EXPERIENCES OF WORKPLACE VIOLENCE AMONG MENTAL HEALTH CARE WORKERS

A QUALITATIVE STUDY OF VIOLENCE FROM THE PERSPECTIVE OF CARE PROFESSIONALS

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Violence and threats of violence is described as a common and relevant issue in various care units. Mental health care workers often feel frustrated and unsatisfied in their work with mentally ill patients. Experienced mental health care workers find that learning how to treat and cope with violent patients is beneficial. The aim of this study was to gain knowledge and understanding of mental health care workers experiences and perspectives on workplace violence. The method used was qualitative semi-structured interviews with mental health care workers of different care facilities. The results found that the patients' illness appear to be the source of the violence. The environment can also be a source of violence. Violence was common in caring situations, particularly when mental health care workers were physically close to their patients. The mental health care workers experienced feelings of anger, humiliation, remorse, and helplessness. The participants expressed that they questioned their own abilities and at times believed that their ability to communicate with patients and relax them was inadequate. Colleagues, relatives, and friends were perceived to be the most supportive, and the most common way of coping with violence in the workplace. Furthermore, the conclusion of the study is that the environment must be adjusted to meet the needs of the mental health care workers in meetings with threatful and violent patients. Mental health care workers need education and guidance on how to proceed as well as encouragement to report violent incidents.

Keywords: Health care workers, mental illness, patients, violence, workplace

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Introduction

> *"I do not experience it as anger towards me, if you think like that you cannot work at a job like this, you know? If you feel that it is aimed at you then it will be very difficult for you. If you are going to work with people who have mental problems you must understand that it is not directed at you, but it is their disease that makes them so that they become such. Sure, sometimes it can be that the chemistry does not match between some people and so on, it can be the tone of your voice or bad communication that triggers them. But they are not all gone as you say, their short-term memory is often not clear but they still talk and have a certain understanding for some moments. But at the same time, anything can irritate them and become a trigger for a violent outburst."*

- Blanka

Work plays a major role in societies where employment is considered to be the norm. It has been established that work has several benefits. However, when the workplace becomes a "toxic" or "unsafe" environment, job tenure becomes a complex problem, for instance when a worker is the victim of workplace violence. Violence at the workplace has been described as a significant and growing issue in the field of health care. The health care sector accounts for six out of ten reports of workplace violence or threats (Nordin, 1998). In his report, Nordin (1998) discusses the prevalence of violence and threats. He discovered that over a third of caregivers of mentally ill patients believed they had an increased risk of being exposed to violence at work in the previous five years, and that two-thirds of mental health care workers had been exposed to violence or threats at work in the previous twelve months.

The relationship between psychiatric illness and criminality, such as violence, has been a constant debate and research topic in the field of criminology. Over the past few decades there has been a renewed focus and media attention on the importance of good mental health during the covid-19 pandemic. A link between the factors of mental health and violence is significant for health care workers who can experience it as a daily occurrence. Though popular belief is that people with mental illness are more prone to commit acts of violence and aggression and that they are dangerous and "crazy" individuals as the media portrays them. An informational perspective from individuals who call them their patients, becomes of great relevance in our society and to the field of criminology as it can provide a useful insight into the conversation of safety in work environments. The discussion of safety at work piqued my curiosity and I found an interest to investigate the perspective of health care workers whose working life can be an arena for violence.

Violence in the workplace has grown since the 1970s to involve more than only bank and shop robberies. According to studies, the image of perpetrators and victims has changed and come to include new actors such as patients, nurses, and companies (Wikman, 2008). As a result, the shift is not just about wider concepts of what constitutes violence, but also about new groups that are identified as victims and perpetrators. Working conditions in the care professions, in particular, have increasingly been characterized as violent. It is fair to assume that this shift in attitude toward workplace violence has had repercussions on the problem's exposure in various types of statistics, including what people answer in victim surveys.

Christiansen (2005) has analyzed the increase in the self-reported exposure to occupational violence in Sweden's neighboring country Denmark. As society's attention to violence in working life has increased, he found changed attitudes among occupational groups and a changed pattern of reporting. Victim surveys show that the likelihood to report has increased in Denmark and that this increase is particularly large for work-related violence (Balvig & Kyvsgaard, 2006). Christiansen (2005) found in his study a connection between factors that have to do with well-being and exposure to violence. Workers who express that they are stressed, burnt out and exhausted, etc. are also to a greater extent exposed to violence (Jerre, 2009). The fact that most violent acts never come to the attention of the authorities characterized a significant portion of what occurs in the workplace. The more severe the act of violence is considered to be, and the weaker the relationship there is between the victim and offender, the higher is the trend to report (Jones, 2011).

Aim and research questions

The aim of this thesis is to gain knowledge and understanding of mental health care workers experiences and perspectives on workplace violence. To fulfill the aim, the following research questions were formulated:

- What experiences do mental health care workers have on workplace violence?
- How do health care workers cope with violence at their workplace?

Background

Literature

Previous research found that there are various reasons as to why exposure to violence in health care is significantly higher than in other occupations, as well as how mental health care workers have coped with being vulnerable for exposure to violence. In states of confusion and delusions, where the patient perceives situations incorrectly and feels attacked, as well as schizophrenia and borderline conditions characterized by anxiety and insecurity, acting out and violence can occur. In manic conditions, borderline can lead to aggression and threats, intoxication and other poisoning conditions, disorientation in organic psychoses, and developmental disorders and neurological diseases such as dementia and frontal lobe injuries (Cullberg, 2000: Lokensgard, 1997). Therefore, working with patients who have a psychiatric diagnosis can become a reason for higher likelihood of being exposed to violence.

Mental health care workers experienced anxiety, anger, fear, shame, and frustration, according to Ferns and Chojnacka (2005), who reported on incidents of violence and aggression against caregivers. There was also the perception that incidents were not worth reporting and that they were an unavoidable part of the job that had to be accepted. Regardless of which natural reactions are

encountered, it is critical to increase awareness and process them with colleagues in order to build appropriate reactions and behaviors (Lokensgard, 1997).

To be able to conduct an in-depth discussion on the topic of interest, the central terms have to be specified. There are several definitions for work-related violence. They often depend on the perspective that is used as the starting point for what is studied and can therefore vary in both qualitative and quantitative surveys (e.g. Åkerström 1993). Some include both verbal threats and physical violence. Others have a narrower definition and/or focus on whether there was an intent behind the action. According to the Swedish definition of work-related violence in the Swedish Work Environment Authority's (Arbetsmiljöverket) regulations on threats and violence in working life include: “Everything from murder to harassment in the form of threats via letter or telephone” (AFS 1993, p. 2,7). The International Labour Organization (ILO) defines threats and violence as:

> “Any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work.” (Chappell & Di Martino 2006, p. 30).

A contributing factor as to why it is difficult to find a precise definition for violence at work is the regard that different professional groups have dissimilar views on what is to be seen as threats and violence. Incidents of violence are also framed by a context, both *before* and *after*, which in turn affects what qualifies as violence (Chappell & Di Martino, 2006).

The various data materials available provide relatively consistent descriptions of developments over time. Although data differ in level, the trends are similar. During the 1990s, workplace-related violence increased, especially among women, according to survey and interview studies. The increase began as early as the mid-1980s and stopped in the early 2000s and then increased again. Incidents of violence against employees in health care, school and care today constitute a large part of the occupational violence that is reported to authorities or reported in victim surveys (Wikman, 2012).

The complexity behind the concept of violence at workplaces is one of the reasons why experiences by care professionals are of great significance when gathering information as they encounter it first hand with their patients. The mental health care worker’s knowledge becomes primary information when creating a contextual background and understanding of each patient’s case. Their ways of coping and approaching violence as a part of their work can provide intel for perception and awareness of how a workday can transpire.

Additionally, because the concept of violence has different meanings for different people and can vary depending on who commits the violence - a partner, patient, etcetera - the perception of what constitutes violence can vary over time (von Hofer, 2006). Factors that can affect whether an act of violence is reported to the authorities or not are the severity of the violence, the victim’s relationship to the perpetrator, whether it is financially profitable to make a report (possibility of compensation from insurance) and the general social norm (Wikman, 2012).

Åkerström (1997) has shown that workplaces can often be characterized by local cultures which in turn can have an impact on the probability to report. Meaning,

that what is perceived and defined as violence is also context-dependent, as the same type of incident can be perceived differently depending on who the victim is, the scene, and the perpetrator. Further, several professions that are particularly exposed to violence in their working life, experience that the encounter with violence is an everyday risk and a part of their working responsibility (Åkerström, 1993). This, in turn, suggests that many incidents of violence and threats are never registered, neither through police reporting nor incident reporting. The number probably varies between different care units. As stated, generally, incidents of severe violence are reported more often than less serious ones, and violence between strangers is reported more than violence between acquaintances (Brå 2008, Jones et. al 2011). Relationship to perpetrators is also a contributing factor to if incidents are reported or not. For care professionals, it is likely that the victim more rarely interprets the situation as a criminal incident. Thus, making it less likely that he/she would contact the police or even report the incident, as it is less probable that the care professional views themselves as a subject to violence in an investigation. This, then, adds to the factor of the violence being contextual as different natures of violence allow us to assume different dark figures between the types of violence since the concept of violence is labeled by the victim (Wikman, 2012).

Theoretical background

Researchers have shown that violence is regarded as an increasingly serious societal problem. A consequence of raised attention and a change in sensitivity to what is viewed as violence is that several events are perceived as reasonable to report to the authorities, which is then reflected in the increases in registered violence (Wikman, 2012).

The phenomenon of workplace violence is interpreted as an outcome or side effect of a patient's mental illness. Mental health care workers saw patients' mental illness as a clear reason for the aggressive behavior. In psychiatry, the mental health care workers referred to the patient's mental state and diagnosis as the explanation for the aggressiveness. Acute psychosis, paranoia, and other similar symptoms are mentioned as possible causes (Duxbury, 2002). In order to prevent inappropriate behavior, a strong emphasis must be placed on creating a safe and accepting environment. All patients, including those with a proclivity for aggression, should be treated with the utmost respect in both everyday interactions and the implementation of measures. Mental health care workers should be aware of the conditions that can lead to aggressive behavior. Furthermore, have knowledge of how to act in violent behavior situations, as well as practical arrangements to avoid harm (Lokensgard, 1997). To create a working environment of security and tolerance the factor of *stress* obtained by the workers has to be considered, as it has shown to have a prevalent role in how mental health care workers approach mentally ill patients as well as cope with becoming victims of their violence.

The role of stress and mental illness in violent activity and victimization has been studied to better understand why people with mental illnesses are more likely to be violent and victimized. This research is guided by the logic of the stress process model, the dominant approach to understanding the social patterns of psychological distress — more common, subclinical symptoms of anxiety and depression (Mirowsky & Ross, 2003). According to the theory, stress (or life strain) puts people at risk for mental illness, and stress is socially distributed, with

socioeconomic status, gender, age, and marital status all playing a role. Hiday (1995) was one of the first to propose a model that incorporates these ideas into the treatment of violence and severe mental illness. In her model, economic vulnerability not only puts people at risk for having mental illness symptoms but also puts them at risk for experiencing more stress and conflict as a result of the disadvantage that mental illness causes. Particularly in socially disorganized environments where violence is more prevalent, aggressive behavior becomes both an externalized expression of symptoms and a way of coping with conflict, fear, and goal-blockage.

The American equivalent of the Swedish Work Environment Authority (OSHA) has developed a typology that is often used in research on work-related violence. The typology that this research paper can be said to focus on is *client-related violence*. Client-related violence includes aggressive acts by consumers, clients, patients or their relatives against staff in care, or staff with a service function. Occupational groups who have regular interaction with their clients are the most vulnerable to abuse. The majority of Swedish studies on client-related abuse focuses on surveys of health care workers. However, it is not always from a criminological standpoint, but rather from a perspective of workplace or public health issues. Client-related violence is the typology that is most noticed by research overall (Wikman, 2010). This form of violence also includes *vicarious trauma*, which means a change in a worker's self that occurs as a result of empathic contact with mentally ill clients and their accounts of emotional events. Alternatively, this type of burnout symptoms can come from being exposed and/or taking part in other people's exposure to violence, e.g. police or care professionals.

Friedman (2006) states that patients with severe psychiatric illnesses, such as depression or bipolar disorder, were found to be two to three times more likely than people without such illnesses to be violent. In absolute terms, the lifetime prevalence of violence among people with serious mental illness was 16 percent, as compared with 7 percent among people without mental illness (Friedman, 2006). While not all forms of mental disorders are linked to violence - anxiety disorders e.g. does not appear to raise the risk - and although most individuals with schizophrenia, severe depression, or bipolar disorder do not engage in violent behavior, the existence of such a disorder is significantly associated with an increased risk of violence (Friedman, 2006). However, considering that psychiatric conditions occur to a greater extent in perpetrators of lethal violence than in the population, there are very few people with mental illness who commit these crimes. The annual 20–40 perpetrators with diagnosed mental illness can be compared to the more than 400,000 people who were cared for in psychiatric outpatient and/or inpatient care in 2017 (Brå, 2020). In other words, the majority of psychiatric patients do not have additional risk factors that, in addition to mental illness, are usually necessary to commit lethal violence. Mental illness in itself thus has, except in isolated cases, a low explanatory value in the case of lethal violence.

Methodology

The empirical data presented in this thesis was accumulated through semi-structured interviews with the informants, mental health care workers. Additionally, several hours have been spent going through various documents,

articles, and recordings to create a greater understanding of the guidelines associated with discussing mental health and to individuals who work within the health care specter. This section will focus on the methodology and the material that has been collected, including the methods used to find participants.

The collection of data, interviews, was carried out between April 2021 and May 2021. The interviews started with a briefing of what the researcher's intent with the interview is, as well as providing them with an opportunity to question or ventilate any potential thoughts about the project, as recommended by Spradley (1980). Conducting semi-structured interviews allows a greater possibility for acquiring data on a socially sensitive and to an extent stigmatized subject such as mental illness, as well as maintaining the secrecy the mental health care workers have to respect and uphold. Semi-structured interviews with flexible and open-ended questions allows for fewer biases. In other words, the chosen method gave a lesser chance of partiality since there is a smaller chance of the informant feeling forced or pressured into an expected answer or accommodating to the researcher's preconceptions. Thus enhancing the chance for a more in-depth and genuine answer.

Furthermore, to analyze the findings a thematic approach of analysis was adapted. In qualitative research, thematic analysis is a common method of analysis. Thematic analysis is a foundational method of analysis, according to Braun and Clarke (2006, p. 79), who define it as "a method for identifying, analyzing, and reporting patterns within data". Braun and Clarke (2006) describe a six-phase method, which includes an iterative and reflective process that develops over time and involves a constant moving back and forward between phases. After the material for this paper was accumulated, the process of identifying possible themes began. Through the processes of familiarizing with all of the acquired materials a few themes were found. However, in order to focus the study and to be able to answer the research questions the two following themes were decided to be utilized: 1. Workplace 2. Workers and their patient's.

Participants

The participants of this project consist of five mental health care workers, who have been recruited through friends that work in health care. The participants work in different care units such as hospitals, psychiatric wards, retirement homes, tending to different mentally ill patients. The majority of the informants are female, and the age span is between 24 – 55 years old. The participants were presented with an informational letter that explained and provided information about the aim and the course of action they would have to take if they wanted to participate. To register an interest in participating in the project, the mental health care workers would contact the researcher through email - where they would determine the time and place for the interview. Participation consisted of an interview of about 30 minutes where different questions regarding their work environment were discussed.

Anonymization played a key role in this project. To ensure that all participants' integrity was upkept, confidentiality was maintained, and that the informants felt secure in being able to share their experiences and thoughts, all personal information that is publicized was anonymized by giving the participants pseudonyms. The interviews were recorded with the participants' consent. Further, after publication the sensitive information was destroyed.

Limitations

Qualitative research that deals with semi-structured interviews often face different limitations. One is recall bias, which occurs when participants intentionally or unintentionally omit details of previous experiences. According to Spencer, Brassey and Mahtani (2017) “the accuracy and volume of memories may be influenced by subsequent events and experiences”. A second limitation of this study would be applicability. Meaning, that the conclusions drawn from this study cannot be applied or generalized for other health care systems. The information presented by the informants is individualistic and situational to them. What the provided information can do is provide insight on mental health care workers' experiences and their approach on how to cope with the small margin of mentally ill patients who are violent against them in the scene of their workplace.

Ethical considerations

For research involving individuals to be considered valid and credible, appropriate ethical considerations have to be applied when acquiring information. Anonymity, voluntary participation, informed consent, right to withdraw, etcetera, are all a part of upholding ethical measures when approaching informants. The informational letter included information about the study’s purpose, aim, procedure as well as confirmation that all of the collected data will be kept in confidentiality and later destroyed when the project has ended. This was to ensure that the informants would be aware of all the steps in the study and emphasize that participation is voluntary. This study involves and addresses the work lives of mental health care workers, for that reason, correct ethics are of great importance in this study. The project has been approved by the Malmö University Ethics councils as it deals with participants' health, which could be a possible ethical issue. However, since the correct means have been taken into account and followed, as mentioned above, the study was able to proceed and take place.

Results

In this section the results from the conducted semi-structured interviews will be examined and presented thematically to uphold clarity and distinctness. The themes are 1. Workplace 2. Workers and their patients. The section regarding the workplace will present how different health care sectors manage and use their resources to guide the care professional to cope with violence. The segment of workers and their patients will focus on how different diagnoses of patients can result in a variation of how the health care workers both approach and experience violence in regard to the patient’s mental health.

What experiences do mental health care workers have on workplace violence?

Theme 1: Workplace

Occupational threats and violence occur to a varying extent among different occupational groups. Since workplace violence is concentrated in a few professional classes, the vast majority of employees face a relatively low risk of

being subjected to violence or threats at work. According to the Work Environment Survey (Arbetsmiljöundersökningen), almost half of all police officers, nurses, and caretakers are exposed to violence or threats of violence within a year (Wikman, 2012). The degree of vulnerability is determined in part by the health care sectors targeted and in part by the surveys used. This section will contextualise experiences of workplace violence among health care workers within the framework of the first theme “Workplace”, as a tool for thematic analysis.

Health care workers’ workload appears to vary greatly depending on several variables, such as staffing, medication, work shifts, and the number of patients present, according to the participants. However, the prevalence of stress shows to be a constant regardless of those mentioned variables. Though the care professionals express a contentedness and a feeling of safety in their workplace, they do highlight the difficulty of “always being prepared for the worst” as an anxious burden in their work. Despite the constant concern of not knowing what they have to encounter when they step into a patient’s room, the health care workers accept that vulnerability as they view it as a part of their profession.

In contrast to other communities, those employed in health care, education, and care had a worsening work atmosphere during the 1990s, according to Bäckman (2001). The risk of workplace violence may have arisen as a result of job reductions and institution closures, as well as increased pressure on workers. This understanding is supported by the fact that the increased sensitivity to violence or threats at work can be traced mostly to groups that experienced worse work environment growth than others during the 1990s (Wikman, 2012). Increased exposure to unfavorable working environments may reduce the tolerance for additional workplace stressors like threats or violence. Where such a working environment occurs, this reduction in intolerance will lead to an increase in the tendency to report. It is possible that, as a result of increased sensitivity and as a result of negative working environments, more incidents would be viewed as hostile or as undue aggression than previously.

The study found that communication is a big part of the mental health care workers work and is one of the staff's most important tools for managing certain situations. Having experience of feeling inadequate in their communicative ability and not having control over the situation feels like a great burden for all staff. One informant explains:

> *Sometimes we have situations with patients who are not allowed to go out. Then they can stand and bang on the door "how the hell are you going to solve this?" you think to yourself then. It usually works to talk to them to make them realize the situation. But, it takes a while to understand how to reach your patients and make them calm and understand that violence is not the answer because everyone is different.*

- Matea

According to a study about the evolution of violence-related work environment conditions (Jerre, 2009), women report being more frequently subjected to work environment conditions linked to a higher risk of violence, such as interaction with clients with serious issues, working alone, and a high workload. This could also be found in this study. Although the majority of the participants were women, they believed that most of the patients did not act in violent manners towards the men on their staff as they did towards their fellow female co-workers. The

proportion of people who say they have been subjected to workplace abuse has been that since the 1990s, long before working conditions deteriorated. As a result, according to Jerre (2009), any improvements in the working environment alone cannot account for the rise in workplace violence recorded in various sources of data. Several reasons, therefore, seem rational and, in some cases, compensatory for understanding why more people claim to have been exposed to workplace abuse.

While it can be assumed that mentally ill criminal offenders commit crimes as a result of, or because of their mental disorder, new research has found that only about a fifth of criminal behavior is partially or entirely linked to mental health symptoms (Peterson, 2014). Between 1988 and 2000, a study in Sweden looked at 98,082 people who were released from a hospital with a diagnosis of serious mental illness (psychotic disorder, bipolar disorder, and depression with psychosis) to see how it affected violent crime (Fazel & Grann, 2006). During that time period 6.6 percent of people diagnosed with serious mental illness were convicted of a violent crime, compared to 1.8 percent of people without a diagnosis of severe mental illness who were convicted of a violent crime (Fazel & Grann, 2006).

Aggression can be expressed openly and directly but also indirectly. It can be expressed through silence and passivity as much as words and deeds. Aggression can be directed toward oneself, other people, or more impersonal objects like society or the "system" by a person. It can be painful and humiliating to be reprimanded and threatened by a patient. When confronted with aggressiveness, care personnel may feel disappointed in their own lack of self-control and professionalism, to name a few sentiments and reactions. Experiencing this type of empathic contact violence is not necessarily common for the health care workers, though still exists to a high degree according to the informants. Being subjected to threats by a member of the patient's family is not uncommon in the health care sector either, an informant said:

> *Families often have a hard time accepting the fact that they themselves cannot take care of their close ones. And then they feel as if nothing is good enough. They take out their disappointment and anger on others, which for the most part is us, the people who take care of their family members and their every need, every day. They can yell threats and demand things from me that are not a part of my job. I almost always feel uncomfortable when they come to visit.*

- Bianca

The broad variations in the degree of violence based on the different data sources indicate the significance of the meaning and context for the victims' interpretation of what constitutes workplace violence. This is illustrated by the quote, as the informant expresses a severe discomfort and exposure to threats but does not necessarily classify it as violence. The issue of context also becomes evident during survey data, as the questions regarding exposure to violence in the Survey of Living Conditions (ULF), the National Safety Survey (NTU), and the Work Environment Survey and Brå are all worded similarly. However, when Brå performs the study, past experiences seem to become more apparent, perhaps because many respondents do not consider the violence they are subjected to at work to be criminal violence. On the other hand, if the provider is the Swedish Work Environment Authority, many more claim to have been subjected to violence in the previous year. As a result, when violence is seen through the lens

of the workplace, more violence is apparent than when viewed through the lens of crime (Wikman, 2012).

Occupational violence in health care, education, and care sectors accounts for a substantial portion of the occupational violence reported to authorities or reported in victim surveys. The empirical evidence is still limited, for example, concerning the reporting routines of different professions. Whether the rise indicates that vulnerable individuals are exposed or whether it is due to an increased awareness of the problem and a broader understanding of violence is not entirely clear. Employees' propensity to make negative aspects of their work environment may have been influenced by increased exposure to violence and threats from labor unions, past experiences, or other circumstances. The shift would most likely be due to changes in the work climate, rather than just an increased proclivity to report.

The study found that there are several and different experiences of workplace violence. According to the mental health care workers, the patient’s illness appeared to be the source of violence. Violence was common in situations where care was given and when mental health care workers were physically close to their patients, in particular in intimate and vulnerable circumstances. This could e.g. be situations where the patient would visit the bathroom or need help with personal hygiene. Such incidents with violence often caused the mental health care workers to experience feelings of anger, humiliation, remorse and helplessness.

How do mental health care workers cope with violence at their workplace?

Theme 2: Workers and their patients

According to Fazel and Grann (2006) 1 in every 20 violent crimes were committed by people who have a severe mental illness. The mental health care workers have called for more support after incidents with aggressive and violent elements. There is a scarcity in this area throughout (Badgar & Mullan, 2003; Duxbury, 2002; O'Brien & Cole, 2004). Research about severe symptoms of mental illness and violence has presented mixed results of the ways in which mental health care workers cope with violence at their workplace. Depending on the study, questionnaire, and location different results could be shown regarding a probable association with a higher risk of violent behavior and mental illness. The following chapter will explore how mental health care workers cope with violence at their workplace through the theme “Workers and their patients”.

Since the informants work in different sectors of health care, both hospital, and care residence, a distinction could be made about the different workplace’s way of action when it came to guidance on how their employees can cope with workplace stressors such as violence. Informants working in hospital settings generally had more resources in the sense of staff present during different work shifts. In general, there are half as many employees as patients in hospitals, which is a contrast to the care residencies where there would be at most two workers taking care of up to 14 patients. As well as a distinction in the staff versus patient ratio, the different workplaces had dissimilar approaches on what takes place after a violent incident has occurred between a staff member and a patient. Informants

working in hospitals explained how there are several steps of briefing and debriefing with both chiefs and coworkers, whilst the care residence informants would for the most part resolve the incident solely with their supervisor or chief and not other coworkers.

For the care residence informants, private relationships were perceived to be the most supportive. Finding support in them was thus the most common way for residence informants to cope with situations of violence in the workplace. The presented contrast between the ways of coping with workplace violence in the informants, supports the implication that violence in the context of the workplace is formable and conditional to the individuals and the workplace's perception of what categorizes as (criminal) violence. Health care workers' views and experiences of coping with violent events were illustrated in a report by Chambers (1998), where the health care workers expressed disappointment with the management. They felt that they had to persist and fend for themselves. There was also a sense of desperation and a belief that talking to their supervisors would not help. According to studies, health care workers are lacking information about what assistance the employer should provide for coping with threatening and violent events and recovering from them (Badgar & Mullan, 2003; O'Conell, 2000).

To deal with the reactions that followed aggressive and violent occurrences, the mental health care workers employed a variety of tactics, some of which were more effective than others. When it comes to the less effective tactics, additional attention and assistance from management may be able to reduce the negative repercussions. When it comes to quality development and workplace difficulties, these considerations appear to be critical. To deal with the unpleasant, humor was adopted. In the aftermath of incidents, humor became a technique of expressing uncomfortable emotions. The personnel chuckled and joked about various made-up protection equipment they should use when in contact with particular patients, for example. Because there was a desire to remain in their field, the mental health care workers believed it was critical to understand how to handle these occurrences. Taking what had occured personally was not an alternative for the mental health care workers. The positive emotions felt when making good connections with patients were used to balance out the negative. Patients who expressed regret for their actions were seen as positive and helpful in their recovery.

While violent events in healthcare environments are fairly infrequent, they still occur, in differing ways and aspects. Since violence is a notion that is perceived differently, a victim's idea of the concept becomes essential to the likelihood of the incident being reported. When the offender is an individual with mental health issues under the victim's care, it can become difficult to view the incident from a criminological standpoint. An example of this is highlighted by one of the informants, who explains:

> Patients can form a special bond or attachment to a specific staff member. They feel safe around them and therefore want their constant attention and presence. This can in turn become very complicated and challenging for the caretaker. We have had situations where the care professional has become worn out and burnout because of these situations. Because the patient decides on one person as a kind of contact person for them. Which puts a burdensome challenge on their work responsibilities.
>
> \- Mateo

Analysing the results from the study, mental health care workers appear to cope with violence in the workplace differently depending on the character of the workplace. Mental health care workers employed in hospitals emphasized the prevalence of a more distinct code of conduct for coping with their experiences of violence. Mental health care workers employed in care residencies, on the other hand, expressed that they relied on the support of colleagues, relatives and friends to cope with workplace violence. The informants called for further education and guidance on how to proceed with patients who are inclined to violence, as well as encouragement to report violent incidents. Informants however also expressed that learning how to approach violent patients could be beneficial for coping with violence at their workplaces.

Discussion

The aim of this paper was to study mental health care workers' experiences and perspectives on workplace violence. The conducted semi- structured interviews have provided the study with revealing and descriptive information about the health care sector as a place of work and how the notion of violence is perceived by the workers. The knowledge gained concurs with the results found in previous research on the topic. The study provides a small-scale impression of the investigated research field, that is why the results from this study should be interpreted with caution. Two research questions were established at the beginning of this paper and they have been answered in the result section. The following segment will discuss the acquired results.

Result discussion

The study showed that there were various forms of violence, both physical and verbal, and that their frequency differed. Patients' illnesses and the environment were seen as primary causes for violent occurrences. Aggression and violence were mostly common in intimate patient work. Aggression, fear, frustration, and shame were among the various emotional responses among mental health care workers. The staff felt both empathy and antipathy towards the patients. Conversations were mostly used to deal with violent patients, but restraints such as removal from the scene or belting were also used according to the informants. The workers used a variety of tactics to deal with the situation. Humor and casual interactions were seen as effective tactics. Colleagues, friends, and family were the primary sources of support for the mental health care workers. Some mental health care workers expressed that the employers did not provide them with adequate resources, instruction, or training on how to cope with violence in their workplace.

Occupational violence in health care, education, and care sectors accounts for a substantial portion of the occupational violence reported to authorities or reported in victim surveys. The empirical evidence is still limited, for example, concerning the reporting routines of different professions. Whether the rise indicates that vulnerable individuals are exposed or whether it is due to an increased awareness of the problem and a broader understanding of violence is not entirely clear. Employees' propensity to make negative claims about their work environment may have been influenced by increased exposure to violence and threats from

labor unions, past experiences, or other circumstances. The shift would most likely be due to changes in the work climate, rather than just an increased proclivity to report.

The majority of mental health professionals believed that they required more training in various fields in order to properly manage situations. Self-defense, dispute resolution, managing harassment and verbal abuse, reporting events, and paying attention to threats were all things that needed to be learned. Incoherence to the studies presented in the background, the staff wanted to learn more about the elderly patients with dementia, discussions about roles, boundaries, and ethics. The workers felt that they had a responsibility for their professional development and that they wanted to communicate training needs to their managers.

The results found through this research paper are consistent with the studies found when researching the existing studies in the field of interest. As Friedman (2006) has found, the patients with severe psychiatric illnesses such as bipolar disorder, dementia, schizophrenia, and severe depression had been found to be more significantly associated with an increased risk of violence by the care professionals. Additionally, the remarks made by Wikman (2008) about how violence in the workplace had been on an increasing curve, was also acknowledged by the care professionals who had worked in the health care sectors for a longer time. The reason why this was a conflicting question for the informants, was because they could not pinpoint a specific reason as to why there has been an increase of violence in their workplace over time. However, they did recognize that the study of mental health is a constantly evolving science, and that their own perception of what they themselves consider to be an act of violence also has changed over time - that they "stand up more for themselves" than what they believed that they did in the beginning of their career. This assumption would also be compatible with the existing studies which address the wider concept of what constitutes as violence, and more specifically violence in a workplace environment has changed and become more evident for some. Though, it is still important to note that the mental health care workers still hold different definitions of work-related violence. Despite the Swedish Work Environment Authority's definition of regulations on threats and violence in the working life.

Through the theory of stress and the stress process model, a dominant approach to understanding the social patterns of psychological distress, present in most of the mental illnesses, was enabled to analyze the findings of the paper Mirowsky & Ross, 2003). The results were in unison with the theory's view of stress (or life strain) putting people at risk for mental illness, as well as stress having a socially distributing factor which could also play a role in the patient's mental health, and therefore its actions towards the mental health care workers (Hiday, 1995). By examining the results of the already accepted knowledge by researchers and the results of this study, an interpretation of the research questions could be evaluated. To implement this theory on workplace violence and improve the circumstances the different sectors of care would have to secure a risk analysis to find right measures based on their specific necessities, to improve the insufficient and sufficient factors present in the workplace. By doing so, the workers' ways of coping with experiences with violence and their workplace would have an increased chance of progress and advance. Without a job-specific study, there's a chance that measures to repair things that aren't functional will be implemented, and underlying causes like a stressful work environment, rather than unstable

patients, will be viewed as the cause for the violence (Paterson, 2009; Jones, 2011).

Method discussion

Since a qualitative approach would include more accurate details to illustrate a complicated problem, it was chosen to conduct this study. Furthermore, there have already been a number of articles published in this field, implying that grasping all types of knowledge would take a significant amount of time. As a result, the qualitative approach proved to be a cost-effective data collection method, as it offered a significant amount of informational data during the ten-week writing period. If the databases or informants chosen had been different, the outcome may have been different.

The semi-structured interviews were of great importance in order to find answers for the research questions. They provided insight from the standpoint of the caregivers on both the issues and possible ways of finding and accomplishing improvements for both the workers and their patients which is a significant strength for applying this method. However, there is a possibility that different participants in different care units would not express or share the same thoughts and emotions as the participants of this study, which is an important factor to consider.

Articles were chosen based on previously established inclusion and exclusion criteria, but due to the vast number of articles available, the scope of the analysis was determined by the thematic approach to answering the research questions. A different decision may have an effect on the outcome. Restrictions were imposed in order to keep the study's aim and research questions in focus. This is a strength since the content only applies to a specific patient group. Other forms of violent and aggressive interactions can become apparent with a different choice of restraints.

Selected articles as material had a fair and transparent explanation of their method and selection, as well as an ethical justification for, among other things, maintaining privacy and ensuring the reliability of results. Before carrying out this research, it's possible that a more critical mindset could have been adopted. The aim, method, selection, analysis, validity, reliability, omission, and possibility of generalization were all examined in all articles, which is seen as a strength for the qualitative study's findings. Regardless to which professional group the respondents in the studies belong to, the findings refer to them as mental health care workers. Perhaps a more precise definition could have been provided. The decision to write in this manner was based on the belief that most experiences are similar regardless of the current professional category. Articles were chosen from various countries, which can be both a strength and a weakness, as discussed in the later section addressing the limitations of the study and the utilized methods.

Meetings in health care were decided to be defined in both psychiatric hospitals and care residents. The decision was made based on the belief that both specializations of mental health care workers encounter hostile and violent patients. This also made it possible to provide a wider range of research.

Differences between specialties are poorly defined with this method, but as it was not the aim of the study, this was disregarded. The author read and translated the articles in order to ensure that the overall image was viewed equally. This strategy seemed necessary in order to strengthen the credibility of the results. The material was accumulated in such a way that the content of the articles provided suggestions for how the material could be categorized, increasing the reliability of the results' design.

The limitations with this study must be considered. While the study is a small-scale interpretation of a selected five care professionals, the few informants may or may not be representative for other places of health care sectors. Cultural differences may place a role in the analysis of workplace violence (van Londen, 1990). Articles for the study were chosen from various parts of the world, which can be both a strength and a weakness. A strength because it impacts a large number of health care workers around the world, but a limitation because people perceive and describe emotions and perceptions differently depending on their background. It can also be noted that the majority of the respondents are women, which in turn can affect the experiences of violence. This is however difficult to avoid as there are significantly more women working in the care professions.

Additionally, because the interviews were conducted through the video communications tool Zoom, the setting for which the interviews were held in were not the most natural or controlled and could have possible effects on the informant's comfort and confidence in the researcher. Causing a possibility of the informant altering or omitting information during the interview. Semi-structured interviews have a great advantage to let the informant express themselves more freely. However, it can also be a hindrance for the researcher, as open-ended questions are difficult to analyze and compare.

During the interviews, the primary emphasis was on the informant. I would periodically glance at the computer to remind myself of any questions I had forgotten; otherwise, I would not utilize or take notes on the computer. To completely grasp the observations I made and include them in the transcriptions of the interviews, I would record the interviews and then quickly type out a review of the major distinguishing aspect of the interview as soon as the interview had been conducted. The informants would occasionally lose their train of thought or start discussing different aspects or experiences about their workplace that were not related to the questions asked to them. This became a challenge for the interviews, as I had to find follow-up questions, in order to steer the informants back to the primary questions, without jeopardizing the flow of the interview or the informants' comfortability. The short time spent with the informants had to be cost-efficient so that as much information as possible could be obtained. This could also be seen as a limitation with the interviews, as more interviews with the informants could be of great importance for acquiring further substantial and informative data for the study.

These limitations are reasons why the results for the study should be interpreted with caution, as the results are cultural and individual specific for this study's informants.

Conclusion

This study was able to meet its main purpose: to understand mental health care workers' experiences and perspectives on workplace violence. The conclusions show that education and formal interactions, such as guidance and reflection on experiences, are critical. Because the findings demonstrate that mental health care workers understand the reasons of aggression as internal variables that interact with a variety of external elements such as treatment, communication, and the environment, it is believed that more research in this area is necessary in order to view violence in the field of a workplace from the criminological standpoint. This study's findings cannot be generalized on the account of the small pool of informants. The tolerance for violence and the propensity to report varies between different occupational groups and situations, as stated previously (Stanko, 2003). Wikman (2012) states "before an action is implemented, one should ask the questions for what problem is this a solution to". Therefore, the most beneficial approach to improving the circumstances would be for the sectors of care to make a risk analysis and find measures based on their specific content and employee's needs. To secure the mental health care workers' ways of coping with violence at their workplace to progress and advance. Without a work-specific analysis, there is a risk that initiatives to improve things that are not "broken" would occur, and underlying factors such as it being a stressful work environment rather than turbulent patients that cause the violence.

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