

Original Article

Mental Health Nurses' Perspective of Work-Related Violence in Indonesia: A Qualitative Study

Iyus Yosep

Faculty of Nursing, Universitas Padjadjaran, Indonesia

Henny Suzana Mediani

Faculty of Nursing, Universitas Padjadjaran, Indonesia

Zabidah Putit

Faculty of Pharmacy and Nursing, Univeristy of Nizwa, Oman

Helmy Hazmi

Faculty of Medicine, Univeristy of Malaysia Sarawak, Malaysia

Ai Mardiyah

Faculty of Nursing, Universitas Padjadjaran, Indonesia

Correspondence: Iyus Yosep, M.Si., M.Sc, PhD (c) Faculty of Nursing, Univeristas Padjadjaran , Jl. Raya Bandung-Sumedang KM. 21, Hegarmanah, Jatinangor, Hegarmanah, Jatinangor, Kabupaten Sumedang, Jawa Barat 45363 Email: iyuskasep_07@yahoo.com

Abstract

This study explored nurses' perspective of work-related violence and traumatic experience related to workplace violence in Indonesia. A qualitative approach with Focus Group Discussions (FGDs) was conducted to forty nurses who are working in one of referral mental health hospital West Java, Indonesia. This study found that nurses experienced violence included: physical assault, verbal violence, sexual harassment, and intimidation of family, the threat of a lawsuit. Their responses to the violence were unpredictable situation, desire to leave the job, anticipatory and spiritual responses. Director in a mental hospital should have an attention to developing protection and insurance programs for nurses.

Keyword: mental health; nurse; violence; workspace.

Introduction

Work-related violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person or a group or community that either result in or have a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Sheldon & Howells, 2017). Violence in the workplace has become an ill-fated reality in a health care setting, particularly among nurses who are working in a mental health hospital whereas the nurses exposed to the patients with schizophrenia more frequently. Several studies have been reported a higher prevalence of violence against nurses ranged from 35.1% to 72.8% (Lee, Pai-Yen 2010; Spector, Zhou Che,

2014; Chang et al. 2015). The high rate of violence in nursing is attributed to dissatisfaction with nursing performance, mainly in communication and interpersonal relation aspects (Purpora & Blegen 2015; Speroni et al. 2014).

However, in some cases, violence committed by mental health patients often viewed as a reasonable action. This statement is supported by research findings that psychopathy and clinical factors are strongly correlated with the frequency of violence (Doyle et al. 2012). Another study mentions that most violence is carried out by patients with schizophrenia at the time of auditory hallucination (Bucci et al. 2013; Scott & Resnick 2013). On the contrary, the patient's violence is intolerable because it

may deteriorate the nurse's condition and may cause trauma to the nurses. If nurses experience trauma, their function as facilitators in restoring patient's health will be affected. Therefore, Whittington (2002) proposed the idea of zero tolerance to violence, in which it is important to have practical policies, protocols, and procedures in place to manage aggression and violence in the Mental Hospital.

The experience of violence affects the mental health nurse performance. The previous Study by Zabidah (2011) found that there are psychological problems such as fear, anxiety, uncertainty, depression, disturbed sleep, fragility, vulnerability, lost esteem and confidence, as the impact of traumatic experiences. An adaptive coping response for nurses in the case of violence may be analogized to the case of 'exposure to the terror,' as the study reported by Bleich, Gelkopf & Solomon (2003) concluded that the most prevalent coping mechanism is active information search about loved ones and social support.

While the prevalence of the different type of violence against mental health nurses has been well-documented in previous studies, little studies explore the experience of mental health nurses against violence particularly in a developing country such as Indonesia. Data about the violence and traumatic experiences of mental health nurses are very important. The relevant data will enhance the hospital management to improve policies that promote an optimum work climate and provide appropriate interventions for mental health nurses and patients. It will allow the mental health nurses to give their patients the best intervention and, thus, minimize the rate of relapse in patients with mental illness in Indonesia. The aimed of this study was to explore nurses' perspective of work-related violence and traumatic experience related to workplace violence in Indonesia.

Methods

Study design: This study was conducted using a qualitative approach with a semi-structured interview to the nurses who are working in one of referral mental health hospital West Java, Indonesia.

Participants: The sampling technique used in this study is purposive sampling. The inclusion criteria were mental health nurses having a

minimum educational background of Diploma III, having worked for at least one year, and having experienced violence. Forty nurses were selected by ethics committee. The ethics committee consisted of three representatives of senior mental health nurses, plus one representative of a psychiatrist and one representative of psychologist and social worker. The FGD participants have 5 year of experiences in minimum and have passed through some selection stages.

Interview guideline: The topics of discussion with nurses were related to three key questions, namely: (i) what nurses experienced in relation to violence at the mental hospital, (ii) what nurses felt and did when exposed to such violence, and (iii) what nurses did further in relation to their roles as therapists for the patients. While the focus of discussion with patients was oriented towards two main points, the anger expressed in the hospital and the experience of expressing anger and communicating with nurses when anger occurred. The guidelines for questions were developed by the researcher under the close guidance of supervisors who were expert in both qualitative research and mental health psychiatric. Guidelines for the question about qualitative data were focused on the experiences of exposure to violence. Key questions were as follows:

1. Have you ever been treated harshly, felt threatened by the patient or family?
2. Give an example of the type of threat or violence you have felt.
3. As the type of violence includes physical, verbal, psychological and sexual abuse, which typically happens most often to you in the mental hospital?
4. What feelings or impacts arise when you experience violence?
5. What do you usually do with patients after the occurrence of violence?

Procedure: Focus group discussion was done with the groups of nurses. Focus Group Discussions (FGDs) were conducted to gain different perceptions and domains of mental health nurses with psychiatric disorders. Focus group discussions helped explore the critical perceptions and values of the mental health nurses especially about experiences of violence. Also, FGD helped to understand the collective consciousness of the group in question (mental health nurses) regarding skillful patient

handling, values and meanings attributed to experiences of violence as well as patients' reaction to the discussion. Three sessions of Focus Group Discussions (FGDs) were conducted with the mental health nurses to make a qualitative assessment of exposure to violence. Each of the sessions was attended by different batches with different educational backgrounds to find the meaning and value of mental health nurses. Audio recording and notes were taken for the sessions, and all necessary precautions had been announced to carry out the session successfully. Each FGD session was attended by ten mental health nurses. Moderators were selected from senior lecturers from the department of Mental Health Nursing Universitas Padjadjaran and senior mental health nurses from West Java Mental Hospital, whom they have trained as moderators in focus group discussion and participated in briefing session before using the FGD guide. The focus group discussion among nurses was divided into four groups, i.e., Groups A, B, C, and D, each with 10 participants, but 2 participants of Group B withdrew.

Data analysis: Procedures of inductive category development were compiled (Mays, 2000). The main idea of the procedure is to formulate a criterion of definition, derived from the theoretical background and the research question, which determines the aspects of the textual material taken into account. Following this criterion, the material is worked through, and categories are deduced tentatively and step by step. Within a feedback loop, the categories are revised, eventually reduced to main categories and checked in respect to their reliability (Mays, 2000). Deductive category application works with previously formulated, theoretically derived aspects of analysis, which are brought into connection with the text. The qualitative step of analysis consists of a methodologically controlled assignment of the category to a passage of text (Mays, 2000).

Credibility, Reliability, and Validity of Study: The focus of reliability, which has gained the most acceptances among researchers, is the concept of honesty and trustworthiness. Respondent validation, or "member checking," includes techniques in which the investigator's account is compared with those of the research subjects, to establish the level of correspondence between the two sets. Study participants' reactions to the analyses are then incorporated

into the study findings. In this research, FGD data transcripts were confirmed with nurses. The third is reflexivity. Reflexivity means sensitivity to how the researcher and the research process have shaped the collected data, including the role of prior assumptions and experiences, which can influence even the most avowedly inductive inquiries. This study made use of "guidance" that had been agreed by all the moderators who in the early stage, they were given direction by the researcher to equate perspectives and focus more on data considered traumatic by the informants. To achieve this, in addition to using open-ended communication techniques, this study mostly used clarifying, focusing, restating and listening techniques. The last is attention to negative cases as well as an exploration of alternative explanations for the collected data. A long established tactic for improving the quality of explanations in qualitative research is to search for, and discuss, elements in the data that contradict, or seem to contradict, the emerging explanations of the phenomena under study.

Results

The present research used Focus Group Discussion (FGD) as a method of collecting qualitative data on nurses at mental hospitals in West Java, Indonesia. In the execution of the Focus group discussion, some participant tends to be more expressive, and some participants were rather quiet. Hence the excerpts used under each theme were extracted from the significant responses of certain particular participant rather than by consensus.

Experienced in workplace violence: Figure 1 describes a nurse's experience of violence. Main themes of content that appear have been classified based on the keywords that are very important related to violence. Keywords were often expressed by participants and often appeared during Focus Group Discussion. Next, the main theme is grouped based on several sub-themes in which have the same meanings. The main themes are as follows: 1). Physical Assaults & Fight with the patient. 2). Sexual Harassment. 3). Violence & Psychological Trauma. 4). Intimidation by Family. 5). Verbal Violence. 6). Treat of Lawsuit.

Physical Assault and Fight with Patients: Based on the content analysis, the repetition of keywords appears in the majority of participants

describing violence, physical assaults, and fights between nurses and patients. The keywords include:

"Throwing, fighting, rampage, smashing, spitting, hitting, pushing, attacking, kicking, punching, breaking, slapped, tortured, angry, spouting out, pulling, watering, striking hard, scratching, engaged in a fist fight, biting, chasing, go berserk." Meanwhile, physical violence is shown

by physical data as a "target or engagement" in violence such as "forehead, face, lips, body, eyes, hands, mouth, feet, cheeks, abdomen, shoulders, chest, hairs, and head." "He grabbed soap and threw it to my face... Yes, it was painful." "The patient was eating ...took the meal, at once...threw it." "A tool for cleaning the floor was grabbed, so I wrestled (fighting against the patient)."

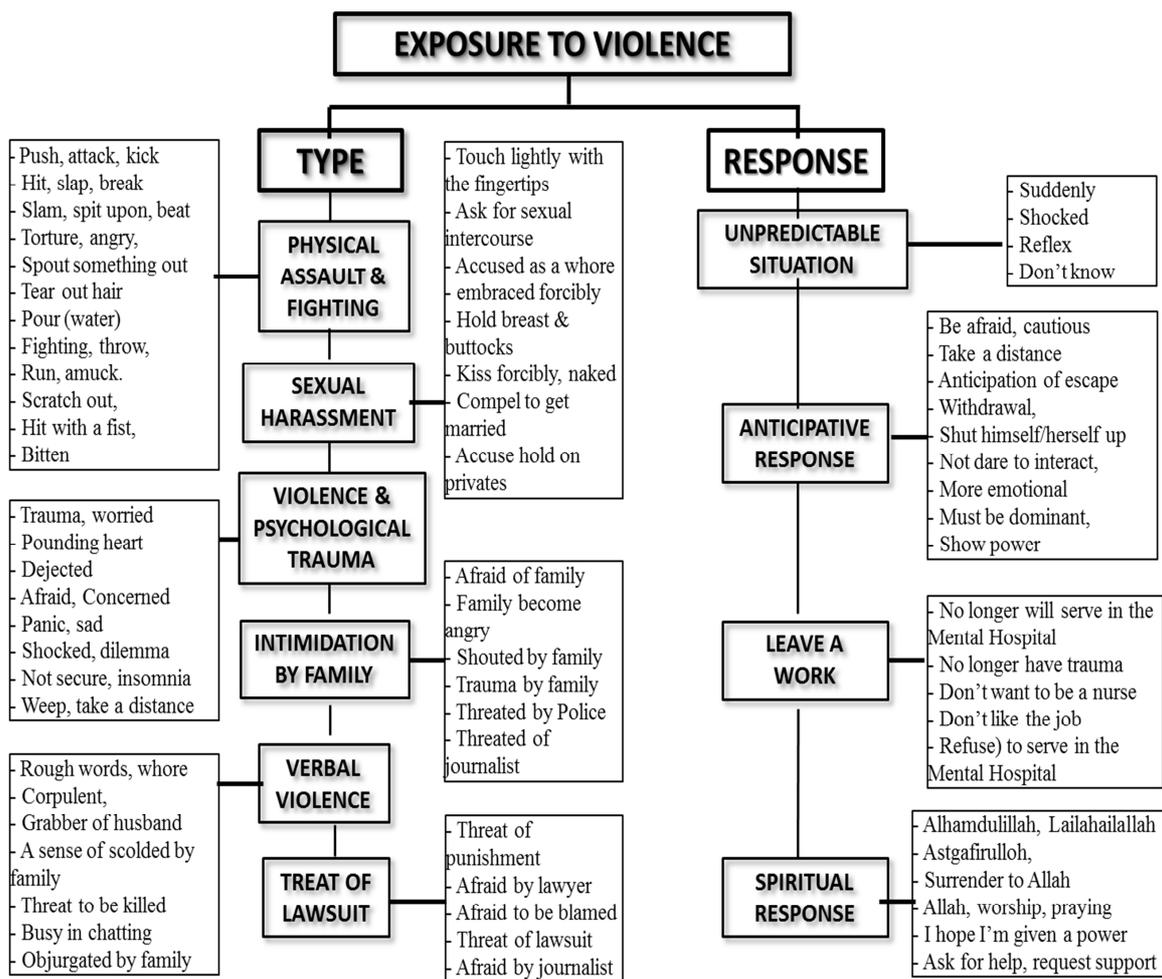


Figure 1. Type of and response to violence

Psychological Violence & Trauma: Further analysis of the data revealed the emergence of several psychological symptoms. The psychological symptoms were fear, worry, trauma, anxiety, pounding heart (frequent pulsate), a sense of disorder after being scolded by family, scolded by patient, panic, sadness,

the risk of death, shock and dilemma. For more details, see the excerpts of content that repeatedly appeared on each participant. Based on the content, the remarks of nurses were more predominated by the words "fear, shock, anxiety, worry, dilemma, and unsafe," resulting in sleep disturbances, crying, withdrawal, and

even a desire to quit their profession appear. Other important matters are intimidations in the form of a threatened lawsuit and the weapon hold-up of weapon. Physical responses that arose due to the psychological pressures could be a pain, as well as some of the other traumatic symptoms. For more details, observe the following data:

We asked the security for help; her family was angry because of the lower class ward." "The patient scolded me. I got panicked. If I die, my child would be an orphan. I was so sad and filled in tears."

Verbal Violence: The content analysis of verbal violence can be observed by keywords such as: despising rude words as a prostitute, body fat, or snatching other's husband or insulted as a blackmailer. Other verbal data are being scolded or cursed by family, a threat to kill and abandonment of duty as a nurse. The nurse was called blather. Also, verbal threats were made in the form of a threat with a weapon and the prosecution. These were expressed in the following excerpts.

"Two of those patients I vividly remember. She said: "You are a prostitute." I asked myself, Do I look like a prostitute?"

Sexual Harassment: The results of content analysis representing sexual harassments against those nurses who worked for mental hospitals are indicated by several keywords expressed such as: pinch, inducement of intercourse, accused as prostitute, embraced by force, holding sexually sensitive areas (sexual organs such as breasts or buttocks), forcibly kissing, naked in front of the nurse, invited or forced intercourse, telling having groped public, etc. Most of the nurses were commonly harassed or victimized by male patients. However, some male nurses fell victim of female patients in the hospital. The participants described it as follow:

"He tends towards sexual abuse. It is worrying because there is no document or reports in the past that the patient has a high libido, so I tried to keep a distance ... he suddenly pinched my hands, and invited to do intercourse".

Intimidation of Family: Intimidation of family was one of the violence that nurses experienced.

The findings from various FGD revealed various keywords repeatedly mentioned that includes "afraid of the family," "his or her family is grumpy," "shouted by family," "trauma of family," and threats by patients' family who held a certain profession such as "police or journalist." Patient's families holding a profession as a journalist might threaten to defame the families through mass media and blew up news that services provided by the mental hospital are poor.

"We asked the security guard for help; then the family got angry because I have mistakenly placed the patient at a lower class ward."

Threat of Lawsuit: Other findings from FDG were threats of litigation by patients or their families. The keywords that frequently appeared were "legal, lawyer, blame, the threat of pursuit, journalist" etc. The data below showed that nurses were frequently faced with a difficult situation. They have to be familiar with all patients' behaviors. When a nurse wanted to protect herself by taking hard actions forcibly, she would surely be in danger of prosecution and conviction.

"From the beginning to the end of the therapeutic process of bipolar patients, if we were not right and not professional, they would complain to their lawyer and wrote all of our everyday actions."

Nurse's response to workplace violence: There was four themes found for the response of nurse to the violence. 1) Unpredictable situation. 2). Anticipative Response. 3). Leave Work. 4). Spiritual Response.

Unpredictable Situations: The word "suddenly" has dominated the traumatic events encountered by nurses in mental hospitals. The repetition of the words "suddenly, startled, reflex, do not know" showed that the situation was unpredictable. For instance, when his or her hallucination suddenly emerged, he or she hit, threw, kicked, clawed, bit, hit by a machete, suddenly hit from behind, slapped, presumed that the nurses were his or her enemy, and even my mouth ever got torn or thrown into a room (full of feces). For more details, observe the description of the data below:

"When he was reminded to take medication, he suddenly attacked me; He suddenly pointed his hand to my veil and eyes."

Contemplating to Leave Work (Job): The respondents disclosed their contemplation of quitting or leaving their job. They expressed in various ways such as: "I no longer want to serve in a mental hospital because I do not want to experience that trauma again.", "I do not aspire to be a nurse." "I want to leave the job" appeared in forms of "lazy to work," "I'm still denying (refusing) to serve in the mental hospital," and some even thought of getting sick leave two months. The data was captured as in the following excerpts:

"When he hallucinates, 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."

Spiritual Response: Some respondent tends to place their trust and reliance on Allah in the face of violence from their patients while at work. They expressed in various manners that includes "Alhamdulillah, lailahailallah, astagfirullohalazim" or "Surrender to Allah," "O, Allah!", worship, praying, or expressions of request: "O, Allah, I hope I am given strength, O Allah, I ask for help, O Allah, I ask for support." Excerpts, as gathered, include:

"O Allah! If I die from patient's torture, If I cannot escape it (deceased), my son will be an orphan at the time."

Anticipatory Response: One of the main findings in this research was "Anticipating responses and showing power." Keywords of anticipatory responses that appeared were that although nurses "is being afraid," they are more "cautious" after some exposure to violence. Other responses were "look after distance." Also, some nurses tried to provide anticipatory responses in the way of: "We have first to see roughly where nurses should be able to run away when violence took place." The response is made as a form of vigilance. Other nurses gave responses in the form of "withdraw!" Expression "better shut myself up" was a response focusing on the nurses' personal safety. Another expression that came up was "I do not dare to interact with the patient." However, there were respondents who said:

"nurses tend to be more emotional in acute spaces." A few nurses revealed that "first of all, we should be dominant and show who are superior (the most powerful) at the room." It is intended to protect them from any exposure to violence by patients.

"I tend to be more emotional in an acute room, we have to in a predominant position. Firstly, to show who the boss at the room is, something likes at a prison."

Discussion

Most nurses explained that they had experienced violence and traumatic experience. This was consistent with earlier studies stated that violence is, actually, a fact of working life for nurses. Lütznén et al. (2010) reported that those nurses are working in a mental health environment deal with the moral burden. 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 (Kamchuchat et al., 2008).

This study also found that nurses frequently encounter situations that are difficult to anticipate. Unlike general hospitals, the mental hospital has a specific phenomenon where nurses are deemed responsible for violation of patients' rights such as isolation, drug administration without informed consent and exercising restraint over patient's aggressive behavior. Several studies reveal that half of the patients with mental illness face harsh treatment such as the use of legal force known as "a show of force" (Alegría et al., 2008; Birnbaum, 2012; Lawn et al., 2014; Lidz et al., 2014; Tingle 2015). On the other hand, it is patient is regarded dangerous to nurses, especially patients within raging, furious, aggressive or threatening conditions under the effects of addictive substances (McVicker 2010; Valenti et al. 2015). Nurses are faced with, frequently, multiple difficulties in the mental hospital. Nevertheless, violence is, actually, a fact of

working life for nurses. Similar to previous studies, Roche et al. (2010b) study on psychiatric nurses concludes that "perceptions of violence affect job satisfaction," while Lütznén et al. (2010) reported that nurses are serving in the mental health environment deal with a sense of "moral burden."

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 (Sharkey, 2012). 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.

Conclusion

This study highlight that nurses experienced verbal violence, sexual harassment, intimidation from family, the threat of a lawsuit, unpredictable situation, desire to leave the job, spiritual response, and anticipatory response. It is very important to provide nurses with legal protection against lawsuits and to establish an ethics team that can protect "nurses' or patients' rights." Furthermore, it is proposed to provide

an insurance program for nurses in mental hospitals, particularly in cases of physical injury and psychological trauma.

References

- Alegría, L., Margarita, Polo, L., Antonio, Gao, L., Shan, Santana, L., Luz, Rothstein, L., Dan, Jimenez, L., Aida, Hunter, L., Mary, Mendieta, L., Frances, Oddo, L., Vanessa & Normand, L., Sharon-Lise. (2008). Evaluation of a Patient Activation and Empowerment Intervention in Mental Health Care. *Medical Care*, 46(3): 247-56.
- Birnbaum, R. (2012). Remembering the "Right to Treatment". *The American Journal of Psychiatry*, 169 (4); 358-9.
- Bleich, A., Gelkopf, M. & Solomon, Z. (2003). Exposure to terrorism, stress-related mental health symptoms, and coping behaviors among a nationally representative sample in Israel. *JAMA*, 290 (5): 612-20.
- Bucci, S., Birchwood, M., Twist, L., Tarrier, N., Emsley, R. & Haddock, G. (2013). Predicting compliance with command hallucinations: Anger, impulsivity and appraisals of voices' power and intent. *Schizophrenia research*, 147(1):163-8.
- Chang, H.-Y., Shyu, Y.-I.L., Wong, M.-K., Friesner, D., Chu, T.-L. & Teng, C.-I. (2015). Which Aspects of Professional Commitment Can Effectively Retain Nurses in the Nursing Profession?. *Journal of Nursing Scholarship*, 47(5).
- Doyle, M., Carter, S., Shaw, J. & Dolan, M. (2012). Predicting community violence from patients discharged from acute mental health units in England. *Social psychiatry and psychiatric epidemiology*, 47(4):627-37.
- Kamchuchat, C., Chongsuvivatwong, V., Oncheunjit, S., Yip, T.W. & Sangthong, R. (2008). Workplace violence directed at nursing staff at a general hospital in southern Thailand. *Journal of occupational health*, 50 (2): 201-7.
- Lawn, S., Mcmillan, J., Comley, Z., Smith, A. & Brayley, J. (2014). Mental health recovery and voting: why being treated as a citizen matters and how we can do it: Involuntary patients' right to vote. *Journal of Psychiatric and Mental Health Nursing*, 21 (4): 289-95.
- Lee, S., Pai, H.C. & Yen, W.J. (2010). Nurse violence in the workplace: a study of experiences and related factors in Taiwan. *Hu Li Za Zhi*, 57 (2):61-9.
- Lidz, C.W., Mulvey, E.P., Hoge, S.K., Kirsch, B.L., Monahan, J., Eisenberg, M., Gardner, W. & Roth, L.H. (2014). Factual sources of psychiatric patients' perceptions of coercion in the hospital admission process.
- Lütznén, K., Blom, T., Ewalds-Kvist, B. & Winch, S. (2010). Moral stress, moral climate and moral

- sensitivity among psychiatric professionals. *Nursing Ethics*, 17(2):213-24.
- Mays, N. & Pope, C. (2000). Qualitative Research in Health Care: Assessing Quality in Qualitative Research. *British Medical Journal*, 320 (7226): 50-2.
- McVicker, L. (2010). Killer will remain locked up: Judge rules mental patient still poses a danger. *McClatchy - Tribune Business News*.
- Purpora, C. & Blegen, M.A. (2015). Job satisfaction and horizontal violence in hospital staff registered nurses: the mediating role of peer relationships. *Journal of Clinical Nursing*, 24(15-16):2286-94.
- Roche, M., Diers, D., Duffield, C. & Catling Paull, C. (2010b). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1):13-22.
- Scott, C.L. & Resnick, P.J. (2013). Evaluating Psychotic Patients' Risk of Violence: A Practical Guide: Investigate Persecutory Delusions and Command Hallucinations. *Current Psychiatry*, 12 (5):28.
- Sharkey, V. (2012). Uniform approach: Mental health nurse uniforms create a barrier and are a leap back in time, a The NMC's Judith Ellis rgues Valerie Sharkey. *Nursing Standard*, 26(45):26-7.
- Sheldon, K., & Howells, K. (2017). Assessment of Violence and Homicide. Assessments in Forensic Practice: A Handbook, 28-51.
- Spector, P.E., Zhou, Z.E. & Che, X.X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *International Journal of Nursing Studies*, 51 (1); 72-84.
- Speroni, K.G., Fitch, T., Dawson, E., Dugan, L. & Atherton, M. (2014). Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors', *Journal of Emergency Nursing*, 40(3):218-28.
- Tingle, J. (2015). The urgent need to improve care for people with mental ill health', *British Journal of Nursing*, 24(13): 710-1,.
- Valenti, E., Banks, C., Calcedo-Barba, A., Bensimon, C., Hoffmann, K.-M., Pelto-Piri, V., Jurin, T., Mendoza, O., Mundt, A., Rugkåsa, J., Tubini, J. & Priebe, S. (2015). Informal coercion in psychiatry: a focus group study of attitudes and experiences of mental health professionals in ten countries. *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, 50(8).
- Whittington, R. (2002). Attitudes toward patient aggression amongst mental health nurses in the 'zero tolerance' era: associations with burnout and length of experience. *Journal of clinical nursing*, 11(6):819-25.
- Zabidah, P. (2011). Domestic Violence: Implication for Health Practitioners. *International Journal of Public Health Research Special Issue: 22-22*.