Exploring Experiences of Workplace Violence and Attempts to Address Violence Among Mental Health Nurses in the Kingdom of Saudi Arabia

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Abstract

Introduction: Workplace violence has emerged as a global phenomenon requiring immediate attention. The nursing profession is primarily affected, and the unique vulnerability of nurses to workplace violence is particularly evident in the field of mental health nursing.

Aims: This study explores the experiences of mental health nurses with work-related violence and attempts to combat this violence in the context of inpatient mental health facilities in Saudi Arabia.

Methods: This research comprises a qualitative exploratory study consisting of semistructured interviews with 16 participants using open-ended questions. The participants are psychiatric/mental health nurses with experience in the field, so this methodological approach facilitates a detailed investigation of their encounters with workplace violence.

Results: This study reveals that nurses experience violence in accordance with two main themes and subthemes: experiences of workplace violence, the influence of violence on work settings, and efforts required to combat violence. Data show that these participants consider of prime importance access to training to increase safety through knowledge, improved communication, and protective skills, along with adequate staffing and a safe built environment.

Conclusion: The research findings confirm the urgency of addressing the needs of mental health nurses in inpatient psychiatric hospitals. Policymakers in the healthcare field must be aware of the inpatient psychiatric care climate and the need for support from those who staff these areas of practice. Training in specialized knowledge and skills is required to ensure a safe work environment as well as appropriate staffing levels, and a safe built environment. These conditions may be required to recruit and retain mental health nurses capable of providing best-practice care.

Keywords

violence, psychiatric, mental health, experiences, nurse

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Introduction and Background

Workplace violence is not new or unique to any particular profession or setting. The World Health Organization defines violence as “the use of physical/verbal force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (WHO, 2022). Meanwhile, Yenealem et al. (2019, p. 2) defined work-related violence as “the employment of deliberate force, direct assaults, harassment, and intimidation, either real or threatened, the potential result of which can be physical harm, psychological damage, impaired development, or death.” The phenomenon of workplace violence is an...
increasing concern in healthcare, specifically mental health (MH) inpatient settings.

**Review of Literature**

Research indicates that violence against nurses has increased, ranging between 35.1% and 72.8% depending on the nation studied (Allen et al., 2019; Sun et al., 2017). Sun et al. (2017) characterized violence as verbal abuse, threats to reputation, intimidation, physical violence, and sexual harassment, occurring at rates of 76.3%, 40.8%, 27.6%, 24.1%, and 7.8%, respectively, at the time in China. Similarly, 46.9% of healthcare providers (HCPs) in the Kingdom of Saudi Arabia (KSA) experienced workplace violence in the form of verbal violence (90%), intimidation (34.4%), and physical violence (3%; Alsmael et al., 2020). In the United States, acute inpatient psychiatric settings, emergency departments, and acute care hospital settings, where patients receive psychiatric and substance misuse treatment, were identified as having higher rates of violence against nurses (Allen et al., 2019).

This prevalence is credited to discontent with the standards of nursing care, particularly interpersonal communication and relations (Alshehry, 2022; Befus et al., 2019; Samadzadeh & Aghamohammadi, 2018; Yenealem et al., 2019). Nurses must address these issues, irrespective of the challenges they encounter when managing patients with MH disorders (MHDs).

Nurses are caregivers and are thus responsible for delivering physical and psychological assistance to their patients. However, nurses must also be guaranteed their dignity and physical and mental well-being. In their work, nurses are obliged to engage in active patient management and collaborate with multidisciplinary MH teams seeking to regulate manifestations of hostile and violent patient behavior (Yenealem et al., 2019).

Nurses must be prepared to deliver care consistently to patients and must be adept at communicating with patients in a manner that engenders a peaceful and secure inpatient environment. For this reason, nurses must ensure that conflicts between patients are promptly addressed to prevent them from intensifying. In addition, nurses should be prepared to communicate with patients in the aftermath of a conflict (Samadzadeh & Aghamohammadi, 2018).

The leadership role of nurses includes their positive influence over others in the workplace to realize predefined objectives. To ensure their role as leaders is effective, nurses must be able to both identify needs and motivate others in the pursuit of satisfying these needs. Moreover, nurses must formulate and implement interventions designed to ensure a harmonious workplace that stress is minimized and that there is zero tolerance for aggression and violence (Laeque et al., 2018).

Acts of violence or aggression by MH patients are sometimes accepted as a common feature of MHDs, a view supported by research indicating a correlation between psychopathy or clinical factors and the frequency with which violence occurs. Research indicates that patients with schizophrenia are particularly predisposed toward committing violence when they experience auditory hallucinations (Sideras et al., 2015). Nevertheless, any exhibition of patient violence is unacceptable, not least because it can potentially traumatize nurses. Specifically, nurses who experience trauma are unlikely to function effectively as caregivers. Thus, the implications of violence and aggression for the overall standards of patient care emphasize the need for zero-tolerance policies (Laeque et al., 2018). Moreover, psychiatric institutions must ensure they address violence and aggression by implementing appropriate policies, protocols, and procedures.

Violence has implications for the ability of MH nurses (MHNs) to perform their duties effectively. According to Havaei and MacPhee (2020), distress, disquiet, doubt, depression, disturbed sleep, and decreased self-esteem are all evidence of the psychological consequences of the trauma experienced by nursing personnel. AlQuwez (2020) found that general incivility toward nurses was negatively associated with patient safety competence. Thus, Bleich et al. (2021) suggested that nurses use coping mechanisms to adapt to workplace violence in a manner akin to that employed by individuals exposed to terror, namely, by the provision of social support.

Workplace violence is characterized by aggregate trauma, and moreover, it is a global issue impacting medical workers, many of whom have left their jobs because of verbal intimidation or actual physical assaults. Psychiatric nurses are more susceptible to workplace violence than other nurses, and they seldom report incidents, which makes it imperative that effective interventions be employed to address the subjective experiences of nurses, with the objective being to limit and prevent workplace violence. However, a review of the existing literature in this area has revealed that most research on workplace violence in nursing environments has emphasized its causes and prevalence. In comparison, there have been scant explorations of psychiatric nurses’ experiences.

**Aim**

While there has been considerable research on the incidence of violence against psychiatric nurses, there is relatively little evidence of their experiences of violence, especially in KSA. Therefore, this study examines the experiences of MHNs with workplace violence and the attempts to combat this violence in the context of MH hospitals in KSA.

The resultant data can improve hospital policies designed to enhance work environments and can aid in developing ideas suitable to address violence, thereby permitting MHNs to provide patients with optimum care. This approach should also reduce relapse rates amongst psychiatric patients in KSA.
Theoretical Considerations

The health promotion model developed by Pender et al. (2011) outlines external factors that influence physical health and MH. MHNs who have experienced occupational violence and incivility may have increased susceptibility to physical and mental problems; thus, it is important for nurses to be aware of the role of the violence they experience or witness as a potential threat to their health and for them to endeavor to practice self-care (Nilsson, 2022).

Watson’s paradigm of caring has important perspectives in the provision of patient care, as it views care through the lens of satisfying needs, noting that survival and biophysical needs supplant the satisfaction of psychosocial needs (Watson, 2020). Human behavior is driven by the need for homeostasis, and a disturbance or a perceived threat to this state may promote violent behavior unless addressed through appropriate care (Gonzalo, 2021).

Methods

Study Design

The current study adopts a qualitative exploratory method of inquiry due to the paucity of published research in this field coupled with the opportunity to explore unanticipated features of care in the locale under study. Characterization of the aspects of care that may emerge might in future facilitate quantification of these data which would subsequently be employed in policy formation, built environment design, and building appropriate curricular content in the education and training of MHNs.

Research Question: How do MHNs perceive the profile of nursing care provided to consumers of mental healthcare in inpatient psychiatric facilities and how might work-related violence be mediated?

Sample and Setting

A purposive sample was collected of 16 BSN- or MSN-prepared female psychiatric nurses/MHNs aged 29–40 years and employed in inpatient MH institutions with a minimum of five years’ professional experience in the MH care field. All other potential volunteers were not accepted. Recruitment was initially based on students enrolled in graduate MHN practitioner programs, and additional participants were gathered from this group using the snowball method. Participants were interviewed in a conference room at the College of Nursing, King Saud University.

Data Collection

Semistructured interviews were employed for data collection purposes to identify the attitudes of a larger number of participants, thereby promoting relevant discussion and information sharing (Nyumba et al., 2018; Tashakkori & Cresswell, 2007). It is also important to provide opportunities to discuss relevant experiences, perspectives, emotions, and concepts, thus acknowledging the importance of this issue and encouraging interaction with researchers during the data collection process (Merriam & Grenier, 2019; Scager et al., 2016).

The promotion of discourse was facilitated by the use of a guide for the semistructured interviews. Open-ended questions were designed to prompt communication and elicit perspectives, insights, sentiments, and experiences relevant to patient care (Sedig et al., 2020), as exemplified in the following question: “Can you tell us about your experiences with work-related violence?” Theoretical sampling allowed additional inquiries during the interviews as per the answers to the predetermined open-ended questions. Thus, the subject guides were helpful because they assisted in evolving the discussion and in collecting comprehensive descriptions of the experiences of nursing personnel. In other words, additional questions could focus on the participants’ responses to the initial probes, as suggested by Hennink et al. (2019).

Data Analysis

Braun and Clarke (2020), and subsequently Braun et al. (2022), observed the benefits of thematic analysis, particularly because it facilitates the identification of recurrent motifs and themes, in addition to safeguarding the appreciation of participants’ perspectives during the data evaluation process. Inductive codes were provided by participants during the group meeting. These were combined with relevant field notes and transcribed into digital format. NVivo software was employed in the extraction of themes from these data and notes using Silver and Lewins’ (2014) approach. The characterization of themes was further finalized through review by the researchers. Supplementary threads and subthemes identified during this process were contemplated with the help of a proficient peer researcher, and the data, codes, and classifications were independently reviewed by two analysts, after which it was possible to arrive at a consensus about the meaning and significance of the analyzed data.

Rigor

An important concern in data collection is trustworthiness, of which Polit and Beck (2016) propose four categories: credibility, dependability, transferability, and confirmability. Upon review of the research design and results, principal investigators did not find threats to the credibility of the study.

The recorded semistructured interviews and unstructured dialogues of the interviews provided inductive themes which were found to be dependable vehicles for qualitative data collection (Doody et al., 2013).
The trustworthiness of data collection is addressed by detailing the collection and processing procedures (Elo et al., 2014). The principal investigators conducted a comparative evaluation, after which regular consistency checks on the subject areas explored were performed. Peer debriefing occurred between the inquiry team and its fellow teaching faculty, and reflection was employed to enhance credibility and dependability and address potential bias or outcome expectations (Hays et al., 2016). Further, the trustworthiness of the results is also enhanced by proper attention to data analysis. Care was exercised to identify and evaluate the fit of the data in key categories at all stages to ensure proper abstraction (Hsieh & Shannon, 2005). An audit trail and investigator field notes were employed to enhance confirmability, and dependability was enhanced through member checking, which was conducted at the termination of the interview sessions.

Decisions concerning the suitability of use of these data may be satisfied by considering the characteristics of target populations and their congruity with the sample.

**Ethical Considerations**

The study protocol received approval from the university review board, and all participants gave written and verbal informed consent. The interviews were digitally recorded and transcribed. Subsequently, the data were stored in a locked facility, and subjects were assured their data would remain confidential and secure.

Moreover, they were informed of their right to withdraw their participation at any stage without the need to explain. All aspects of their participation were deemed pertinent, and the sessions were devised and delivered in a manner that permitted the participants to ponder the events.

**Results**

Two main themes and associated subthemes which emerged from the current study were: nurses’ experiences of workplace violence in inpatient psychiatric settings, the characterization of the nature of the violence as they experience it, their attempts to combat this violence, and its effects on the work environment. The excerpts allocated to each theme were obtained from the responses of specific participants rather than from any consensus.

**Main Theme One: Experiences of Workplace Violence**

Two subthemes emerged from the responses provided. These were: (1) physical and psychological effects and (2) verbal and sexual abuse.

**Subtheme One: Physical and Psychological Effects.** The content analysis indicated that keyword repetition is present in the descriptions of violence provided by most participants, as all recounted incidents involving violence, physical fights, and fights between nurses and patients. A detailed evaluation of the data suggested that nursing personnel might experience several potential psychological symptoms, namely, dread of physical harm; concern; anxiety; and sensations of chaos, panic, and despair:

- We often sometimes fought, during which the patients might attempt to bite or scratch us. Consequently, we attempted to defend ourselves and protect the patient. However, the patients were extremely aggressive.

- Aggression sometimes involved the use of materials available to the patients such as food.

- They throw anything at our faces, including food. And they push me.

- Although more serious physical aggression was also experienced:

  - On one occasion, I was hurt when the patient scratched me with her fingernails.

  - The following excerpt clarifies the nurses’ descriptions of the emotions they experienced and the effect on their psychosocial well-being:

    - Fear, shock, anxiety, worry, and concerns over personal safety which lead to disturbing feelings, sleep disorders, sobbing, social withdrawal, and the desire to change occupations.

  - Their views concerning the effect on the outlook for future events can be summarized as follows:

    - I feel dejected and hopeless when I encounter patient aggression.

    - There was a feeling of being unable to defend themselves adequately:

    - Aggressive patients are dangerous! I often fear that they might kill me.

  - A subsequent data evaluation indicated that multiple psychological symptoms are experienced by the participants, including fear, disquiet, anxiety, and feelings of chaos, panic, and melancholy.

**Subtheme Two: Verbal and Sexual Abuse.** Several participants recounted incidents when they were chastised, scolded, or cursed by patients, as well as exposed to death threats:

- Aggressive patients attempt to intimidate me with death threats and curses!
Further, verbalization was extreme and possibly unfamiliar to the nurses:

Patients use bizarre language to threaten us.

The following observations imply the possibility of sexual abuse against nurses in MH hospitals:

The patient held me by force, gripping my hands and trying to lie down on me.

Most nurses experience harassment from patients at some point. According to the participants:

It was a great concern to me because no previous reports of the patient exhibiting issues with their libido were present in their record. Therefore, I attempted to keep away from that patient.

The nurses noted that sexual behavior might be expressed by either gender toward them (female nurse):

I am a female. However, the female patients try to touch private areas on my body. They attempt to embrace me sexually and kiss me against my will!

Main Theme Two: The Impact on Work Settings and Attempts to Combat Violence

Subtheme One: Unpredictable. Words dominated the traumatic experiences of nurses in MH hospitals. Yet, the reiteration of these words does not indicate these situations were unforeseen. It may be the lack of relation to the situation in which it occurred and that the triggers involved are alarming:

I have no idea what to do when they bite or assault me unexpectedly.

Attacks were seen to stem in great part from hallucinatory events:

When their hallucination suddenly begins, they hit, throw, kick, claw, and bite anything. They hit nurses from behind, slap them, and act as if the nurses are their nemeses.

Internalizing the motivations for an attack by a patient caused the nurses to personalize them.

They can suddenly attack and bite us. They believe we are their adversaries, which is why they hate us.

Subtheme Two: Work Affiliation. Some participants stated they no longer wished to be affiliated with the field of MH nursing and now intended to leave:

I no longer wish to work as a mental health nurse. I would prefer to transfer to another department in the hospital, such as the ICU.

Planned avoidance by leaving a potentially violent atmosphere was cited, as well as emotional exhaustion, emotional trauma, and burnout:

I have no nursing aspirations anymore. I dread experiencing situations akin to those I have already encountered. I intend to go into administrative work and avoid working directly with patients.

Further, emotional trauma from past experiences is evidenced as an intention to discontinue work in the MH field of practice:

I feel traumatized and dissatisfied. I want to stop working in a psychiatric hospital.

Subtheme Three: Professional Reaction of Staff. Nurses wished to become empowered with self-defensive skills:

I need awareness to confront patient behavior. Moreover, patients would then be reluctant to be abusive because they would be fearful.

Thus, the nurses felt the balance of power in relations with patients must be openly acknowledged by the patient population and maintained to ensure peace:

When patients feel that the nurses are empowered, they become fearful, and we need to keep a distance between the patients and ourselves.

Further, awareness of the cultural, social, and personal backgrounds of patients was deemed important, as the participants believed awareness of the effects of the onset of mental illness and confinement to inpatient MH care on social and economic factors may mediate patients’ propensity toward violent behavior such as a background of harassment or abuse from family members or adverse living conditions.

We must appreciate the situation faced by patients, in addition to learning to identify specific behavioral patterns and signs.

Nurses offered statements that emphasized that challenges to personal status or position were inappropriately met with a defiant attitude on their part:

We must consider what is required when patients abuse us. For example, we may need to withdraw without responding to de-escalate the situation.

Subtheme Four: Required Improvements. The participants suggested that it is important to improve their professional
standing, caring skills, and knowledge related to MHDs, as well as to improve communication and defensive skills. They emphasized gaining skills in using methods whereby physical restraint may be executed without harm to the patient, other patients, and those in attendance including staff members. They also emphasized that there was a need to improve their personal communication skills:

Intervention and interaction skills must be improved.

The method considered to accomplish this was in the form of in-service workshops:

We have to be more knowledgeable and to access more training, particularly training that will allow us to learn how to deal with patients and communicate with them more effectively.

Further, communication skills between nurses and patients were emphasized for de-escalating potentially violent interactions:

Successful communication between nurses and patients is critical in order to ensure the safety of both groups.

It is essential to secure more knowledge of the competencies and skills required of a mental health nurse.

Subtheme Five: Patient Safety. Most participants emphasized the importance of safety and the safeguarding of patient rights in ward contexts:

Ensuring patient rights is a priority.

In addition, adherence to the Patient’s Bill of Rights regarding safety was mentioned by participants as a component of preemployment and in-service education:

We were given a lot of orientation about protecting patients from getting injured, especially anyone who we think is vulnerable.

Nurses seek to preserve or engender a calming effect to overt violence and act in ways designed to protect their patients:

It is important to protect patients from violence committed by other patients.

Discussion

Evidence-based research indicates that nurses face potential violence in MH settings, and these studies found that 50% of nurses encounter workplace violence perpetrated by patients with MHDs (Oram et al., 2017; Sedig et al., 2020; Yenealem et al., 2019). Thus, the rates of violence toward HCPs reported in KSA MH inpatient settings are similar to those in other nations (Basfr et al., 2019).

However, the responses of MHNs to workplace violence incidents may differ between locations based on policies, social and cultural values, administrative structures, and the attitudes of MHNs toward workplace violence, where a lack of institutionalized support for nurses who have suffered workplace violence may play an important role in influencing their choice of field of practice and their willingness to continue to care for patients at all.

Among MHNs who have suffered a workplace violence incident, 28.7% did not respond at all, 16.1% pretended nothing happened, and 30% requested a transfer to another department. Furthermore, as preferred methods of addressing the incidence of workplace violence directed toward them, 23.5% of MHNs talked to family and friends, 25.5% warned the patient, 40.6% spoke with colleagues, and 54.2% reported the incident to the nursing manager. In addition, police notification or legal redress was employed in 6.8% and 8.4% of cases, respectively (Basfr et al., 2019).

These data suggest that institutional policies or protocols for protecting MHNs in an organized way may be weak or absent, putting the onus on the nurses themselves to ameliorate the workplace violence perpetrated against them. This may be due to various contributing factors, such as absent or weak policy addressing workplace violence at an institutional level, poor preparation or unwillingness of administrators to recognize the problem, or poor recognition of the legitimacy of these concerns based on the assumption that violence toward MHNs is expected as part of the work and therefore not necessary to address it at the institutional level. However, the nurse may not be equipped to address these concerns.

Training MHNs in appropriate ways to address violence in their practice prepares them to capable to address and advocate for safe working conditions. This training would be appropriately placed in theory and clinical curricula. Attitudes of complacency toward violence in any field of practice have no place in any type of training at whatever level. As expressed clearly by the participants, while they desired more training to gain insights into the processes of MHDs and the ways to protect themselves from harm to their psyche caused by attacks, they were also anxious to be assisted practically in de-escalating potential violence and to have skills to protect themselves and patients from danger resulting from physical assault.

The current research examines MHNs’ experiences with work-related violence within KSA MH hospitals, and the results from the interviews revealed two main themes and related subthemes, including experiences of violence in the workplace, the influence of violence on work environments, and attempts to combat violence. In addition, this research concludes that nurses experience frequent incidents of unexpected violence and harassment. While patient safety is
always an essential component of quality care, the safety needs in inpatient MH care are not identical to those in other practice areas, and they therefore must be considered when assessing problems encountered during the delivery of high-quality MH care (Archer et al., 2020; Littlewood et al., 2019). Liu et al. (2019) pointed out that persons suffering from severe MHDs have higher morbidity and mortality risks based on such patterns as multiple hospitalizations, impulsivity, physiological and emotional dysregulation, cognitive deficits, poor social skills, low motivation, mistrust of HCPs, poor diets, sedentary lifestyles, and substance abuse.

According to Yang et al. (2018), nurses working in MH environments are required to manage ethical responsibilities, and most nurses stated that they had personally encountered both violent and traumatic incidents. These data agree with previous research that observed violence against nursing professionals as commonplace. Reports by psychiatric nurses have expanded this observation by outlining the specific nature of the violence they encounter, whether physical, sexual, psychological, or a combination.

### Physical Violence

The participants mentioned multiple categories of physical violence, including assaults in the form of beating, biting, scratching, hitting, grabbing, and pushing (Yenealem et al., 2019). According to Yang et al. (2018), hitting, slapping, pushing, jostling, scratching, biting, spitting, and kicking were the most common forms of violence experienced by nurses.

### Psychological Violence

On occasion, violence was exhibited as verbal intimidation, and dissatisfaction with communication often prompted patients to exhibit this form of violence against nurses (Bachynsky, 2020; Chambers & Ryder, 2018). More specifically, verbal abuse was identified as the most common form of workplace violence encountered by nurses, including verbal, emotional, and psychological abuse (Boafo et al., 2016), while verbal violence included cursing, threats, and intimidation (Alkorashy & Al Moalad, 2016). Psychiatric nurses typically miscalculate the impact of verbal abuse and regard this form of violence as a normal part of their work. Other forms of violence have been studied, such as self-directed and object-directed violence (Cheung & Yip, 2017), as noted by the researcher. For example, patients frequently threaten nurses with legal litigation (Liu et al., 2019), although KSA does not provide this avenue of redress to intimidate healthcare workers.

### Sexual Violence

The concept of sexual violence can encompass harassment that is verbal or physical (Mento et al., 2020), including inappropriate gestures and comments, but sexual violence that comprises physical harm or rape is the most commonly understood form (Pandey et al., 2017). Psychiatric nurses working in hospitals are particularly vulnerable to sexual assault (Varghese et al., 2022), and the current study reveals that nurses identify several forms of sexual harassment, namely, choking, inducement of sexual intercourse, being accused of prostitution, being forced to hug, touching of private body parts, being forced to kiss, nudity in front of nurses, and forced sexual intercourse (Pandey et al., 2017).

### Influence on Work Settings and Combating Violence

The research conducted by Knight and Hester (2016) confirms earlier studies involving MHNs in that it suggests that perceptions of violence influence job satisfaction. Furthermore, Trevillion et al. (2016) observed that MHNs are obliged to assume a heavy moral burden: in addition to the numerous challenges encountered by nurses working in MH hospitals, violence has become a routine occurrence they are obliged to endure. This violence is an unpredictable and dangerous reality for nursing professionals, especially when patients become enraged, become aggressive, or feel threatened by their environment (Copeland & Henry, 2018; Hylén et al., 2017).

Experiences of violence can impact physical and psychological health, in addition to attitudes toward work, and the experience of physical and mental harm can prompt nurses to create distance between themselves and their patients. Furthermore, the realization that violence may be an integral aspect of their working lives could cause nurses to fear their work and their patients (Dean et al., 2021). Whilst dedicated nurses may become verbally or physically aggressive toward disruptive patients, Boafo (2018) reviewed numerous articles that reached similar conclusions. Thus, Dean et al. (2021) suggested that nurses may begin to avoid patients and consider leaving their profession following workplace violence.

Reducing violence requires professional knowledge, communication skills, teamwork, and ward safety, all of which require training. Eliminating violence against MHNs is unfeasible due to the nature of some psychiatric conditions. However, the situation can be improved. Psychiatric nurses consider enhanced on-site training beneficial (Casey, 2019), and it could also assist in developing individual skills and allow nurses to increase their experience and overcome future situations more effectively. Successful communication is critical because it allows nursing personnel to appreciate the medical needs of their patients, provide suitable treatment, avert conflict, as well as reduce workplace violence. Psychiatric nurses also consider it necessary to include love and care in the organizational culture (Tang & Thomson, 2019). The physical and mental exhaustion experienced by psychiatric nurses emphasizes the need for consistent team
support so nurses can express their feelings regarding aggressive treatment. Thus, a nurse-centered strategy should be favored when managing violent incidents (Chou & Tseng, 2020) to safeguard MHNs from workplace violence. Nola J. Pender’s (2011) health promotion model suggests that preventing violence improves MHNs’ physical and mental wellbeing, as mental harm is particularly serious and can lead to anxiety and depression (Casey, 2019) or patient avoidance (Varghese et al., 2022). In other words, nurses who experience workplace violence tend to have impaired performance. Further, it is important to increase self-awareness of self-protection and to respond rapidly to violent incidents to protect MHNs from physical and mental damage.

The current study indicates several factors associated with workplace violence, namely, patient-, nursing-, social-, and environment-related factors. Patient-related factors pertain to the psychiatric diagnosis and any previous history of violence or drug abuse (Trevillion et al., 2016), while nursing-related factors encompass poor communication between nurses and patients, reduced psychological quality, poor professional knowledge, inadequate nursing skills, a tendency to stereotype patients, and staffing shortages (Liu et al., 2019). Further, social-related factors include gender and racial bias (Gerup et al., 2020), while environment-related factors include an excessive workload, the physical layout of the wards, and the ward atmosphere (Fabri et al., 2022). According to Chou and Tseng (2020), the determinants of violence include patient traits, management, staffing procedures, and the ward environment, and Liu et al. (2019) observed that violent episodes result from the interaction of different factors, such as staff behavior, patient conduct, the hospital environment, nursing roles, and wait times. Havaei and MacPhee (2020) divided violent factors into two groups: static factors that cannot be changed and dynamic factors that can be altered to improve results, to which the current research adds other variables, including racial discrimination.

**Conclusion**

Nurses are a vulnerable yet essential group within the health system, but they have a heightened vulnerability to workplace violence. Their experiences of workplace violence indicate that more work is required to address this issue to decrease its negative emotional and physical impact on these nursing professionals and to permit them to optimize their personal and professional development. Although the systemic change from policymakers may be necessary to increase safety for nurses working in high-risk areas—especially inpatient MH care—positioning nursing clinical supervision to advocate for the inclusion of nurse safety in the policy structure may be valuable. These advanced care nurses may advocate for greater awareness of nurses’ negative experiences, may identify the causes of workplace violence, and may devise effective solutions that can diminish workplace violence in consultation with members of multi-disciplinary teams and policymakers.

**Study Limitations**

The current research has several limitations, many of which are linked to the use of qualitative research methods. For example, there is the issue of representativeness. The study included 16 female participants aged 29–40 years from one city in KSA. Hence, the extent to which it truly represents the situation in the KSA as a whole is open to debate. Moreover, participants’ length of experience was necessarily required to have worked at least five years for inclusion in the study actual length of MH work experience was not tabulated, and the effect of the extent it would represent the total MHN workforce. However, since the participants provided authentic experiential data, the strength of this endeavor may outweigh its limitations and enhance its usefulness.

A purposive sample was collected of 16 BSN- or MSN-prepared female psychiatric nurses/MHNs aged 29–40 years and employed in inpatient MH institutions with a minimum of five years.

**Implications for Practice**

The findings outlined in this paper may provide improvement in care and change in levels of violence in inpatient psychiatric facilities. This research can be appreciated in the context of current aims to improve the quality of psychiatric nursing under clinical conditions, and the data emerging from this study can assist hospital management in refining and adjusting policies to create a superior work environment and ensure the delivery of suitable MH interventions.

This paper recommends the adoption of semistructured interviews in future qualitative research because this interview format provides direct data about the experiences of MHNs. Furthermore, focus groups have a limited number of participants and are more likely to encourage conversation wherein participants are prompted to explore a topic in greater detail.

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**References**

Alkorashy, H. A. E., & Al Moalad, F. B. (2016). Workplace violence against nursing staff in a Saudi university hospital. *International Nursing Review*, 63(2), 226–232. https://doi.org/10.1111/inr.12242

Allen, D. E., Mistler, L. A., Ray, R., Batscha, C., Delaney, K., Loucks, J., Nadler-Moodie, M., & Sharp, D. (2019). A call to action from the APNA council for safe environments: Defining violence and aggression for research and practice improvement purposes. *Journal of the American Nurses Association*, 25(1), 7–10. https://doi.org/10.1177/1078390318809159

AlQvez, N. (2020). Examining the influence of workplace incivility on nurses' patient safety competence. *Journal of Nursing Scholarship*, 52(3), 292–300. https://doi.org/10.1111/jnu.12553

Alshehry, A. S. (2022). Nurse–patient/relatives conflict and patient safety competence among nurses. *Inquiry*, 59, 49580221093186. https://doi.org/10.1177/0049580221093186

Alsmael, M., Gorab, A., & AlQhatani, A. (2020). Violence against healthcare workers at primary care centers in Damman and Al Khobar, Eastern Province, Saudi Arabia, 2019. *International Journal of General Medicine*, 13, 667–676. https://doi.org/10.2147/IJGM.S267446

Archer, S., Thibaut, B. I., Dewa, L. H., Ramtale, C., D’Lima, D., Simpson, A., Murray, K., Adam, S., & Darzi, A. (2020). Barriers and facilitators to incident reporting in mental healthcare settings: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, 27(3), 211–223. https://doi.org/10.1111/jpm.12570

Bachynsky, N. (2020). Implications for policy: The triple aim, quadruple aim, and interprofessional collaboration. *Nursing Forum*, 55(1), 54–64. https://doi.org/10.1111/nuf.12382

Basfr, W., Hamdan, A., & Al-Habib. (2019). Workplace violence against nurses in psychiatric hospital settings: Perspectives from Saudi Arabia. *Sultan Qaboos University Medical Journal*, 19(1), e19–e25. https://doi.org/10.18295/squmj.2019.19.01.005

Befus, D. R., Kumodzi, T., Schminkey, D., & Ivany, A. S. (2019). Advancing health equity and social justice in forensic nursing research, education, practice, and policy: Introducing structural violence and trauma-and-violence-informed care. *Journal of Forensic Nursing*, 15(4), 199–205. https://doi.org/10.1097/JFN.0000000000000264

Boafo, I. M. (2018). The effects of workplace disrespect and violence on nurses’ job satisfaction in Ghana: A cross-sectional survey. *Human Resources for Health*, 16(1), 1–10. https://doi.org/10.1186/s12960-018-0269-9

Boafo, I. M., Hancock, P., & Gringart, E. (2016). Sources, incidence and effects of non-physical workplace violence against nurses in Ghana. *Nursing Open*, 3(2), 99–109. https://doi.org/10.1002/nop2.43

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflective) thematic analysis?. *Qualitative Research in Psychology*. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., Clarke, V., & Hayfield. N. (2022). ‘A starting point for your journey, not a map’: Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis. *Qualitative Research in Psychology*, 19(2), 424–445. https://doi.org/10.1080/14780887.2019.1670765

Casey, C. (2019). Management of aggressive patients: Results of an educational program for nurses in non-psychiatric settings. *MedSurg Nursing*, 28(1), 9–21.

Chambers, C., & Ryder, E. (2018). Compassion and caring in nursing. Routledge.

Cheung, T., & Yip, P. S. (2017). Workplace violence towards nurses in Hong Kong: Prevalence and correlates. *BMC Public Health*, 17(1), 1–10. https://doi.org/10.1186/s12889-017-4112-3

Chou, H. J., & Tseng, K. Y. (2020). The experience of emergency nurses caring for patients with mental illness: A qualitative study. *International Journal of Environmental Research and Public Health*, 17(22), 8540. https://doi.org/10.3390/ijerph17228540

Copeland, D., & Henry, M. (2018). The relationship between workplace violence, perceptions of safety, and professional quality of life among emergency department staff members in a level 1 trauma centre. *International Emergency Nursing*, 39, 26–32. https://doi.org/10.1016/j.ienjr.2018.01.006

Dean, L., Butler, A., & Cuddigan, J. (2021). The impact of workplace violence toward psychiatric mental health nurses: Identifying the facilitators and barriers to supportive resources. *Journal of the American Psychiatric Nurses Association*, 27(3), 189–202. https://doi.org/10.1177/10783903211010945

Doody, O., Slevin, E., & Taggart, L. (2013). Focus group interviews in nursing research: Part 1. *British Journal of Nursing*, 22(1), 16–19. https://doi.org/10.12968/bjon.2013.22.1.16

Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utrainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open*, 4(1), 1–10. https://doi.org/10.1177/2158244014522633

Gerup, J., Soeren森, C., & Dieckmann, P. (2020). Augmented reality and mixed reality for healthcare education beyond surgery: An integrative view. *International Journal of Medical Education*, 11, 1–18. https://doi.org/10.5116/ijme.5e01.e1a

Gonzalo, A. (2021). Jean Watson: Theory of human caring. https://nurseslabs.com/jean-watsons-philosophy-theory-transpersonal-caring/#watsons_theory_and_the_nursing_process

Havaci, F., & MacPhee, M. (2020). The impact of heavy nurse workload and patient/family complaints on workplace violence: An application of human factors framework. *Nursing Open*, 7(3), 731–741. https://doi.org/10.1002/nop2.444

Hays, D. G., Wood, C., Dahl, H., & Kirk-Jenkins, A. (2016). Methodological rigor in journal of counselling & development qualitative research articles: A 15-year review. *Journal of Counselling & Development*, 94(2), 172–183. https://doi.org/10.1002/jcad.12074

Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? Estimating sample sizes in focus group research. *Qualitative Health Research*, 29(10), 1483–1496. https://doi.org/10.1177/1049732318821692

Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277–1288. https://doi.org/10.1177/1049732305276687
Hylén, U., Kjellin, L., Pelto-Pirilä, V., & Warg, L. (2017). Psychosocial work environment within psychiatric inpatient care in Sweden: Violence, stress, and value incongruence among nursing staff. *International Journal of Mental Health Nursing, 27*(3), 1086–1098. https://doi.org/10.1111/imn.12421

Knight, L., & Hester, M. (2016). Domestic violence and mental health in older adults. *International Review of Psychiatry, 28*(5), 464–474. https://doi.org/10.1080/09540261.2016.1215294

Laeche, S. H., Bilal, A., Hafeez, A., & Khan, Z. (2018). Violence breeds violence: Burnout as a mediator between patient violence and nurse violence. *International Journal of Occupational Safety and Ergonomics, 25*(4), 604–613. https://doi.org/10.1080/10803548.2018.1429079

Littlewood, D. L., Quinlivan, L., Graney, J., Appleby, L., Turnbull, P., Webb, R. T., & Kapur, N. (2019). Learning from clinicians’ views of good quality practice in mental healthcare services in the context of suicide prevention: A qualitative study. *BMC Psychiatry, 19*(1), 1–8. https://doi.org/10.1186/s12888-019-2336-8

Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Tang, Y., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occupational and Environmental Medicine, 76*(12), 927–937. https://doi.org/10.1136/oemed-2019-105849

Mento, C., Silvestri, M. C., Bruno, A., Muscatello, M. R. A., Cedro, C., Pandolfo, G., & Zoccali, R. A. (2020). Workplace violence against healthcare professionals: A systematic review. *Aggression and Violent Behavior, 51*, 101381. https://doi.org/10.1016/j.avb.2020.101381

Merriam, S., & Grenier, R. (2019). *Qualitative Research in Practice: Examples for Discussion and Analysis* (2nd ed.). Wiley.

Nilsson, H. (2022). Spiritual self-care management for nursing professionals: A holistic approach. *Journal of Holistic Nursing, 40*(1), 67–73. https://doi.org/10.1177/0898010921121103

Nyumba, T., Wilson, K., Derrick, C., & Mukherjee, N. (2018). The use of focus discussion methodology: Insights from two decades of application in conservation. *Methods in Ecology and Evolution, 9*(9), 20–32. https://doi.org/10.1111/2041-210X.12860

Oram, S., Khalifeh, H., & Howard, L. M. (2017). Violence against women and mental health. *The Lancet Psychiatry, 4*(2), 159–170. https://doi.org/10.1016/S2215-0366(16)30261-9

Pender, N., Murdough, C., & Parsons, M. (2011). *Health promotion in nursing practice* (6th ed.). Pearson.

Pandey, M., Bhandari, T., & Dangal, G. (2017). Workplace violence and its associated factors among nurses. *Journal of Nepal Health Research Council, 15*(3), 235–241. https://doi.org/10.3126/jnhrc.v15i3.18847

Polit, D., & Beck, C. (2016). *Nursing Research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.

Samadzadeh, S., & Aghamohammadi, M. (2018). Violence against nursing students in the workplace: an Iranian experience. *International Journal of Nursing Education Scholarship, 15*(1), 20160058. https://doi.org/10.1515/ijnes-2016-0058

Scager, K., Boonstra, J., Peeters, T., Vulperhorst, J., & Weigant, F. (2016). Collaborative learning in higher education: Evoking positive interdependence. *CBE Life Science Education, 15*(4), ax69. https://doi.org/10.1187/cbe.16-07-0219

Sedig, L. K., Spruit, J. L., Paul, T. K., Cousino, M. K., Pituch, K., & Hutchinson, R. (2020). Experiences at the end of life from the perspective of bereaved parents: Results of a qualitative focus group study. *American Journal of Hospice and Palliative Medicine®, 37*(6), 424–432. https://doi.org/10.1177/104990911989891

Sideras, S., McKenzie, G., Noone, J., Dieckmann, N., & Allen, T. L. (2015). Impact of a simulation on nursing students’ attitudes toward schizophrenia. *Clinical Simulation in Nursing, 11*(2), 134–141. https://doi.org/10.1016/j.ecns.2014.11.005

Silver, C., & Lewis, A. F. (2014). Computer-assisted analysis of qualitative research. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (pp. 606–638). Oxford University Press.

Sun, T., Gao, L., Li, F., Shi, Y., Xie, F., Wang, J., Wang, S., Zhang, S., Liu, W., Duan, X., Liu, X., Zhong, Z., Li, L., & Fan, L. (2017). Workplace violence, psychological stress, sleep quality and subjective health in Chinese doctors: A large cross-sectional study. *BMJ Open, 7*(12), e017182. https://doi.org/10.1136/bmjopen-2017-017182

Tang, N., & Thomson, L. E. (2019). Workplace violence in Chinese hospitals: The effects of healthcare disturbance on the psychological well-being of Chinese healthcare workers. *International Journal of Environmental Research and Public Health, 16*(19), 3687. https://doi.org/10.3390/ijerph16193687

Tashakkori, A., & Cresswell, J. (2007). *Exploring the nature of research questions in mixed methods research*. *Journal of Mixed Methods Research, 1*(3), 207–211. https://doi.org/10.1177/15586898007302814

Trevillion, K., Corker, E., Capron, L. E., & Oram, S. (2016). Improving mental health service responses to domestic violence and abuse. *International Review of Psychiatry, 28*(5), 423–432. https://doi.org/10.1080/09540261.2016.1201053

Varghese, A., Joseph, J., Vijay, V. R., Khakha, D. C., Dhandapani, M., Gigan, G., & Kaimal, R. (2022). Prevalence and determinants of workplace violence among nurses in the South-East Asian and Western Pacific Regions: A systematic review and meta-analysis. *Journal of Clinical Nursing, 31*(7–8), 798–819. https://doi.org/10.1111/jocn.15987

Watson, J. (2020). Watson’s caring science and human caring theory. https://www.watsoncaringscience.org/jean-bio/caring-science-theory/

World Health Organization. (2022). The VFA approach. https://www.who.int/groups/violence-prevention-alliance/approach

Yang, B., Stone, T., Petrini, M., & Morris, D. (2018). Incidence, type, related factors, and effect of workplace violence on mental health nurses: A cross-sectional survey. *Archives of Psychiatric Nursing, 32*(1), 31–38. https://doi.org/10.1016/j.apnu.2017.09.013

Yenealem, D. G., Woldegebriel, M. K., Olana, A. T., & Mekonnen, T. H. (2019). Violence at work: Determinants & prevalence among health care workers, northwest Ethiopia: An institutional based cross-sectional study. *Annals of Occupational and Environmental Medicine, 31*(1), 1–7. https://doi.org/10.1186/s40557-019-0288-6