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ACİL SERVİSTE ÇALIŞAN HEMŞİRELERİN İLETİŞİM BECERİLERİ İLE AGRESYON ALGILARI VE ŞİDDETE MARUZ KALMA DURUMLARI ARASINDAKİ İLİŞKİNİN BELİRLENMESİ

Öz

Amaç: Acil serviste çalışan hemşirelerin iletişim becerileri ile agresyon algıları düzeyleri ve hemşirelerin maruz kaldığı şiddet arasında ilişkisel bir bağ olup olmadığını varsa bu ilişkiyi etkileyen faktörleri ortaya koymaktır.

Yöntem: İlişkisel araştırma tipindeki bu araştırma 15/05/2018-15/08/2018 tarihleri arasında Samsun ili merkezindeki kamu hastaneleri ve özel hastanelerin acil servislerinde çalışmakta olan, çalışmaya katılmayı kabul eden 232 hemşire ile gerçekleştirilmiştir. Veriler araştırmacı tarafından literatür doğrultusunda geliştirilen hemşireleri tanıtıcı bilgi formu, şiddet değerlendirme formu “Etkili İletişim Becerileri Ölçeği” ve “Agresyon Algılamaları Ölçeği” (POAS) kullanılarak toplanmıştır. Verilerin analizinde tanımlayıcı analizler, Kruskal Wallis, Mann Whitney U ve Spearman korelasyon analizi testi kullanılmıştır.

Bulgular: Çalışmaya katılan hemşirelerin %73,7’sinin şiddete maruz kaldığı belirlenmiştir. Çalışmamızda, Etkili İletişim Becerileri Ölçeğinin alt boyutları ile Agresyon Algılamaları Ölçeğinin Disfonksiyonel (kabul edilemeyen-istenmeyen agresyon) alt boyutu arasında hafif bir pozitif korelasyon bulunmuştur ($p < 0.001$).

Sonuç: Çalışmaya dahil edilen hastanelerin acil servis kliniklerinde çalışan hemşirelerde şiddete maruz kalma oranı yüksek olup, acil servislerde iyileştirici ortamın sağlanmasına yönelik düzenlemeler yapılması gerekmektedir.

Anahtar kelimeler: Acil servis, hemşire, şiddet

DETERMINING THE RELATIONSHIP BETWEEN COMMUNICATION SKILLS OF NURSES WORKING IN EMERGENCY SERVICE AND THEIR AGGRESSION PERCEPTION AND EXPOSURE TO VIOLENCE

Abstract

Objective: The objective of the study is to determine whether there is a relationship between the communication skills of the nurses working in the emergency department and the level of aggression perceptions and the violence that nurses are exposed to, and if any, to determine the factors that affect this relationship.

Method: This research was carried out between the dates of 15/05/2018-15/08/2018 with 232 nurses who accepted to participate in the emergency services of Public Hospitals and Private Hospitals in the center of Samsun. Data were collected using the nurses introductory information form, violence assessment form, "Effective Communication Skills Scale" and "Aggression Perceptions Scale" (APS) developed according to the literature by the researcher. For analyzing the data, descriptive analyses, Kruskal Wallis, Mann Whitney U and Spearman correlation analysis tests were used.

Findings: It was determined that 73,7% of the nurses included in the study were exposed to violence, 66,4% were exposed to verbal violence. In our study, a slight positive correlation was found between the sub-dimensions of the effective communication skills scale and the non-functional (unacceptable-unwanted aggression) sub-dimensions of the aggression perception scale ($p < 0.001$).

Result: In the hospitals included in the study, the rate of exposure to violence in nurses working in emergency departments was found high, and therefore arrangements should be made in order to provide a healing environment in emergency services

Keywords: Emergency department, nurse, violence

INTRODUCTION

Emergency services are complex, crowded and dynamic centers where there is intense stress. The daily activities of the emergency department cause high levels of stress, especially when the number of patients who were given care is high (Bruce & Suserud, 2005; Ross-Adjie et al., 2007; Healy & Tyrell, 2011).

It is difficult to perform nursing in the emergency departments where the patient circulation is very intensive and under intensive stress. Indeed, a qualified emergency nurse must be competent in terms of knowledge and skills and attitudes, and should continuously take of her/his professional development by improving advance skills such as communication skills, critical thinking, decision making, problem solving (Schrivier et al., 2003).

Communication Skills

Communication, which is a concept that we have been hearing very often in recent years, is a series of processes that allow two people to understand each other by sharing their feelings, thoughts and knowledge (Cüceloğlu 2005; Üstün 2005). For this reason, communication is of vital importance not because it is a personal skill, but it is a series of learned techniques. Communication technique is closely related to personal concept, personal trust and personality.

Evidence-based studies on the importance of developing interpersonal, professional and inter-professional communication skills in health services are increasing, undergraduate and graduate programs frequently include this title and in-service training programs have being organized (Doğanay & Keskin, 2008). A communication in cooperation with the patient is necessary to enable the patient to participate in his/her own treatment process. There are many studies that mention about the importance of communication in patient care to emphasize this situation (Tutuk & Al, 2002; Korkut 2005; Çam et al., 2007). In a study conducted to evaluate nurses' communication skills, it was emphasized that it is important to get to know the patients closely in order to provide effective health care in cooperation with the patient (Thomas et al., 2007). Communication skills are expressed as perceiving the messages in the interpersonal exchange of thoughts and emotions correctly (Ersanlı, 2016). It will provide the patient with trust for us to reach the patient in order to provide health care, to reach out to the individual we care for, to value the individual, to try to understand the individual, to deal with and to recognize him/her. It is the communication knowledge and skill through which the health care professionals reach out to the individual whom they care for (Üstün, 2005).

Communication is extremely important to meet the patient to be cared for, to listen to the patient history, to make a diagnosis, to plan the treatment, to give direction to care and in order to increase the effectiveness of care (Bowles et al., 2001; Babadağlı et al., 2006). Good communication between nurses and patients is also an effective factor in patients' overall satisfaction. In a study conducted by Akkaya et al. it has been found that the nurses working in the emergency room had a positive impact on the patients' satisfaction level with their medical care experience and behaviours (Akkaya et al., 2012). An effective communication provides positive results such as meeting patient's needs, increasing the quality of treatment and care, shortening the duration of hospitalization, increasing the psychological and physiological well-being and accelerating the improvement (Terakye, 1998).

Communication skills are one of the most important competencies which an emergency nurse must have. This skill has verbal and nonverbal components such as using body language, listening, asking questions, summarizing, empathy, and each is critical for communication skills (Çalışkan & Yeşil, 2005; Levent, 2011).

Aggression

Despite the fact that there has been a lot of research on aggression and violence, which has been defined as a universal epidemic in the world for the last 20 years, aggression and violence in health care services have been increasing in general. In healthcare institutions, attacks and violent incidents cause harm to patients and personnels, disrupt the relationship between patients and personnels, and create a threat to the therapeutic environment, causing both the patient and the personnel to be adversely affected.

When the origin of aggressive behavior is examined, it can become destructive because of the rage, and its of intensity and duration which occurs as a secondary feeling in cases of being hurt, resentment, offense, loneliness, fear, not being understood, rejection, disappointment, sadness that belongs to human nature Aggression is a term used to describe all verbal and physical attacks, with a tendency to harm, with behavioral and uncontrolled emergence of anger. Aggression can occur in many forms as a behavior that causes physical or psychological damage and is intended to cause harm, and it can be evaluated in a wide range from increase in the patient's voice (verbal aggression) to the armed attack (physical aggression) (Bilgin & Özcan, 2012).

Violence

Violence is the imposition of physical coercion, or use of force for the purpose of, or leading to death, wounding, mental injury, developmental disorder towards someone else, the group or the community (Annagür, 2010). Violence, has appeared as a public health and vocational/occupational health problem in recent years which threatens the peace of society (Altıntaş, 2006; Önal, 2012). Performed studies have revealed that compared to other areas violence mostly occurs in the field of health, and health care professionals carry 16 times more risk of being exposed to violence than other professionals (Annagür, 2010; Gillespie et al. 2010; Çamcı & Kutlu, 2011).

In a study by Gerberich et al. (2004), it was determined that 67.2% of the personnell were exposed to violence by the patients and their relatives. In another study, Abbas et al. (2010) reported that 62.8% of the nurses were subjected to violence by the patients and their relatives. In the study conducted by Ünlüsoy Dinç (2010), it was determined that 67.1% of the nurses were subjected to violence and 54.9% of them were exposed to violence by the physicians. Çamcı & Kutlu (2011) reported that 82.1% of nurses were exposed to violence and 17.9% of them stated that those who applied violence were the administrators. According to the studies of Günaydın & Kutlu (2012), it was found that 64.1% of the nurses experienced violence and 3.2% of them were subjected to violence by the doctors and 1.1% by the nurses.

Violence may occur in many forms as the physical, psychological, sexual, verbal and economical violence (Ünlüsoy Dinç, 2010). In the study performed by Sucu et al., not accepting the patient to the hospital, demanding drug and material from the relatives of the patient, not meeting the hospital expenses, were among the reasons of the violence that the nurses working in the emergency department have experienced (Sucu et al., 2006).

When we look at the types of violence in our country and abroad, it is remarkable that verbal violence is more common than physical violence (Abbas et al. 2010; Ünlüsoy Dinç, 2010). In a study conducted by Gacki-Smith et al. (2009) with nurses working in the emergency, more than 70% of nurses resported that they were exposed to verbal violence (screaming, curse, threatening, verbal sexual harassment); and more than 50% were exposed to physical violence (spitting, push, kicking). In the study conducted by Ünlüsoy Dinç (2010), it has been found that the nurses' rate of exposure to to any kind of violence was 67.1%. The violent behaviors that the nurses are mostly exposed to are pushing (39.5%) / beating / slapping / and punching (34.6%). The most frequently encountered form of verbal abuse by the nurses was reported to be shouting (54.4%) and the most frequently encountered form of sexual harassment was verbal sexual abuse (71.1%). Generally, it is stated that nurses have been imposed mobbing behaviour by making them responsible for (14.1%) the mistakes made and by showing that they are unsuccessful (14.9%) (Ünlüsoy Dinç, 2010). In a study done by İlhan et al. with 1179 people who

applied to health care institutions, about "Violence against healthcare professionals in the eyes of society: reasons, attitudes, behaviors ", 19.5% of the respondents who participated in the research reported that they have witnessed the physical violence, 32.7% reported to have witnessed verbal violence towards healthcare professionals (İlhan et al., 2013).

According to the common report of the World Health Organization (WHO), the International Labor Organization (ILO) and the International Nurses Association (ICN) in (2002) with the title "Workplace Violence in the Health Sector", most of the cases of violence takes place in the health sector (Annagür, 2010; Ünsal Atan and Dönmez 2011; Çamcı and Kutlu, 2011). In this report, as the rates of violence against health care professionals in different countries reveal, 3-17% of the workers in general have been exposed to physical violence, 27-67% to verbal violence, 10-23% to psychological violence, 0.78% to sexual violence, 0.8-2.7% to ethnic violence, respectively (Bilgin & Özcan, 2011; Ünsal Atan & Dönmez, 2011; Al et al., 2012). Another important point is that the actual frequency is not known because of the shortcomings and obstacles in reporting the exposure to violence in the institution which is being serviced, and it is limited to the reported cases (Al et al., 2012).

Violence occurs due to individual, institutional and systematic reasons. One of the most common cause of violence is the lack of communication, the other problems that the nurses encounter with patients and/or other health care providers have also been reported to be originated from same communication mistakes (Tjia et al., 2009).

In the emergency departments disagreements caused by the lack of communication between patients and patient relatives in the chaos environment may result in a situation of violence due to the reasons such as density of patient circulation, tension of patients who are waiting for immediate aid and their relatives, inadequate number of health care professionals, and working conditions

Objective of the Research

The aim of this study is to determine whether there is a relational link between communication skills and the level of aggression perception of the nurses and the violence that health care professionals are exposed to. The results obtained from the study will be used in the preparation of vocational violence education programs with the vocational/interprofessional communication and cooperation for nurses.

MATERIAL AND METHOD

Universe and Sampling of the Study

This study, which is an example of the relational screening model, includes the nurses who are working in the emergency departments of 5 public hospitals in Samsun city center that affiliate to the Samsun Public Hospitals Association (Samsun Education and Research Hospital, Samsun Gazi State Hospital, Samsun Gynecology and Children's Hospital, Samsun Chest Diseases and Surgery Hospital, Samsun Mental Health and Diseases Hospital) and the six private hospitals in the center of Samsun (Anatolian Hospital, Medical Park Hospital, Atasam Hospital, Medicana Hospital, Liv Hospital, Port Hospital) (N = 310). It was aimed to reach 241 nurses at %95 confidence limit with %3 error. As a result of the study, 232 nurses were reached due to the reported and leave nurses.

Data Collection

The data were collected through a survey in which three tools were used.

1.Introductory information form: The form developed by the researcher in accordance with the literature consists of 21 questions which examines the sociodemographic characteristics of nurses (age, gender, educational status, job liking, job satisfaction levels, duration of duty in the occupation etc.) and their situation of exposure to vocational violence.

2. Effective Communication Skills Scale (ECSS): is a five-point Likert-type scale that has been developed by Buluş et al. (2017) and graded between "not suitable at all" to "completely appropriate". Scale is composed of a total of 34 items and 5 sub-dimension as "Ego Developer Language" (items 1,2,3,4,5,6), "Active Listening" (items 7,8,9,10,11,12,13,14), "Self-Knowledge - Openness" (items 15,16,17,18,19), "Empathy" (items 20,21,22,23,24,25,26,27), "Using the 'I' Language" (items 28,29,30,31,32,33,34). Since each sub-dimension in the scale measures different structures, the scoring is done using the sub-dimensions, not using the total. The items 15, 16, 28, 32 and 33 in the scale are scored in reverse order. Thus, the higher the overall score from each sub-dimension, the higher the level of using the communication skills. When the Cronbach's alpha coefficients of the subscales of the ECSS are examined, it is seen that the sub-dimension of "Empathy" has the highest coefficient value with 0.85, and the sub-dimension of "Ego Developer Language" has got the lowest coefficient value with 0.73. The fact that other sub-dimensions have a coefficient ranging between these values indicates that the items are completely consistent and highly reliable with the entire scale. In this study, the highest Cronbach's alpha value belongs to the sub-dimensions of "Active Listening" 0.95, "Empathy" 0.94, "Ego Developer Language" 0.92, "Using the 'I' Language" 0.86, and the lowest value is "Self Knowledge - Openness" with a value of 0.83 (Table 3). Effective Communication Skills Scale Cronbach's alpha coefficient value was found to be 0.96.

3. Aggression Perceptions Scale (APS): APS is a 5 point Likert-type scale which is graded between "I definitely agree" (5) and "I definitely don't agree" and developed originally by Gerard Jansen et al. (1997) and psychometrically evaluated by Bilgin H. et al. (2011) in Turkish. The scale is composed of two sub-dimensions and 29 items in total which consists of functional/acceptable-healthy reaction (items 3, 6, 7, 8, 16, 18, 20, 23, 24, 25, 27, 28), dysfunctional / unacceptable-undesirable aggression (items 1, 2, 4, 5, 9, 10, 11, 12, 13, 14, 15, 17, 19, 21, 22, 26, 29). The average scores of the sub-dimensions are obtained through dividing the score by the number of items in that sub-group. High average scores indicate the height of that sub-dimension (higher functional sub-dimension score expresses that aggression perceived as functional/acceptable, higher dysfunctional sub-dimension score shows that aggression is perceived as "dysfunctional/unacceptable". When the Cronbach's alpha coefficients of the sub-dimensions of the Aggression Perceptions Scale were examined, they found that "dysfunctional" sub-dimension was 0.81 Cronbach's alpha value of the "functional" sub-dimension was 0.85. The former represents a negative moral judgement of aggression, and the latter is an understanding that aggression is an element of normal human behaviour that can be healthy.

The questionnaire was pre-tested in a group of 10 people and the nurses who participated in the pilot study were not included in the sampling. The study was carried out upon the approval of the Clinical Research Ethics Committee of the Ondokuz Mayıs University (03.30.2018/issue; B. 30.2.ODM.020.08/1514). Informed consent was obtained from the managers in the hospitals and the nurses included in the study in order to collect data.

Data Analysis

Statistical analysis of the data was carried out by using SPSS 21 package program in the computer environment. In the analysis of the obtained data; frequency analysis was utilized to determine the demographic characteristics of the respondents; Mann-Whitney U and Kruskal Wallis H tests were applied as non-parametric tests for the variables that cannot fulfill the condition of equality of variations of the groups. Correlation Analysis method was used to determine the direction and strength of the relationship between the effective communication skill levels and the levels of aggression perception.

FINDINGS

40.5% of the 232 (n = 96.3%) nurses who agreed to participate in the study, were between ages of 19-28 and 37.1% of them were bachelor. It was found that 67.7% of the nurses liked their profession, 46.1% were satisfied with the service in which they work, 82.8% of them worked in night shifts, 67.7% of them described the quality of work life as good (Table 1).

Table1. Sociodemographic Characteristics of Nurses Working in Emergency Department

Features		n	%
Age Groups	19-28 years	94	40,5
	29-37 years	84	36,2
	38 years and above	54	23,3
Education status	Vocational school of health	69	29,7
	Prebachelor's degree	72	31,0
	Bachelor's degree	86	37,1
	Postgraduate degree (Master's)	5	2,1
Working Year	1-7 years	99	42,7
	8-15 years	86	37,1
	16 years and above	47	20,3
Year of work in Emergency Department	1-4 years	103	44,4
	5-9 years	91	39,2
	10 years and above	38	16,4
Status of loving the profession	Love	157	67,7
	Does not love	27	11,6
	Indecisive	48	20,7
Satisfaction with the service	Satisfied	107	46,1
	Unsatisfied	28	12,1
	Partly satisfied	97	41,8
Working type	Day shifts	40	17,2
	Night shifts	192	82,8
Quality of work life	Perfect	5	2,2
	Very good	23	9,9
	Good	157	67,7

	Poor	45	19,4
	Very poor	2	,9
Job satisfaction	Very good	14	6,0
	Good	66	28,4
	Mediocre	116	50,0
	Partly poor	29	12,5
	Poor	7	3,0
Participation in communication skills training	Yes	195	84,1
	No	37	15,9
Good communication skills	Nurse-patient communication	210	17,9%
	Nurse-physician	208	17,7%
	Nurse- Nurse	206	17,5%
	Nurse- Other medical staff	173	14,7%
	Nurse- <u>Head nurse</u>	132	11,2%
	Nurse - Department Manager	128	10,9%
	Nurse - Institution Manager	119	10,1%

It was determined that 73.7% of the nurses were subjected to violence during their professional life, 66.4% were exposed to verbal violence, 44.4% were exposed to violence by relatives of the patients and 37% were subjected to violence by patients. Nurses think that the incidents of violence occur due to the reasons such as patient's agitation, patient's low level of education, rejected requests, patient psychology, ineffective communication, dissatisfaction with treatment, and long waiting times. It was determined that the cases of violence occurred mostly between 16.00 - 00.00 hours. 31.9% of the nurses who was exposed to violence reported that they gave a verbal response against it, 22.8% of them stated that they tried to calm the person who used violence. 53.9% of the nurses stated that they did not care about the event as the reason for not doing anything against the violence, and 15.9% stated that they did not do anything because they were afraid of negative consequences (Table 2).

Table 2. Exposure to Violence of the Nurses Working in Emergency Department

Features		n	%
Violence exposure	Yes	171	73,7
	No	61	26,3
Who resort to violence	Relatives of the patients	138	44,4
	Patients	115	37,0
Type of violence	Verbal violence	154	66,4

	Physical violence	13	5,6
	Psychological violence	9	3,9
The cause of violence *	Low education level of the patient	34	14,7
	Ineffective communication	16	6,9
	Patient psychology	32	13,8
	Rejection of requests	33	14,2
	Agitation of the patient	35	15,1
	Not satisfied with the treatment	13	5,6
	Long standby time	9	3,9
	Other (The idea of not being concerned, work intensity etc.)	3	1,3
Frequency of violence *	No Violence	22	9,5
	Every day of work	16	6,9
	Once a week	36	15,5
	Once in a month	73	31,5
	Once a year	46	19,8
Time of exposure to violence *	Between 08-16 hours	35	15,1
	Between 16-00 hours	118	50,9
	Between 00-08 hours	35	15,1
Reaction to violence *	I tried to calm the person who was violent.	53	22,8
	I gave a verbal answer.	74	31,9
	I answered physically	6	2,6
	I did not do anything	21	9,1
	I reported in violence to the relevant units	10	4,3
	I got away from the scene	12	5,2
The reason for not doing anything because of the event*	I did not mind	125	53,9
	I was afraid of the negative results	37	15,9
	I feel guilty	1	,4
	Other	9	3,9
Willingness to receive training on aggression and violence	Yes	123	53,0
	No	72	31,0

* More than one reply was given

Cronbach's alpha value of the Nurses' Aggression Perceptions Scale was 0,85, Functional sub-dimension Cronbach's alpha value was 0,88, dysfunctional Cronbach's alpha value was found as 0,89. Nurses' Aggression Perceptions Scale dysfunctional sub-dimension average score was 68,24 (16-80), functional sub-dimension mean score was 23,63 (11-55). This finding shows that nurses perceive the aggression as dysfunctional/unacceptable. It was determined that the score averages of the participants' Aggression Perceptions Scale and two sub-dimension scores do not differ according to age, gender, educational status, year of work, job liking, job quality, and exposure to violence ($p > 0.01$) (Table 3).

Table 3. Comparison of the Sociodemographic Characteristics of the Nurses and the Aggression Perceptions Scale Sub-Dimensions

		Dysfunctional subdimension		Functionalsubdimension	
		Med (Min-Max)	p/ χ^2 /U	Med Min-Max)	p/ χ^2 /U
Age Groups	19-28 years	68,2 (30,3 - 80,3)	p=0,901 $\chi^2=0,208$	22,1 (11,1 - 55,4)	p=0,594 $\chi^2=1,041$
	29-37 years	68,2 (16,1 - 80,3)		23,2 (11,1 - 55,4)	
	38 years and above	67,7 (16,1 - 80,3)		25,7 (11,1 - 52,4)	
Gender	Woman	69,3 (16,1 - 80,3)	p=0,110 U=5697,50	22,1 (11,1 - 55,4)	p=0,029 U=5467,00
	Male	66,2 (30,3 - 80,3)		25,2 (11,1 - 55,4)	
Education status	Vocational school of health	64,3 (16,1 - 80,3)	p=0,258 $\chi^2=5,303$	26,3 (11,1 - 55,4)	p=0,112 $\chi^2=7,502$
	Prebachelor's degree	68,8 (30,3 - 80,3)		24,1 (11,1 - 55,4)	
	Bachelor's degree	69,3 (44,3 - 80,3)		22,1 (11,1 - 55,4)	
	Masters	74,3 (52,2 - 76,3)		19,1 (19,1 - 29,3)	
	Doctorate	64,8 (64,2 - 65,3)		39,3 (35,2 - 43,3)	
Working Year	1-7 years	68,2 (30,3 - 80,3)	p=0,837 $\chi^2=0,357$	22,1 (11,1 - 55,4)	p=0,379 $\chi^2=1,943$
	8-15 years	66,3 (36,2 - 80,3)		25,1 (11,1 - 55,4)	
	16 years and above	68,3 (16,1 - 80,1)		24,2 (11,1 - 43,1)	
Year of work in Emergency	1-4 years	68,3 (16,1 - 80,3)	p=0,816 $\chi^2=0,407$	21,2 (11,1 - 55,4)	p=0,090 $\chi^2=4,815$

Department	5-9 years	69,2 (30,3 - 80,3)		25,3 (11,1 - 55,4)	
	10 years and above	66,3 (16,1 - 80,3)		24,1 (11,1 - 52,4)	
Status of loving the profession	Love	66,3 (16,1 - 80,3)	p=0,162 $\chi^2=3,638$	24,1 (11,1 - 55,4)	p=0,211 $\chi^2=3,110$
	Does not love	70,3 (36,2 - 80,3)		23,2 (11,1 - 48,4)	
	Indecisive	69,3 (30,3 - 80,3)		22,1 (11,1 - 55,4)	
Satisfaction with the service	Satisfied	66,3 (16,1 - 80,3)	p=0,287 $\chi^2=2,496$	25,1 (11,1 - 55,4)	p=0,209 $\chi^2=3,130$
	Unsatisfied	69,7 (30,3 - 80,3)		22,6 (13,1 - 52,4)	
	Partly satisfied	69,3 (44,3 - 80,3)		23,1 (11,1 - 55,4)	
Working type	Day shifts	67,3 (16,1 - 80,3)	p=0,984 U=3812,50	22,2 (11,1 - 55,4)	p=0,513 U=3587,50
	Night shifts	68,2 (30,3 - 80,3)		24,1 (11,1 - 55,4)	
Quality of work life	Perfect	50,2 (16,1 - 80,3)	p=0,489 $\chi^2=3,430$	33,3 (11,1 - 55,4)	p=0,340 $\chi^2=4,522$
	Very good	70,3 (54,2 - 80,3)		22,1 (14,1 - 52,4)	
	Good	67,8 (30,3 - 80,3)		24,2 (11,1 - 55,4)	
	Poor	69,2 (36,2 - 80,1)		22,2 (11,1 - 49,3)	
	Very poor	71,8 (63,3 - 80,3)		30,6 (27,2 - 34,1)	
Job satisfaction	Very good	58,7 (16,1 - 80,3)	p=0,057 $\chi^2=10,180$	28,7 (11,1 - 55,4)	p=0,089 $\chi^2=8,078$
	Good	66,8 (48,2 - 80,3)		26,7 (11,1 - 52,4)	
	Mediocre	69,3 (36,2 - 80,3)		23,1 (11,1 - 55,4)	
	Partly poor	70,2 (30,3 - 80,1)		21,1 (11,1 - 49,3)	
	Poor	63,3 (50,3 - 72,3)		20,1 (14,1 - 28,1)	
Participation in communication skills training	Yes	68,2 (16,1 - 80,3)	p=0,833 U=3432,50	24,1 (11,1 - 55,4)	p=0,359 U=3264,50
	No	68,8 (36,2 - 80,3)		22,1 (11,1 - 52,4)	
Violence expo-	Yes	67,3 (16,1 -	p=0,556	23,2 (11,1	p=0,151

sure	80,3)	U=4921,50	- 55,4)	U=4569,50
No	69,2 (38,1 - 80,3)		24,1 (11,1 - 55,4)	

Nurses average score from the Effective Communication Skills Scale received 35 (8-40) from active listening sub-dimension, 33 (8-40) from Empathy sub-dimension, 27 (7-35) from using the 'I' language sub-dimension, 25 (6-30) from ego developer language sub-dimension, and finally 20 (5-25) mean score from self-knowledge - openness sub-dimension.

Active listening sub-dimension mean scores of the Effective Communication Skills Scale of the Participants was found to not to differ according to the properties such as age, gender, educational status, working year in the emergency, liking the profession, working style, participation to education ($p > 0.01$). It was detected that the Active Listening Sub-Dimension Mean Score differs according to the quality of work life ($p = 0.011$). The median values of those who call the quality of work life as good are higher than those who call the quality of work life as poor. (Table 4).

It was determined that the Effective Communication Skills Scale Empathy Sub-dimension mean score do not differ according to the characteristics such as educational status, working year, job liking and quality of work life ($p > 0.01$). On the other hand, it was observed that the Empathy Sub-Dimension mean score ($p = 0.041$) differs according to the working style and status of participation in education ($p = 0.020$). It was observed that the nurses who participated in the education and worked continuously during the day had higher empathy scores. (Table 4).

The comparison of Effective Communication Skills Scale using the 'I' language sub-dimension score was determined to differ according to the participation status of the nurses in education ($p = 0.002$). Whereas the Effective Communication Skills Scale, using the 'I' language sub-dimension median value of the nurses who participated in the education was 28 and the median value of those who do not attend the education was 24. Nurses who participated in education have a higher level of ability to use the 'I' language. (Table 4).

Table 4. Comparison of Socio-Demographic Characteristics of Nurses and Effective Communication Skills Scale Sub-Dimension Scores

		Med(Min-Max)	p/ χ^2 /U
Active listening sub-dimension			
Quality of work life	Perfect	24 (8 - 40)ab	p=0,011 $\chi^2=13,141$
	Very good	36 (27 - 40)ab	
	Good	35 (13 - 40)a	
	Poor	32 (12 - 40)b	
	Very poor	35 (32 - 38)ab	
Empathy sub-dimension			
Working type	Day shifts	36 (8 - 40)	p=0,041 U=3038,50
	Night shifts	32 (11 - 40)	
Participation in com-	Yes	33 (8 - 40)	p=0,020

munication skills training	No	31 (11 - 40)	U=2730,50
	Using the 'I' the language sub-dimension		
Participation in communication skills training	Yes	28 (7 - 35)	p=0,002 U=2441,50
	No	24 (14 - 35)	

a-b: No difference between groups with the same letter

In our study, when we examine the relationship between the two sub-dimensions of the aggression perceptions scale, we see a negative very low level of correlation between Functional (acceptable-healthy reaction) and Dysfunctional (unacceptable-undesirable aggression) sub-dimensions $r = -.142^*$ ($p < 0.001$). It was reported that there is a negative low level of correlation between the Aggression Perceptions Scale "Functional" (acceptable-healthy reaction) and Effective Communication Skills Scale Ego developing language sub-dimension ($r = -.138^*$) ($p < 0.001$). Similarly, It was reported that there is a negative low level of correlation between the Aggression Perceptions Scale "Functional" (acceptable-healthy reaction) and Effective Communication Skills Scale self recognition and openness sub-dimension ($r = -.179^{**}$) ($p < 0.001$). The higher the nurses' level of Ego developing language, the more unacceptable their perception of aggressive behavior was regarded (Table 5).

Table 5. The Relationship Between Effective Communication Skills Scale and Aggression Perceptions Scale

Measure	1	2	3	4	5	6	7
1. Functional sub-dimension (acceptable-healthy reac-	-	-,142*	-,138*	,085	-,179**	,011	-,056
2. Dysfunctional sub-dimension(unacceptable-	-,142*	-	,411**	,251**	,390**	,245**	,234**
3. Ego developing language sub-dimension	-,138*	,411**	-	,540**	,494**	,515**	,486**
4. Active listening sub-dimension	,085	,251**	,540**	-	,501**	,743**	,443**
5. self recognition and openness sub-dimension	-,179**	,390**	,494**	,501**	-	,539**	,659**
6. Empathy sub-dimension	,011	,245**	,515**	,743**	,539**	-	,552**
7. Using the 'I' the language sub-dimension	-,056	,234**	,486**	,443**	,659**	,552**	-

Note.Spearman's correlation coefficient. * $p < .001$

DISCUSSION

Occupational Health and Safety Administration (OSHA) reported that 75 per cent of 25,000 workplace attacks per year occurred in health services and social work environments, and health care workers were four times more likely to be subject to violence than workers in the other

sector (Osha, 2015). This finding coincides with the National Crime Victims Survey and Bureau of Labor Statistics (BLS) data (Harrel, 2011).

It has been indicated that the actual number of violent incidents involving health workers was probably higher than the recorded cases because it is stated that the reporting was made voluntarily (Rosenman et al., 2006). Only 30 percent of the nurses report cases of workplace violence, the fact that although those who work in health care are exposed to very frequent violence, still there is a low number of reports is attributed health workers thinking that violence is a part of the job (McPhaul & Lipscomb, 2004; Speroni et al., 2014).

In a study conducted by the American Nurses Association, for a period of three years, 25 percent of nurses and nursing students who participated in the study reported having been physically assaulted by a patient or a relative of the patient and about half of them were subjected to bullying (American Nurses Association, 2016). Abdellah & Salama (2017) has found that 59.7% of the health care workers in the emergency department were exposed to violence and 58.2% of them were exposed to verbal violence. Relatives of the patients are held responsible for 89.7% of these verbal abuse. Alexander et al. (2004) have determined that the most common form of violence was verbal abuse. Similarly, Arnetz (1998) identified the most common type of violence as verbal threat (53%). Crilly et al. (2003) have reported that 53% of the violence was in the form of verbal violence and 26% was in the form of both verbal and physical violence.

In our country, the rate of exposure of nurses to violence varies by 60-90% (Alçelik et al., 2005; Gökçe & Dündar, 2008). It is stated that the most frequent type of violence that is experienced by the patients and their relatives was verbal, and the most frequent places of violence for nurses were emergency and psychiatry services (Günaydın & Kutlu, 2012).

In the present study, we found that 73.7% of the nurses who were included in the study were subjected to violence, 66.4% of them were verbally violated, 44.4% of them were subjected to violence by their relatives, and 37% of them were exposed to violence by the patients.

Abdellah and Salama (2017) have determined the causes of violence as the waiting period and high expectation levels of the patient and family. In another study, stressful conditions such as long waiting periods or crowding in the clinical setting, reporting bad news about diagnosis or prognosis are included as provocateurs of violence (Occupational Safety and Health Administration, 2015). Aksakal et al (2014) determined that nurses with longer working hours (above 40 h) had a greater risk of experiencing violence.

In our study, the most common causes of violence were agitation of the patient, low education level of the patient, rejection of requests, patient psychology, ineffective communication, dissatisfaction with the treatment, long waiting times. It is thought that violence against health workers occurred due to unrest, tension and anxiety caused by the stress of the patients and their relatives.

Bilgin et al. (2016) have not found any difference between APS and the study year, age or marital status. Muro et al. (2002) reported that the scores of nurses in APS differed according to the gender. In our study, it was determined that the Aggression Perceptions Scale and two sub-dimension mean scores of the nurses participating in the study showed no difference according to age, gender, educational status, working year, job liking, quality of work life, exposure to violence ($p > 0.01$).

In our study, it was found that the mean scores of the Effective Listening Sub-dimension scores of nurses did not differ according to age, gender, educational status, year of emergency in nurses, job liking, working style, participation in education ($p > 0.01$). On the other hand, it was observed that the Effective Listening Sub-dimension mean score varied according to the quality of work life ($p = 0.011$). It was determined that the effective listening skills and effective listening sub-dimension score of the ones who described the quality of work life as very good were higher.

It was determined that the Effective Communication Skills Scale Empathy Sub-dimension mean score do not differ according to the characteristics such as educational status, working year, job liking and quality of work life ($p > 0.01$). On the other hand, it was observed that the Empathy Sub-Dimension mean score ($p = 0.041$) differs according to the working style and status of participation in education ($p = 0.020$). It was observed that the nurses who participated in the education and worked continuously during the day had higher empathy scores.

Effective Communication Skills Scale The Use of I Language Sub-dimension Score was found to vary according to the level of participation in education ($p = 0.002$). The Effective Communication Skills Scale Using the I Language Sub-Dimension score of the participants of education were found to be higher, and those who participated in the education use the I language better

Violence against the health workers are thought to have increased due to their lack of experience in dealing with aggressive behavior and managing crisis and lack of education (Büyükbayram & Okçay, 2013). When the relationship between the non-functional (unacceptable) subscale of aggression perceptions scale and violence was examined, a weak relationship was found between them ($r = 0.39$).

In our study, there was a mild positive correlation between effective communication skills scale ego developing language sub-dimension and aggression perceptions scale Dysfunctional (unacceptable-undesirable aggression) sub-dimensions ($p < 0.001$). While effective communication skills Ego developing language sub-dimension score increases, those who see aggression as unacceptable behavior slightly increase.

CONCLUSION AND SUGGESTIONS

In our country, aggressive behaviors towards health care professionals are increasing especially in risky places like emergency service (Boafo, 2016). The results of the study indicate that the working conditions of the nurses and the emergency service environments are risky in terms of exposure to violence (Abdellah & Salama, 2017). When the nurses are in contact with the patients and their relatives in the emergency departments for longer periods in the same environment, and their spatial and temporal proximity to them, they become open to the effect of aggressive situations.

More than half of the nurses working in the emergency department were found to be subjected to violence and this result was found to be consistent with the literature. Participants find the aggression unacceptable and their thoughts do not change according to their personal, professional characteristics and exposure to violence. This finding shows that aggression is perceived as a bad and non-human situation among nurses no matter who or what. Changing negative perceptions of aggression is a challenging and lengthy process, which is a good starting point for education studies. Another result of our study is related to the communication skills levels of nurses. 84% of respondents in the study reported to have participated in the education program

in order to develop their communication skills and the participants were found to got higher scores from Effective Communication Skills Empathy Sub-Dimension and Using the I Language.

As there is a positive mild correlation between the effective communication skills scale ego developing language sub-dimension and the disfunctional (unacceptable) sub-dimension of aggression perceptions scale, post-graduation, trainings should be arranged for the health workers at certain intervals in order to develop their communication skills and to deal with aggression.

In our country, further regulation and effort are needed for reducing the number of patients in emergency services, making arrangements for providing therapeutic environment, educating the health care professionals/nurses about coping with aggression and about communication skills, for improving the quality of patient care, increasing the measures to ensure the safety of the environment and recording the cases of violence.

STRENGTHS AND LIMITATIONS OF THE STUDY

Conducting the research with low number of participants at the local level is the limitation of our study. On the other hand, no other study has been found which investigated the relationship between communication skill levels of the nurses working in the emergency departments and the level of aggression perception and their exposure to violence.

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