



Occupational disappointment and emergency nurses: A qualitative descriptive study

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Abstract

Background: Occupational disappointment is a novel concept in emergency nursing. It is a feeling of disheartenment with career choice. It results from prevalent, unaddressed verbal abuse in the emergency department directed towards nurses from patients and/or their visitors. Occupational disappointment is conceptually different from burnout and compassion fatigue. In the context of the COVID-19 pandemic, it is important to acknowledge this phenomenon and understand its implications while considering strategies to mitigate it.

Methods: A qualitative descriptive methodology was used in this study. Nurses were interviewed to explore the question: How do emergency department nurses experience occupational disappointment as a result of verbal abuse?

Findings: Three major themes were identified: (1) nurses' experiences of occupational disappointment; (2) nurses' responses to occupational disappointment; (3) nurses' concerns regarding occupational disappointment. While organizational policies for addressing verbal abuse exist, the development of a procedure attached to the policy would help guide nurses when managing this violence. Failure of nurse leaders to implement such measures contributes to nurses' occupational disappointment, consequently affecting nurses' practice, mental health,

and retention. While these implications are not new, the COVID-19 pandemic has exacerbated this phenomenon. The magnitude of verbal abuse that emergency nurses currently face has increased exponentially; a renewed urgency for strategic action is necessary.

Conclusion: Occupational disappointment is a direct result of verbal abuse and an indirect result of organizational failures to support nurses and empower them to mitigate this abuse.

Keywords: emergency department, emergency nurses, occupational disappointment, verbal abuse, verbal violence

Verbal abuse is frequently experienced by healthcare workers. Nurses working in the emergency department (ED) are particularly susceptible to this type of abuse (Al-Shamlan et al., 2017; Partridge & Affleck, 2017). ED nurses are subjected to verbal abuse because they provide care for patients who are stressed or aggressive, as well as those under the influence of drugs and/or alcohol (Al-Shamlan et al., 2017; Banda et al., 2016; Copeland & Henry, 2017; Partridge & Affleck, 2017; Pich et al., 2017; Zhang et al., 2017). Some ED nurses regard verbal abuse as part of the job (Hogarth et al., 2016; Hyland et al., 2016). Verbal abuse is such a part of ED nurses' everyday work, and it occurs with such frequency that nurses do not consider it to be violence at all (Baig et al., 2018). This acceptance of verbal abuse may seem like it is an expectation of nurses' work rather than an anomaly; this may be an important reason why verbal abuse continues to be prevalent in the ED.

Further, the negative effects of verbal abuse include nurses losing their concentration at work, as well as nurses experiencing mental exhaustion; these effects have an impact on patient care (Hassankhani et al., 2017; Yoon & Sok, 2016). There are also organizational impacts related to verbal violence directed toward nurses such as increases in sick leave, resignations, and recruitment difficulties (Howerton Child & Sussman, 2017; Li et al., 2017).

Finally, nurses enter the profession to help people and then are faced with verbal abuse, which is disheartening and can ultimately result in occupational disappointment (OD) (Howerton Child & Sussman, 2017, p. 547). Importantly, OD is distinguished from burnout and compassion fatigue. Burnout is a chronic response to repeated stressful exposures. Compassion fatigue is abrupt and a result of being exposed to someone else's trauma. OD is unique because it is not considered to be traumatic in nature, yet the negative stimulus is identifiable, directed to, and felt by the ED nurse (Howerton Child & Sussman, 2017). The phenomenon of OD results in a feeling of dissatisfaction in career choice as a result of endemic verbal abuse that is left unaddressed (Hassankhani et al., 2017; Howerton Child & Sussman, 2017).

The potential for the COVID-19 pandemic to exacerbate OD is concerning. Abuse of nurses and healthcare workers has increased during the COVID-19 pandemic (Alsuliman et al., 2021; Bitencourt et al., 2021; Devi, 2020; Yang et al., 2021). Additionally, nurses are working under extraordinarily challenging conditions. Navigation of the health system by patients and their families has become both changeable and challenging. During COVID-19, at times, healthcare resources have been scarce and there has been controversy regarding fair distribution of these resources. Inevitably, such controversial and high-stress situations have led to abuse of healthcare workers in both the workplace and in public spaces in their communities (Alsuliman et al., 2021; Bitencourt et al., 2021; Dye et al., 2020; Larkin 2021; Yang et al., 2021).

Method

Research design and question

Qualitative descriptive (QD) methodology in nursing research explores phenomena such as people's concerns and responses to events (Bradshaw et al., 2017; Kim et al., 2017). With this as context, QD methodology was employed to answer the research question: How do ED nurses experience OD as a result of verbal abuse? This topic was of particular interest to the first author, a female RN employed in an ED who had experienced verbal abuse from patients and their families. The first author became increasingly aware of incidents of abuse towards staff both in person and via online platforms. Over time, a change in staff sentiment towards the ED and the patients they served was also noted by the first author. This study followed the Adherence to Consolidated Criteria for Reporting Qualitative Studies (COREQ) guidelines (Tong et al., 2007).

Sample

Purposive sampling was used to recruit six female nurses aged 24 to 43 years with 2 to 18 years of experience. Purposive sampling allows for recruitment of participants who possess

the experience required for the study (Bradshaw et al., 2017); this type of sampling is strategically purposeful in obtaining information-rich data to reveal insight (Patton, 2015). In QD research studies, sample sizes are relatively small; the research is focused on in-depth contact with participants (Bradshaw et al., 2017). The six participants in this study represented a range of ages and years of nursing experience; nurses worked in two of four ED sites. An adequate sample size is one that sufficiently answers the question while obtaining data rich in information (Bradshaw et al., 2017; Sandelowski, 2000). With this as context, the researcher determined the sample size to be adequate for this QD study.

The following are the inclusion criteria for the nurses participating in this study: currently or previously employed at one of four EDs within a larger hospital corporation in an urban centre in eastern Canada; have experienced verbal abuse from patients/visitors; self-identify as having experienced OD and able to provide contextual insight into the experience of OD.

Research Ethics Board (REB) approval (File no. 23900) was obtained from the post-secondary institution in which the first author was enrolled at the time of the study. Additionally, REB approval (RID# 2020-005) was obtained from the hospital corporation in which the four EDs were located from which participants were recruited. Recruitment emails were sent to nurses employed at the four ED sites. The researcher explained the study to potential participants who responded to the recruitment email. Informed consent was obtained from all participants. All participants who consented to the study completed the interviews; there was no attrition.

Data collection and analysis

Data were collected using in-depth, semi-structured interviews of up to 40 minutes. The primary source of data collection in QD research is semi-structured, in-depth interviews (Bradshaw et al., 2017; Sandelowski, 2000). These interviews were conducted exclusively by the first author with the guidance of the second author. The interview guide was developed by the first author with direction and oversight from the second author. Interview questions were informed by a review of relevant literature and qualitative interviewing scholarship (Kvale & Brinkman, 2009). At the beginning of each interview, trust between researcher and participant was forged through kinship ties; the first author described her role as an ED registered nurse with a decade of experience, her interest in OD and goals of uncovering the meaning of OD in ED nursing culture. Throughout the research process, the first author kept a reflexive journal and engaged in periodic debriefings with the second author. Participants were interviewed via the telephone. Interviews were conducted in September and October 2020. Following informed consent, interviews were digitally recorded. See Table 1 for interview questions.

Digital audio recordings were transcribed verbatim. Transcripts were anonymized and imported into NVivo (released in March 2020). Field notes were written following all interviews. Interview data were analyzed using qualitative content analysis, a strategy frequently employed in QD methodology researchers (Vaismoradi & Snelgrove, 2019). Qualitative content

Table 1

Interview Questions

1. What is your interpretation or understanding of the term occupational disappointment?
2. Tell me about a time when you experienced verbal abuse from a patient and/or their visitor that led to a feeling of occupational disappointment.
3. What were the actions you took, or didn't take, in response to a patient's verbal abuse directed towards you?
4. How did the feeling of occupational disappointment change or alter your nursing practice?
5. Do you think that occupational disappointment amongst emergency nursing staff is addressed by those in leadership?
6. What are some suggestions you think would be effective in managing emergency nurses' experiences of occupational disappointment?

analysis is an inductive approach with the purpose of deriving concepts, themes, or a model through interpretation from raw data (Vaismoradi & Snelgrove, 2019). In following this process, the first author reduced the data to coded units. The process of constant comparison helped to identify events, compare them to emerging themes, and highlight main ideas as codes related to the phenomenon (Vaismoradi & Snelgrove, 2019). Emerging sub-themes in the data included organizational supports, nurses' mental health, nursing practice, and feeling powerless. Codes were identified and categorized independently by the first author into the prominent themes of nurses' experiences, concerns, and responses to OD. Once themes and sub-themes were developed, each transcript was then reanalyzed using an iterative process of reading, reviewing, and refining.

Results

Three major themes were derived from the data related to ED nurses and the phenomenon of OD: 1) nurses' experiences of OD (with subthemes of powerlessness and normalizing); 2) nurses' responses to OD (with changes in nursing practice, retention, and nurses' mental health as subthemes); 3) and nurses' concerns regarding OD (ineffective leadership was a subtheme).

Nurses' experiences of OD

Powerlessness

In response to verbal abuse in the ED, nurses often felt powerless. They stated that departmental policy related to verbal abuse was rarely enforced resulting in a feeling of powerlessness: "We have this code of conduct... a whole nice paper on the wall posted all over the place about patient conduct... except theirs is tolerated and ours isn't... it will always come down to we [the nurses] should have done something differently." The threat of being labelled a "bad nurse" online on social media also loomed over nurses, contributing to feelings of powerlessness: "I haven't seen that nurse back since she [the patient] did that. She pushed a great, experienced nurse out

of our emergency department because of a bunch of comments she wrote [on Facebook]." For that nurse, OD persisted online on a Facebook post retelling a one-sided account of a patient-nurse exchange well after the occurrence: "Now there's a storyline in the world that's fake and your face is attached... you don't get the opportunity to defend yourself... the deck is stacked against you in terms of your ability to say, 'That's not actually what happened.'" The threat of being anonymously verbally abused online was spoken about in detail by nurses interviewed signaling the impact and importance comments on social media could have on nurses' experiences of OD.

Normalizing

The act of normalizing verbal abuse by ED nurses was reflected in a lack of consequences for patients' abusive behavior: "I find the consequences to their behavior are very minimal so then it becomes normalized because... they do it all the time and there's no consequence for their actions... you do get used to it. It is very normalized." Nurses questioned how they were expected to manage this abuse when there was no overt discussion about it. Consequently, nurses proceeded with their work, not dealing with the issue: "What happens when a patient yells at you? How do you get over this? How do you not let this affect your care? How do you approach the patient? ... Those discussions are... not happening at all."

Nurses' responses to OD

There are clear responses related to the profound influence of OD in terms of nursing practice, retention of nurses in the health system, and nurses' mental health.

Nursing practice

Nurses indicated that OD influenced their practice subsequently, impacting patient care. For example, in the waiting room a nurse described her thinking process before she cares for a rude patient: "You see the patient's chart and you think he's so rude, he can probably wait, but you try not to, but it's very hard when someone is personally attacking you and then you have to go care for them." The nurse considered levelling a punitive measure towards the patient displaying abusive behavior. This is a common reactive strategy.

Instinctual behavior was also spoken of as a way to manage emotions in response to verbal abuse while remaining able to continue to work: "I'm like flatter than flat, I will not have the same response... I say [to myself], 'Why do you do this?' However, I just can't help it. I can't help but just be very flat. It's terrible."

One nurse noted that her practice changed when treating difficult patients:

"[You've] already red-flagged that person in your mind... I don't think you'd spend idle time, maybe chitchatting with patients like this to find out more information... why would you want to spend time with somebody who's just cussed you out?" "Idle time" is the few moments during a shift when nurses are not inundated with immediate tasks; it is often the only time for health teaching and uncovering subtle aspects of patients' health histories. Feeling exhausted by a patient's abuse thwarts nurses' ability to uncover important information and can deleteriously affect holistic patient care.

Retention

The impact of OD on the well-being of nurses and its subsequent impact on remaining in the profession is evident: *"I don't work full-time in emergency, to me it's not worth it ... I'd rather make no money the next day than be yelled at and be treated inappropriately and... nothing is ever done about it."* Furthermore, the impact on new graduates in the context of the sustainability of a lengthy career as an ED nurse was substantiated: *"I am a new nurse... When I graduated nursing school, I knew I wanted to be an emerg[ency] nurse... I'm struggling with that right now ... I'm two years into a profession that I need to do for 30 years... Now every time I have to get in my car and go to work, every second I'm googling other things I can do with my life."*

It is not surprising that because of ongoing abuse, nurses are exhausted, disheartened and leave the profession feeling unfulfilled, unrecognized, and not appreciated by patients and hospital administrators, as indicated by this nurse: *I left in less than two years because I was consistently let down.... As a nurse, you cannot get a restraining order on a patient... They can fully assault you and you're the one who has to get a new job if you're uncomfortable, because you can't deny access to somebody into an emergency department, so... you will never get a restraining order, you're the one who has to get a new job."*

Nurses' mental health

It is not surprising that a significant consequence of OD was the profound impact on nurses' mental health. The nurses compared how difficult cases or events in the ED were noted, addressed, and debriefed with recommendations for change, yet the verbal abuse and persistent feeling of OD was always left unaddressed. Referring to episodes of patient aggression, one nurse stated, *"I do find that I get anxious. I'm anxious for a period of time after that. It makes me very uncomfortable."*

An experienced nurse described that the mental health of ED nurses became important to leaders only when it became fiscally significant: *"I don't think there's ever conversation [about OD]. If you're off on mental health [leave]... then they're concerned about you, but not concerned about the people who are just coping... if it's affecting the budget then maybe it will be looked at."* Notably, the stressors of OD infiltrated the personal lives of nurses long after their shifts ended: *"They [recollections of verbal abuse] come up in your dreams, or you're out with your friend... explaining a situation and they look at you like you're on a different planet. They are like, 'That doesn't happen to me at work.'"*

Nurses' concerns regarding OD

Ineffective nursing and organizational leadership

Nurses linked their experiences of OD to ineffective nursing and organizational leadership. Nurses, as frontline staff, reported they could not mitigate the precipitants of verbal abuse such as staffing shortages and overcrowding. These issues needed to be managed by leaders such as the nurse managers in the ED and in the hospital. Nurses agreed their experiences of OD were ineffectively addressed by their leadership. *"Our occupational disappointment is influenced by many things... I know patient flow in our department is a... huge factor in verbal abuse... On the front line, we cannot control that... please don't take it out on us."*

Leadership often failed to acknowledge incidents of verbal abuse or offer strategies to address these incidents. This inattention was concerning to nurses: *"I think, one, the corporation doesn't support us but, two, they actively undermine the situation."* The hesitation to offend the public was viewed to be a root cause for the lack of overt denunciation of verbal abuse towards nurses: *"I feel they're too afraid to step on the public's toes, as opposed to protecting their worker"* and *"I've seen many times where we've been verbally assaulted by a patient, and you go get management and they're shaking hands and walking them [the patient/visitor] out the front door. To me you're just saying, 'It's okay to do what you want to do here' instead of saying 'this is zero tolerance... you have to leave.'"* At the level of management in the ED, the fear of backlash over addressing verbal abuse aimed at nurses extends to the virtual world: *"I think there's a lot of fear with the whole Facebook thing... a lot of management's reactions [are] based out of fear... instead of the whole corporation... saying, 'This is our mission, if patients are unsatisfied, then they're unsatisfied, but we're not going to let our nurses get hurt or endure any more of this behaviour.' I don't know if it's the corporation or if it's out of fear... of losing [their] jobs, being named and that..."*

Lack of training to effectively respond to verbal abuse and potentially mitigate OD was articulated: *"I don't think you receive any kind of training, so when, not if, when, you're verbally attacked in this department, this is how you can and should respond."* Lack of clear strategies for nurses to employ when verbal abuse occurs was reiterated: *"We don't really have a clear, concise role written out as to what the steps are if a patient acts like this, because some people will just stand there... and some of us get upset."* All nurses interviewed indicated that leaders needed to acknowledge that OD exists, and strategies are required to mitigate OD at its onset, that is, when verbal abuse is leveled at a nurse in the ED.

Discussion

Occupational disappointment is a relatively new phenomenon. It can be experienced by ED nurses as a result of verbal abuse from patients and/or their visitors (Howerton Child & Sussman, 2017). Occupational disappointment is delineated from compassion fatigue which is abrupt and results from another person's trauma and burnout, which is chronic, and resulting from repeated stressors (Howerton Child & Sussman, 2017). In this study, nurses reported experiencing OD because of persistent, unaddressed verbal abuse on the job and, to a degree, online. Nurses expressed feelings of powerlessness and they normalized the abuse as part of the context of working with patients and families in an ED. To minimize the effect of OD, nurses altered their practice by providing a minimum standard of care or, ultimately, they left the ED in search of alternate employment. Occupational disappointment takes a toll on nurses' mental health. In this study, OD manifested in nurses feeling stressed and anxious while working, however these feelings persisted when nurses went home. Nurses felt unsupported by nursing and organizational leaders. While references were made to "zero tolerance" hospital policies, the inability to operationalize these policies was evident. Interestingly, Howerton Child and Sussman (2017) reported that managerial involvement and support were

neutral factors related to OD. However, a suggestion that managers should engage with staff to make known what support they are able to offer (Howerton Child & Sussman, 2017, p. 550).

There has been an increase in violence against nurses and healthcare workers since the beginning of the COVID-19 pandemic (Alsuliman et al., 2021; Bitencourt et al., 2021; Devi, 2020; Larkin, 2021; Yang et al., 2021). This increase in violence underscores the urgency of the implications of this study. The following are several implications for leaders in nursing and health care organizations related to mitigation of OD in ED nurses. Organizations must encourage and support nurses to report verbal abuse (Al-Shamlan et al., 2017; Hassankhani et al., 2017; Hogarth et al., 2017; Lenaghan et al., 2018; World Health Organization, WHO, 2021). When abuse is reported, it is being formally acknowledged. While previous research indicates a need for policy (Hassankhani et al., 2017; Hogarth et al., 2017; WHO, 2021; Yang et al., 2021), the findings from this study align with this research and could be applied to a local context. A specific step-by-step procedure would provide nurses with an algorithm to follow in the event of verbal abuse from patients or visitors. Including frontline nurses in the development of this policy and procedure could alleviate nurses' feelings of powerlessness and normalization of abuse as an expectation of working in the ED. This would signal that verbal abuse is not acceptable and mitigate a major precipitant of OD. The importance of tending to and supporting nurses' mental health cannot be understated (Havaei, 2021; Liu et al., 2020; WHO 2021). The Canadian Federation of Nurses Unions (2017) acknowledged that violence in healthcare settings has a profound impact on nurses' mental health. The deliberate and consistent implementation of policy and procedure could make strides toward lessening the effects of verbal abuse and OD on nurses' mental health.

Retention of nurses in the profession is a global issue (Efendi et al., 2019; Marufu et al., 2021). From an economic and pragmatic standpoint, challenges with retention of nurses leads to increased costs and creates staffing problems due to recruitment and deployment of unskilled nurses compromising quality of care (Ashton et al., 2018; Howerton Child & Sussman, 2017; Yoon & Sok, 2016). Enacting clear and direct policies and procedures related to intolerance of abuse, is an opportunity for nurse leaders to demonstrate continued investment in their skilled nursing staff in the ED.

Nurses in the ED require greater support from the organization and leadership, as well as advanced training related to recognizing and responding to violence and harassment (Al-Qadi, 2020; Aljohani et al., 2021; Ashton et al., 2018; WHO, 2021). International recommendations for addressing workplace violence including briefings related to potential security issues, as well as debriefings following incidents of violence (WHO, 2021). These recommendations align with the responses of the nurses in this study, as they advocated for debriefing following incidents of abuse in the ED, as well as additional training in recognizing and effectively responding to verbal abuse. The nurses in this study recognized that they wanted the skills to deal with their feelings of OD after encounters with difficult patients; a

peer support group could serve as a supportive environment to process feelings. Studies indicate nurses would benefit from additional educational opportunities related to both preventing and managing abuse in the ED (Aljohani et al., 2021; Ashton et al., 2018; Hassankhani et al., 2017; Yoon & Sok, 2016). While nurses are required to refresh their skills on cardiac life-saving events, it is compelling to consider supporting nurses to periodically renew their skills and knowledge related to managing violence and harassment. Howerton Child and Sussman (2017) asserted that that violence prevention education should be tailored to the time-pressed, acute environment of the ED.

There is a substantive body of literature detailing abuse of nurses and healthcare workers in the ED (Aljohani et al., 2021; Ashton et al., 2018). However, the description of the phenomenon of OD is novel. The acknowledgment of verbal abuse, as a precipitant of OD is significant. Further, the subsequent impact on nurse retention, nurses' mental health and overall well-being as a result of OD is notable. Studies during the COVID-19 pandemic have demonstrated that verbal abuse is widely experienced by nurses and healthcare workers (Bitencourt et al., 2021; Yang et al., 2021). The pandemic has added urgency to the need for collective thinking followed by deliberate strategic action based on this research study and the many studies preceding it.

Limitations

It is important to acknowledge several limitations in this study. First, the sample for this study is specific to two EDs within the health region in which the nurses were currently or formerly employed. Findings in this study may not be generalizable to situations other than those in close contextual similarity. Second, with respect to the COVID-19 pandemic, interviews that would have been traditionally held in a face-to-face setting instead were conducted on the telephone. Though virtual conferencing was offered, all participants chose to be interviewed over the telephone. This presented a potential limitation, as the researcher-participant engagement manifested in nuances of body language or facial expression in discussion of a sensitive topic such as OD were unable to be seen and noted as part of the context of the data collection.

Conclusion

The exploration of OD as a phenomenon experienced firsthand by emergency nurses because of verbal abuse is essential given the profound toll it takes on both nurses and patients. Considering the COVID-19 pandemic has magnified stressors in an already strained system, nurses experience verbal abuse on the job while paradoxically being hailed as frontline heroes. The concerns and life experiences of the nurses in this study suggest that OD occurs due to verbal abuse, but also indirectly because of organizational shortcomings. This reflects a rally cry that is evident as nurses' voices amplify and challenge what should not be tolerated as part of their job. This study suggests that OD results in the deleterious effects on nurses' retention, mental health, and practice. Future research should explore OD with the aim of a deeper understanding of its root causes and potential solutions, however the acknowledgement of it as a unique phenomenon remains an important first step.

Implications for Emergency Clinical Practice

- Emergency nurses must be aware of current institutional policies addressing verbal abuse in the workplace.
- Engaging in education related to preventing and managing abuse can improve emergency nurses' verbal abuse mitigation skills.
- Nurse leaders must advocate for immediate debriefing following incidents of verbal abuse, signalling the importance of processing workplace violence, critical incidents, and difficult clinical cases.
- Nurse leaders must allocate paid time for nurses to complete continuing education related to violence prevention.

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Conflicts of Interest

None

Authors' contributions

JZ conceived this study. LC and KC contributed to study design. JZ developed the study protocol under the guidance of LC. Data collection and analysis was performed by JZ in consultation with LC. JZ, LC and KC prepared, revised and approved the manuscript.

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