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Experience of Workplace Violence from the Patients among Mental Health Nurses in Indonesia: A Mixed Method Study

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Abstract

BACKGROUND: Workplace violence by patients and visitors (PVV) against nurses is regarded a devastating occupational issue around the world. The most frequent perpetrators of violence against nurses were patients, followed by their families and other health-care professionals.

AIM: This study aimed to use a mixed method to analyze PVV against nurses in mental health hospital in Indonesia.

METHODS: The 250 mental health nurses at two general public hospitals in Bandung were recruited with stratified convenience sampling by years of working experience.

RESULTS: All nurses experienced workplace violence from both patients and their families. At least nurses experienced more than 3 types of violence with the most frequent type of violence were verbal and physical violence. The six themes were emerged including variation of violence in nurse, traumatic impact of violence, impacts of violence on profession, violence not only come from patients but also family, reason of violence, and spiritual coping.

CONCLUSION: It is necessary to prioritize more efficient and approachable methods for nurses to deal with patients' aggressive behavior and to establish constant training program.

Introduction

Workplace violence by patients and visitors against nurses is regarded a devastating occupational issue around the world [1], [2], [3], [4], [5]. The most frequent perpetrators of violence against nurses were patients, followed by their families and other health-care professionals [4], [5]. Workplace violence is a disturbing problem affected safety and well-being of both patients and nurses, characterized in dismissiveness, abuse, harassments, and physical injury [6]. This condition also could produce a long-term problems, including less efficient and less effective of organization operations [7], [8].

In addition, the lack of safety in the nurses' work situation could indeed reduce the performance of their services and end up making patients and family members less satisfied [9]. Due to underestimation of violence assessment particularly if no physical accident has occurred, the real prevalence of workplace violence in hospital settings is complicated to evaluate [10].

The scope of this problem that crosses cultures and geographic boundaries is shown by research articles published worldwide [2], [5], [11]. Although violence in the setting of hospitals is important to recognize, the majority of studies involved violence in the health-care sector were restricted to limited sample size. Only few researches have focus on exploring violence done by nurses to patients [12], [13] and violence between nurses and patients [14]. Violence done by those suffering from mental illnesses is considered reasonable. It is supported by research that explains the origins of psychiatric disorders and by the fact that clinical characteristics are closely connected with the occurrence of violence [15]. Another study claims that most schizophrenic aggressiveness occurs during auditory hallucination [16], [17]. According to Yosep *et al.* [18], the majority of violence among nurses in mental hospitals is caused by alcohol or other substance abuse problems connected with insufficient medication adherence, implying that both nurses and patients share responsibility for resolving it. There is limited study on exploring the violence experienced nurses as a victim. In addition, violence takes multiple forms and occurs with varying levels across different units, indicating that experiences of those involved in violent incidents have to be examined more deeply and discussed in depth of the experience of nurses and reason of violence [19], [20]. Therefore, this study

aimed to use a mixed method to analyze violence by patients and visitors against nurses in mental health hospital in Indonesia.

Methods

Study design

A mixed method research design was used in this study. Identifying violence in the workplace by qualitative methods or surveys could contribute to an understatement of detailed courses and conditions for mental health nurses and their post-violence responses, as well as quantitative factors including the frequency, type, and severity of violence, and a mixed quantitative and qualitative approach suggests to be beneficial [21]. A quantitative research was conducted to identify the prevalence of different violence type. In addition, qualitative research was carried out through an in-depth individual interview on the experience of violence by nurses, with the outcomes of the two approaches integrated and reported [21].

Setting and samples

A study involved the 250 mental health nurses at two general public hospitals in Bandung, West Java, Indonesia, who understood the objective and procedures of this study and voluntary given consent to the study. The criteria for eligibility were nurse with at least one year‘s work experience, graduated from a minimum of Diploma III as the lowest educational level in nursing higher education. Nurses that take leave are excluded. Among the nurses, stratification convenience sampling was carried out: <5 years, 5–10 years, 10–15 years, and over 15 years of nursing career. The nurses participating in the survey and those who are interested in further discussion of the topic were offered a qualitative, in-depth interview. Eligibility criteria for qualitative study were nurse who completed the survey and willing to share their experience. Interviewees were selected in each group (stratified by working experience) and conducted until no new item was saturated. A total of 20 nurses engaged in the qualitative study.

Ethical considerations

This study was approved by the Institutional Review Board of affiliated university (Approval no. III/013/KEPK/STIkep/PPNI/Jabar/2019). The participants were provided full overall description and procedure of the study before actually conducting data collection, and those interested in taking part voluntarily were requested to fill the written consent form. They were provided description that the information gathered would be used for the research purpose and coded to protect personal information.

Measurements

The study was focused on health-related workplace violence developed by the WHO. The questionnaire included sociodemographic information, workplace characteristics, descriptions of violence types (psychological aggression, verbal abuse, sexual, and physical violence). In their previous 12 months, the respondents were questioned about the last violent incidents and were asked to reflect on the descriptions of the violence. The participants were asked about perpetrators, divided into patients, their families, and both patients and their families. In the current analysis, the Cronbach’s alpha of violence exposure was 0.910.

Data collection

Data were collected from February to November 2019 at two public hospitals in Bandung through a survey of 250 nurses employed in mental health hospitals. During the same time, an in-depth interview was conducted with qualitative analysis. On average, it took them 20–30 min to complete the questionnaires, and they were all returned. The 20 nurses took part in the survey and agreed to a further in-depth interview session around 45–60 min using. The data were audiotaped with a tape recorder and subsequently transcribed with the consent of the respondents. The interviews guidelines were: (1) Can you please let me know of the violence you suffered during your work as a mental health worker, from patients and families/relatives. (2) Please tell me, what you think of violence and how you have reacted to patient and visitor violence.

Data analysis

[22] Content analysis technique has been used to analyze qualitative data. The themes, categories, and code were contrasted based on the similarities and differences. To verify the researchers’ perception of the data, the participants were given a simple version of the interviews. Peer checking was requested to confirm the data. A group of nursing faculty and clinical experts have reviewed all coded data and categories several times during the analytical process for auditability.

Results

Table 1 presents the general characteristics

of the nurses in two mental health hospitals in Indonesia. The majority of participants were female (78%), had diploma degree (55.6%), permanent staff (72.0), and work at acute (26.0) and chronic room (20.8). About 95 (38.0) had 5–10 years of career experience. Table 2 presents characteristics and types of violence experience. About 97.2% (243 respondents) experienced violence from patients, 74.1% (180) from their families, and all nurses experienced violence from both patients and their families. About 53.3% (130) said that the perpetrators was male and 33.6% (84) experienced violence from both patients and their families at night, and 37.6% (83) experienced violence during routine treatment.

Table 1: Demographic characteristics of studied participants (n = 250)

Characteristics	n (%)
Gender	
Male	55 (22)
Female	195 (78)
Education level	
Diploma III	139 (55.6)
Bachelor	108 (43.2)
Master degree with specialist	3 (1.20)
Working experience (years)	
Less 5	54 (21.6)
5–10	95 (38.0)
10–15	77 (30.8)
More 15	24 (9.6)
Working unit	
In-patients department	51 (20.4)
Acute room	65 (26.07)
Chronic room	52 (20.8)
Emergency room	43 (17.2)
Drug addiction and rehabilitation unit	39 (15.6)
Employment type	
Permanent	180 (72.0)
Contract and temporary	70 (28.0)

Table 2 summarizes the types of violence. At least nurses experience more than 3 types of violence from patients, their families, and two type of violence from both patients and their families. The most frequent type of violence from patients was verbal violence (49.4%), followed by physical violence (28.8%), psychological violence (16.5%), and sexual violence (8.2%). The most frequent type of physical violence from families was verbal violence (46%) and physical violence (30%).

Table 2: Characteristics and types of violence experience (n = 250)

Characteristics	By patients only (n = 243), (%)	By family only (n = 180), (%)	Both (n = 250), (%)
Perpetrators sex			
Female	113 (46.5)	135 (75.0)	120 (48.0)
Male	130 (53.5)	45 (25.0)	130 (52.0)
Time of violence experience			
Day	80 (32.9)	71 (39.4)	70 (28.0)
Evening	65 (26.8)	67 (37.2)	65 (26.0)
Night	77 (31.8)	26 (14.4)	84 (33.6)
Anytime	21 (8.5)	16 (9.0)	31 (12.4)
Procedures			
Mechanical restraint	57 (23.4)	31 (17.3)	50 (24.0)
Unit rounds	73 (30.0)	55 (30.5)	61 (30.0)
Routine treatment	92 (37.9)	34 (18.9)	83 (37.6)
Admission of new patients	21 (8.7)	60 (33.3)	56 (8.40)
Type of violence			
Physical violence	70 (28.8)	35 (19.4)	75 (30)
Verbal violence	120 (49.4)	105 (58.3)	115 (46)
Psychological violence	40 (16.5)	29 (16.1)	40 (16)
Sexual violence	20 (8.2)	11 (6.1)	20 (8.2)
Number type of violence, means ± SD	3.45 ± 1.10	3.07 ± 1.82	2.95 ± 0.84

SD: Standard deviation.

A total of 20 nurses participated in a personal in-depth interview for qualitative data collection. Table 3 presents themes, categories, code, and example answers from mental health nurses' experience of violence. The analysis of the interviews regarding workplace violence drew a total of 26 subcategories, 15 categories, and six themes. The six themes were variation of violence in nurse, traumatic impact of violence, impacts of violence on profession, violence not only come from patients but also family, reason of violence, and spiritual coping.

Discussion

Over 90% of respondents had verbal violence from patients and their families. This shows that psychiatric nurses suffered severe violence. The literature review also showed that the nurses at a psychiatric hospital have experienced more frequent violence [23]. More than a half of nurses in Taiwan were reported having experienced physical violence and verbal abuse [24]. A systematic review was conducted by Spector *et al.* [25] through the CINAHL, Medline, and PsycInfo databases. The empirical report using a nursing sample included data on the rates of violence exposure including bullying and sexual harassment. A total of 136 articles provide data on 151,347 nurses from 160 samples. Findings of the study indicate that there are five types of violence, namely, physical, non-physical, bullying, sexual harassment, and combined. Overall, violence exposure rates are 36.4% for physical violence, 66.9% for non-physical violence, 39.7% for bullying, and 25% for sexual harassment, with 32.7% of nurses reporting having been physically injured in an assault. Rates of exposure vary by world region (Anglo, Asia, Europe, and Middle East), with the highest rates for physical violence and sexual harassment in the Anglo region, and the highest rates of non-physical violence and bullying are found in the Middle East. On the contrary to the above description, nursing is considered as a profession with high salary and attractive to many people in developed countries [26], [27], amidst the different conditions in the developing countries such as Indonesia, the Philippines, and Malaysia. However, the presence of violence signals an "alarm" that violence against nurses calls for special attention in many countries.

This study confirms the findings that almost all participants have been subjected to patient violence. The finding of the in-depth interview showed that nurses consider mental health violence "an experience they had never experienced before" supported the violence that psychiatrists are exposed to indefensibly. This was consistent with earlier studies stated that violence is, actually, a fact of working life for nurses. Lützen *et al.* [28] reported that those nurses are working in a mental health environment deal with the moral burden.

Table 3: Themes, categories, code, and example answers from mental health nurses' experience of violence (n = 20)

Themes	Categories	Code	Example answers
Variation of violence in nurse	• Physical violence • Verbal violence • Sexual harassment	• Push, attack, kick • Hit, slap, break • Rough words, whore • Touch lightly with the fingertips • Accused as a whore, embraced forcibly • Hold breast and buttocks	• *"When I was pregnant, I have once been attacked by a patient who was apparently hallucinating. He hit right in my stomach"* • *Two of those patients I vividly remember. She said: "You are prostitute." I asked myself, do I look like a prostitute* • *"I was shocked that he hugged me from behind, and to my surprised the patient was naked. I immediately ran, he was trying to catch me and I feared of being embrace again…"*
Traumatic impact of violence	• Hard to forget • Does not want to happen again • Undesirable to happen	• Not secure shocked • Being irritable • Dilemma • Insomnia	• *"I was shocked, I did not try to run away, I was just shocked and silent; I sweated out. I did not try to escape, I was just surprised, I walked away silently"* • *"I was afraid and anxious when I was on duty in the night. I was always in fear; I still remember the trauma until now." I felt panicked when patients threatened to kill me"* • *"Whenever I am on night duty, I was afraid. I feared a patient who had committed suicide by hanging himself with bedspreads"*
Impacts of violence on profession	• Desire to leave a profession • High emotional exhaustion	• Leave a work • No longer will serve in the mental hospital • Refuse to serve in the mental hospital	• *"There was a female patient who opened her shirt and got naked on the top of a trellis. We were afraid. I persuaded her to go down, but she did not comply. She suddenly fell over me. Since then, I did not want to be a nurse"* • *"When he hallucinate, he would strike me; it traumatized me and from now on I will not want to work in a psychiatric hospital anymore; I do not want to experience that trauma again"*
Violence not only come from patients but also family	• Intimidation by families • Threat of lawsuit	• Afraid and threat of family • Patient families with journalist professions threatened to defame through media • Blow up news that the hospital provides particularly bad services	• *"I was shouted and scolded by his family, because his family might had an appointment with the doctor for consultation, and the doctor did not confirm but his words were unpleasant or rough to listen"* • *"Legally, if there the nurses made no effort, we were certainly wrong, but if we caught a patient who ran away, there was the patient's law protected right"*
Reason of violence	• Communication barrier • Low motivation to perform therapeutic communication • Mistrust	• Do not want to talk many with patients • Take a distance with patients • Lazy to work • Lazy to perform therapeutic communication • More often use social communication	• *"I felt that the trauma had not come from my patients but from their family, so I want to talk many things with patients"* • *"Some patients were restrained at their chair; they endlessly yelled fat, fat, bad, fat, pain. I wanted to reply Yes, I am fat, I'm too lazy to work"*
Spiritual coping	• Spiritual expression • Spiritual responses	• Astgafirulloh, surrender to Allah • I hope I'm given a power • Ask for help, request support • Allah, worship, praying	• *"I usually tried to take a deep breath Astagfirullohalazim, I thought restraint is not good, because it is really immoral"* • *"A big and tall patient liked to read the Holly Qur'an. One day he must go to the Rehabilitation room. When he sought the Qur'an, it was torn and cluttered. It was burned by another patient using cigarettes lighting. Masha Allah, then he was angry and fighting. There were two patients whose teeth were loosened and bleeding*"

The violence was some time come in the form of family intimidation. Patient families with journalist professions threatened to defame through media and to blow up news that the hospital provides particularly bad services. Literature study explains that factors responsible for the increase in violence to nurses were dissatisfaction of patients and their families. Resentment of patients and their families about aspects of communication stimulates them to commit violence in nurses [29]. This study also found that nurses frequently encounter situations that are difficult to anticipate.

This study found that nurses experienced workplace violence more frequently from both patients and their families as found by the previous study [4]. However, the findings of the in-depth interview revealed that, although families did a violence less often than patients, their violence is more difficult to manage emotionally than that of patients resulting in an increase in negative feelings when patients are in difficult situation or have an inadequate improvement [30], [31]. In addition, the high rate of violence in nursing is ascribed to discontent with nursing performance, especially aspects of communication and interpersonal relation [5], [32]. As the changes in the conditions of patients are the main cause of violent events [11], health-care professionals who care for irreparably patients with ubiquitously expressed need to be aware of the potential of violence once they become much worse and make better planning.

A sense of desire to leave a profession concerned with violence is an issue deserving attention. Shortage of nurses became a worldwide issue [33], [34]. Such shortage is worsened by increase in violence to nurses [35]. A research in Malaysia reports a nursing shortage issue that requires a safe and supportive working environment [36]**.** In addition, a critical shortage of trained nurses served as nurses in Australia was reported [37]. However, if a nurse is exposed to violence, he/she will leave his/her profession as a nurse [38]. More efficient and approachable methods for nurses to deal with workplace violence and to establish constant training program is needed.

The qualitative findings deliver data on keyword "stay away from," for example, "If I do not know the patient, I stay away from him/her," "I stay away myself from the patient," or another expression such as ". if, for example, my own do not dare to interact with the patient." The data indicate that nurses prefer not to interact and communicate with the patient. Earlier studies concluded that nurse's low motivation to perform therapeutic communication and "uniform approach" might be regarded as a barrier of communication and low trust of mental health

patients [39]. Such low trust prevents patients from communicating their problems to the nurses. A specific approach is required in communication with aggressive patients to minimize violence over nurses, regardless of nurses' feeling threatened. The spiritual response is coping of the mechanism whereby nurses handed their problems over God almighty after all of the best efforts have been pursued. Nevertheless, quantitatively, these data are not yet tapped. The spiritual expression is depicted on the results of qualitative research, in which the content in the form of "spiritual responses" by nurses who have exposure to violence appears in multiple expressions. Most of the expressions are: "Alhamdulillah, lailahailallah, astagfirullohalazim" or "Surrender to Allah," "O Allah!," worship, praying, or requests such as "O Allah, I hope I am given strength, O Allah, I ask for help, O Allah, ask for Your help." Spiritual coping is included in constructive problem solving.

Study limitation

Due to the recruitment of participants into one province in two general public hospitals, the generalization of research results is restricted.

Conclusion

Mental health nurses' experience severe violence verbally and physically both patients and their families in mental health hospital. Violence occurred in many types that lead to traumatic event and significant impacts on profession. Communication barriers and mistrust were one reason of violence. Nurses try to cope violence happen in their life with more spiritual approach. It is suggested that subsequent research should focus on the development of realistic solutions and programs to address and evaluate the effectiveness of mental health abuse and its related issues. Develop an electronic system and environmentally friendly to support health care workers, is necessary, or when patients are offensive, irritated, uncontrollable, harmful, and aggressive. It is also critical that nurses be legally protected from lawsuits and that an ethical team be set up that will safeguard the rights of nurses and patients.

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Ethical Consideration

Ethical approval was granted to the Institutional Review Board (4983/UN6.L/LT/2019).

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