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Research Article

Patient Violence towards Mental Health Nurses: A Concept Analysis

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Purpose. To analyse the concept of patient violence towards mental health nurses. *Design and Methods.* A hybrid model was adopted with literature review of 103 studies and interviews with seven mental health nurses. *Findings.* Patient violence was defined as a violent incident committed by patients towards nurses vulnerable to physical, verbal, emotional, and sexual violence. It was a common and frequent phenomenon with multifactorial causes and is prone to be unreported. *Practice Implications.* Our study findings function as the conceptual framework to measure patient violence in relevant research and allow policy development to protect mental health nurses at the practice.

1. Introduction

Patient violence frequently occurs in mental health practice [1, 2]. Violence incidents were more highly reported in hospitals with a department of mental health (37.7%) than without it (6.4%) in South Korea [1]. Thus, mental health staff is more likely to be exposed to violence than the staff of other departments [2]. The Bureau of Labor Statistics of the United States [3] reported that psychiatric aides were more injured by other persons with intention (254.3 per 10,000 full-time workers) than nursing assistants (38.3 per 10,000 full-time workers). Mental health nurses frequently encounter violence from patients during their practice [4]. For example, most nurses had ever experienced at least one incident of verbal or physical violence from a patient while on duty [5].

Previous studies found that nurses exposed to patient violence experienced negative emotional responses such as fear, anxiety [5], and post-traumatic stress symptoms [6]. Additionally, patient violence is associated with burnout, low job satisfaction, and professional discouragement among nurses [5, 7]. Vulnerable mental health nurses, predominantly long-employed or novice nurses were usually the targets of violence [8]. However, nurses handled problems passively because their actions might cause legal issues even if they felt that the patients violated their human rights [9]. Hence, patient violence is usually one-sided and has been accepted as part of the nursing system [9, 10].

Previous studies have presented the concept of patient violence with interchangeable terms, such as aggression and assault, making it difficult to describe the phenomenon. Such terms have been interchangeably used, and the nurses' experience of being victimised by psychiatric patients has not been defined clearly. The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation [11]." The Emergency Medical Service Act of the Republic of Korea defines violence as "assault, intimidation, hierarchy, force, vandalism, and occupation [12]." The terms "violence" and "aggression" are often used interchangeably in mental health research. According to Allen and Anderson [13], aggression

is motivated by the intention to dominate or hurt someone and can take on diverse forms. In contrast, violence refers to physical harm, which is the result of aggression. They placed the two concepts on a continuum and argued that severe aggression results in violence. However, these two concepts' distinctiveness is not remarkable in mental health research.

Moreover, the term "workplace violence" is widely used to represent violence among coworkers. It is defined as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behaviour that occurs at the work site [14]. However, this concept is hard to describe precisely patient violence because it involves violence from other employees, clients, customers, and visitors. Therefore, it is essential to conceptualise patient violence towards mental health care providers in research and nursing practice. Exploring the concept of patient violence is essential for better understanding the phenomenon and recommending systematic improvement.

Patient violence is a common issue in mental health settings. However, terms describing this phenomenon have been used interchangeably in the literature. Previous literature and policies have focused on a narrow definition of patient violence, which excluded the emotional violence experienced by mental health nurses during practice. Clarifying the concept is emphasised regarding the need to improve the nursing environment and safety. This study aimed to analyse the concept of patient violence towards nurses by identifying its definition, antecedents, consequences, and attributes.

2. Method

2.1. Design. This study adopted a hybrid model that Schwartz-Barcott and Kim [15] developed. This model comprises three phases by combining literature findings and empirical data.

2.1.1. Theoretical Phase. We examined the definitions and similarities/differences among the concepts in the literature. The theoretical review was performed based on the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-analysis [16]. The following eight electronic databases were searched, with no specified publication period: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane, Embase, PsycInfo, PubMed, Web of Science, Korean studies Information Service System, and Research Information Sharing Service. We used the following Medical Subject Heading (MeSH) keywords: "Violence," "Aggression," "Mental health," "Nurse," and "Inpatients." The university librarian confirmed these search strategies and keywords. The databases were searched and analysed in December 2020 by two authors.

The inclusion criteria were as follows: (1) studies related to a violent phenomenon by patients towards nurses; (2) studies including nurses in mental health hospitals; (3) articles such as dissertations, editorials, observational research, and literature reviews; (4) studies published in English and Korean. The exclusion criteria were as follows: (1) studies including patients in a forensic ward or prisoners; (2) studies not related to violence towards nurses (e.g., physical restraint); (3) studies on violence by elderly patients with dementia; (4) studies not including nurses; (5) studies published in other languages; (6) studies that did not focus on patient violence/aggression incidents (e.g., focus on developing patient safety protocols or approaching overall workplace violence rather than violent events by patients); and (7) articles including conference proceedings, papers or abstracts, letters, or experimental researches.

2.1.2. Fieldwork Phase. The fieldwork phase was performed as a phenomenological method [17] to understand the meanings of the concept and followed the Standards for Reporting Qualitative Research guidelines [18]. We interpreted the meaning from empirical data collected from inpatient nurses.

2.1.3. Final Analytic Phase. In the final analytical phase, the researchers synthesised the results of both theoretical and fieldwork phases to derive the definition and identify the concept's attributes.

2.2. Participants. We used both purposive sampling and snowball sampling methods. Registered nurses who had work experience at the mental health unit for at least one year were recruited. The nurses who (1) were not working during the data collection period, (2) only had experience in a community setting, and (3) already participated in other studies were excluded.

2.3. Data Collection. Qualitative data were collected from January to February 2021. Most of the interviews were face-to-face; however, some were conducted by phone during strict enforcement of the COVID-19 quarantine. Each interview lasted approximately 20 minutes to 1 hour for seven participants. All interviews were recorded through a voice recorder and transcribed by researchers. The other researcher confirmed the contents by comparing the recorded files and transcriptions. The semistructured interviews included predetermined questions, such as "Could you tell me about your experience of exposure to violence?," "How did you feel when you experienced patient violence?," and "Could you define patient violence? In your view, which types of patient violence exist?." Data were collected until theoretical saturation was reached and no new information could be obtained from the participants.

2.4. Data Analysis. During the theoretical phase, two researchers (YSC and KHL) independently screened and analysed the literature, and the third researcher (HJK) was the external validator. Researchers screened titles and abstracts of the literature and reviewed full-text articles based on inclusion criteria. Subsequently, the data were extracted from the selected studies.

Researchers were trained in qualitative research ethics and methodology before the fieldwork phase. Qualitative data were analysed by the phenomenological method [17] that involved: (1) repeated reading of all transcribed interviews; (2) extracting significant statements; (3) exploring the meaning; (4) clustering themes; (5) developing an exhaustive description; (6) summarising and organising fundamental structure; and (7) validating the data. Researchers discussed the interpretations of the significant statements and classified them according to themes.

Data analysis in the theoretical and fieldwork phases proceeded concurrently [15]. We then compared the results of these phases to obtain the data for the final analytic phase. Two researchers (YSC and KHL) classified the findings of each phase and discussed them to synthesise; the third researcher (HJK) confirmed the data.

We followed the PRISMA guidelines [16] to analyse the literature during the theoretical phase. All authors discussed and confirmed the analysed data. Further, a nursing expert in concept analysis reviewed the quantitative data.

Lincoln and Guba's [19] criteria for evaluating trustworthiness, such as peer debriefing, participant checks, and thick descriptions, were used during the fieldwork phase. An anthropologist with abundant qualitative research experience reviewed our qualitative data; three participants reviewed the data to ensure credibility. We also used the consolidated criteria for reporting qualitative research (COREQ) checklist to evaluate the qualitative design [20].

2.5. Ethical Considerations. This study design was approved by the affiliated university institutional review board of Yonsei university (approval no. Y-2020-0188). All participants provided written informed consent and participated voluntarily. We also informed the participants that they could withdraw the study paritipation anytime. Interviews were conducted privately or by phone, per the participants' convenience and safety.

3. Results

3.1. Theoretical Phase. Of the 1,620 studies identified from the database search, 412 duplicate studies were removed. On screening the titles and abstracts of the remaining 1,208 studies, 238 studies were suitable. Then, 34 studies, which not retrieved were excluded. On assessing the full texts of the 204 studies, 101 studies were excluded according to the eligibility criteria. Finally, 103 studies were eligible for analysis (see Figure 1).

3.1.1. Definitions and Types of Violence. There was a lack of operational definitions of patient violence in the selected studies. Aggression or violence was usually defined as physical or verbal behaviour by a patient against property, self, other patients, or staff [21, 22]. However, Ezeobele et al. [23] adopted the definition of Bushman and Huesmann [24] to explain aggression as intended behaviour to harm another person.

Many studies focused on verbal and physical violence. Only 18 studies included sexual harassment as a type of violence. Emotional violence was usually classified as "nonverbal" violence, like psychological harm, including physical threat and emotional abuse (see Table 1) [7, 25, 26].

3.1.2. Antecedents. According to Duxbury's [27] theoretical framework, predictable antecedent factors, internal ($n = 74$), external ($n = 53$), and situational factors ($n = 60$) were derived. Internal factors were related to individual variables of patient violence, such as early-stage in admission [28], length of hospitalisation, involuntary admission [8], age, mental illness, and history of violence [29]. However, several studies explained that the diagnosis of mental illness and gender were debatable as the antecedents of violence [8, 30]. In contrast to patients' perspectives, nurses believed that mental illness contributed to patient violence [31]. Moreover, it was inconsistent in explaining the causes of patient violence as a gender factor [30].

The external/environmental factors were overcrowding, coercive treatment, restricted environment (e.g., locked door, limit-settings, and lack of privacy), and insufficient staffing levels [8, 29].

The situational factor was negative relationships between staff and patients, such as inappropriate communication. It was divided into nurse and patient factors. Nurse factors were employee age [8] and lack of communication skills [29]. Patient factors were dominant interpersonal style and lack of communication skills [6].

However, some studies also identified unpredictable factors ($n = 15$). For example, Sim et al. [9] reported that incidents could occur unprovoked.

3.1.3. Consequences. Nurses experienced wide range of physical injuries and even death from patients' violence ($n = 26$). However, nurses' most frequently reported consequence was the emergence of psychological responses as a postevent effect ($n = 38$). Psychological trauma was influenced by their professional experience [6]. Nurses had to return to the ward the next day and take care of their assailants [32]. Thus, nurses exposed to patient violence felt that the ward environment was unsafe. They tried to keep a safe distance from the patients and withdraw from therapeutic relationships [32]. After exposure to violence, peer support was a common strategy used by the nurses ($n = 15$) [5].

3.1.4. Attributes. Patient violence was a common and frequent phenomenon in mental health settings ($n = 34$). Most nurses had been exposed to verbal or physical violence from their patients [5]. Moreover, patient violence was multifactorial and was incited by various reasons (internal, external, situational, and unpredictable factors). Patients behaved violently with or without intention due to their psychotic symptoms [33]. Thus, defining patient violence was challenging due to its complexity [32].

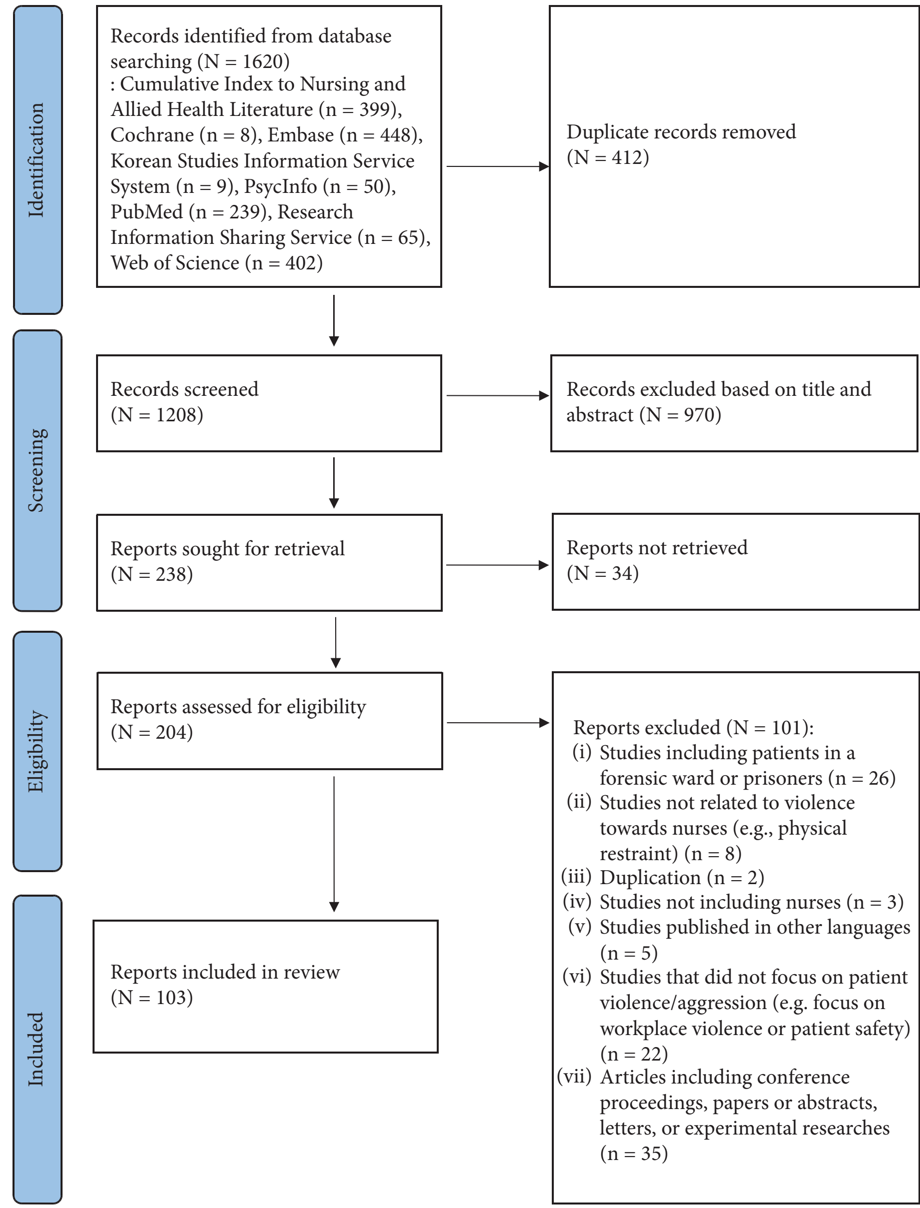

Figure 1: Flow diagram of the database search.

Nurses were vulnerable to violence ($n = 22$). Incidents were directed one-sidedly from patients to nurses because nurses could not actively manage the problems due to legal issues [9]. The theme of "part of the job" was commonly derived from qualitative studies [32, 34]. Nurses considered violence from their patients to be a normal phenomenon. Therefore, nurses believed they should tolerate patient violence [34]. Hence, nurses suppressed negative emotions to maintain a therapeutic perspective [9]. They also attempted to correct their behaviour to prevent further violence and attributed the violent event to their carelessness [34].

3.2. Fieldwork Phase. Seven staff nurses from four hospitals participated in the study (Table 2). The nurses received mandatory violence management training from their workplaces, including learning de-escalation skills or getting acquainted with response procedures according to hospital guidelines.

Four categories and 12 theme clusters were derived from seven one-to-one qualitative interviews (Tables 3 and 4).

3.2.1. Definitions and Types of Violence. Most participants used the term "acting out" to describe patient violence. They thought it was a phenomenon caused by patients' inner mental dynamics.

"It is literally 'acting out,' whether verbal violence or physical attack. Acting out causes direct harm to others through the patient's inner aggression. We use it to mean the same thing as violence." (Participant 2).

Four types of violence (physical/verbal/emotional violence/sexual harassment) were identified from the interview data. Specifically, emotional violence included verbal insults

Table 1: Summarised results of the theoretical phase.

Category	Items	Indicators
Types of violence	Emotional violence	Accusing a nurse unfairly
		Bullying/mobbing
		Humiliate to nurses
		Questioning nurses' decisions
	Physical violence	Physical assaults
		Physical threats
	Sexual harassment	Sexual abuse (physical or verbal)
	Verbal violence	Verbal abuse
		Verbal threats
Antecedents	Predictable factors	Internal factors
		External factors
		Situational factors
	Unpredictable factors	Unexpected
		Unprovoked
Consequences	Physical injuries	Death
		Physical injuries (from mild to severe)
	Psychological responses	Burnout
		Emotional distress
		Loss of confidence and self-esteem
		Maintaining physical/psychological safe distances from violent patients
		Psychological trauma
		Sceptical attitude to their jobs
	Seeking support	Seeking emotional support from colleagues
Attributes	Common and frequent	Common phenomenon
		Frequently occurred
	Multifactorial	Caused by predictable (internal/external/situational) or unpredictable factors
		Hard to define
		Intentional or not
	Vulnerability of nurses to violence	Blaming the victims
		One-sidedness
		Part of job (a culture that accepts the violence)
		Self-criticism

Table 2: General characteristics of the participants.

Participant	Sex	Age (year)	Types of institutions	Department	Total number of beds in institution	Work experience	Position	Education level
1	Female	28	Public	Day hospital care	902	4 years 5 months	Staff nurse	BSN
2	Female	26	Public	Semiopen ward	902	3 years	Staff nurse	BSN
3	Male	34	Private	Open ward	252	4 years 6 months	Staff nurse	BSN
4	Female	27	Private	Open ward	268	4 years 8 months	Staff nurse	MSN
5	Female	35	Private	Locked ward	268	10 years	Staff nurse	BSN
6	Female	30	Private	Open ward	268	2 years 10 months	Staff nurse	BSN
7	Female	28	Private	Open ward and locked ward	242	3 years 8 months	Staff nurse	BSN

and physical gestures intended to hurt the nurses' emotions. Participants described emotional violence as spreading rumours about nurses, constantly reminding them of the assailant's presence or demanding apologies repeatedly.

3.2.2. Antecedents. Predictable (internal, external, and situational) and unpredictable factors were organised from the interviews. As the internal factors, participants believed that patient violence was caused by patients' psychotic symptoms (e.g., hallucinations), which affected their ability for impulse control. Sometimes patients could not manage their anger and vented on nurses. Additionally, involuntarily admitted patients tended to be more violent and denied treatments because they could not accept their admission.

External factors were restricted environment and ward regulations. Patients were under stress due to restrictions. Moreover, nurses reported that violence was more frequent due to the COVID-19 quarantine that curtailed visits and patients' autonomy. As a situational factor, nurses attributed causes of violence to themselves since they believed their words incited participants. Nurses also explained that predicting patient violence was hard because it often occurred suddenly, even during routine care. Thus, they could not grasp why the violence occurred.

3.2.3. Consequences. Three theme categories (physical injuries, psychological responses, and seeking support) were derived. Nurses experienced physical injuries ranging from mild to severe such as cornea damage. However, psychological responses were the most common since they are expected consequences of all types of violence. The memories of such events lasted and accumulated with time. It also triggered anxiety in similar situations at work. Furthermore, they felt emotional distress when patients intentionally attacked them. To maintain their nursing performance, nurses believed that patients had no intention to commit violence, but the psychotic symptoms caused it.

Moreover, nurses had a sceptical attitude to their jobs. They regretted working in mental health hospitals and thought, "Why do I have to work like this?" They would even consider resigning if the hospital did not resolve their concerns. Therefore, they maintained physical and psychological safe distances from violent patients to protect themselves.

After the incidents, nurses primarily needed support from their institutions. They expected their hospitals to resolve their concerns but were disappointed by insufficient support. There was a lack of psychological support or regular consults. The administrators did not take any actions, such as separating nurses from patients. Even if nurses reported incidents, their administrator neglected them and expected the nurses to endure violence. It aroused nurses' psychological responses and reinforced sceptical attitudes leading to dependence on peer support and maintaining distance from violent patients.

3.2.4. Attributes. Patient violence was a common and frequent phenomenon in mental health hospitals. Violence was accepted as a usual event because it occurred daily. Nurses did not report incidents and endured. They primarily focused on dealing with their tasks quickly during work hours and trivialised their injuries. They also feared blame from colleagues who questioned their competency. Another reason was helplessness since nurses believed that their working environment could never improve.

Patient violence was one-sided because nurses could not actively respond to violent patients (e.g., responding violently towards patients). They felt responsibility as therapists towards their patients. Nurses had compassion for their patients because they were isolated in society. Moreover, nurses believed that reporting incidents could interrupt patients' treatments. They tended to endure violence, but under stress. Senior nurses thought violent behaviour was common in mental health units and forced their colleagues to accept it. The colleagues blamed the victims' behaviour, stating that they should speak softly, maintain a safe distance, and not nag their patients. Victimised nurses believed their behaviour incited the patients.

3.3. Final Analytical Phase. Based on the findings of both the theoretical and fieldwork phases, we identified the definitions and attributes of patient violence. Common factors were included, and unique or similar factors were discussed to identify extended attributes (Table 5).

Patient violence included physical, verbal, emotional violence, and sexual harassment. The comprehensive definition of the concept was that patient violence is a violent incident committed by patients towards nurses who are

Table 3: Themes derived in the fieldwork phase.

Category	Theme cluster	Theme
Types of violence	Emotional violence	Bullying (e.g., spreading rumours, constantly reminding of patients' presence, or demanding apologies repeatedly)
	Physical violence	Physical assaults (e.g., slapping the cheek, scratching, or pinching)
		Physical threats (e.g., throwing something towards the nurse)
	Sexual harassment	Physically touching with sexual intention
		Verbal insults with sexual intention
	Verbal violence	Insults about nurses' appearance
		Swearing at nurses
		Verbal threats
Antecedents	Predictable factors	Internal factors
		External factors
		Situational factors
	Unpredictable factors	Hard to grasp the reason
		Occurred suddenly
Consequences	Physical injuries	Physical injuries
	Psychological response	Emotional distress
		Maintaining physical/psychological safe distances from violent patients
		Psychological trauma
		Sceptical attitude to their jobs
	Seeking support	Disappointed with lousy support from their institution
		Seeking emotional support from colleagues
Attributes	Common and frequent	Common phenomenon
		Frequently occurred
	Hiding incidents	Fear of blame from colleagues
		Feeling helplessness
		Considered their injuries as trivial
	Vulnerability of nurses to violence	Accepted patient violence as natural
		Blaming the victim
		One-sidedness
		Responsibility to their patients and profession
		Self-criticism

Table 4: Participant's statements on each theme cluster

Theme cluster	Significant statements
Emotional violence	"The patients did not act up, but they knew where I was and gossiped about me such that I was able to hear. It made me conscious of them." (Participant 3) "A patient demanded an apology from me. I apologised to her, but she did not accept it. She needed my apology repeatedly." (Participant 6)
Physical violence	"The patients slapped my cheek or pulled my hair... They suddenly dropped something loudly, kicked a trash can, or threw the pills to the ground." (Participant 1)
Sexual harassment	"A male patient touched my thigh while I moved among the chairs." (Participant 1) (Participant 4)
Verbal violence	They also mocked her saying, "It is the reason why she isn't married yet."
Predictable factors	"I think that patients with mental illness cannot control their impulses. If they fail to regulate their emotions, it causes violence." (Participant 2) "Mental health wards are restrictive in nature, and patients cannot go outside freely. Thus, they are prone to project their emotions onto nurses, such as feeling suppressed or stressed." (Participant 5) "Trivial words or a slip of the tongue might incite patient violence. I realised that speaking carefully to patients is important." (Participant 6)
Unpredictable factors	"The patient asked me help to stand up. Thus, I approached the patient. But she suddenly grasped my hair and choked my neck. I never expected it." (Participant 7)
Physical injuries	"My cornea was torn by the violence." (Participant 7)
Psychological response	"I felt shame and thought that the patient ignored me as a therapist. I do not want to think about whether the patient acted intentionally. I have to provide care to them in any case. If a patient had the intention to hurt me, it would influence my motivation. However, if I consider it a psychotic symptom, it would be simple because I just continue with my job." (Participant 1)
Seeking support	"Hospital administrators think that employees should endure violence. I think this culture requires changed. It was the hospital's duty to compensate when an employee was injured. However, the hospital did not do it." (Participant 5)

Table 4: Continued.

Theme cluster	Significant statements
Common and frequent	"I have been exposed to violence every day. It is natural what patients curse me after drinking. Verbal violence occurs every day." (Participant 5)
Hiding incidents	"My injuries were invisible, and I was not bleeding (laughing). In addition, there was no closed-circuit television in the hospital rooms. Thus, I decided to hide my injury." (Participant 4) "I felt helpless because patient violence is not managed actively, and the situation will not improve. Therefore, I manage violence as much as possible and do not expect any changes." (Participant 1)
Vulnerability of nurses to violence	"The only people who can understand the patients are the therapists. How could we sue them? We are like a family. They do not have any real family or income. I do not want to give them to experience failure, and I want them to continue with treatments. I have to do my duty because I am a nurse, even if they attacked me." (Participant 1) "After my colleagues blamed me, I doubted myself and though "It might be my fault. I should have been more careful." My behaviour might incite violence." (Participant 7)

Table 5: Results of the final analytic phase.

Category	Items	Indicators
Types of violence	Emotional violence	Bullying (e.g., accusing a nurse unfairly, demanding apologies repeatedly, spreading rumours, constantly reminding of patients' presence, or questioning nurses' decisions)
	Physical violence	Physical assaults
		Physical threats
	Sexual harassment	Sexual abuse (physical or verbal)
	Verbal violence	Verbal abuse
		Verbal threats
Antecedents	Predictable factors	Internal factors
		External factors
		Situational factors
	Unpredictable factors	Occurred suddenly (unexpected)
		Unprovoked
Consequences	Physical injuries	Death
		Physical injuries (from mild to severe)
	Psychological response	Burnout
		Emotional distress
		Loss of confidence and self-esteem
		Maintaining physical/psychological safe distances from violent patients
		Psychological trauma
		Sceptical attitude to their jobs
	Seeking support	Seeking support from their institution
		Seeking emotional support from colleagues
Attributes	Common and frequent	Common phenomenon
		Frequently occurred
	Multifactorial	Caused by predictable (internal/external/situational) or unpredictable factors
		Intentional or not
	Unreported	Did not consider incidents as important
		Fear of blaming
		Feeling negative emotions
	Vulnerability of nurses to violence	A culture that accepts the violence
		Blaming the victims
		One-sidedness
		Responsibility to their patients and profession
		Self-criticism

vulnerable to violence. It is a common and frequent phenomenon in mental health settings, caused by multiple factors, and is prone to be unreported. Antecedents of patient violence were classified into two types of factors. Predictable factors included internal, external, and situational factors. Another category was unpredictable factors. Consequently, nurses experienced physical and psychological harm and sought support. Based on the results, a conceptual framework of patient violence was derived (see Figure 2).

4. Discussion

This study explored the concept of patient violence towards mental health nurses and aimed to refine the definition and attributes of this concept. Patient violence is a term widely used in mental health research to describe or predict aggressive behaviour of mental health inpatients. However, the scope and terminologies are ambiguous, leading to confusion in appraising the phenomenon. Previous perspectives had limitations in identifying the concept of patient violence towards mental health nurses because they classified violence using narrow criteria. For example, they focused on whether it was intentional or not and if physical harm was caused [13]. The Oxford English Dictionary [35] defined violence as "behaviour involving physical force intended to hurt, damage, or kill someone or something." Similarly, WHO [11] defined violence as the intentional use of physical force or threatening. Another interchangeable term was aggression, usually defined as physical or verbal behaviour in studies [22]. Additionally, based on the psychoanalytical perspective, most participants in our study used the term "acting out" to refer to patient violence and considered it a defence mechanism. Acting out was defined as "the action or an act of expressing repressed or unconscious feelings in overt behaviour [36]." However, these definitions could not thoroughly describe the phenomenon in mental health care settings.

Patient violence had been diversely expressed as a struggle to recover the lost autonomy of the patients [8] or an unconscious consequence of psychotic diagnosis [29]. Patients may intentionally display violent behaviour as resistance to a restricted environment. However, psychotic symptoms are also a significant variable in defining the concept, regardless of whether it is intentional. For example, patients who experience threatening hallucinations can unintentionally harm the nurses to defend themselves. Thus, an expanded definition that encompasses these aspects of patient violence is needed.

We classified the types of violence as physical, verbal, emotional, and sexual harassment. The usage of the concept of violence is not limited to its physical form in mental health research. Some types of violence, such as violence towards the environment (e.g., kicking something), were included as physical threats in the theoretical phase if they were explicitly described as targeted towards the nurses. The physical, sexual, and verbal violence coincided in literature and interviews. Emotional violence was not well defined in the literature and was described as a part of nonverbal violence, such as actions intended towards psychological harm. However, emotional violence emerged in the qualitative data as bullying, which included specific behaviour such as spreading rumours. Therefore, we synthesised emotional violence by combining the results.

Our study highlighted that we included emotional violence as a type of patient violence. Emotional violence has been generally investigated in cases of child abuse. From a child abuse perspective [37], emotional violence occurs in intimate relationships, including observable violent acts and lack of immediate protection. However, it is difficult to manage or prevent it because emotional violence might not be visible as physical harm. In the present study, emotional violence was described as bullying, which included specific behaviours such as making nurses constantly aware of the presence of patients. It is related to passive aggression, relevant in the high-context culture of East Asia. In high-context cultures, people prefer to communicate indirectly and deliver their meanings implicitly [38]. Thus, sensitively reacting to the patient's verbal or nonverbal expressions is essential for mental health nurses in East Asian cultures. Hence, our definition of emotional violence included verbal insults and physical gestures intended to hurt the nurses emotionally.

Duxbury's [27] theoretical framework was adopted to classify the types of antecedents. The theoretical phase provided information about each factor, and the fieldwork phase identified the nurses' perceptions of them. Internal factors indicate individual variables, such as the acute phase of mental illness, history of violence, and involuntary admission. Most participants believed psychotic symptoms as a significant antecedent. Their words reflected this perspective, such as "acting out." External factors stand for environmental factors, such as ward atmosphere, restricted environment, and lack of privacy. Participants frequently referred to the restricted environment because hospitals strongly limited visitors due to quarantine during the pandemic. Situational factors, such as inappropriate communication, indicate negative relationships between patients and nurses. Literature considered both nurse and patient causes, whereas participants criticised themselves. They believed that they failed to notice patients' symptoms. Additionally, some types of patient violence were described as occurring suddenly and were hard to grasp the causes in literature and interviews. Therefore, it was classified into unpredictable factors in this study. Changing internal or unpredictable factors to prevent violence is hard, whereas external and situational factors are modifiable variables by institutions and nurses. Therefore, it is necessary to focus on modifiable factors and develop strategies to control the risk factors of patient violence.

Three consequences were refined in the final analytic phase. "Physical injuries" were commonly reported in both literature and interviews. As "psychological responses," emotional distress, maintaining physical/psychological safe distances from violent patients, psychological trauma, and sceptical attitude to their jobs coincided in both literature and interviews. Burnout emerged in the theoretical phase [7], but its components (emotional exhaustion and

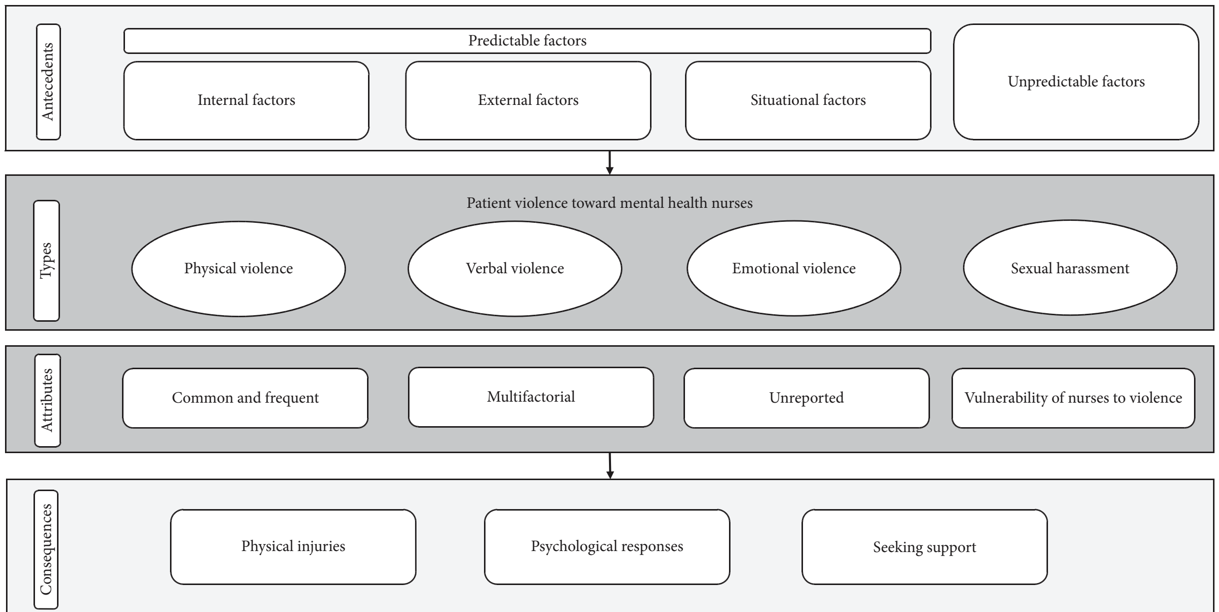

Figure 2: Conceptual framework on patient violence toward mental health nurses.

decreased personal accomplishment) were also identified in the interviews. Loss of confidence and self-esteem [5, 32] was included as an indicator after identification in the interviews. Under "seeking support," nurses needed emotional support from their colleagues. Seeking support from the institution was emphasised in the fieldwork phase. However, nurses were disappointed with poor institutional support [32, 34] and faced hard emotional labour while caring for violent patients [39]. These results implied that active interventions are needed at the institutional level to protect employees and ensure high-quality nursing care.

Four attributes were derived from both phases, which were complementary descriptions of each phase. First, patient violence occurs commonly and frequently. Most nurses experienced at least one violent incident by a patient [5]. In the qualitative data, participants identically reported being exposed to violence daily. Second, patient violence had a multifactorial cause. The literature review revealed the complexity of patient violence. It consisted of predictable/unpredictable and intentional/unintentional factors, making it hard to define. Similarly, participants reported contrasting explanations for the causes of violence. Third, patient violence is mostly unreported [25, 32]. It emerged in the qualitative data as "hiding incidents." This theme cluster was also validated in the literature ($n = 8$) and provided a complementary explanation to the interview data. In the final analytic phase, the "feeling negative emotions" item was derived from "feeling helplessness" in interviews, and it was complemented in literature as "feeling negative emotions during reporting." While reporting an incident, nurses re-experienced negative emotions and considered it a punishment [34]. Furthermore, the "fear of blaming" was derived from the "fear of blame from colleagues" theme in interviews. The item "did not consider incidents as important" also emerged. Interview participants felt their injuries from violence as trivial to report. The fourth attribute was that mental health nurses were vulnerable to violence. The item "a culture that accepted the violence" was synthesised by combining "part of job" in literature and "accepted patient violence as natural" in interviews. Several results emerged in both phases, including "blaming the victim," "one-sidedness," and "self-criticism." However, "responsibility to their patients and profession" was described in the theoretical phase. Nurses had rapport with their patients and felt strongly responsible for their patients and profession, even if patients were their assailants. One of the participants considered herself the "family" of the patients. Similarly, in Taiwan, the nurses criticised themselves and thought their assailants were just patients with no intention to harm [25]. These beliefs led nurses to endure violence to continue with patients' treatment.

4.1. Limitations. There are several limitations to this concept analysis. First, the selected literature was limited to medicine, nursing, and psychology, focusing on inpatient and usual care of mental health services. A more comprehensive systematic search in a wide range of disciplines is recommended for concept analysis [15]. Thus, it is necessary to explore how this concept has been operated in urgent care and public health, such as emergency rooms and community mental health clinics. For instance, a restricted environment was an antecedent of patient violence in this study, but it is hard to apply in community settings. Moreover, patient violence also frequently occurs in emergency rooms [40, 41], but it has unique antecedents (e.g., long waiting times) [1, 40]. Thus, identifying how patient violence differs between mental health inpatient wards and others is needed.

Second, the interview participants were seven Korean registered nurses. There were very few male nurses and no administrators in our study. The dominant violence type and nurses' perceptions of them could be different across the

characteristics of each gender group [2, 4]. Therefore, further studies should include various ethnic groups, male nurses, and administrators to identify ethnic, sexual, and hierarchical differences in the perception of patient violence. Additionally, mental health patients may be included in the fieldwork phase considering that patient violence has interactive dynamics between patients and nurses.

5. Conclusion

We explored the definition and attributes of patient violence towards mental health nurses using a hybrid method. Even though several limitations, this study provides a clear definition of patient violence toward mental health nurses. We expanded the definition of patient violence from physical to invisible psychosocial aspects and identified its attributes. Patient violence is a common and frequent phenomenon in mental health settings, caused by multiple factors, and is prone to be unreported. It is caused by predictable or unpredictable factors and results in physical and psychological injury to mental health nurses leading to the requirement for support. Clarifying the definition and attributes of the concept may contribute to a better understanding of the phenomenon. Based on the results, a structured conceptual framework was suggested to describe the mechanism of patient violence. Identified antecedents and consequences may be used for developing interventions and policies to protect nurses from violence in mental health settings.

6. Implications for Nursing Practice

This study suggests nursing practice, research, and theory recommendations with an in-depth understanding of the concept and provides the definition. The conceptual framework of this study provides a comprehensive understanding of patient violence in terms of its definition and attributes. Thus, it allows the development of a measure of frequency and severity of patient violence utilising the conceptual framework. This study identified the invisible psychological aspects of patient violence in nursing practice, including emotional violence and psychological responses. These types of violence, especially emotional aspects, have not been highlighted, even though nurses have commonly experienced them. Therefore, institutions in clinical settings should intervene actively to protect nurses from patient violence using the expanded definition of this study. Hospitals and nursing administrators could modify safety manuals and guidelines to protect nurses and prevent violence. The concept of patient violence towards mental health nurses should be introduced in nursing research and theory to develop policies and laws protecting patients and nurses. Our results can help improve the working environment of mental health nurses and enhance nurses' professionalism and safety.

Data Availability

The data used to support the findings of this study have not been made available.

Ethical Approval

This study was approved by the affiliated university institutional review board of Yonsei University (approval no. Y-2020-0188).

Conflicts of Interest

The authors declare no conflicts of interest.

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Supplementary Materials

Appendix 1: List of selected studies. Appendix 2: Summary of the analysed literature. (*Supplementary Materials*)

References

[1] The Ministry of Health and Welfare of South Korea, "Protect public health by creating a safe medical environment for medical institutions," 2019, http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&CONT_SEQ=348926&page=1.

[2] J. Liu, Y. Gan, H. Jiang et al., "Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis," *Occupational and Environmental Medicine*, vol. 2019, no. 76, pp. 927–937, 2019.

[3] U.S. Bureau of Labor Statistics, "Table R100. Incidence rates for nonfatal occupational injuries and illnesses involving days away from work per 10,000 full-time workers by occupation and selected events or exposures leading to injury or illness," 2021, https://www.bls.gov/web/osh/cd_r100.htm.

[4] O. O. Isaiah, A. B. Lawal, A. O. Oluseyi, R. N. Ejidokun Adeolu, and O. O. Oriola, "Experience and attitude of psychiatric nurses toward inpatient aggression in a nigerian psychiatric hospital," *International Journal of Caring Sciences*, vol. 12, no. 3, pp. 1547–1560, 2019.

[5] I. Zaczyk, M. Młocek, E. Wilczek-Rużyczka, and M. Kwak, "Patient aggression on inpatient psychiatric wards and professional burnout among nurses," *Polish Nursing/Pielegniarstwo Polskie*, vol. 70, no. 4, pp. 339–345, 2018.

[6] G. d'Ettorre and V. Pellicani, "Workplace violence toward mental healthcare workers employed in psychiatric wards," *Safety and Health at Work*, vol. 8, no. 4, pp. 337–342, 2017.

[7] J. A. Ruiz-Hernández, M. Sánchez-Muñoz, J. A. Jiménez-Barbero et al., "User violence in mental health services: adaptation of an instrument. Healthcare-Workers' aggressive behavior scale-users-mental health version (HABS-U-mh)," *PLoS One*, vol. 14, no. 3, Article ID e0212742, 2019.
[8] M. Salzmann-Erikson and L. Yifter, "Risk factors and triggers that may result in patient-initiated violence on inpatient psychiatric units: an integrative review," *Clinical Nursing Research*, vol. 29, no. 7, pp. 504–520, 2020.
[9] I. O. Sim, K. M. Ahn, and E. J. Hwang, "Experiences of psychiatric nurses who care for patients with physical and psychological violence: a phenomenological study," *International Journal of Environmental Research and Public Health*, vol. 17, no. 14, p. 5159, 2020.
[10] V. L. S. Campbell, H. L. Foley, K. W. Vianna, and F. Brunger, "Folie du système? Preventing violence against nurses in inpatient psychiatry," *Psychiatric Quarterly*, vol. 90, no. 2, pp. 413–420, 2019.
[11] E. G. Krug, J. A. Mercy, L. L. Dahlberg, and A. B. Zwi, "The world report on violence and health," *The Lancet*, vol. 360, no. 9339, pp. 1083–1088, 2002.
[12] Korean Ministry of Government Legislation, "Emergency medical service act," 2021, https://www.law.go.kr/LSW/lsInfoP.do?efYd=20210408&lsiSeq=217267#0000.
[13] J. J. Allen and C. A. Anderson, "Aggression and violence: definitions and distinctions," in *The Wiley Handbook of Violence and Aggression*, P. Sturmey, Ed., John Wiley and Sons, New York, NY, USA, 2017.
[14] Occupational Safety and Health Administration, "Workplace violence," 2021, https://www.osha.gov/workplace-violence.
[15] D. Schwartz-Barcott and H. S. Kim, "An expansion and elaboration of the hybrid model of concept development," in *Concept Development in Nursing Foundations, Techniques, and Applications*, B. L. Rodgers and K. A. Knafl, Eds., pp. 129–159, W. B. Sanders, Paducah, KY, USA, 2000.
[16] M. J. Page, J. E. McKenzie, P. M. Bossuyt et al., "The PRISMA 2020 statement: an updated guideline for reporting systematic reviews," *International Journal of Surgery*, vol. 88, Article ID 105906, 2021.
[17] P. Colaizzi, "Psychological research as the phenomenologist views it," in *Existential-Phenomenological Alternatives for Psychology*, R. S. Vale and M. King, Eds., Oxford University Press, Oxford, UK, 1978.
[18] B. C. O'Brien, I. B. Harris, T. J. Beckman, D. A. Reed, and D. A. Cook, "Standards for reporting qualitative research," *Academic Medicine*, vol. 89, no. 9, pp. 1245–1251, 2014.
[19] Y. S. Lincoln and E. G. Guba, *Naturalistic Inquiry*, Sage, New York, NY, USA, 1985.
[20] A. Tong, P. Sainsbury, and J. Craig, "Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups," *International Journal for Quality in Health Care*, vol. 19, no. 6, pp. 349–357, 2007.
[21] N. J. de Bles, A. W. P. Hazewinkel, J. P. A. M. Bogers et al., "The incidence and economic impact of aggression in closed long-stay psychiatric wards," *International Journal of Psychiatry in Clinical Practice*, vol. 25, no. 4, pp. 430–436, 2020.
[22] E. Giarelli, R. Nocera, M. Jobes, C. Boylan, J. Lopez, and J. Knerr, "Exploration of aggression/violence among adult patients admitted for short-term, acute-care mental health services," *Archives of Psychiatric Nursing*, vol. 32, no. 2, pp. 215–223, 2018.
[23] I. E. Ezeobele, R. McBride, A. Engstrom, and S. D. Lane, "Aggression in acute inpatient psychiatric care: a survey of staff attitudes," *Canadian Journal of Nursing Research*, vol. 51, no. 3, pp. 145–153, 2019.
[24] B. J. Bushman and L. R. Huesmann, "Aggression," in *Handbook of Social Psychology*, S. T. Fiske, D. T. Gilbert, and G. Lindzey, Eds., John Wiley and Sons, New York, NY, USA, pp. 833–863, 2010.
[25] W. C. Chen, H. G. Hwu, and J. D. Wang, "Hospital staff responses to workplace violence in a psychiatric hospital in Taiwan," *International Journal of Occupational and Environmental Health*, vol. 15, no. 2, pp. 173–179, 2009.
[26] R. Jalil, J. W. Huber, J. Sixsmith, and G. L. Dickens, "Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: cross sectional questionnaire survey," *International Journal of Nursing Studies*, vol. 75, pp. 130–138, 2017.
[27] J. Duxbury, "An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design," *Journal of Psychiatric and Mental Health Nursing*, vol. 9, no. 3, pp. 325–337, 2002.
[28] G. Moursel, Z. Çetinkaya Duman, and R. Almvik, "Assessing the risk of violence in a psychiatric clinic: the Brøset Violence Checklist (BVC) Turkish version—validity and reliability study," *Perspectives in Psychiatric Care*, vol. 55, no. 2, pp. 225–232, 2019.
[29] S. Yalcin and H. Bilgin, "Risk predictions of physical aggression in acute psychiatric wards: findings of a prospective study," *Nursing and Health Sciences*, vol. 21, no. 3, pp. 316–322, 2019.
[30] V. Hamrin, J. Iennaco, and D. Olsen, "A review of ecological factors affecting inpatient psychiatric unit violence: implications for relational and unit cultural improvements," *Issues in Mental Health Nursing*, vol. 30, no. 4, pp. 214–226, 2009.
[31] J. Duxbury and R. Whittington, "Causes and management of patient aggression and violence: staff and patient perspectives," *Journal of Advanced Nursing*, vol. 50, no. 5, pp. 469–478, 2005.
[32] K. N. Stevenson, S. M. Jack, L. O'Mara, and J. LeGris, "Registered nurse's experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study," *BMC Nursing*, vol. 14, no. 1, p. 35, 2015.
[33] A. Higgins, P. Barker, and C. M. Begley, "Clients with mental health problems who sexualize the nurse-client encounter: the nursing discourse," *Journal of Advanced Nursing*, vol. 65, no. 3, pp. 616–624, 2009.
[34] C. I. Yang, W. P. Hsieh, L. H. Lee, and S. L. Chen, "Assault experiences: Lessons learned from mental health nurses in Taiwan," *International Journal of Mental Health Nursing*, vol. 25, no. 3, pp. 225–233, 2016.
[35] Lexico, "Violence," 2022, https://www.lexico.com/definition/violence.
[36] Lexico, "Acting out," 2022, https://www.lexico.com/definition/acting_out.
[37] D. Glaser, "Emotional abuse and neglect (psychological maltreatment): a conceptual framework," *Child Abuse and Neglect*, vol. 26, no. 6-7, pp. 697–714, 2002.
[38] P. Broeder, "Informed communication in high context and low context cultures," *Journal of Education, Innovation, and Communication*, vol. 1, no. 3, 2021.
[39] J. Oates, A. Topping, I. Ezhova, E. Wadey, and A. Marie Rafferty, "An integrative review of nursing staff experiences in high secure forensic mental health settings: implications for

recruitment and retention strategies," *Journal of Advanced Nursing*, vol. 76, no. 11, pp. 2897–2908, 2020.

[40] G. d'Ettorre, V. Pellicani, M. Mazzotta, and A. Vullo, "Preventing and managing workplace violence against healthcare workers in Emergency Departments," *Acta Biomedica Atenei Parmensis*, vol. 89, no. 4-S, pp. 28–36, 2018.

[41] B. Llor-Esteban, M. Sánchez-Muñoz, J. A. Ruiz-Hernández, and J. A. Jiménez-Barbero, "User violence towards nursing professionals in mental health services and emergency units," *The European Journal of Psychology Applied to Legal Context*, vol. 9, no. 1, pp. 33–40, 2017.