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Nurses' Experiences of Workplace Violence

A Literature Review

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Description

Nurses rank among the most trusted professionals, and yet, paradoxically, they are also among the professionals that experience more violence at work. Workplace violence, and specifically violence against nurses, is a pervasive and serious problem in the field, and it has been for decades; to make matters worse, according to reports, violence in the health care environment is escalating.

The focus of this thesis is to provide an overview of nurses' experience of workplace violence (WPV) from the perspective of the practicing clinicians. Creating awareness to the situation is important for new nurses and other people who are involved in the health care system, so that there could be a common consensus on the extensiveness of workplace violence and the need for finding solutions.

The present study was carried out as a literature review. Collection of data was done through the database Cinahl. From a total of 68 studies, 8 were selected based on the inclusion criteria of the study. The selected articles were analyzed using a qualitative content analysis.

The unifying result of this study were discrepancies or contradictions on clinicians' experiences and knowledge about workplace violence and the posited solutions. Three main categories were generated under that rubric: Zero tolerance policy vs "It's part of the job"; Individual vs institutional and social responsibility; and Sacrifice vs neglect.

Keywords
Workplace violence, health care setting, nurses' experiences, management policies, nurses' knowledge

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1 Introduction

Nurses rank among the most trusted professionals according to various Gallup polls in different countries (American Nurses Association 2015; Luotetuin Merkki 2016), and yet, paradoxically, they are also among the professionals that experience more violence at work, or most, as in the case of Finland (Tilastokeskus, 2009). The violence can be both verbal and physical, verbal being the most commonly experienced (ibid.). Workplace violence can cause stress, fear, and frustration, and lead to lowered work performance or to the nurse changing their workplace or profession. Workplace violence can be perpetrated by colleagues, patients, or visitors. (Fafliora, Bampalis, Zarlas, Sturaitis, Lianas and Mantzouranis 2014; NACNEP 2007.)

The focus of this thesis is to provide an overview of nurses' experience of workplace violence (WPV) from the perspective of the practicing clinicians. There are many variations and forms of WPV, and it can have a significant effect to the clinicians' health and the workplace atmosphere. Creating awareness to the situation is important for new nurses and other people who are involved in the health care system, so that there could be a common consensus on the extensiveness of workplace violence and the need for finding solutions. This thesis is done as a literature review, where numerous studies were selected and analyzed to provide insight to the topic.

2 Workplace violence, a world-wide phenomenon

What is workplace violence

Although there is no single unified definition of what workplace violence (WPV) is, since it varies depending on countries and institutions, according to the European Risk Observatory Report (EU-OSHA, 2010, 9) there is a growing concern about it in the European countries, and worldwide as well, and measures are being taken to curve the problem. Under the umbrella of WPV, all forms of abuse are classified and studied (ibid.). For the purposes of this study, workplace violence will be outlined in accordance to the definition used in the European Commission (ibid., 16): "Incidents where staff are abused, threatened or assaulted in circumstances related to their work,

including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being and health" and the one provided by the National Advisory Council on Nurse Education and Practice (NACNEP 2007, 8): "[any physical or verbal act that includes] intimidation, harassment, stalking, beatings, stabbing, shootings, and other forms of assault." The European Risk Observatory Report (EROR, 2010) also provides a list of different forms of harassment and WPV, which include, in addition to the previously listed ones, sexual violence and harassment, one-off incidents or more systematic, and thus long-lasting, patterns of behavior. WPV ranges from minor acts, to homicide, and can be perpetrated by peers, managers or supervisors, and clients/patients. This type of violence can also be called third-party violence.

In a survey carried out by the European Agency for Safety and Health at Work (2010) in 2008, included in the EROR, it was reported that in 14 out of 20 European Union member states surveyed, respondents considered that the level of acknowledgment of third-party violence was inappropriate, and listed as the main four causes lack of awareness, low prioritization of the issue, limitation or lack in specific regulation on the subject, and lack of appropriate methods/tools for assessing and managing the issue. Moreover, in the same survey, disparate opinions among stakeholders emerged when answering the question: "Do you think that workplace violence, bullying and mobbing represent occupational health concerns in your country?" 43% of employers' associations responded affirmatively, but 74%, nearly a two-fold difference, of trade unions responded yes to the same question, while 69% of government agencies responded also positively, which implies there is no consensus among stakeholders about the importance of WPV.

Types of workplace violence

There are multiple ways violence can manifest in the workplace. It can be physical violence, which can include for example hitting, kicking, scratching, pulling, and biting, or verbal violence, such as yelling, threatening, and profanity (Christie 2014; NACNEP 2007). Physical violence is the more reported one, even though verbal violence is the more commonly occurring (Christie 2014; NACNEP 2007; Howerton 2013; Kaur, & Kaur 2015). Verbal violence can also sometimes be seen as a precursor to physical violence (Howerton 2013; Valente & Fisher 2011).

Patient perpetrated violence is the most common form of WPV (NACNEP 2007). Studies note that the physical violence is often perpetrated by patients who have psychiatric problems or are under the influence of drugs or alcohol (Christie 2014; Howerton 2013.) This makes psychiatric wards and emergency departments high-risk zones of patient perpetrated violence (NACNEP 2007). Emergency departments also have longer waiting times and are often overcrowded, which further increases the risk of violence (NACNEP 2007). Family members and visitors can also be the perpetrators of workplace violence (NACNEP 2007).

Another form of workplace violence is nurse to nurse violence, called horizontal violence (Armmer, & Ball 2014; Purpora, Blegen, & Stotts 2013). In a study conducted by Armmer and Ball (2014) nurses reported the most common forms of horizontal violence were: being responsible of a colleague's work, being reprimanded or confronted in the presence of others and being lied to.

Violence in the health care environment

WPV, and specifically violence against nurses, is a pervasive and serious problem in the field, and it has been for decades (Christie 2014, 1; EROR 2010, 53). To make matters worse, violence in the health care environment is escalating, according to Christie (2014). McPhaul and Lipscomb (in NACNEP 2007, 8) argue that it is a complex and dangerous problem, which complexities are partly due to a culture resistant to admit that health care providers are at risk of patient perpetrated violence, and that if it does exist, it is part of the job, a statement consistent with the findings of Christie (2014), Clark (2016) and Howerton (2013). To further complicate the problem, perception of violence in the health care system is affected by the media: in the European Risk Observatory Report, media efforts in Europe to raise awareness about the subject are mentioned and appreciated (EROR 2010, 39). But NACNEP (2007, 8) reports that the media in the USA has extensively covered workplace murders perpetrated by employees in the field, a rare event, in detriment of coverage of the persistent violence experienced by nurses in their work.

Prevalence of violence in the nursing profession

Christie (2014, 69) provides a general overview of workplace violence experienced by emergency department nurses around the world (see Table 1). It presents a bleak

picture: an overwhelming majority of emergency department nurses experience verbal violence, and a variable, but considerable number of them experience physical violence at work. In the European context, the EROR (2010, 50) also provides statistics, taken from the NEXT study: in 2003-2005, an average of 3.6% of nurses reported that they were bullied by their superiors at least once a week. The European Working Conditions Surveys (EWCS) of 2007 tackled the problem of WPV and harassment, and found that workers in the health care field experience more violence than workers in any other profession; in fact, health care workers are three times more at risk of threats and violence than the average worker in the European Union (see Figure 1).

Table 1. Christie, 2014. Breakdown of global studies related to patient perpetrated violence in emergency departments

Country	Authors	1. HCW in study # subjects	2. #ED nurses in study # (%)	3. #ED RNs Verbal Violence # (%)	4. #ED RNs Physical violence # (%)	5. #ED RNs Verbal & physical # (%)
Australia	Chapman et al, 2009	113	26 (23%)	**	**	**
	Luck et al, 2007	20	20 (100%)	**	20 (100%)	**
Brazil	Cezar & Marziale, 2006	47	33 (70%)	33 (100%)	*	*
	De Vasconcellos et al, 2012	30	30 (100%)	30 (100%)	16 (53%)	16 (53%)
China	Kwok et al, 2006	420	16 (4%)	16 (100%)	16 (100%)	16 (100%)
Europe (10 countries)	Estryn-Behar et al, 2008	13,820	1621 (12%)	*	584 (36%)	*
Iran	Esmaeilpour et al, 2011	196	196 (100%)	180 (92%)	39 (20%)	*
	Hasani et al, 2010	166	32 (19%)	32 (100%)	5 (16%)	*
Italy	Zampieron et al, 2010	595	38 (6%)	*	*	*
Jordan	Ahmad, 2012	447	76 (17%)	*	*	*
	Kitaneh and Hamden, 2012	240	49 (20%)	29 (59%)	10 (20%)	9 (18%)
Lebanon	Alameddine et al, 2011	256	106 (41%)	85 (80%)	21 (20%)	*
Nigeria	Ogundipe et al, 2012	81	81 (100%)	72 (89%)	53 (65%)	*
Spain	Roldan et al, 2013	315	94 (30%)	*	*	*
Taiwan	Lin & Liu, 2005	205	44 (22%)	17 (39%)	5 (11%)	*
	Chen et al, 2012	791	131 (17%)	*	14 (11%)	*
	Pinar & Ucmak, 2011	255	255 (100%)	233 (91%)	191 (75%)	*
United States	Uzun, 2003	467	32 (7%)	31 (97%)	**	**
	Catlette, 2005	8	8 (100%)	*	*	*
	Erickson, 2000	56	56 (100%)	*	46 (82%)	*
	Gacki-Smith et al, 2009	3,465	3,465 (100%)	693 (20%)	866 (25%)	*
	Gates et al, 2011	230	230 (100%)	*	*	*
	Gates et al, 2006	242	95 (39%)	93 (98%)	64 (67%)	*
	Kansagra et al, 2008	3518	1935 (55%)	*	*	*

*Denotes not reported   **Denotes not applicable to that study

column	--LEGEND--
1.	Total number of Health Care Workers (HCW) participating in study.
2.	Total number of ED nurses in study, followed by (%) of ED to HCW in study.
3.	Number and % of ED nurses (#2) that experienced verbal PPWPV.
4.	Number and % of ED nurses (#2) that experienced physical PPWPV.
5.	Number and % of ED nurses (#2) that experienced both verbal and physical PPWPV.

In Finland the situation is similar. The same EWCS of 2007 found that the UK and Ireland and the Nordic countries have the highest rates of threats and threats of violence reports (EWCS 2007, 36), and that Finland reports of bullying and harassment at work are the highest in the entire European Union (EWCS 2007, 37). Finland's statistics (2007) confirm the report: combined, 40,000 workers in the health care field, which is up to 18% of the total amount, experienced violence at their workplace in 2007, making the field the most violent field of work in the country. It is of notice that in Finland there is no significant difference of reported WPV regarding
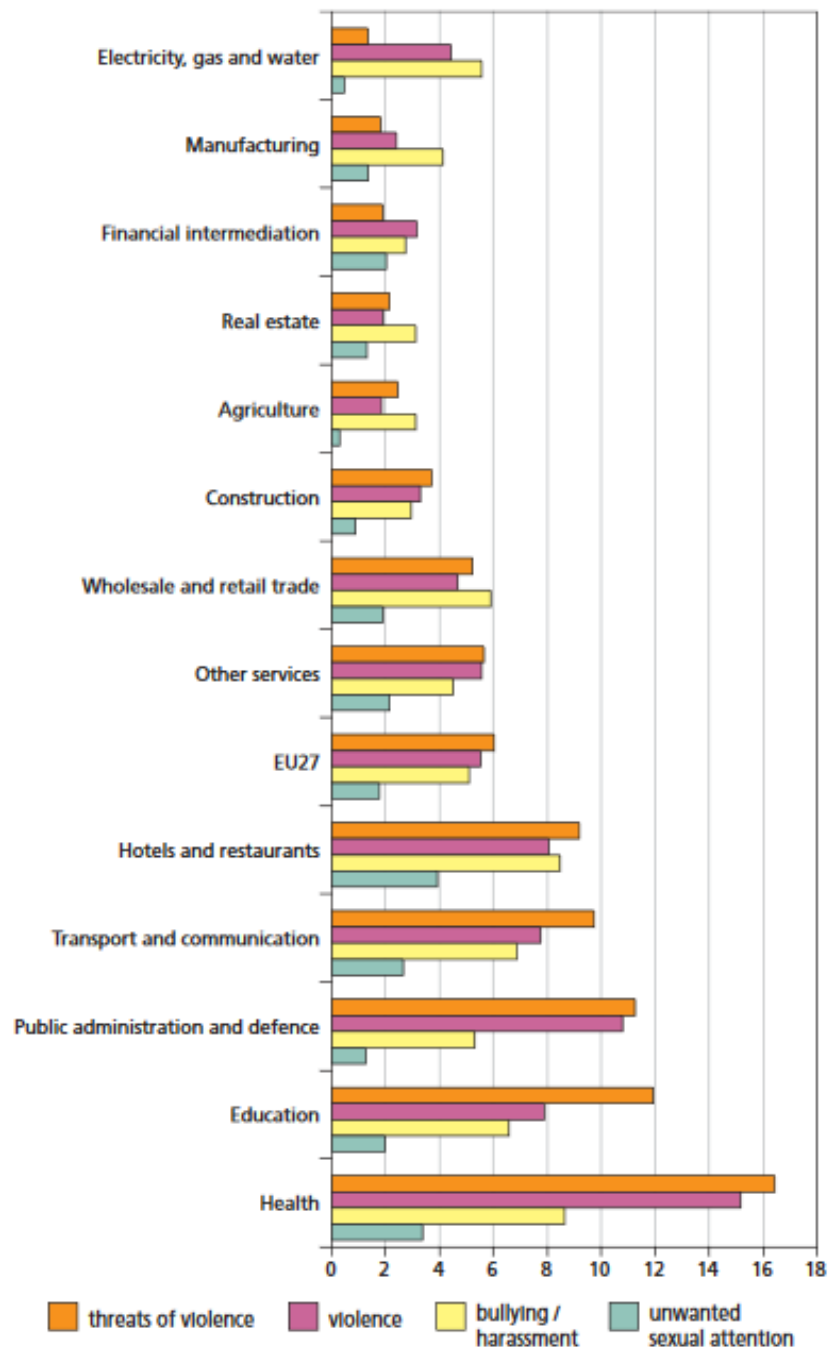
Figure 1. EWCS, 2007. Level of violence and harassment, by sector, EU27 (%)

gender, a marked difference when compared to the claims of the NACNEP report (2007, 11). In that report, there is yet another factor that complicates the picture: physicians are also among the frequent aggressors, and half of sexual assaults against nurses where committed by a physician, in a study by Williams (1996) cited in the same report. Finally, the NACNEP (2007, 10) report states that even considering the large and disparate numbers, we should be aware that WPV goes often unreported, which adds up to an already concerning problem. The statistics by EWSC (2007) and NACNEP (2007) are already slightly dated, but the problem has remained a significant burden on the health care workers.

Causes and effects of WPV in the health care environment

Research has been done to determine the prevalence and effect of WPV, and the nurses' experiences of it (Christie 2014; Howerton 2013; NACNEP 2007.) Both verbal and physical WPV have been noticed to have a negative impact on the wellbeing of the nurses encountering it (Christie 2014, 57-56; Howerton 2013.) Common feelings that nurses report include powerlessness, anger, frustration, fear, and anxiety (Christie 2014, 53; Clark 2016, 11.) Exposure to WPV causes many nurses to experience some form of depersonalization and burnout and contemplate leaving their workplace or profession (Christie 2014, 57.) Physical symptoms, such as headache, insomnia, stomachache, and feelings of exhaustion, were also reported by nurses (Christie 2014, 58).

According to research, many nurses believe that WPV is "part of the job" (Christie 2014; Howerton 2013). The reporting of violent incidences is often foregone, also seen as time consuming and ineffective as it is seen to not have any real effect on the situation (Christie 2014; NACNEP 2007, 10). The support that nurses get from administration is often perceived to be lacking and they are seen to be on the patient's side, making it difficult for nurses to feel empowered and protected (Christie 2014, 53-56; NACNEP 2007, 10).

Nurses' coping methods

Coping methods that nurses use after experiencing WPV include confrontive, optimistic and evasive (Howerton 2013, 54). Based on existing studies, support from

peers was found beneficial and important, and it is an important coping mechanism for many nurses (Christie 2014, 53-55; Clark 2016, 113-115). Talking and joking about violent events that occurred at work with colleagues can help relieve the negative feeling associated with the experience; exercising was also found to be a way to de-stress (Christie 2014, 54-55).

Some nurses might unfortunately cope with the situation by taking revenge on a patient and by enjoying the pain caused by procedures (Christie 2014). Unhealthy coping methods can also include alcohol, smoking, over-eating, and drug abuse (Christie 2014, 55).

Job dissatisfaction caused by WPV and the insufficient support and action taken by administrators to relieve the situation causes nurses to contemplate leaving their workplace or profession (Christie 2014, 54; NACNEP 2007).

3   Aims, Purpose and Research Questions

The aim of this study is to investigate nurse's experiences of workplace violence, as reported by themselves.

The purpose of the study is to provide an overview of the problem and raise awareness about it, especially for nursing students and recently graduated nurses when facing WPV.

Research question

- What are nurses' experiences of workplace violence?

4   Methodology

4.1 Literature review

According to Hart (1998), a literature review is "an objective, thorough summary and critical analysis of the relevant available research and non-research literature on the topic being studied" (in Cronin et al., 2008), and it has as its purpose to provide an updated overview of the topic at hand, as well as to serve as the basis for other

research goals (ibid.). In addition to this definition, Rew (2010) proposes that a literature review should allow replication, a basic tenet of the scientific method. In a good literature review, the researcher draws data and information from diverse sources and avoids personal biases as much as possible, includes well-specified methods for data collection and analysis, and uses the professional terminology correctly (Cronin et al., 2008).

Ward-Smith (2016) adds nuance to the writing of a literature review by including in her article the definition of grey literature: all research, be it academic, governmental, produced by businesses and industries, that is not managed by commercial publishers, which she argues should be part of any literature review. According to this author, grey literature, it being an alternative source of information, can serve to counter the effect of biases in the published materials controlled by the commercial publishers (ibid.). Lastly, a literature review can be non-peered reviewed, also called non-scholarly, and peer-reviewed, that is, a publication that was reviewed by an impartial and blinded peer (ibid.).

Overall, the processes, or steps included in a literature review can be summarized as follows in Table 2:

Table 2. Cronin et al., 2008; Rew, 2010. Steps of a literature review

Formulation of the research question and purpose
Definition of the inclusion and exclusion criteria for the literature search
Selection and extraction of the data or literature
Evaluation of the quality of the data/literature used in the review
Analysis, synthesis and interpretation of the data
Dissemination of the relevant results and findings

Literature reviews are useful for identifying the best evidence-based practices and for determining whether or not there is enough scientific information regarding a particular subject (Ward-Smith, 2016). A literature review, as opposed to a simple combing of

readily available information, is done in a systematic method, and as such is focused and has a broad scope, while limiting the reader's or clinician's own bias (Rew, 2010). According to the same author (Rew, 2010), these characteristics of the literature review make the clinician more confident about the obtained information and provide a clear and accessible synthesis of the results (ibid.). In a profession where little time is available for clinical practitioners to do original research (ibid.), reliable and efficient sources of information are rather important, and that is what a literature review is.

4.2 Scientific article selection process

Data for the present literature review was retrieved from CINAHL. The key words used in the search were nurs* AND experience* AND workplace violence (see Table 3). For the selection process, the PRISMA diagram was used (see Figure 2) to identify

Table 3. Keywords and databases

Key Terms	Database	Results	Chosen on the basis of the title	Chosen on the basis of the abstract	Relevant studies
Nurs* AND Experienc* AND Workplace violence	CINAHL	68	48	37	8

the number of studies found and demonstrate the process of excluding studies to find studies relevant to this literature review. The PICO model (UIC, 2016; see Table 4) was used during this stage to provide a clearer format to the selection. As shown in Table 4, the population, form of intervention and the outcome of the studies were analyzed to find studies that had the required features. For the second stage of the selection, the inclusion criteria established in Table 5 was followed.
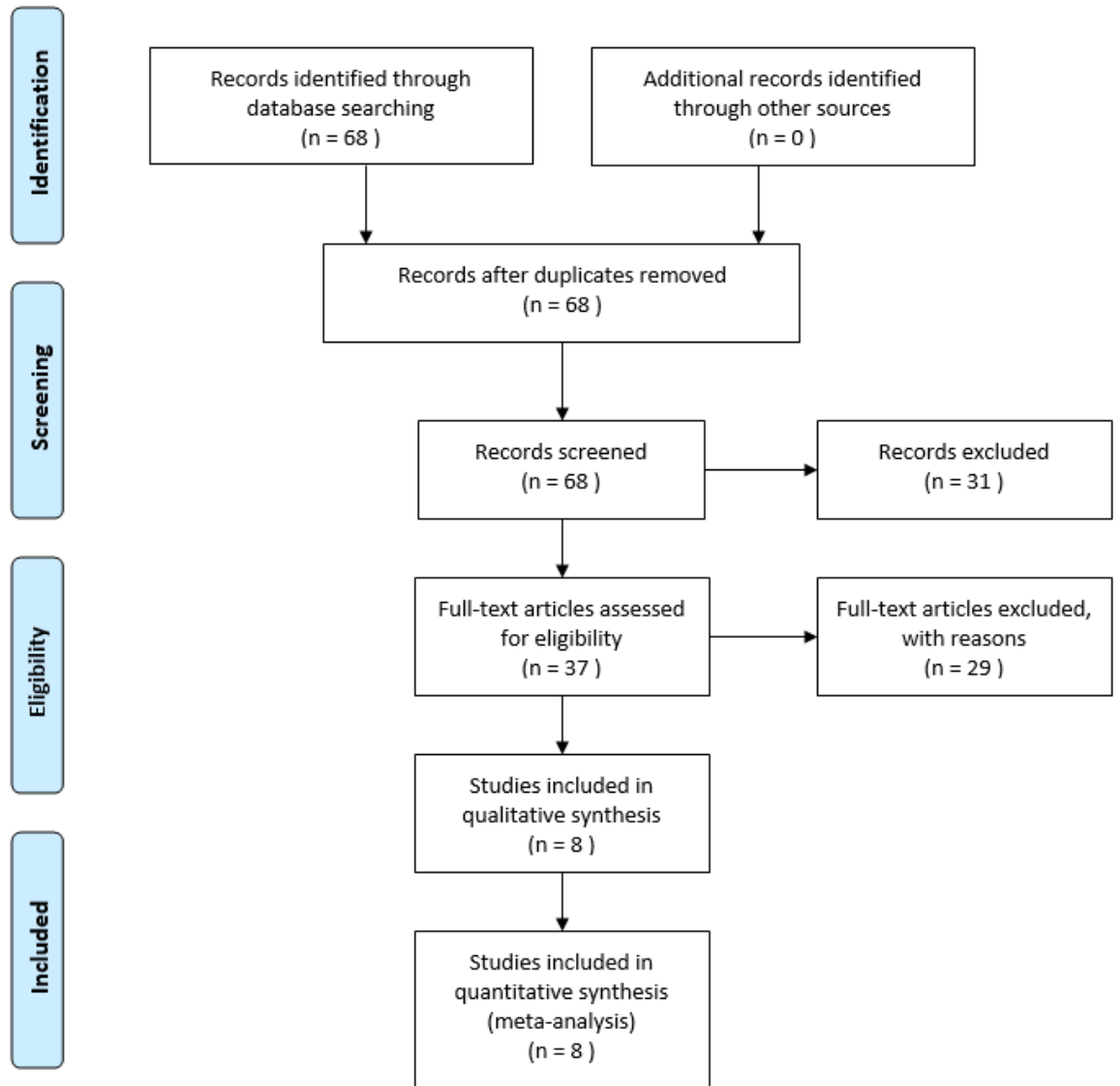
Figure 2. PRISMA diagram

Table 4. UIC, 2016. PICO model

Population	Nursing staff
Intervention	Nurses' recollections, opinions, surveys, studies
Comparison	No
Outcome	Workplace violence as experienced by the nursing staff; causes; effects; resilience of staff

From the overall material deemed as pertinent after processing the data according to the inclusion criteria, articles or academic papers that best responded to the criteria of the research were selected, that is, quantitative and qualitative studies dealing directly with nurses' experiences of workplace violence.

Once the core bibliography and data were selected, the individual evaluation of the quality of the chosen studies proceeded. The selected studies and their core characteristics are listed in Appendix 1.

Table 5. Inclusion criteria

Inclusion criteria
Peer-reviewed or academic study
Time of publication 2007-2017
Deals directly with nurses' experiences
Full text available
English language

4.3 Data Extraction and Content Analysis

In the present literature review a qualitative content analysis was used to systematically analyze quantitative and qualitative studies to find common categories and themes that tell of the nurses' experiences with WPV. We decided to use it because it is a method that allows a systematic analysis of verbal, written and visual communications (Cole, 1988, in Elo and Kyngäs, 2008), and nurses' experiences are relayed through language. This method, as described by Elo and Kyngäs (2008), enables the researcher to conceptualize a phenomenon by establishing content-related categories through a process of distilling of words.

According to Elo and Kyngäs (2008) cited above, a content analysis can be inductive or deductive, depending on the goals of the researcher. The inductive approach was chosen, since it suits better the research question. The inductive approach is used when there is not enough knowledge about the phenomenon, or when it is dispersed and not systematized (Elo and Kyngäs, 2008).

Following the inductive approach proposed by Elo and Kyngäs (2008), notes and headings on the texts were made in the process of open coding; secondly, the findings were grouped into similar, general fields, which allowed posteriorly a more refined distillation of groups. Next, connections were made by comparing and contrasting different categories, thus allowing the identification of general patterns. In the abstraction phase three categories were identified, and those provided a general description of the main findings. The data analysis process is exemplified in Figure 3.

Open coding
- Nurses' experiences of WPV

Grouping
- Nurses' reactions to WPV: emotional responses and explanations

Comparing
- Nurses' knowledge about WPV
- Institutional/ management policy

Categorization
- Discrepancy between nurses' perceived inevitability of WPV and acceptance of it as "part of the job", and applicability of zero tolerance policy
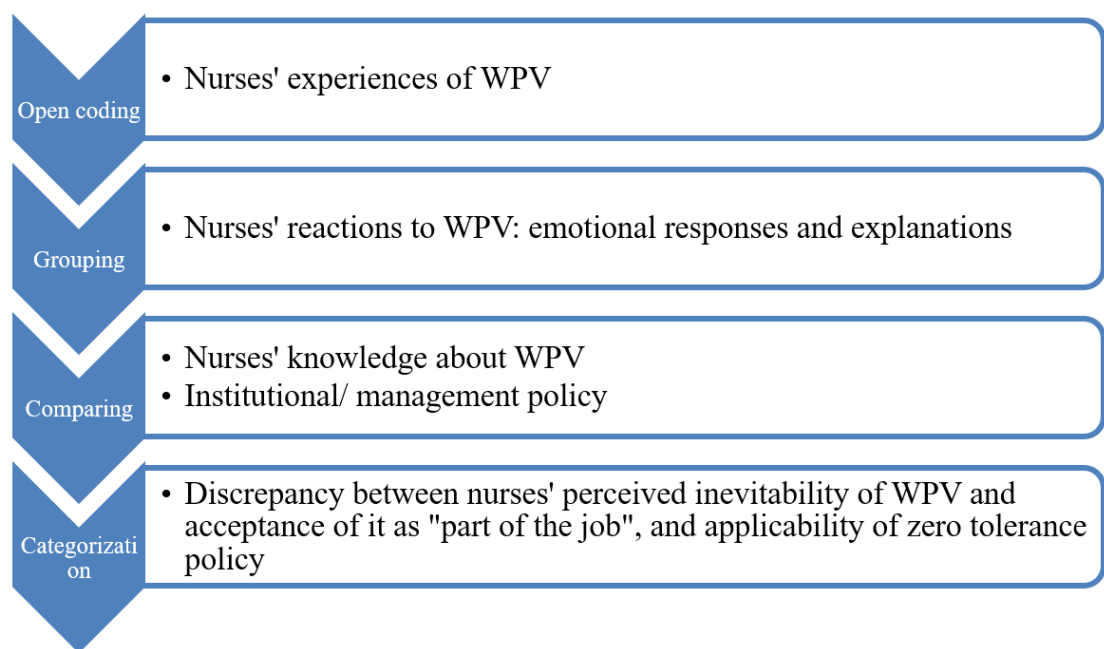
Figure 3. Example of data analysis process

5 Results

Qualitative findings

The findings of this qualitative analysis were grouped into three main categories, schematized in Figure 4.

Zero tolerance vs "part of the job"	• Institutional zero tolerance policies to WPV • Practitioners' perceived inevitability and naturalization of WPV
Individual vs institutional and social responsibility	• Practitioners' sense of guilt and responsibility for WPV • Responsibility and implications of WPV in health care institutions and society at large
Sacrifice vs neglect	• Priorities of the nursing staff as workers • Perceived indifference/inadequacy of management's response to the problem

Figure 4. Schematization of the qualitative results.

Zero tolerance for something that is part of the job

In many of the articles reviewed, clinicians stated that WPV is "part of the job" (Chapman, Perry, Styles, & Combs 2009; Currid 2009; Stevenson, Jack, O'Mara, & LeGris 2015; Renker, Scribner, & Huff 2015) a finding that in itself is not novel, and that is reiterated in Christie (2014), Clark (2016), Howerton (2013), and Bigony (2009). Nonetheless, there is a discrepancy between clinicians' experience and expectation that one nurse exemplified very clearly in Stevenson et. al.(2015):

> *"I never thought I would sign up to be... assaulted as a career path. That was something I never realized that happened so frequently and that it was almost okay for nurses to be beat up all the time or verbally or physically assaulted and I guess that's normal practice and it's going to take a lot longer to change that."*

In Stevenson and others (2015), and Renker and others (2015), clinicians' report is more categorical: workplace violence is in fact inevitable due to the nature of the job.

There is, however, a contradiction between this implied acceptance of the phenomenon and the authors' suggestions and recommendations. A zero-tolerance policy is suggested as part of a comprehensive set of implementations to deal with WPV (Currid 2009; Nguluwe, Havenga, & Sengane 2014; Renker et al. 2015). The discrepancy is self-evident. If WPV is accepted by clinicians as part of the job, and is indeed inevitable, a zero-tolerance policy becomes literally impossible, lest patients are left without care.

This discrepancy was noted particularly by Renker and others (2015). In their research, one clinician suggests precisely a blank application of the zero-tolerance policy: violent patients, especially repeating offenders, should not be accepted or should be expelled from the facilities, or their care conditioned.

Individual vs institutional and social responsibility for WPV

There was a consistent trend in the reviewed literature regarding the nursing staff's understanding of the origin or workplace violence: in Avender et al. (2016), Currid (2009), Morken, Johansen, & Alsaker (2015), Nguluwe et al. (2014) and Renker et al. (2015), nurses' identified causes and risk factors of WPV such as patients and relatives' expectations of care and the design of care settings. Also, nurses posited the origin of the WPV they experienced in the diagnoses and habits of the patients, such as a mental condition or drug abuse. Concomitantly, and in relation to both of them, clinicians identified a cause and risk of WPV that is related to management: in Boafo (2016), Currid (2009) Morken et. al. (2015), Nguluwe et al. (2014), Renker et al. (2015) and Stevenson et al. (2015), understaffing and lack of resources was found to have a direct effect on workplace violence, a finding corroborated by many other authors and reports (The Joint Commission 2018; NACNEP 2007; EROR 2010; Bigony 2009; Clark 2016; Wiskow 2003).

The contradiction or discrepancy we found in relation to these three marked trends is this: although nurses in Boafo (2016), Renker et al. (2015) and Stevenson et al. (2015) do identify a lack of interpersonal skills or training and attitudes of the nursing staff as

a cause of workplace violence, that is, a problem emanating from the nursing staff, we found that also in Avender et al. (2016), Currid (2009) and Stevenson et al. (2015), clinicians felt strongly the burden of the responsibility of WPV in the form of self-blame, as it was expressed with painstaking clarity by a clinician in Stevenson and others (2015):

> *"I know in a reflective sense... [we] are the best tools for preventing situation, but that form of questioning comes to me as so blame-driven. 'You just were assaulted, you just were hurt', now suddenly you're asking 'what could you have done differently'. Not 'what could the system have done differently', it's what could you have done differently... and it's always the first question that always comes up."*

And in Currid (2009, 44): "...you do miss things because the place is very stressful and you have to deal with an incredible amount of work all the time, but you do still blame yourself if things go wrong..."

This characterization of the unjust burden of responsibility as experienced by clinicians is at least tacitly in discrepancy with the authors' suggestions and recommendations because they are related directly to, and are indeed within the purview of, management: in all but one of the articles (Avender et al. 2016; Boafo 2016; Chapman et al. 2009; Currid 2009; Morken et al. 2015; Nguluwe et al. 2014; Renker et al. 2015), researchers suggest training of the nursing staff as necessary for dealing with WPV, and in all of them measures pertaining to management, such as a zero tolerance policy, formal management support after a WPV episode and preventive measures, are recommended. The overwhelming pre-eminence of the recommendation of training the nursing staff implies, under the light of our contrast, a neglect of other causes and risk factors identified by the nurses in these studies. And in fact, this identification of external factors is non-concordant with the heavy burden of guilt expressed by some of the participants of the reviewed literature.

Sacrifice and neglect: different priorities for management and the nursing staff

The third category this literature review rendered was what was categorized as a difference perceived by the clinicians regarding management priorities concerning WPV. In Chapman et al. (2009), Currid (2009), Morken et al. (201), Renker et al.

(2015) and Stevenson et al. (2015), the issue was discussed. In Morken and others (2015), and in Stevenson and others (2015), clinicians reported contrasting experiences after a WPV episode regarding support from management staff. On the one hand, clinicians reported receiving support, which led to a better management of the episode and a feeling of safety; on the other, clinicians felt abandoned by management and expressed a feeling of helplessness; in addition to this, in Morken and others (2015), clinicians stressed the importance of informal peer support as part of the processing and recovery post-assault. This finding only stresses the importance of appropriate management measures after the incident, and at the same time, exemplifies a conflict stated bluntly in Stevenson and others (2015): "[T]hroughout the narratives, nurses were often conflicted between their role of acting as the care provider who needed to deliver care in the best interest of their patients versus acting in a way that would protect their own health and safety."

Clinicians often related their perceived difference in priorities and sense of abandonment relating it to the efficacy of reporting the incident. In Morken and others (2015), one clinician expressed it as follows: "The employer was not there for me. It was so unpleasant that I will never report again, no matter what happens. This is also the attitude of my colleagues. We still fill in the violence reports, but *nothing really happens*."

A similar quote was found in Currid (2009), regarding management policies: "...they (management) would not be there to support you if something in the unit were to happen, because I have witnessed a situation...'"

And in Renker and others (2015): "Policies and procedures don't change even if reported, no one cares."; "I don't believe that any policy will change until someone is seriously injured or hurt."; "Management seems to take the side of verbally abusive patients and visitors." According to the same authors (Renker et. al., 2015) 64% of the clinicians in the study answered negatively when questioned if they believed management was committed to eliminating WPV, and to further complicate matters, clinicians were reported as arguing that management staff prioritized patient satisfaction over the staff's well-being. Emphasis should be made that patient satisfaction and quality of care were not equated; rather, clinicians reported

management saw patient satisfaction as an important way to attract possible patients/clients, and thus increase the hospital's revenue.

This conflict perceived by the clinicians had then more than two facets, and it was not related exclusively to management and the nursing staff, but included the patients as well, as argued in Currid (2009):

> *"[O]rganisational pressures [lack of resources and staff] often competed with demands from patients and others, but organisational pressures such as ward management issues seemed to take priority over patient care... This may, in part, reflect an ever-increasing drive on target attainment and efficiency in today's climate of standard-driven care."*

The contradiction/discrepancy has yet another aspect to it, and that can be found in the difference between two very simple facts: the standard of quality in care nurses are obliged to provide, and the very resources available to them in order to concretely provide it appear to be inadequate, which results in emotional strain. Quoting a study by Hummelvoll and Severinsson (2001), Currid (2009) goes on to elaborate on this issue: "Organisational needs may take priority over patients' needs. This type of environment is known to give rise to stress in nursing as it creates a 'therapeutic superficiality' where nurses are unable to provide the care that they want to deliver."

6 Discussion

6.1 Ethical considerations, validity and reliability

Considering the ethical considerations of any research is important for the accountability, trustworthiness and truthfulness of the research done (Resnik 2011). The study should aim to achieve validity, reliability and precision (Houser 2008). In literature reviews, such as this one, the studies used should follow the guidelines and common values of ethically conducted research. The literature review itself should also follow these values and aim to be transparent and reliable.

In the reviewed studies, the participating nurses and other staff members were interviewed about their experiences. Respecting the participants and providing confidentiality and safety for them is important in research (Ethical Considerations).

In some of the studies that were discussed, the nurses were afraid of repercussions of speaking of the violence they've experienced. Thus, it was important that the researchers in these studies made sure all the information was given confidentially and with consent and was handled anonymously. The nurses were told of the research beforehand and given the option to not participate. Since this study was a literature review, the issue of ethical considerations was circumscribed to reliably presenting the data and accurately citing the studies that were used.

Validity in research is essential to make sure the studies are done in a way that appropriately takes into consideration the different methods and purpose of the study (Houser, 2008, 298; Leung 2015, 325). The validity of this literature review was considered in the choice of the methodology, data analysis and the results of the review. Measures were taken to ensure the reasoning of the authors in their choice of methods and data selection were explained, although their inexperience in scientific research may have affected the correctness of the choices.

In this literature review the aim was to make the results replicable by carefully documenting our process of selecting and analyzing the studies. Doing this has helped make the review more reliable. Reliability in research is important in order make the results more consistent and therefore more predictable and conclusive (Houser 2008, 297-298; Leung 2015, 326).

Plagiarism is the failure to distinguish your own work from others' and refer to the original source correctly to avoid misunderstandings of the ownership of the work (Price 2014, 46). In this literature review great attention was paid to the proper referencing of the studies and other utilized sources. The authors were careful to present the data accurately to avoid falsification, which is defined by Polit and Beck (2008, 188) as altering the data and results in a way that changes the original intent or meaning of the results.

There were various limitations to this study. The small number of articles reviewed, their varied focus, the different health care settings were the researches were carried out (although in five out of eight articles the research pertained acute psychiatric and emergency wards) and also what we considered to be our main interest, that is, the actual experiences of workplace violence of the nursing staff, was scarce; we had only snippets and quotes available.

6.2 Discussion of main results

The qualitative analysis of the literature under review proved to be nuanced. Our analysis and condensation of the articles' own categories rendered three main categories that we organized as contradictions or discrepancies between the clinicians' experience and expectations and/or the authors' suggestions and recommendations.

The thread that we eventually identified as running through all the research was that the issue of WPV in the health care system is larger than it appears, in the sense that it happens in larger social and political circumstances. For example, in the case of the first discrepancy we found, if WPV is accepted by clinicians as part of the job, and is indeed inevitable, a zero-tolerance policy becomes literally impossible, lest patients are left without care, a finding corroborated in Copeland and Henry (2017), who suggest a re-evaluation of the meaning of the policy in practice. In Renker et. al. (2015), for example, it was some of the nurses supported the idea of penalizing violent patients; the researchers agreed with this stand in their conclusions. It is worth of notice that the research in this case was conducted in the United States, where healthcare is paid and provided largely on a privatized basis through insurance companies (The U.S. Health Care System, 2017), a situation that could make rejecting "unwanted" patients possible, but it would not function in countries like Finland, where the large majority of the population is covered under the obligation of the state to provide healthcare services (Terveydenhuolto Suomessa, 2013) This finding does not demonstrate a point, but rather calls for a deliberation that should include all of the stakeholders, including, of course, the clinicians.

Regarding the second finding, the contradiction or discrepancy between the clinicians' sense of individual responsibility, in the background of the perceived absence of explicit institutional and social responsibility, clinicians in the reviewed literature proffered their views with varying levels of depth and vehemence and expressed them starkly in terms of guilt and even despair. It was beyond the scope and the intentions of this literature review to discuss the relevance and pertinence of managerial measures to address the problem of WPV, and we by no means are putting them into question nor evaluating their efficacy, but we simply intend to point out that there is an inner contradiction in an approach that restricts its field of influence to a particular location or institution. Or at the very least, it seems to us an evident complication for

management measures to be carried out in the first place due to external constrictions, such as understaffing and under-resourcing, a problem made patently clear in Currid's research (2009).

Stated succinctly, workplace violence, and in this case workplace violence directed towards nurses, is a social problem that involves all levels of government, since availability of resources in the public sector depend on governmental policy and budget assignation in countries where health care is provided by the state. It is also a social problem, since availability and education of the health care staff, social expectations, appreciation and attitudes of patients and relatives are recognized as key factors in WPV. As such, in the larger context, workplace violence can hardly be solved with managerial, localized measures. One clinician in Avander and others (2016) expressed an opinion on WPV with this phrase: "Then it's probably, I think, today's society." Furthermore, the necessity for a wider approach to tackle the issue was also noted by the authors. In their recommendations, Renker and others (2015) and Stevenson and others (2015), point out that adequate staffing is necessary, and Avander and others (2016) suggest the creation of forums for the health care staff to discuss the subject. In a more straightforward fashion, Chapman and others (2009) conclude that their "findings have implications for organizations, government and society at large."

As far as our third finding is concerned, we would argue, as we argued in the previous category, that an emphasis should be made on the social aspect touched upon by Currid (2009): management policies go beyond the localized or particular health care setting, since they are planned and enforced in what Currid (2009) calls "today's climate of standard-driven care". We did not delve into the issue because that was not the purpose of this review, but would like to use this finding to stress that the apparent divide between management and the staff's priorities as perceived by the clinicians in the reviewed literature is in fact wider, in the sense that it encompasses more than just particular good or inadequate management practices and policies.

Our findings point out to the necessity to consider the issue in a larger, more comprehensive framework. If we are to draw conclusions from our review within that larger framework, we would point out yet again to the social and political aspects of workplace violence, and emphasize the active role the rank and file nurses could take

not only at a personal and institutional level, but within the very communities they serve, as it is in fact suggested in Hwang (2016).

6.3 Conclusions and recommendations for future research

Workplace violence towards the nursing staff is a complicated problem in which numerous variables are involved, from personal to institutional and social factors, management policies and economic constrains. Nurses' experiences of WPV are indeed heterogeneous, but nonetheless, there is a strong concern, and more importantly, a wealth of experiential knowledge among the nursing staff regarding the origin, causes and consequences of WPV, and also pragmatic suggestions on how to tackle the issue, a finding that confirms what Copeland and Henry (2017) found in their research. Although it is recognized as a serious problem, and measures have been, and are, taken to curb it, WPV remains an unsolved issue that affects the nursing staff and that also affects patient safety and the quality of care. It is worth noting that the reports available to us for this research regarding the scope of the issue date back ten years or more, and a more recent and broader picture is necessary. Nonetheless, the solutions posited by the researches whose articles we reviewed, include mostly managerial solutions, which the clinicians, subjects of study in the same articles, often found inadequate or insufficient, thus creating discrepancies or contradictions on how to tackle the problem.

The National United Nurses (2019), a USA-based trade union, claims that the single most important factor related to WPV is understaffing, a claim supported by the findings in the NACNEP (2007) report. And it is relevant, whether that is the case in its specificity or not, because it underlines the fact that WPV is not a problem exclusive to particular health care settings, but related to larger social, political and economic frameworks. This becomes evident simply by pointing out that understaffing is related to budgetary issues, and budgetary issues are related to governmental policies, economic circumstances, and design and purpose of health care provision. With the review we made of the literature relevant to the subject, we conclude that the clinicians studied in the researches, at least partially are aware of the situation, and that they have a wealth of experiential knowledge on the issue, that should not be undermined. On the contrary, active participation of nurses in the larger

framework, in public discussions and research on the results of such interventions seems to us recommendable.

Clark (2016) states that "there is a gap in the literature, as there are few studies that explored the human experience of returning to work after assault." And Howerton (2013) claims that "to date, the link between WPV and decreased patient safety with regards to RNs' psychological wellbeing and perceived organizational support has not been researched." More studies about the intervention and support methods and their efficiency is also needed (Armmer, & Ball 2014; Howerton 2013; Clark 2016, 128).

Studies done on a larger scale and in more diverse surroundings is needed as many of the studies are done in urban areas with small sample sizes (Armmer, & Ball 2014; Avander et al. 2016; Clark 2016).

Also, research on studies on the role nurses working on the field play in programs designed to curve WPV is necessary.

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Appendices

Appendix 1. Reviewed articles

Author(s)	Publishing year and country	Title	Aim	Participants, sample size	Data collection and analysis	Main findings
Avander, K., Heikki, A., Bjerså, K., & Engström, M.	2016, Sweden	Trauma Nurses' Experience of Workplace Violence and Threats: Short- and Long-Term Consequences in a Swedish Setting	Explore trauma nurses' experiences and consequences of WPV	14 nurses	Semi-structured group interviews	Consequences and efforts to avoid WPV led to a decreased quality of nursing care
Boafo, I.M.	2016, Ghana	"...they think we are conversing, so we don't care about them..." Examining the causes of workplace violence against nurses in Ghana	Explore the main causes of WPV against nurses from the nurses' perspective	24 nurses	Semi-structured in-depth interviews and 592 cross-sectional questionnaire surveys	WPV can be instigated by the nurse or the patient with the main causes including ineffective communication, perceived unresponsiveness and long waiting times
Chapman, R., Perry, L., Styles, I. & Combs, S.	2009, Australia	Consequences of workplace violence directed at nurses	Examine nurses' perspectives of WPV's consequences	113 questionnaires to nurses, 35 nurses were interviewed	Questionnaire and semi-structured interviews	WPV is seen as a part of the job and has negative effects to the health of the nurses and the quality of care
Currid, T.	2009, United Kingdom	Experiences of stress among nurses in acute mental health setting	Explore the stressors and nurses' experiences of stress	8 staff members	Semi-structured interview	Nurses frequently experience WPV which negatively affects nursing

			in acute mental health care			care and nurses' level of stress
Morken, T., Johansen, I.H. & Alsaker, K.	2015, Norway	Dealing with workplace violence in emergency primary health care: a focus group study	Exploring how personnel handle WPV in emergency primary health care and the effect of organizational factors	37 physicians and nurses	Focus group discussion	Personnel handle WPV and threats by preparing, communicating with the patient, working in pairs and groups and getting support from the manager
Nguluwe, B.C.J., Havenga, Y. & Sengane, M.L.M.	2014, South Africa	Violence experienced by nurses working in acute care psychiatric wards at a Gauteng hospital	Explore nurses' experiences and perceived effects of WPV in acute care inpatient psychiatric wards at a hospital in Gauteng	13 nurses	Semi-structured interview	Nurses experience and are affected by WPV and see the risk factors to be patient-related
Renker, P., Scribner, S.A. & Huff, P.	2015, USA	Staff perspectives of violence in the emergency department: Appeals for consequences, collaboration, and consistency	Identify and describe nurses' experiences and perceptions of WPV	41 registered nurses and 10 paramedics	A cross-sectional mixed-method descriptive design, survey and interview	WPV has maladaptive reactions in staff and developing policies and practices is necessary to decrease WPV
Stevenson, K.N., Jack, S.M., O'Mara, L. & LeGris, J.	2015, Canada	Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study	Explore nurses' experiences of WPV in acute care inpatient psychiatric setting	12 registered nurses	Semi-structured interview	Nurses experience WPV and have difficulties balancing the responsibility to provide care with the need to protect oneself