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Abuse in the workplace: experience of specialist registrars

AIMS AND METHOD

A survey was conducted to determine the experience of verbal and physical abuse among specialist registrars and the availability of training on managing abusive patients. A self-report questionnaire was sent to all specialist registrars working in the Northern Deanery.

RESULTS

Completed surveys were received from 30 out of the 49 trainees (61% response rate). Twenty-three respondents (77%) reported being abused; all reported verbal abuse and 2 (9%) reported physical abuse. The experience of trainees of abuse differed between White doctors and those from other ethnic groups. The majority of trainees had received no training to deal with abuse.

CLINICAL IMPLICATIONS

In view of the high prevalence of abuse experienced by trainees, interventions to prevent both verbal and physical abuse should be identified. There should also be formal support for managing abuse and improved recording of abusive incidents.

Psychiatry is an exciting and dangerous branch of medicine, which poses challenges to staff. This can include violence and maltreatment from a number of different sources, including patients. Professionals working in mental health trusts are on average two and a half times more likely to experience violence in the workplace than professionals working in other National Health Service trusts in the UK (Department of Health, 1999). Among hospital doctors, those working in psychiatry, accident and emergency and obstetrics and gynaecology were more likely to report violence in the workplace (British Medical Association, 2003). One study surveyed residents in all specialties and areas of medicine and found that 24% of the 200 residents who responded had been physically assaulted by a patient (Fink, 1991). Milstein (1987) found that the frequency of assault was approximately twice as high among psychiatric residents as among medical residents. Thus, although all medical residents are at significant risk of being assaulted by patients, psychiatrists in training may be at greatest risk. We know of no UK study that has investigated verbal and physical abuse among psychiatric trainees and the training available for trainees to deal with such abuse. In the first European study 56% of psychiatric trainees had experienced at least one physical assault by a patient and 72% had been threatened by a patient. Only a small minority had received any training related to patient violence (Pieters *et al*, 2005).

Studies from the USA and Canada have reported similar findings (Chaimowitz & Moscovitch, 1991; Schwartz & Park, 1999) and surveys have revealed that psychiatric residents feel their training in violence management is inadequate (Chaimowitz & Moscovitch, 1991; Fink *et al*, 1991; Black *et al*, 1994).

The aim of this study was to investigate the experience of abuse in the workplace of specialist registrars in psychiatry working in the Northern Deanery.

Method

Questionnaires were sent in March 2005 to all specialist registrars in psychiatry training in the Northern Deanery. Responses were anonymous. The questionnaire asked about any verbal and physical abuse experienced during specialist registrar training and aimed to identify gaps in training and to look at the perceptions of those trainees who had been abused (Box 1). All trainees were sent a brief covering letter, a questionnaire and a return envelope. A second copy was sent to those who had not replied.

Results

Of 49 psychiatric trainees, 30 completed the questionnaire (61% response rate). Of those that responded, 17 (57%) were male and 13 (47%) female. The median length of training as specialist registrar in psychiatry was 18 months. The ages of the respondents ranged from 29 to 43 years. Twenty respondents (67%) were White and 10 (33%) were from other ethnic groups.

The specialties of the 30 specialist registars that returned completed questionnaires are shown in Table 1. Most (n=16, 53%) were working in general adult psychiatry.

Experience of abuse

Twenty-three respondents (77%) had experienced abuse since becoming a specialist registar. More than half had

Box 1. Questions sent to specialist registrars regarding their experience of abuse

- What is your current post?
- Since becoming a specialist registrar in psychiatry, how many times have you been verbally or physically abused?
- In which environment/s did the abuse occur?
- Following any incidents, have you ever sought support? If yes, who did you receive support from?
- In these incidents of abuse, which people did you consider were being abusive?
- Would you consider that you were abused in your workplace because of gender, ethnicity, religion, accent, disability, other? Please state
- Have you had any formal teaching on dealing with abuse?

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Table 1. Specialty of the 30 specialist registrars returning a completed survey

	n (%)
Specialty	
General adult psychiatry	16 (53)
Learning disability	4 (13)
Old age psychiatry	4 (13)
Child and adolescent psychiatry	3 (10)
Forensic psychiatry	2 (7)
Psychotherapy	1 (3)

been abused between 2 and 5 times. Two male respondents (9%) reported physical abuse (1 working in adult psychiatry and 1 in learning disability). Eight female respondents (61%) reported being abused, as did 15 male respondents (88%). Experience of abuse according to ethnic origin is shown in Table 2.

Sixteen incidents of abuse occurred on the ward, at the police station, in the clinic, in the accident and emergency department and during a home visit.

When asked who they had been abused by, out of the 28 responses 21 (75%) indicated a patient, 6 (21%) a carer and 1 trainee had been abused by a consultant.

Support following abuse

Twelve (52%) trainees sought support following an incident of abuse. Four (33%) reported receiving support from nursing staff, 3 (25%) from a peer, 3 (25%) from their educational supervisor, 1 (8%) from a consultant and 1 (8%) from a medical secretary.

Perceived reasons for abuse

Seven of the White doctors (44%) did not give a reason for the abuse, 6 (37%) felt that it was an inherent part of the profession, 2 (13%) felt it was because of their gender and 1 (6%) felt it was because of their accent. Of the doctors from other ethnic groups who reported abuse, 3 (43%) felt that they were abused because of their ethnicity, 2 (29%) because of their accent, 1 (14%) because of their gender, and 1 (14%) because of the nature of their job.

Table 2. Experience of abuse by specialist registrars according to gender and ethnicity

	Abuse	Verbal abuse	Physical abuse
Gender			
Male	15	15	2
Female	8	8	0
Ethnicity			
White	16	16	2
Other ethnic group	7	7	0

Box 2. Further comments from trainees

- How tolerant can we be?
- Can we refuse to treat when we are abused?
- What are our rights?
- Psychotherapy training will be helpful to deal with abuse
- We should see abuse as not acceptable
- We need policies that do something rather than just tick boxes
- How do we access help and support following abuse?
- We should look at issues in the context of patient–doctor power imbalance.

Previous training

Twenty-three respondents (77%) reported not receiving any training to deal with abuse. Of the 7 trainees (23%) who reported previous training, most had received training in breakaway and de-escalation techniques.

Further comments

Further comments made by trainees are shown in Box 2.

Discussion

The results of this and previous studies clearly show that trainees in psychiatry are at high risk of abuse (Chaimowitz & Moscovitch, 1991; Schwartz & Park, 1999; Pieters *et al*, 2005), with verbal abuse being most common. Although physical abuse was much less common, this was prevalent in this relatively small sample.

However, there are limitations to our study as the number of trainees who responded was relatively small (*n*=30, response rate 61%) and there is a possible bias since respondents who had been abused might have been more likely to reply. This could have resulted in an elevated prevalence of abuse. Another limitation of the study is the absence of further breakdown of the type of physical abuse (i.e. pushing, slapping, punching) and whether an injury was sustained.

There were no differences reported by trainees in the earlier or later years of training, which is similar to the survey of psychiatric trainees in Belgium (Pieters *et al*, 2005).

The perception of abuse appears to differ between White trainees and those from other ethnic groups, the majority of whom reported ethnic origin as a reason for abuse. This may be owing to prejudice or the perception of prejudice. Of the White doctors, 41% gave no reason for the abuse and 35% felt that abuse was an inherent part of their profession.

The majority of respondents reported no previous training to help deal with abuse, which is in line with other studies from Belgium, Canada and USA (Chaimowitz & Moscovitch, 1991; Fink *et al*, 1991; Black *et al*, 1994; Pieters *et al*, 2005).

Hatti *et al* (1982) emphasised the importance of interpersonal dynamics in such training and suggested that clinicians may be best served when training directs

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their attention to the anxieties and fears aroused when confronting a violent patient. In addition to practical training in breakaway and de-escalation techniques, there should be debriefing immediately following an abusive incident to help trainees cope with the feelings aroused. Trainees should be aware of policies for reporting abusive incidents in their trust, particularly whom they should contact after an incident.

If we accept that experiencing abuse is an inherent part of psychiatry, there would be the danger of turning training into an unpleasant and dangerous period. When trainees were asked about their perceived reasons for being abused, none cited the 'abuser' as being responsible for their actions, instead they perceived aspects of themselves such as ethnicity, gender, accent and their job as psychiatrists to be responsible. Training should reduce beliefs that being abused is part of the job or that the resident is to blame for assaults.

The period of specialist registrar training may be a high-risk time for abuse because specialist registrars may be more likely to confront patients with compulsory detentions. It would be interesting in the future to compare rates of abuse among psychiatric senior house officers and consultants and to conduct collaborative surveys between different psychiatric training regions in the UK.

Declaration of interest

None.

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