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Occurrence of workplace violence and the psychological consequences of it among nurses working in psychiatric outpatient settings

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vi. Ethical statements

The study was conducted according to Finnish Medical Research Act (2010/794) and guidelines of ethical research conduct by Finnish National Board on Research Integrity.

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Occurrence of workplace violence and the psychological consequences of it among nurses working in psychiatric outpatient settings

Abstract

Introduction

There is a scarcity of studies concerning violence and its consequences in psychiatric outpatient setting.

Aim

This study aimed to explore the occurrence of workplace violence and the psychological consequences of exposure to violence among nurses working in psychiatric outpatient settings.

Method

Research followed a cross-sectional survey design. Data were collected with the VIA-Q instrument.

Results

During the 12 months prior to the study, nurses (n = 181) had most often experienced psychological violence, with fatigue being the most common consequence. Harassment most often caused feelings of violated integrity, whereas physical violence most often caused

insomnia. Significant relationships between exposure to violence and psychological consequences were identified.

Discussion

Workplace violence can manifest in a broad array of psychological symptoms and be harmful for nurses in psychiatric outpatient settings. It is important to discuss the subject of workplace violence and its place in the nursing curriculum, and to reflect on how nurses are educated and trained to face violence in psychiatric nursing.

Implications for Practice

De-escalation interventions should be implemented in psychiatric outpatient settings. Organizations should take steps to abolish internal violence. Nurses need appropriate education in order to prepare them to manage workplace violence.

KEYWORDS

nursing, psychiatric outpatient settings, psychological strain, workplace violence

Accessible summary

What is known on the subject?

- There is a scarcity of studies concerning violence in psychiatric outpatient settings in the 2010s in spite of the deinstitutionalization of psychiatric services.
- Previous research on violence in psychiatric outpatient settings has failed to consider the association between the psychological consequences of violence, exposures to violence, and background factors.

What the paper adds to existing knowledge?

- It has been known for some time that exposures to violence are harmful for psychiatric inpatient nurses; the paper demonstrates that psychiatric outpatient nurses are also at risk.
- The psychological consequences of exposure to violence are highly individualized and influenced by background factors.
- Nurses who face harassment have a greater risk of suffering psychological symptoms.

What are the implications for practice?

- De-escalation interventions should be implemented in psychiatric outpatient settings.
- Organizations should consider the possibility of internal violence occurring when planning preventive interventions to manage and reduce workplace violence.
- Education targeted at violence prevention, management, and debriefing should be organized systematically in psychiatric outpatient units and be taken into consideration in the mental health nursing curriculum.

Introduction

Violence may occur in different types of healthcare settings; hence, healthcare professionals in general, including nurses, are at high risk of experiencing workplace violence (ILO, 2002). Recent reviews (Edward et al., 2016; Flannery, Wyshak, & Flannery, 2018; Spector, Zhou, & Che, 2014) provide substantial evidence for this claim. In line with this general picture, violence against nurses has increased in mental healthcare settings (Flannery et al., 2018), and nurses working in the field of psychiatric nursing have a noticeably higher risk of exposure to workplace violence than nurses working in other healthcare fields (Spector et al., 2014). In previous studies, approximately 40–65% of psychiatric nurses have reported experiences of workplace violence (Andersen, Hogh, Elklit, & Biering, 2019; Fujimoto, Hirota, Kodama, Greiner, & Hashimoto, 2017; Itzhaki et al., 2015; Pekurinen et al., 2017). Although violent incidents are more common in psychiatric inpatient settings (d'Ettorre & Pellicani, 2017), violence also occurs in psychiatric outpatient settings (Konttila, Pesonen, & Kyngäs, 2018). It is important to note that there are strong intercountry differences in how psychiatric services are organized (Flannery et al., 2018; Spector et al., 2014). For example, in Europe (which includes Finland), the legislation on mental health services has noticeably changed, with the most recent shift characterized by deinstitutionalization and a strong focus on outpatient services (European Commission, 2013).

Violence is, of course, harmful in many ways, and it can have serious physical and psychological consequences (Di Martino, 2003). Physical injuries are an example of the immediate consequences of physical violence, while psychological consequences, such as emotional reactions, are indirect effects (Konttila et al., 2018). These latter consequences can cause long-term effects and the severity of the symptoms can vary greatly (Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2018). For example, a review by d'Ettorre and Pellicani (2017) reported that up to 10% of workplace violence victims suffer post-traumatic stress six months after the exposure. Furthermore, Andersen et al. (2019) indicated that work-related threats can increase the risk of post-traumatic stress disorder (PTSD) even four years after the exposure.

Workplace violence can be seen also as an assault against the psychological self (Chapman, Styles, Perry, & Combs, 2010). An individual's ability to deal with psychological strain is related to resilience, which essentially describes the ability to adapt to stress and adversity

(Foster et al., 2019). As such, individuals with high resilience will handle stressful situations noticeably better than individuals with low resilience (Ang, Uthaman, Ayre, Lim, & Lopez, 2019). Itzhaki et al. (2015) found that resilience has an important role in an individual's ability to cope with difficult situations. This may explain why some people handle difficult situations and psychological strain more easily than others (Foster et al., 2019; Ang et al., 2019). Therefore, it is important to provide victims with sufficient time and support in their psychological recovery (Chapman et al., 2010); for example, Stevenson, Jack, O'Mara, and LeGris (2016) found that in addition to appropriate debriefing, nurses need support from their managers after violent incidents.

Rationale

The overall impacts of violence (Flannery et al., 2018), or the psychological consequences of violence (d'Ettorre & Pellicani, 2017), are topics that have received limited research attention in the context of psychiatric outpatient settings. However, the findings of previous studies do support the contention that both workplace violence and its consequences are complex phenomena (Edward, Oysey, & Warelow, 2014; Flannery et al., 2018; Konttila et al., 2018; Spector et al., 2014). For example, Bernaldo-De-Quirós, Piccini, Gomez, and Cerdeira (2015) found that physical and verbal violence increased psychological morbidity among healthcare workers in pre-hospital emergency care. Avander, Heikki, Bjerså, and Engström (2016) revealed that the long-term consequences of violence can even extend into nurses' personal lives, causing fears about privacy and being publicly identified, but there is little known about how exposures to violence in psychiatric outpatient settings influence nurses' health (especially so given that none of these previous studies focus on psychiatric outpatient settings).

Some previous studies have investigated the consequences of exposure to violence in contexts of psychiatric inpatient care (Hasan, Elsayed, & Tumah, 2018; Itzhaki et al., 2015; Stevenson et al., 2016), psychiatric home visits (Fujimoto et al., 2017), emergency care (Al-Ghabeesh & Qattom, 2019; Bernaldo-De-Quirós et al., 2015; Jeong & Kim, 2017), and trauma nursing (Avander et al., 2016). Furthermore, additional studies have compared the consequences of workplace violence across different healthcare settings (Andersen et al., 2019; Choi & Lee, 2017; McTiernan & McDonald, 2015; Pekurinen et al., 2017; Rees, Wirihana, Eley, Ossieran-Moisson, & Hegney, 2018; Shea et al., 2017). Nevertheless, the

recent systematic review by Konttila et al. (2018) is an outstanding exception to this general research trend; crucially, it indicated that violence appears also in psychiatric outpatient settings. The results of this review indicated that nurses may face verbal violence in psychiatric outpatient settings, which may have psychological consequences such as anxiety, emotional exhaustion and feelings of vulnerability, and violated psychological integrity (Konttila et al., 2018). However, Konttila et al.'s (2018) review, important though it was, failed to indicate cultural differences and consider the association between the psychological consequences of violence, exposures to violence, and background factors. Moreover, there is an even more marked scarcity of studies concerning violence in psychiatric outpatient settings in the 2010s in spite of the deinstitutionalization of psychiatric services. Therefore, this present study is designed to explore incidences and psychological consequences of violence in psychiatric outpatient settings. It will provide knowledge about the prevalence of workplace violence from the perspective of Finnish nurses, knowledge that can be used in the evidence-based development of nursing procedures and practices.

Aims and objectives

The aim of this study was to explore the occurrence of workplace violence and the psychological consequences of exposure to violence among nurses working in psychiatric outpatient settings. More specifically, the presented research had two clear objectives: 1) clarify the prevalence of violence and the psychological consequences of it; and 2) evaluate the relationships between the psychological consequences of violence, background factors, and exposure to violence.

Methods

Study design

The presented research employed a cross-sectional survey design.

Setting and study sample

In Finland, public health services are divided into primary healthcare and specialized medical care. Primary healthcare services are provided at the municipal level, while 20 hospital districts (with each municipality a member of one hospital district) organize specialized medical care (Ministry of Social Affairs and Health, 2019). Based on the legislation, municipalities can organize specialized medical care themselves under the control and supervision of the hospital district (Act on Specialized Medical Care, 1062/1989). Psychiatric specialized medical care is divided into inpatient and outpatient services, and, according to the Finnish legislation, the services must primarily be organized on the outpatient basis, e.g. in mental health centers (Mental Health Act, 1116/1990).

The study population in this research comprised all of the nurses working in outpatient settings of adult psychiatric specialized medical care in Finland. Actual participants in the study were selected using two-staged sampling (Polit & Beck, 2011). First, five hospital districts, which statistically have the most psychiatric outpatient visits and two independent municipalities under these hospital districts which provide adult psychiatric specialized medical care were selected by purposive sampling (Polit & Beck, 2011): the objective was to obtain a representative sample of the psychiatric outpatient nurse population. The sample size was estimated by using a normal approximation to the binomial distribution with significance level of 0.05 and a confidence level of 0.95; an expected proportion of 0.40 was estimated from previous evaluations (Andersen et al., 2019; Fujimoto et al., 2017; Itzhaki et al., 2015; Pekurinen et al., 2017; WHO, 2019). The estimated sample size was 368. Additionally, 20% of participants were added to compensate for possible attrition. To ensure a broad national sample and the future psychometric evaluation of the Violence Incidence Assessment – questionnaire (VIA-Q), a goal of 600 respondents was established. Then, adult psychiatric outpatient units (n = 22) from the organizations mentioned above were selected by random

sampling (Grove, Burns, & Gray, 2013). A total of 606 eligible psychiatric nurses currently working at these units were invited to participate.

Instrument

The instrument used in this study was the aforementioned VIA-Q. VIA-Q is a recently developed instrument which can be applied to assess incidences of violence in the context of psychiatric nursing. The instrument has been developed in Finland and it was pre-tested and evaluated in the Finnish language in December 2018. The development process was adapted from DeVellis (2017). According to DeVellis (2017), the theoretical basis and structure of VIA-Q were based on a systematic literature review. The definition for physical violence was adapted from WHO (2002). Psychological violence was defined according to WHO **(**2002), emphasizing face-to-face verbal violence. Harassment was separated out from psychological violence and was defined independently according to the Finnish Occupational Safety and Health Act (738/2002) and ILO (2006); indirect contacts were emphasized. During the development process face-validity and content validity were evaluated. Face-validity was evaluated by an expert in psychiatric nursing (n = 1) and an expert in instrument development (n = 1). Expert panelists (n = 10) evaluated the instrument, and content validity was evaluated by the Content Validity Index (CVI) scale (Polit, Beck, & Owen, 2007). Computed values of I-CVI and Q-CVI varied mainly between 0.9–1; one I-CVI value was 0.7. S-CVI/Ave was 0.99. These values, excluding the value of 0.7 mentioned, indicated good content validity. Additionally, the experts had an opportunity to write comments and suggestions for further development of the instrument. Based on weak CVI-values (< 0.79), a number of additional comments and suggestions, factors and items were generated. The pre-test was conducted in one Finnish psychiatric hospital's inpatient and outpatient units, and responses (n = 118) were analyzed using SPSS 25.0 software. After the pre-test, the instrument's internal consistency was tested by Cronbach's alpha (George & Mallery, 2003) for seven factors separately (excluding questions concerning the background and earlier experiences of violence and harassment). Alpha values varied between 0.509 and 0.910. The results of the pre-test were similar to previous studies and strengthened the construct validity. Evaluations of validity and reliability found the instrument to be applicable and reliable. The development process of the instrument is presented in Figure 1.

[insert Figure 1 here]

Data collection

Paper questionnaires were used for stepwise data collection between the beginning of January 2019 and the end of June 2019. The wide time range was due to differences in how organizations processed research permission forms. Paper questionnaires were sent via post to contact persons who had been appointed beforehand. These contact persons were head nurses or assistant head nurses and they delivered questionnaires to the target units. The questionnaires were then forwarded to every nurse who fulfilled the inclusion criteria for participation. The contact persons invited nurses to take part in this study; nurses also received an invitation letter. Each contact person was subsequently contacted once and asked to remind nurses to complete the survey.

Ethical considerations

The study was conducted according to guidelines of ethical research conduct (RCR 2012). Research permission was obtained from each organization according to its research approval protocol. Formal ethics committee approval was not required for this cross-sectional study (Medical Research Act 2010/794) because all of the participants were employed at the studied organizations and were not exposed to any psychological and/or physical harm. All of the participants received an informative letter about the study which specified that their participation would be voluntary and anonymous (Polit & Beck, 2011; RCR 2012).

Data analysis

Data were analyzed using SPSS 25.0 software (IBM, Armonk, NY). Missing values were not replaced. Descriptive statistics (medians, interquartile ranges) were used to describe the prevalence of workplace violence. The normality of the data set was tested by the Kolmogorov–Smirnov test. The response options ‘often’ and ‘quite often’, as well as ‘quite rarely’ and ‘rarely’, were merged because of the low number of answers per these particular options. The internal consistencies of individual factors measuring the psychological consequences of physical and psychological violence and harassment were evaluated with Cronbach’s alpha, with values > 0.75 indicating high internal consistency (Polit & Beck, 2011). A sum variable measuring the psychological consequences of violence was formulated

based on these analyses of individual numbers of consequences. Spearman's correlation was used to explore the correlation between the psychological consequences of violence, background factors, and exposure to violence, with the threshold for statistical significance set at $p < 0.05$ (Polit & Beck, 2011). Open-ended questions were analyzed using thematic classification and quantification due to the brevity of the answers, while occurrences of different types of violence were reported as frequencies (Vaismoradi, Turunen, & Bondas, 2013).

Results

Sample characteristics

A total of 181 psychiatric nurses, or psychiatric practical nurses with equivalent job descriptions, participated in this study, which represents a response rate of 29.8%. The age of respondents ranged from 24 to 67 years (median 47.5, IQR 17), and most of the participants (84.5%) were female and held a bachelor's degree (92%). The participants had between 0.5 and 44 years (median 19.0, IQR 19) of work experience in psychiatric nursing, with most (61.8%) reporting that they had updated their skills. Most of the participants (79.6%) mainly worked alone and had worked at the present work unit from less than one year to 27 years (median 4.0, IQR 7) (Table 1).

[insert Table 1 here]

Incidence of violence

During the 12 months prior to the study period, 42.5% of the respondents reported exposure to psychological violence, 12.7% reported exposure to harassment, and 7.2% reported experiencing physical violence. Of the participants, 84.4% and 73.9% reported experiencing psychological violence and harassment, respectively, at their present work unit. Experiences of physical violence had predominantly occurred at previous work units. The prevalence of physical and psychological violence, as well as harassment, varied greatly, as the participants' answers regarding the frequency of each type of violence ranged from 'rarely' to 'often'. The types of physical violence that were reported most often included pushing (84.6%), hitting (76.9%), or seizing by the clothes (76.9%). Psychological violence commonly involved yelling (85.7%), vocalized underestimation of professional skills (81.8%), and publicly naming or insulting (81.8%). The respondents specified that harassment was mainly sexual (43.5%) or related to social media (21.7%). Based on responses to the open-ended questions, two cases of death threats and one case of strongly controlling behavior were categorized as psychological violence. A further two cases in which patients underestimated the nurses and their job demands were reported as harassment.

The occurrence of violence during different working hours ranged from 'weekly' to 'never'. Respondents mainly reported experiencing violence or harassment at the workplace, with the perpetrator usually specified as the patient (Table 2). However, according to responses to the open-ended questions, the perpetrator of psychological violence was also sometimes a co-worker (n = 5), superior (n = 5), patient's friend (n = 2), and the organization itself (n = 1). Respondents also reported experiencing psychological violence in a public place (n = 2), on social media (n = 2), and via telephone or email (n = 3). In addition to patients, the respondents reported that co-workers (n = 3), superiors (n = 1), and the organization (n = 1) sometimes perpetrated harassment.

[insert Table 2 here]

A clear majority of the respondents (89%) reported that they had experienced some form of violence at some point in their career, while 11% of the respondents reported that they are exposed to physical violence 'often' or 'quite often'. Furthermore, 26% and 9% of the participants reported experiencing psychological violence and harassment, respectively, either 'often' or 'quite often'. Physical violence, psychological violence, and harassment were experienced 'rarely' or 'quite rarely' by 61.9%, 58%, and 63% of the participants, respectively.

Psychological consequences of violence

The psychological consequences of workplace violence are reported in Table 3. During the 12 months prior to the study, the most reported consequence of psychological violence was fatigue (28.6%). Respondents also reported feelings of violated integrity (22.1%) and depression (16.9%), along with anxiety (20.8%). Harassment most commonly was associated with feelings of violated integrity (39.0%), feelings of insecurity (30.5%), and fatigue (30.5%). Respondents reported most often insomnia (15.4%) after exposure to physical violence. Additional consequences stemming from physical violence included considering changing the workplace (n = 1), feelings of anger (n = 1) and frustration (n = 1), and a decreased sense of dignity (n = 2). Based on answers to open-ended questions, the most commonly reported consequences of earlier exposure to physical or psychological violence, along with harassment, were anticipation (n = 25), changes in one's working and professional

growth (n = 25), prudence (n = 15), stress, anxiety and strain (n = 15), and fear (n = 14) (Table 4).

[insert Table 3 here]
[insert Table 4 here]

A Spearman's rho test was performed to determine whether exposures to violence or background factors were correlated with any of the psychological consequences (Table 5). Exposure to harassment was found to be significantly positively correlated ($p < 0.05$) with insomnia, anxiety, feelings of insecurity, states of trepidation, and feelings of violated integrity. Gender and nightmares were also positively ($p < 0.05$) correlated. Additionally, working experience in psychiatric nursing was positively correlated with states of trepidation ($p < 0.05$) and feelings of depression ($p < 0.01$).

[insert Table 5 here]

Discussion

Our study provides novel knowledge about the occurrence of violence and its consequences in psychiatric outpatient settings, and highlights the need to recognize violence and its psychological consequences in this context. Our findings confirm that nurses do indeed face violence in psychiatric outpatient settings; it mostly stems from patients, but exposure to violence internal to the organization was also reported. We would endorse the views of Jeong and Kim (2017), who concluded that nurses in every field of healthcare need a safe working environment to effectively perform their jobs, because this is related to the quality of care and the individual's quality of life. As we know, de-escalation interventions are widely used in psychiatric inpatient settings (Berring, Pedersen, & Buus, 2016), and they are efficient procedures to reduce conflicts and manage violent situations (Lavelle et al., 2016). However, there is still little that is known about whether these interventions are usable in psychiatric outpatient settings: there is, therefore, a clear need to initiate a discussion concerning these kinds of existing interventions and their appropriateness to manage violent behavior in psychiatric outpatient settings.

The results of our study indicate that exposure to violence can cause different psychological consequences, some of which can be harmful for nurses. Our result concerning the association between psychological consequences and harassment especially highlights how workplace violence can manifest in a broad array of psychological symptoms. Our study also indicates that working experience in psychiatric nursing is associated with psychological consequences of violence. In terms of education, there is some evidence to suggest that there is variation in how aggression management training is provided to nursing students (Searby, Snibe, & Maude, 2019), and we perceive that appropriate education is important from two perspectives. Firstly, and agreeing with Searby et al. (2019), nursing students need certain skills and abilities to manage violence when they become employed. Secondly, as Foster et al. (2019) indicated, mental resilience plays an important role when facing violence, and thus it is important to discuss how education responds to nursing students' individual needs and strengthens their resilience for working life.

What the study adds to the existing evidence?

Firstly, it is important to consider that exposures to violence are harmful for psychiatric outpatient nurses (the harms suffered by psychiatric inpatient nurses have been reported in previous studies: see Hasan et al., 2018; Itzhaki et al., 2015; Stevenson et al., 2016). The results of this study consolidate our understanding of the harmfulness of harassment: when considering correlations between exposure to violence and psychological consequences, nurses who had experienced harassment were found to be significantly more prone to insomnia, anxiety, feelings of insecurity, states of trepidation, and feelings of violated integrity than nurses who had not been harassed. Likewise, Bernaldo-De-Quirós et al. (2015) had previously suggested that the type of violence suffered is related to subsequent psychological symptoms among nurses in emergency care, and the current study provides strong evidence that harassment is also harmful in psychiatric outpatient settings.

Remarkably, in this study population nearly 14.3% of the respondents who had faced psychological violence reported that the perpetrator was a co-worker, superior, or the organization itself. This finding is supported by Al-Ghabees and Qattom (2019), Shea et al. (2017), and Choi and Lee (2017), who all reported that another nurse or colleague was sometimes the perpetrator of violence among nurses working in emergency departments (Al-Ghabees & Qattom, 2019), generally among nurses (Choi & Lee, 2017; Shea et al., 2017), and caring professionals (Shea et al., 2017). Our finding therefore strengthens existing evidence and further emphasizes the pressing need to evaluate internal violence in these organizations more comprehensively**;** as Bloom (2019) suggests, internal violence can be harmful, decrease productivity, and adversely affect employees and organizations as well as the patients they serve. Furthermore, internal violence has been shown to be more detrimental to nurses' health than external violence (Pien, Cheng, & Cheng, 2019).

It is worth emphasizing that this study clarifies that the psychological consequences of exposure to violence are individualized and influenced by gender and working experience in psychiatric nursing. Significantly, this study found that working experience in psychiatric nursing was shown to be significantly correlated with reported feelings of depression and states of trepidation. Likewise, gender and the occurrence of nightmares were significantly correlated. In contrast, Hasan et al. (2018) did not find a relationship between working experience and depression but did report that both age and level of education were related to depression. Furthermore, they found that coping strategies were significantly correlated to levels of depression. Andersen et al. (2019) reported another interesting finding concerning

gender: male members of staff were more likely to develop post-traumatic stress disorder than female staff after work-related threats. Nevertheless, it is important to state that male members of staff are usually involved in more serious situations (Andersen et al., 2019).

Finally, as is well known, violence is common in psychiatric nursing (Andersen et al., 2019; Pekurinen et al., 2017; Stevenson et al., 2016), but the finding that almost nine out of ten nurses in the study population have faced some kind of violence at some point in their career is particularly important in the context of the Finnish healthcare system. In comparison, studies by Itzhaki et al. (2015) and Fujimoto et al. (2017) reported that 56.8% and 53% of nurses, respectively, had been exposed to violence during their careers, figures which are considerably lower than our findings in this study.

Implications for mental health nursing practice

As violent incidents can never be completely prevented, it is crucial to develop efficient interventions that will reduce the adverse effects of violence. The presented results highlight the importance of appropriate and systematic procedures for de-escalation interventions and organizing debriefings after violent situations in psychiatric outpatient settings. In psychiatric inpatient nursing, there are some formal de-escalation interventions to manage violence, such as Safewards (Bowers, 2014, Safewards, 2020), the Omega Program (Geoffrion, Goncalves, Giguére, & Guay, 2018), Early Recognition Method (Fluttert, van Meijel, Nijman, Bjørkly, & Grypdonck, 2010), Constant Special Observation (Stewart, Bowers, & Ross, 2012), and Management of Actual or Potential Aggression (Bloor, McHugh, Pearson, & Wain, 2004; CPI, 2020). Also, there is scant evidence that recovery-focused care could reduce violence and aggression (Lim, Wynadem, & Heslop, 2017) as well as a structured behavioral plan (Bisconer, Green, Mallon-Czajka, & Johnson, 2006). There are also a few interventions that seek to assess the risk of violence to reduce escalation, like START (O'Shea & Dickens, 2015) or DASA (Maguire, Daffern, Bowe, & McKenna, 2019). Based on the results of this study and previous research, we suggest that the use of de-escalation interventions should be implemented and evaluated systematically in psychiatric outpatient settings as well. The review by Ameel, Kontio, and Välimäki (2019a) and the empirical study by Ameel, Kontio, and Junttila (2019b) indicate that only a few nursing interventions in adult psychiatric outpatient care focus on risk management and violence prevention. For example, the Safewards model (Safewards, 2020) is used nationally and internationally in many

psychiatric wards, and it would be fruitful to clarify whether it would be an appropriate intervention to introduce in psychiatric outpatient settings. On the other hand, recovery-focused care is also a plausible intervention, because it enhances collaborative nurse-patient relationships and helps nurses to effectively manage a patient's violent or aggressive behavior (Lim et al., 2017). Implementation of interventions of this kind would be an interesting opening for closer investigations and the development of interventions to manage violence in psychiatric outpatient settings.

Based on the results of this study, the sensitive issue of violence internal to an organization cannot be ignored in psychiatric outpatient settings, and there is a need to investigate it more closely. Therefore, we propose that organizations should consider the possibility of internal violence occurring when planning preventive interventions to manage and reduce workplace violence. From the perspective of organization and management, it is important to invest in the well-being of employees and sustain an atmosphere which is conducive to open dialogue. In reducing and/or eliminating internal violence, managerial and collegial support, as well as appropriate education programs, all play an important role (Bloom, 2019). By considering the possibility of internal violence, organizations can increase nurses' job satisfaction and well-being, decrease staff turnover, and positively influence the quality of care (Zhao et al., 2018). To contribute to the evidence-based development of effective measures, the prevalence of workplace violence and occupational well-being in both different countries and other healthcare sectors needs to be considered closely.

From the perspective of prevention, the results of this study emphasize the importance of education related to violent behavior and violence management. Education should be as up-to-date as possible, and therefore we suggest that education targeted at violence prevention, management, and debriefing should be organized systematically in psychiatric outpatient units and taken into consideration in designing the mental health nursing curriculum. Education increases theoretical knowledge and management skills, strengthens competence, and changes attitudes towards violence (Heckemann et al., 2015). Education can also strengthen nurses' coping abilities and resilience (Chapman et al., 2010), which have a central role in the management of psychological distress (Hasan et al., 2018; Itzhaki et al., 2015; Jeong & Kim, 2017). We propose that newly qualified nurses are familiarized with their working units and afforded mentors during the start of their work, because familiarization helps novices to absorb procedures and enables professional growth

(Tomietto, Rappagliosi, Sartori, & Battistelli, 2015). This is particularly important when inexperienced nurses are working in psychiatric outpatient settings in which the work is mainly performed alone.

Limitations and future directions

Although the research did provide new knowledge on the topic of workplace violence in the context of psychiatric nursing, it has some limitations. Firstly, this study employed the cross-sectional design, which limits us in reaching causal conclusions. Therefore, longitudinal research is needed to evaluate the causality between exposure to violence and its association with psychological consequences. Secondly, as only Finnish nurses participated, the presented results may not be generalizable on an international level. Nevertheless, the results can be exploited in countries where the psychiatric outpatient services are similar. A third limitation pertains to the instrument used in this research. It was recently developed; however, it was thoroughly pre-tested before this study and evaluated to be reliable and valid. Evaluations of internal consistency after pre-testing indicate that only one alpha-value for one factor was poor. This may be explained by the wide deviation of responses. A fourth limitation pertains to self-selection bias. More nurses who had suffered exposure to violence may have participated in the study than in actually the norm; nevertheless, in this study the occurrence of violence was in line with previous evaluations (Andersen et al., 2019; Fujimoto et al., 2017; Itzhaki et al., 2015; Pekurinen et al., 2017; WHO, 2019). Finally, the response rate was low, and this may have influenced the results by skewing them. However, the response rate is in line with typical response rates in other survey studies (Polit & Beck, 2011). To get a better response rate in future, it may be worthwhile sending questionnaires directly to participants and asking them to return the completed forms directly to the researcher.

Conclusion

To conclude, the current study provides a novel perspective on workplace violence in Finnish psychiatric outpatient environments. The study found that workplace violence exists in these settings, and, more importantly, that in addition to violence stemming from external sources, a substantial share of the violence is internal to the organization. Furthermore, the research showed that the psychological consequences of workplace violence are harmful at the individual level. The presented results indicate that nurses who face harassment have a greater risk of suffering psychological symptoms. Hence, it is important to implement appropriate interventions to prevent and manage violence in psychiatric outpatient settings and to support nurses who have faced violent situations; the provision of sufficient education, supervision, and mentoring can all help to reduce the adverse effects of violence.

Relevance statement

It is widely recognized that workplace violence occurs in the context of psychiatric nursing, but little is known about the prevalence of violence in psychiatric outpatient settings although the deinstitutionalization of psychiatric services is obvious. Thus, investigation of this phenomenon in this context is important. This study confirms that violence certainly does occur in psychiatric outpatient settings and has serious psychological consequences. The results of this study highlight the need for systematic implementation of de-escalation interventions, preventive organizational interventions, and appropriate education targeted at violence management in psychiatric outpatient settings.

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Table 1

Participant characteristics (n = 181).

Characteristic	n	%
Gender		
Female	153	84.5
Male	27	14.9
Missing value	1	0.6
Age[a]		
< 30 years	11	6.1
31–40 years	39	21.5
41–50 years	54	29.8
51–60 years	54	29.8
> 61 years	22	12.2
Missing value	1	0.6
Educational level		
Master's degree	15	8.3
Bachelor's degree	92	50.9
Vocational qualification	14	7.7
Other	60	33.1
Work experience in psychiatric nursing[b]		
< 5 years	26	14.4
6–10 years	26	14.4
11–15 years	24	13.3
16–20 years	37	20.3
> 21 years	68	37.6
Updating education		
Yes	112	61.8
No	68	37.6
Missing value	1	0.6
Present work unit		
Outpatient unit	79	43.6
Polyclinic unit	94	51.9
Acute unit	6	3.3
Missing value	2	1.2
Main working method in present work unit		
Alone	144	79.6
Pair working	20	11.0
Team working	17	9.4

Work experience in present work unit[c]		
< 5 years	118	65.1
6–10 years	40	22.1
11–15 years	7	3.9
16–20 years	9	5.0
> 21 years	7	3.9

[a] Median value: 47.5 years (IQR = 17.0, range 24–67 years)

[b] Median value: 19.0 years (IQR = 19.0, range 0.5–44 years)

[c] Median value: 4.0 years (IQR = 7.0, range 0–27 years)

Table 2

Incidence of violence during past 12 months, including information about the perpetrator.

	Physical violence (n = 13)		Psychological violence (n = 77)		Harassment (n = 23)	
	n	%	n	%	n	%
During working hours 7–17						
Weekly	1	7.7	6	7.8	5	21.7
Monthly	1	7.7	19	24.7	7	30.4
Rarely	10	76.9	52	67.5	10	43.5
Never	1	7.7	0	0.0	1	4.4
During working hours 17–22						
Weekly	1	7.7	3	3.9	0	0.0
Monthly	2	15.4	6	7.8	2	8.7
Rarely	7	53.8	9	11.7	6	26.1
Never	3	23.1	59	76.6	15	65.2
During working hours 22–07						
Weekly	1	7.7	3	3.9	1	4.4
Monthly	1	7.7	3	3.9	0	0.0
Rarely	6	46.2	7	9.1	6	26.1
Never	5	38.4	64	83.1	16	69.5
Outside working hours						
Weekly	0	0.0	0	0.0	0	0.0
Monthly	0	0.0	0	0.0	0	0.0
Rarely	1	7.7	3	3.9	5	21.7
Never	12	92.3	74	96.1	18	78.3
At workplace						
Often / quite often	8	61.5	55	71.4	16	69.6
Rarely / quite rarely	1	7.7	17	22.1	7	30.4
Never	1	7.7	5	6.5	0	0.0
Missing value	3	23.1	0	0.0	0	0.0
On way to work or at home						
Often / quite often	0	0.0	0	0.0	0	0.0
Rarely / quite rarely	0	0.0	1	1.3	3	13.1
Never	10	76.9	76	98.7	20	86.9
Missing value	3	23.1	0	0.0	0	0.0
At patient’s home / during home visit						
Often / quite often	0	0.0	5	6.5	1	4.4
Rarely / quite rarely	0	0.0	17	22.1	5	21.7

Never	10	76.9	55	71.4	17	73.9
Missing value	3	23.1	0	0.0	0	0.0
Somewhere else						
Often / quite often	0	0.0	1	1.3	2	8.7
Rarely / quite rarely	0	0.0	7	9.1	1	4.4
Never	10	76.9	38	49.4	20	86.9
Missing value	3	23.1	31	40.2	0	0.0
Perpetrator was patient						
Often / quite often	9	69.2	62	80.5	17	73.9
Rarely / quite rarely	1	7.7	13	16.9	1	4.4
Never	0	0.0	2	2.6	5	21.7
Missing value	3	23.1	0	0.0	0	0.0
Perpetrator was patient's next of kin						
Often / quite often	0	0.0	10	13.0	3	13.1
Rarely / quite rarely	0	0.0	35	45.4	5	21.7
Never	10	76.9	32	41.6	15	65.2
Missing value	3	23.1	0	0.0	0	0.0
Perpetrator was another relative of the patient						
Often / quite often	1	7.7	3	3.9	0	0.0
Rarely / quite rarely	0	0.0	21	27.3	5	21.7
Never	9	69.2	53	69.9	18	78.3
Missing value	3	23.1	0	0.0	0	0.0
Perpetrator was somebody else						
Often / quite often	0	0.0	5	6.5	5	21.7
Rarely / quite rarely	0	0.0	5	6.5	1	4.4
Never	10	76.9	38	49.4	17	73.9
Missing value	3	23.1	29	37.6	0	0.0

Table 3

Psychological consequences of violence during past 12 months.

	Physical violence		Psychological violence		Harassment	
	(n = 13)		(n = 77)		(n = 23)	
	n	%	n	%	n	%
Insomnia						
Often / quite often	2	15.4	12	15.6	5	21.7
Rarely / quite rarely	3	23.1	30	38.9	11	47.8
Never	8	61.5	35	45.5	7	30.5
Anxiety						
Often / quite often	0	0.0	16	20.8	6	26.1
Rarely / quite rarely	6	46.2	32	41.5	12	52.2
Never	7	53.8	29	37.7	5	21.7
Fatigue						
Often / quite often	0	0.0	22	28.6	7	30.5
Rarely / quite rarely	8	61.5	30	38.9	11	47.8
Never	5	38.5	25	32.5	5	21.7
Feelings of insecurity						
Often / quite often	1	7.7	12	15.6	7	30.5
Rarely / quite rarely	7	53.8	38	49.4	9	39.0
Never	5	38.5	27	35.0	7	30.5
States of trepidation						
Often / quite often	0	0.0	7	9.1	1	4.3
Rarely / quite rarely	5	38.5	18	23.4	10	43.5
Never	8	61.5	52	67.5	12	52.2
Feelings of depression						
Often / quite often	0	0.0	13	16.9	4	17.5
Rarely / quite rarely	7	53.8	24	31.2	9	39.0
Never	6	46.2	40	51.9	10	43.5
Feelings of distress						
Often / quite often	0	0.0	4	5.3	3	13.0
Rarely / quite rarely	3	23.1	27	35.0	8	34.8
Never	10	76.9	46	59.7	12	52.2
Flashbacks						
Often / quite often	0	0.0	8	10.4	2	1.1
Rarely / quite rarely	1	7.7	12	15.6	3	1.7
Never	12	92.3	57	74.0	18	9.9

Nightmares						
Often / quite often	0	0.0	6	7.8	2	8.7
Rarely / quite rarely	1	7.7	12	15.6	3	13.0
Never	12	92.3	59	76.6	18	78.3
Feelings of violated integrity						
Often / quite often	1	7.7	17	22.1	9	39.0
Rarely / quite rarely	7	53.8	28	36.4	7	30.5
Never	5	38.5	32	41.5	7	30.5
Something else						
Often / quite often	0	0.0	4	5.2	0	0.0
Rarely / quite rarely	0	0.0	2	2.6	0	0.0
Never	13	100.0	71	92.2	23	100.0

Table 4

Consequences of prior exposure to violence, as reported through open-ended questions.

	Frequency
Anticipation	25
Changes in own working, professional growth	25
Prudence	15
Stress, anxiety, strain	15
Fear	14
Changes in work unit's working	8
Intention to change job or workplace	7
Decreased job motivation	6
Resentment, lowered mood, confusion	6
Insomnia, nightmares	4
Exhaustion	4
Observing safety at work	4
Uncertainty about own professional skills	3
Sick leave	2
Avoiding of designated person	2

Table 5

Correlations obtained through a Spearman's rho test.

		Exposure to physical violence	Exposure to psychological violence	Exposure to harassment	Earlier exposure to physical or psychological violence or harassment	Age	Gender	Educational level	Updating education	Working experience in psychiatric nursing	Working experience in current work unit
Insomnia	Correlation Coefficient	-0.148	0.015	0.226*	-0.141	-0.020	0.193	-0.056	-0.030	0.118	-0.043
	Sig. (2-tailed)	1.171	0.889	0.035	0.193	0.853	0.073	0.603	0.784	0.278	0.694
	N	87	87	87	87	86	87	87	87	87	87
Anxiety	Correlation Coefficient	-0.181	0.039	0.263*	-0.103	0.092	0.107	0.041	-0.077	0.093	-0.094
	Sig. (2-tailed)	0.093	0.717	0.014	0.343	0.398	0.324	0.709	0.477	0.391	0.388
	N	87	87	87	87	86	87	87	87	87	87
Fatigue	Correlation Coefficient	-0.066	0.179	0.195	0.053	0.128	0.101	0.050	0.059	0.162	-0.003
	Sig. (2-tailed)	0.545	0.097	0.071	0.627	0.239	0.351	0.645	0.585	0.134	0.981
	N	87	87	87	87	86	87	87	87	87	87
Feelings of	Correlation Coefficient	-0.093	0.023	0.243*	-0.121	0.071	0.122	0.011	0.144	0.132	-0.018
insecurity	Sig. (2-tailed)	0.393	0.833	0.023	0.264	0.518	0.259	0.921	0.184	0.223	0.872
	N	87	87	87	87	86	87	87	87	87	87
States of	Correlation Coefficient	-0.008	0.131	0.233*	0.010	0.092	0.062	0.085	0.001	0.236*	0.032
trepidation	Sig. (2-tailed)	0.939	0.227	0.030	0.930	0.399	0.569	0.433	0.996	0.028	0.766
	N	87	87	87	87	86	87	87	87	87	87

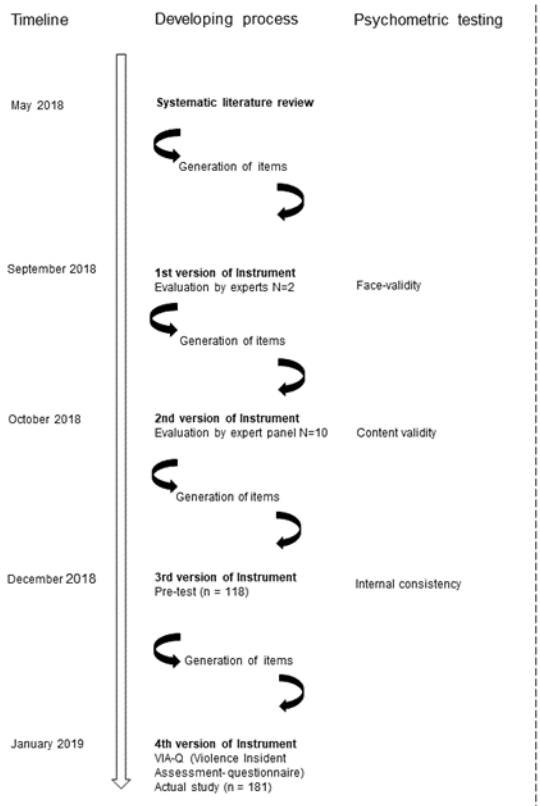
Feelings of	Correlation Coefficient	-0.035	0.073	0.153	-0.088	0.156	0.163	0.106	0.180	0.312**	0.198
depression	Sig. (2-tailed)	0.747	0.501	0.157	0.417	0.151	0.131	0.327	0.096	0.003	0.067
	N	87	87	87	87	86	87	87	87	87	87
Feelings of	Correlation Coefficient	-0.166	0.038	0.188	-0.054	0.097	0.123	0.079	0.087	0.086	-0.047
distress	Sig. (2-tailed)	0.125	0.727	0.080	0.619	0.376	0.255	0.465	0.422	0.430	0.669
	N	87	87	87	87	86	87	87	87	87	87
Flashbacks	Correlation Coefficient	-0.153	0.191	0.069	0.131	0.019	0.166	0.009	0.156	0.079	-0.021
	Sig. (2-tailed)	0.159	0.078	0.530	0.229	0.860	0.127	0.936	0.152	0.472	0.267
	N	86	86	86	86	85	86	86	86	86	86
Nightmares	Correlation Coefficient	-0.155	0.084	0.140	0.014	-0.035	0.236*	-0.053	-0.068	0.027	-0.030
	Sig. (2-tailed)	0.156	0.442	0.203	0.898	0.749	0.030	0.629	0.538	0.808	0.782
	N	85	85	85	85	84	85	85	85	85	85
Feelings of	Correlation Coefficient	0.010	0.007	0.212*	-0.043	-0.055	0.174	-0.130	0.081	-0.017	-0.025
violated integrity	Sig. (2-tailed)	0.927	0.945	0.049	0.691	0.615	0.106	0.268	0.457	0.873	0.820
	N	87	87	87	87	86	87	87	87	87	87
Something else	Correlation Coefficient	-0.173	0.132	0.051	0.116	0.015	0.000	-0.238	-0.068	-0.141	-9.221
	Sig. (2-tailed)	0.246	0.378	0.731	0.436	0.919	0.999	0.107	0.650	0.343	0.135
	N	47	47	47	47	46	47	47	47	47	47

*Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed)

Figure 1

Development process for the VIA-Q instrument and generation of items.



Generation process of structure and items

Factor	Original study
BACKROUND QUESTIONS	Carlsson et al. 2004, Flannery et al. 2001b, Flannery et al. 2007, Soares et al. 2000
PHYSICAL VIOLENCE	Flannery et al. 2001a, Flannery & Walker 2001, Fry et al. 2002, Fujimoto et al. 2017, Lewis & Dehn 1999, Soares et al. 2000, Tonso et al. 2016
PSYCHOLOGICAL VIOLENCE	Flannery et al. 2001a, Fry et al. 2002, Fujimoto et al. 2017, Lewis & Dehn 1999, Soares et al. 2000, Tonso et al. 2016
HARASSMENT	Flannery & Walker 2001, Flannery et al. 2001a, Fry et al. 2002, Fujimoto et al. 2017, Tonso et al. 2016
PERPERATOR OF VIOLENCE AND HARASSMENT	Flannery & Walker 2001, Flannery et al. 2001a, Flannery et al. 2011, Fujimoto et al. 2017, Rao et al. 2007, Swanson et al. 1999, Tonso et al. 2016
FAMILY	Carlsson et al. 2004, Lewis & Dehn 1999
WORKPLACE PROCEDURES	Soares et al. 2000

STRUCTURE / FACTOR	Structure of 1st version	Structure of 2nd version	Structure of 3rd version	Structure of 4th version
BACKGROUND QUESTIONS	n=9	n=10	n=14	n=13
PHYSICAL VIOLENCE	rating scale questions n=55, closed-ended questions n=4	rating scale questions n=58, closed-ended questions n=4	rating scale questions n=62, closed-ended questions n=4	rating scale questions n=62, closed-ended questions n=4
PSYCHOLOGICAL VIOLENCE	rating scale questions n=44, closed-ended questions n=2	rating scale questions n=49, closed-ended questions n=2	rating scale questions n=51, closed-ended questions n=2	rating scale questions n=51, closed-ended questions n=2
HARASSMENT	rating scale questions n=47, closed-ended questions n=3	rating scale questions n=47, closed-ended questions n=3	rating scale questions n=49, closed-ended questions n=3	rating scale questions n=49, closed-ended questions n=3
EARLIER EXPOSURE TO VIOLENCE AND HARASSMENT			rating scale questions n=3, closed ended questions n=3	rating scale questions n=3, closed-ended questions n=3
PERPETRATOR OF VIOLENCE AND HARASSMENT	rating scale questions n=8	rating scale questions n=13	rating scale questions n=24	rating scale questions n=24
FAMILY	rating scale questions n=7	rating scale questions n=7	rating scale questions n=7	rating scale questions n=7
OWN COMPETENCE AND RESOURCES		rating scale questions n=7	rating scale questions n=12	rating scale questions n=12
WORKPLACE PROCEDURES	rating scale questions n=6, closed-ended questions n=1, open-ended questions n=3	rating scale questions n=6, closed-ended questions n=1, open-ended questions n=3	rating scale questions n=8, closed-ended questions n=2, open-ended questions n=3	rating scale questions n=8, closed-ended questions n=1, open-ended questions n=3