

Aggression Management

- Evaluation of a training course -

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Abstract

Although health-workers are at considerable risk for assault, specific practical guidelines for controlling anger and aggression are limited. A training course was developed to provide staff with the skills and knowledge necessary for coping with patients who are aggressive. The course covers topics such as theories of aggression, deconstructing myths, psychopathology related to aggressive behaviour, integrating skills of de-escalation, disengagement, and restraint. In the effect study, staff members of two units were trained in the management of aggressive behaviour. The number of aggressive incidents, and staff members' subjective feeling of safety and rate of absenteeism was registered over a period of three months in two trained and two untrained units. Analysis shows that the trained group was significantly better in dealing with aggression and felt significantly safer.

Background

Not until recently, only police officers, prison workers, and money runners were thought to be at risk for assault and aggressive behavior. Therefore, these professionals get training in dealing with violent confrontations. Health-workers, on the contrary, get no training in this area; although, they are more and more known to be confronted with aggression and violence (CBS 1998, Driessen and Middelhoven 2001).

Research show that health-workers without training are not safe in managing aggression or violence and may even exhibit behaviour which is potentially dangerous to themselves and their clients. The potential harm that aggression and violence cause in health-workers is not only a physical one. There is solid prove that exposure to aggression and violence is also linked with an increase in stress and Post Traumatic Stress Disorders (Engels and Marsh 1986, Turnbull 1993). Without question, these effects can have serious financial consequences for the healthcare centers. This can be as a result of an increased rate of absenteeism, decreased treatment results as well as an exponential growth of legal actions by the employees against the healthcare centers (Ishimoto 1984).

Since October 1994, the law in imposes the employer to care for the safety of its employees. At present, several trainings in aggression management are given by all sorts of agencies, unfortunately without measuring the effectiveness of these trainings. Therefore, a training course was developed to provide health-workers with the skills and knowledge necessary for coping with patients who are aggressive. This training is based on a British approach, adapted and modified to the situation present in the University Hospital of Groningen , The Netherlands (Paterson and Turnbull 1999).

Method

The training consists of four sessions of 2.5 hours each of which 1.5 hours are spent discussing the theory and non-physical intervention. In so doing, actors are also used. Topics involve theories of aggression, deconstructing myths, psychopathology related to aggressive behaviour, integrating skills of de-escalation, disengagement, and restraint. Aside from this, one hour is spent on physical training.

The research was conducted at the University Hospital of Groningen, The Netherlands. The experimental group - the group that underwent the training - consisted of the staff members of the

psychosis cluster (nurses, residents, psychiatrists, psychologists, administrative workers, psycho-motor therapists, creative therapists and other non verbal therapists, N=37) and was trained in the management of aggressive behaviour. The control group - the group that did not get the training - consisted of the staff members of the acute cluster (N=19).

The number of aggressive incidents, staff members' subjective feeling of safety and rate of absenteeism was registered over a period of three months in the trained and untrained group. Pre-measurements, post-measurements and follow-up measurements (after three months) were conducted for both groups.

With the already existing MAG form (record of aggressive incidents), the number of aggressive incidents were registered. Apart from that, two new means of measurement were developed in order to assess the subjective feeling of safety: the QSES-W and the VAS-s. The Questionnaire Subjective Experience of Safety at the Workplace (QSES-W) was developed after intensive consultation with the sub faculty Employment and Organizational Psychology of the University of Groningen⁴. It consists of 10 questions that can be ordered into three different clusters: a cluster control, a cluster emotional/ psychological suffering and a cluster physical threats.

The second measuring instrument was the Visual Analogous Scale for safety (VAS-s). It plots the sense of safety on a scale of zero to ten centimeters.

Results

Because of the small group number, non-parametric tests were used, such as monte carlo analyses⁵. These statistics show that there are no group differences between the experimental and control group at the pre-measurement of the VAS-s and the QSES-W.

Looking more in detail, the results show that the control group remains static. The average difference in the VAS-s scores - the delta -, as a result of the average difference between the pre-measurement and the post-measurement, is zero. In contrast, the experimental group shows a significant increase on the VAS-s (figure 1). The average difference between the pre-measurement and the follow-up-measurement of the VAS-s is 7.14. This difference is significant at a 0.05 level. The results of the control group and the experimental group are significantly different on the VAS-s at follow-up measurement ($p < .01$).

Figure 1: **Difference VAS-s Experimental Group (pre & post)**

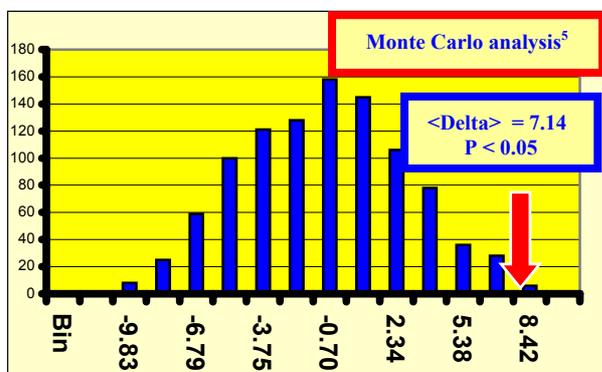
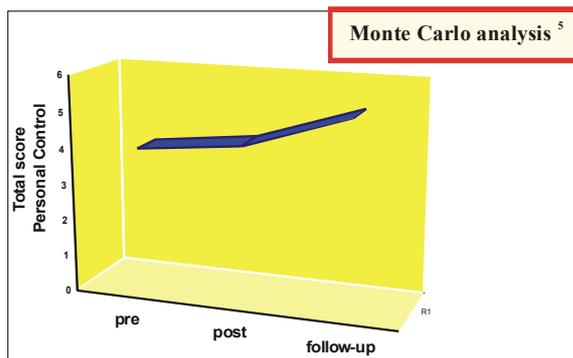


Figure 2 shows that the experimental group also scores higher in the follow-up measurement compared with the pre-measurement on the QSES-W, cluster personal control. Possibilities for personal control include physical possibilities and non-physical possibilities, such as calmness and

domination. An increase in personal control is already visible at post-measurement, however not significantly. The follow up measurement demonstrates a significant rise compared with both the pre- and post-measurement ($p < .01$). The two other clusters of the QSES-W show a likewise pattern. There was a significant decrease on the cluster of emotional/psychological suffering and on the cluster physical threats, both on post- and follow-up-measurement level ($p < .01$). The QSES-W also shows a significant difference, at post-measurement, between the experimental and control group on the cluster control, cluster emotional/psychological suffering and cluster physical threats ($p < .01$).

Figure 2: **Personal control Experimental Group QSES-W**



Discussion

Statistics show that the training involved met the expectations. Health-workers who underwent the training showed more control, an increased sense of safety, and a decreased level of emotional and physical suffering at post- and follow-up-measurements. Statistics also showed that this positive effect is not due to group differences at pre-measurements.

The positive results are shown on the VAS-s as well as the QSES-W. However, these results could not be affirmed by the MAG. This might be due to suppression of reporting aggressive incidents, also reported in other studies (Lindow & McGeorge, 2000). Especially because the QSES-W, cluster physical threats - which could be seen as an alternative for the MAG - shows a decrease after training. As a recommendation, the way aggressive incidents are registered in general, should be questioned.

The overall finding is that this aggression management training proved to be effective. The trained group was significantly better in dealing with aggression and felt significantly safer. However, some effects were not immediately clear after training, but only after three months, like experience of personal control (QSES-W). Further research is therefore recommended on the long-term effects of this training, as well of the validation of the instruments.

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