either to complete it face-to-face with the researcher or to complete it elsewhere and return it by post.

1. ***Aggression offers new possibilities in care***
2. ***Aggression helps to see the patient from another point of view***
3. ***Aggression is the start of a positive nurse–patient relationship***
4. ***Aggression is a healthy reaction to feelings of anger***
5. Aggression is emotionally letting off steam
6. Aggression is energy people use to achieve a goal
7. Aggression is an attempt to push boundaries
8. Aggression is an expression of emotion just like laughing or crying
9. Aggression is a form of communication and as such is not destructive
10. Aggression is for the protection of one's territory and privacy
11. Aggression comes from feelings of powerlessness
12. Aggression will make the patient calmer

Figure 1 Tolerance Scale. Items in ***bold italics*** constitute positive statements about aggression.

STATISTICAL ANALYSIS

Statistical analysis largely consisted of correlational and group-difference statistics (t-test and Pearson's r).

Results

One respondent was excluded from analysis of the Tolerance Scale and the PA subscale of the MBI because of extensive missing data. Two others were excluded from analysis of all three subscales of the MBI for the same reason.

The characteristics of the sample were as follows. Sixty-seven per cent were aged between 30 and 49 years and 62% were female ($n = 23$). All but one of the respondents was a mental health nurse or health care assistant, with 77% ($n = 28$) in senior clinical grades. Eighty per cent ($n = 30$) of the sample had worked for 6 years or more in mental health care. Sixteen per cent ($n = 6$) worked in the community and most of the remainder worked in adult general psychiatry. Of those who responded to the item, 93% ($n = 34$) said they often or occasionally had involuntary admissions to their ward. All but one were permanent members of staff, mainly full-time. Seventy-six per cent ($n = 28$) said they had attended 'Control and Restraint' training in the preceding year. Fifty-four per cent ($n = 20$) encountered aggressive patients at least once a month and 13% ($n = 5$) encountered such patients daily. Twelve respondents (32%) had been physically assaulted at work in the preceding year.

Mean scores for the questionnaires are shown in Table 1. A comparison was made of this group with the sample reported by Jansen (2000) which, it should be noted, included a number of nurses from a different part of the UK. The group studied here were slightly less tolerant but this difference was not statistically significant ($t = 1.18$, 35 d.f., $P > 0.05$). The internal consistency of the Tolerance Scale with this sample was high ($\alpha = 0.76$). The sample mean on the three MBI subscales did not differ significantly from that of the Dutch normative sample (Schaufeli & Van Dierendonck, 1993).

Mean scores on the Tolerance Scale were higher for those aged over 40 years and over, higher grade staff and staff who 'always' or 'often' worked with patients detained under the Mental Health Act, but none of these differences were statistically significant. There was no difference in tolerance between the assaulted and non-assaulted groups of staff. The only significant difference ($t = 2.94$, 31 d.f., $P < 0.01$) on these occupational variables was that staff with more than 15 years of experience were

Table 1 Mean sample scores on the Tolerance Scale and the Maslach Burnout Inventory (MBI)

	n	Mean	SD	Min	Max
Tolerance Scale	36	34.19	7.1	19	47
MBI emotional exhaustion	35	16.77	11.0	1	46
MBI depersonalization	35	5.63	5.7	0	24
MBI personal accomplishment	34	30.26	12.3	1	48

significantly more tolerant (mean = 38.25, SD = 4.91, $n = 16$) than those with 15 or fewer years of experience (mean = 32.05, SD = 6.90, $n = 17$). This tendency was even stronger ($P < 0.001$) for the difference between these two groups on the four positive evaluation items.

Taking the whole group together, more than 20% of the sample agreed or strongly agreed with at least one of the four items containing positive statements about aggression in the Tolerance Scale.

There were a number of significant correlations between the Tolerance Scale and burnout scores. Tolerance correlated negatively with EE ($r = -0.34$, $P < 0.05$) and DP ($r = -0.42$, $P < 0.05$) (see Fig. 2 & 3) and very positively with PA ($r = 0.56$, $P < 0.01$) (Fig. 4).

Discussion

It will be recalled that this study set out to examine if tolerance for aggression varies amongst mental health practitioners, and, if it does, what occupational and stress factors are associated with a more tolerant attitude.

Clearly there is indeed substantial variation in the degree to which practitioners endorse non-condemnatory and positive statements about patient aggression. As stated above, at least one-fifth of the sample endorsed one or more of the four items containing positive statements about aggression in the Tolerance Scale, whilst obviously many disagreed. This sample was slightly less tolerant than the European group studied by Jansen (2000) but the difference was not significant.

The tendency towards toleration was strongly associated with two occupational factors: length of experience and level of burnout. It is noteworthy that staff who have been in the job for more than 15 years display a greater tolerance of this behaviour, at least in terms of their expressed attitudes. It is possible that this sophisticated, and to some extent counter-intuitive, point of view may develop as part of a growing professional wisdom and sense of confidence in dealing with aggressive patients. Less experienced staff were significantly less likely to endorse tolerant statements, perhaps because of greater

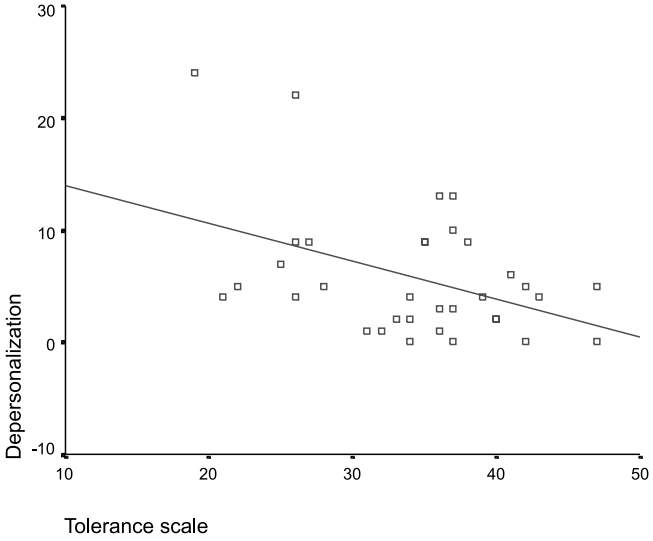

Figure 3 Scattergram plot of Maslach Burnout Inventory depersonalization subscale and Tolerance Scale scores.

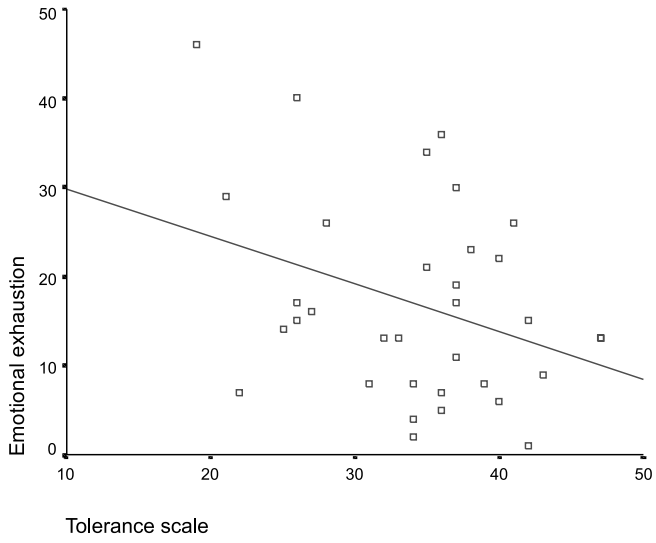

Figure 2 Scattergram plot of Maslach Burnout Inventory emotional exhaustion subscale and Tolerance Scale scores.

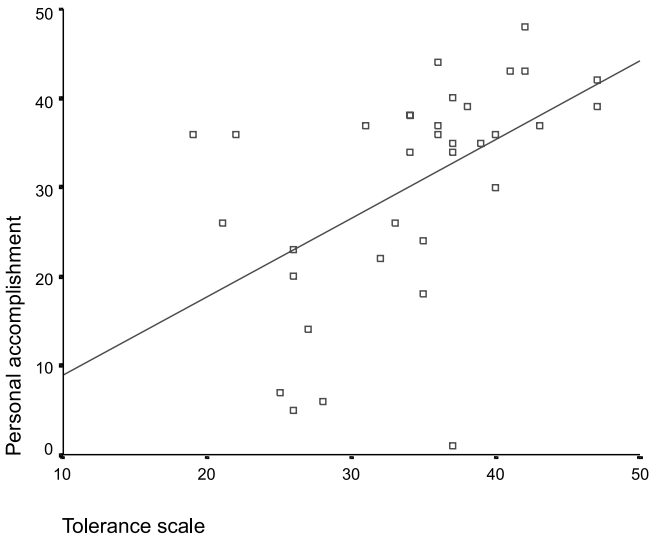

Figure 4 Scattergram plot of Maslach Burnout Inventory personal accomplishment subscale and Tolerance Scale scores.

anxiety and limited experience of seeing all possible sides of the effects of aggressive behaviour.

Equally noteworthy is the significant association between tolerance and burnout, such that tolerant staff reported less EE and DP and a stronger sense of PA at work. Perhaps practitioners' emotional capacity to maintain a sense of patients' personhood and to empathize with their reasons for acting aggressively enables a more positive view of negative behaviour to be adopted. This is enhanced again by a sense of self-efficacy at work, as displayed through a greater sense of PA. The notion of 'personal accomplishment' as measured here relates to 'feelings of competence and successful achievement in one's work with people' (Maslach *et al.*, 1996, p. 4). Emotionally depleted staff who find it hard to get in touch with patients' points of view, and who feel they are not efficacious at work, may tend to reflect this in their difficulties in tolerating aggressive behaviour. This is not to say that 'tolerance' is a preferable state to 'intolerance', as either approach may be associated with inappropriate handling of an aggressive episode.

The limitations of this study should be acknowledged before any great weight is placed on the findings. In particular, the convenience sample was small and self-selecting and the response rate was low. Generalization beyond the group assessed here is not possible, especially as there may be a biasing tendency for assaulted staff to respond to surveys of this type because the topic has higher salience for them. Nevertheless there is preliminary evidence here of variation even in this sort of small group which may well have a disproportionate number of assaulted staff (because of the biasing tendency mentioned above). If so, the relatively large minority endorsing positive statements is more remarkable.

The implications of this small study for a blanket 'zero tolerance' policy towards aggression across the board in the NHS are unclear. It is not desirable to negate the significant benefits of the past 10 years in terms of gaining recognition of the negative impact of all types of workplace aggression and gaining support for assaulted staff. However, there is obviously a mismatch between the 'zero tolerance' expressed in policy statements and the 'variable tolerance' based on therapeutic models of care expressed by the nurses in this study.

There is a final point to be made with regard to the theoretical nature of the tolerance concept. If tolerance is indeed a robust attitudinal dimension, it will exist within a network of other professional and personal attitudes adopted by a nurse. For instance, negative stereotyping by a nurse of patients on the grounds of racial, ethnic or gender characteristics may potentially influence that nurse's tolerance of aggression by a patient from that social group. It is unclear where to locate the tolerance dimension within this network of attitudes, although some of the evidence here suggests that it may be useful to consider tolerance as related to self-efficacy (Bandura, 1999). This widely researched concept focuses on a person's subjective sense of mastery and control in challenging situations. If a person perceives themselves as likely to be effective in such a situation, they will experience less distress during the encounter and possibly manage it more effectively. Experienced nurses and those with a strong sense of PA were found to be more tolerant of aggression in this study and this may be the result of a strong sense of self-efficacy drawn from numerous successful experiences in managing aggression. New staff working with aggressive patients may divide into two groups after being exposed to a number of distressing incidents. Those who feel they have been unsuccessful in managing patient behaviour and/or their own anxiety during incidents may leave to work in other mental health specialities, whilst those who feel efficacious may select themselves to carry on working with this group and further enhance their sense of mastery and control. This sense of control enables them to view patient aggression from a broader and more positive perspective than the less experienced staff. Whatever the mechanisms involved, the relationship with self-efficacy is worth exploring in future research.

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