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The aggressive patient experiences of healthcare professionals exposed to physical violence in a psychiatric clinic: A phenomenological study*

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Abstract

Purpose: This study investigated the experiences of healthcare professionals, exposed to physical violence, related to aggressive patients at a psychiatry service.

Design and Methods: The qualitative study sample consisted of a total of 21 healthcare professionals. The data were collected through in-depth interviews. An inductive qualitative content analysis was used to analyze the data.

Findings: Three themes, the effects of warning signs of violence, clinical management of violence, and effects of violence, and 13 sub-themes were determined.

Practice Implications: The effects of physical violence on healthcare professionals can be seen and will contribute to planning in this regard.

KEYWORDS

aggressive patient, experiences of healthcare professionals, physical violence, violence in psychiatry

1 | INTRODUCTION

Violence is a behavior that is highly frequently observed in psychiatry services. Violent behavior, which may emerge verbally or physically, may lead to highly serious outcomes in the service environment.[1] Prevention and control of this destructive behavior that the person directs to themselves or their environment and elimination of its effects are the responsibility of the healthcare worker (doctor, nurse, and assistive healthcare personnel).[2] Healthcare workers who are in direct contact with patients who have a tendency towards violence and those that take part in aggressive behaviors are at risk in terms of exposure to violence.[3] A large proportion of individuals working in psychiatry services are exposed to violence at least once in their lives.[4] A study conducted in the United States determined that 40% of psychiatric doctors in the sample had been subjected to violence.[5] Another study conducted with 1534 mental health personnel in the Netherlands revealed that 67% of the participants had been subjected to physical violence at least once, and they collectively experienced 2648 violent events in total.[6] A conducted study with 1906 psychiatric nurses discovered that the one-year prevalence of verbal and/or physical workplace violence was 84.2%[7]

Being subjected to physical assault may mentally, physically, and cognitively affect personnel.[8] As a consequence of this effect, the job satisfaction of healthcare workers decreases,[9] their clinical functioning may be disrupted, their interaction with the patient may be disrupted, and the quality of the service provided may decrease.[10] A longitudinal study revealed that, among healthcare workers subjected to violence, negative thoughts about their workplace increased throughout the year following the incident of violence.[8] Studies showing that posttraumatic stress disorder is seen more in nurses subjected to violence,[11] anxiety, and depression symptoms are observed, fear, anger, and distraction are experienced.[12] Additionally, concerning physical violence, in healthcare workers, wounds, tissue injuries, organ losses, physical pain, and even death may be

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encountered.[13] In addition to negatively affecting patients and employees negatively, physical violence also negatively affects the physical and social structure of the working environment. Personnel working at psychiatry services are responsible for establishing, preserving, and achieving the continuity of the therapeutic environment, as well as restructuring it if necessary.[2] If personnel who are negatively affected by violence do not have enough well-being to re-establish the therapeutic environment, safe service environments may be severely damaged.[14] Effective management of the violence in the service environment is influenced by the experiences, perceptions, and views of mental health employees, such as physical and chemical restraint, the persuasion method, and similar practices are preferred in the clinical management of violence.[15]

There are several studies on the topic of violence encountered in psychiatry services. Looking at these studies, it is seen that mostly topics, such as the frequency of violence, its type, characteristics of patients displaying violence, and management of violence have been investigated.[1,4,6,16] Individuals working at psychiatry services are constantly exposed to violent behaviors either directly by experiencing violence themselves or indirectly by witnessing it being directed to someone else.[16] Despite this, there are not enough studies on what healthcare workers working at psychiatry services experience with regard to this physical violence they are subjected to, how they feel and how they are affected. This phenomenological study was planned to have an in-depth understanding of and assess the experiences of employees working at psychiatry clinics who have been subjected to physical violence about aggressive patients. In this study, how the personnel working in the field are affected, how individuals make sense of the violence they have experienced, and how they interpret it are discussed.

2 | DESIGN AND METHOD

2.1 | Design and participants

This study aimed to examine the aggressive patient-related experiences of healthcare workers working in psychiatry services and exposed to physical violence. To achieve this objective, a qualitative method with a phenomenological design was utilized. This way, it was aimed to reveal the main characteristics common in the essence and structure of the experiences of healthcare workers who were subjected to physical violence and the meanings they attached to their experiences.

The research was conducted with personnel working in the psychiatry department in a training and research hospital. It is a clinic where all types of psychiatric diseases are treated. This service has 123-bed and consists of 4 independent parts.

Criterion sampling, which is a probabilistic sampling method, was used. Being a healthcare professional, exposed to physical violence in the last 1 year was determined as the sampling criterion. Individuals meeting these criteria were included in this study. Data collection was continued until data saturation was reached. In this context, data collection was terminated with 21 people when the data started to repeat.

2.2 | Procedure

The self-reports of healthcare professionals, who were exposed to physical violence in the previous year were determined. Considering the frequency of violence, a year period was considered appropriate in terms of reaching the sample. Then, the participants meeting the criteria were informed about the research and voluntary consent was obtained. Interviews were conducted in the interview room of the clinic by experienced researchers trained in qualitative research (DA, NM). The meeting room is a part of the service that is planned for individual or group meetings with patients and their relatives. There were four meeting rooms. During the interviews, the study was prevented from being divided by the warning that there was a meeting on the door. The interviews progressed by asking the personnel who experienced more than one violence about their most recent experience.

2.3 | Measures

The data of the study were collected through in-depth interviews. The data of the study were collected using the sociodemographic Information Form on the individual characteristics of the participants and the Semi-structured interview form. These interviews were conducted on the latest incidents of violence experienced by healthcare workers. The interviews were conducted by a researcher and an observer. To record the data, an audio recording device was used to obtain consent from the participants. Points that were considered highly important were also noted in writing, and each interview took approximately 30–45 min. The aforementioned questions were directed to the participants in a given order. The audio recordings were listened to, and the data were transcribed into a Microsoft Word document. The written documents were checked by the researchers by repeatedly listening to the audio recordings.

2.3.1 | Sociodemographic information form

This form which was created by the researchers by utilizing the literature consisted of 10 questions. This form questioned demographic information, such as age, gender, occupation, and education status, as well as the history of being subjected to physical or verbal violence and having received training on the topic.

2.3.2 | Semi-structured interview form

This form which was prepared by the researchers in line with the literature included four questions. The questions were as follows:

1. What is your physical violence experience inflicted by a patient?
2. What were your physical environment, emotions, thoughts, behaviors, and bodily senses before physical violence?

3. What were your physical environment, emotions, thoughts, behaviors, and bodily senses during physical violence?
4. What were your physical environment, emotions, thoughts, behaviors, and bodily senses after physical violence?

2.4 | Data analysis

To analyze of the data, to form the themes and categories of the study, an inductive qualitative content analysis method was used. The steps to be followed for content analysis were supported by the literature.[17,18] In the content analysis, the data obtained through the interviews were coded first. Afterward, the themes and categories of each theme were determined. Subsequently, the categories and themes were reviewed and defined. Finally, the analysis was completed by interpreting the findings.

Validity and reliability of the study: In the qualitative process, to achieve validity and reliability, credibility, trustworthiness, transferability, confirmability, and invariance were taken as a basis.[19–21] For the data collected in the study to reflect reality and be objectively observed, the data were examined by all researchers. This procedure contributed to the credibility of the research results. Two of the researchers had at least five years of experience at the clinic where the study was conducted, as well as observations regarding the issue. This experience contributed to achieving the trustworthiness of the study. The transferability step was followed for the results of the study to be generalizable to similar environments. Explanations regarding the method, process, and results of this study were transferred to the reader in a comprehensible and detailed manner at this stage. To achieve confirmability, the elements taken as a basis in grouping the findings were shared, and quotes that directed the researchers to the finding were shared. Additionally, the audio recordings, data collection forms, and analyzed data of the study were kept. For the collected data to reflect reality and contribute to the validity of the research results, all researchers took part in the stage of analysis. To achieve invariance, the analysis was repeated by the researchers after a month. The researchers questioned the expert knowledge of the topic of the study with a critical perspective by conducting a literature review. As a result, coding of the data, theme, and category definition and interpretation were carried out based on the principles of validity and reliability.

2.5 | Ethical aspect of the study

This study was conducted in compliance with the ethical principles of the Declaration of Helsinki, and the verbal and written consent of the participants was obtained. In addition to this, the study was found to be ethically appropriate by the decision numbered 18/279 of a university's Non-Interventional Research Ethics Committee in the meeting dated December 21, 2018, and numbered 13.

3 | FINDINGS

The study included a total of 21 healthcare workers who worked at the psychiatry service and were subjected to physical violence. Among these, 38.1% were nurses, 23.8% were doctors, and 38.1% were assistive care personnel. 66.7% of the participants stated that they were also previously subjected to physical violence at the service, and 95% said they were subjected to verbal violence. Additionally, the data collected as a result of the conducted interviews were assessed before the event, during the event, and after the event. The first theme of the effects of warning signs of violence consisted of three categories such as uncertainty, fear, and concern, and wanting to take control. The second theme of clinical management of violence consisted of four categories such as helplessness, protecting self, physical/chemical restraint, and persuading the patient. The final theme of the effects of violence consisted of seven categories such as sadness, anger, and fear, location change, reduction in interaction, tissue injuries and pain, normalization/getting used to, stigma and restructuring of the therapeutic environment (Table 1). Additionally, the statements of the participants concerning these themes and categories were coded and added to this section. The participants were coded as Participant (P), doctor (D), nurse (N), and assistive care personnel (C).

3.1 | Effects of warning signs of violence

In the analysis of the study, it was revealed that the participants noticed some warning signs of violence before being subjected to violence. In the interviews, it was learned that, when the participants noticed these signs, they experienced uncertainty, and this uncertainty led to fear and concern. Additionally, in the statements of the participants, they wanted to take control into their hands. The statements of three participants regarding this theme and these categories are presented below (Table 2).

TABLE 1 Themes and categories created as a result of the interviews

Themes	Categories
Effects of warning signs of violence	Uncertainty
	Fear and Concern
	Wanting to take control
Clinical management of violence	Helplessness
	Protecting self
	Physical/chemical restraint
	Persuading the patient
Effects of violence	Sadness, anger, and fear
	Location change
	Tissue injuries and pain
	Normalization/getting used to
	Stigma
	Restructuring of the therapeutic environment

TABLE 2 Categories and participant statements in the effects of warning signs of violence theme

Uncertainty
"The injection time came up. I went to the patient's room to inform them. C.F. was in their room and hitting their mother. They were shouting. They were hitting their own head with a slipper, and additionally, hitting their head on the wall. When I saw this, I thought 'I wonder what will happen to me now'. I started to be afraid." P18, C
Fear and concern
"I don't remember my emotions before the event much. I did not experience feelings like anger, happiness, sorrow, etc. Mmh, I guess, I had fear". P3, D
"I noticed that the patient was agitated, and I was concerned by thinking of the potential negative consequences of this. More could have happened. The patient could have harmed themselves or others and escape from the clinic." P20, N
Wanting to take control
"The patient was inflicting violence upon the relative of another patient. Of course, I also experienced tachycardia when I saw this. I experienced tension. Tension, stress, discomfort… My emotions also got confused there. I needed to take control of my emotions and the situation. I became stressed and started to think what I should do then. I firstly needed to protect the patient relative that the patient was assaulting, I would inform the doctor on call, the doctor on call would inform me about the treatment needed then. We are trying to coordinate everything at the same time. You try to think of several things at the same time." P8, N
"Again, the situation did not calm down. I decided to go to the environment where the patient was. At the same time, I am giving instructions to caretakers. …because the event could turn into a collective event, or the number of people harmed could have increased. There was no security [officers] around, and I told people to call the security. There were patient relatives around, and they were making our job harder. They were firstly taken out of there. Other patients were directed to their rooms." P11, D

3.2 | Clinical management of violence

In the analysis of the interviews conducted, it was determined that the personnel working at the psychiatry service tried to manage the violent situation with their experience where they were subjected to violence. It was observed that the healthcare workers were exposed to violence before, during, or after the clinical management of the behavior of violence. When the statements of the participants were examined, it was seen that, while they were managing the situation, feelings of helplessness were experienced, and the behavior of protecting self and paternalism emerged. Moreover, it was observed that the violence management approach found in the study also involved physical/chemical restraint and persuading the patient. The statements of four participants on this theme and these categories are given below (Table 3).

3.3 | Effects of violence

When what the healthcare workers experienced after the violence was analyzed on the data obtained as a result of the interviews, it was determined that feelings of sadness, anger and fear emerged after the violent event. It was observed that the feelings of sadness and anger emerged as a result of the violent event that the participants could not manage or cope with. It was found that not feeling safe at the service and thoughts of the possibility of being exposed to violence at any time led to fears. It was determined that the feeling of anger experienced by the employees who were subjected to violence led to the urge towards violence to emerge. It was found that there were participants who thought of leaving the clinic to cope with the possibility of being subjected to violence. It was also among the findings that the interaction of the healthcare workers subjected to violence with the patient was negatively affected. Based on the characteristics of the violence they experienced, some participants were exposed to tissue injuries and pain. It was noticed that normalization of or getting used to violence took place as the participant's duration of working at the clinic increased. This normalization and getting used to was found to be accompanied by stigma. Finally, it was determined that the healthcare workers felt the necessity to restructure the clinical environment where the therapeutic role decreased and deteriorated after the experience of the violent situation. The statements of participants on this theme and these categories are given below (Table 4).

TABLE 3 Categories and participant statements in the clinical management of violence theme

Helplessness
"You feel inadequate while the patient is being intervened with. The caretakers are inexperienced, or they are insufficient in numbers, and thus, you feel helpless by thinking that the intervention will not go well." P11, D
Protecting self
"If you can protect yourself at the moment of violence, you can protect yourself, otherwise, you are left dead. Nobody will care about you. This is why, when the patient gets violent, the first thing to do needs to be to protect myself and intervene with the patient afterwards." P5, D
Physical/chemical restraint
"To manage the agitation of the patient, the doctor had decided to give an injection. I needed to make the injection to the patient in the best way and without harming them. I experienced concern and hesitation. I thought I needed to be strong. The patient was agitated, I needed to make suggestions. I was trying to calm the patient down with suggestions. Meanwhile, we made the injection by physically restraining them." P6, N
Persuading the patient
"The patient had been restrained by the caretakers. I tried to go near the patient and talk to them to calm them down." P3, D

4 | DISCUSSION

This study was conducted to examine the experiences of healthcare workers working at the psychiatry clinic and who had been exposed to physical violence related to aggressive patients. In the scope of the

TABLE 4 Categories and participant statements in the effects of violence theme

Anger/fear/sadness
"I thought intervention with the violent event was delayed. The risk had increased. What needed to be done had not been done on time. After the incident ended, these led me to experience anger." P3, D
"After this event, I no longer want to go into the corridor. I constantly walk looking over my shoulder. The setting is worrying, and I am afraid of walking alone." P15, C
"I was sad, very sad, because I hadn't experienced anything like this in my 20 years as a nurse. I couldn't handle the fact that my own patient could do this to me, and I was angry. I raised my voice. I went near the patient and shouted: "We are trying to do good for you, look what you did". I was also angry at the security officer and caretakers as they did not do their job." P17, N
Location change
"I experienced violence from a female patient. I started to think whether I would get the same treatment from a male patient, and this made me very afraid. For a moment, I thought of getting transferred to another clinic. I thought of talking to the head nurse and not working at all in the men's ward." P2, N
Tissue injuries/pain
"…my head was sliced. The doctor said, "sutures may be needed, go to the emergency unit if you want". One doesn't feel much of a pain with the influence of the event then, but afterwards, my head hurt for days." P16, C
Normalization-getting used to
"I had received training about violence, but I thought I was caught unprepared. I said, similar things have been and will be experienced at this clinic, I have experienced this, too. It was in fact a situation I expected." P9, D
Stigma
"After all, we are working at the psychiatry service, aren't we! They wouldn't be ummm… here if they were normal! A man who isn't normal can be expected to attack, talk to himself or hit someone who is trying to help him." P7, C
Restructuring of the therapeutic environment
"Violence is such an event that, it completely ruins the clinic. An environment of chaos emerges. It affects other patients, patient relatives and healthcare workers negatively. It becomes necessary to reestablish a safety environment and restructure the settings." P12, N

study, based on the interviews carried out with 21 healthcare workers, three themes such as the effects of warning signs of violence, clinical management of violence, and effects of violence, and 14 categories in total were determined. All themes and the categories under these themes are discussed in this section.

4.1 | The effects of warning signs of violence

The effects of warning signs of violence theme consisted of three categories such as fear, concern, wanting to escape and escaping, and wanting to take control. In the interviews that were conducted, it was observed that, when they noticed the warning signs of violence, the participants were affected by these signs. The participants stated that they understood that violent behavior would emerge especially when the patient used verbal violence, walked angrily, and disturbed those around them. By understanding this, the effects of violence on healthcare workers emerge. One of these effects is uncertainty. The healthcare worker who cannot project what the patient will do at that time experiences a feeling of uncertainty on what will happen. Although the course of impulsive behaviors sometimes cannot be estimated even by the person experiencing them, these may lead to a feeling of uncertainty in the person exposed to them.[2] It is thought that this may be the reason why perceptions of uncertainty are formed against the aggressive patient at psychiatric services where impulsivity is prevalently encountered due to many reasons.

The participants stated that, by the time the warning signs of violence were understood, they experienced fear and concern. Experiencing fear and concern before being subjected to physical violence may originate from the risk of being in the same environment with the aggressive patient. Furthermore, it is known that experiencing uncertainty increases concern and leads people to experience fear. Another cause of fear and concern experienced in the psychiatry service environment is that the violent behavior may be accompanied by bizarre behaviors or speech. It may be considered that this situation turns an already destructive act into a bizarre and more fearful incident when observed from the outside. Studies have shown that nurses and assistive healthcare workers do not want to work at psychiatry services. One of the reasons for this is that violent behaviors frequently emerge, they are afraid of working with aggressive patients, and they are concerned about getting harmed.[6,8,14] These findings were supportive of our study.

Another effect of the warning signs of violence was identified as that they induced the wish to take control in the healthcare workers. This wish may be described as wanting to intervene before violence arises and manage the situation without damage or with minimal damage. This way, the situation could be controlled by the healthcare worker rather than the patient. This situation may originate from attitudes towards feeling safe and ensuring the safety of the environment. Studies have demonstrated that in the management of violence, personnel who recognize the warning signs of violence and intervene early and effectively are more successful, and they experience feelings of concern and fear less frequently.[15,22]

4.2 | Clinical management of violence

In the study, the main theme of clinical management of violence was divided into four categories such as helplessness, protecting self, physical/chemical restraint, and persuading the patient. According to the results of the study, by the time violence emerged, and the healthcare worker was subjected to violence, the feeling of helplessness arose. Being subjected to physical violence may mean that the situation has not been managed well, and control has not been

achieved. It is thought that failure to realize the wish to take control that occurs in personnel with the warning signs of violence may lead to perceptions of inadequacy. Feeling inadequacy in terms of managing the situation may lead to the emergence of a feeling of helplessness. Other studies have also reported that, similarly, as a result of the management of the situation, a feeling of inadequacy emerges concerning this management process.[10,23]

Among the results of this study, another wish that occurs during the management of violence was the wish to protect oneself. It is believed that this could be the extension of the wish or behavior to escape that emerges in the healthcare worker right before the violent behavior arises. As this wish has an instinctive aspect, it also has a professional aspect. Trying to protect oneself against harm that could be inflicted upon one while trying to take physical violence under control at psychiatry services is a skill that healthcare workers learn. In the approach towards the aggressive patient, the first step is to ensure one's own safety. Studies have stated that psychiatry personnel experienced physical violence during the management process of violence.[24] Moreover, considering studies on violence management, how critically important protecting oneself is may be understood. 7,16,25

In the scope of the study, it was found that the participants experienced physical violence during physical/chemical restraint that was being performed for the management of physical violence, and restraint was achieved after the physical violence was experienced. Restraint is a very fast and effective method. Feeling uncertainty and fear, they wish to take control, which was the effects of the warning signs of violence, and the uncertainty experienced during violence may be considered as the reasons why personnel turned towards this method. In the literature, similarly, it was stated that the participants preferred to apply physical restraint to protect both themselves and the patient from injury and various damages.[22] Other studies also revealed that employees used chemical restraint ase its outcomes are seen fast and for wanting to keep the control of the situation in their hands.[26] These results were compatible with our findings.

Another approach emerging in the management of violence is persuasion. It was observed that the participants of this study tried to persuade the patient to stop them from continuing the violent behavior and made suggestions to the patient before or after they were subjected to violence. It was understood from the statements of the participants that the situation expressed as trying to persuade the patient was an effort to establish cooperation with the patient and manage the violence in a communication-based manner. Studies have shown that alternative calming methods are as effective as classical methods, and the use of verbal calming techniques is increasingly more prevalent.[15,25]

4.3 | The effects of violence

The effects of violence, which was obtained in the analysis of the study and was the last theme, consisted of 6 categories as sadness, anger, and fear, location change, reduction in interaction, tissue injuries and pain, normalization/getting used to, stigma and reconstruction of the therapeutic environment. It was determined that the participants experienced sadness for both themselves and their patients after being exposed to physical violence. The feeling of sadness emerged after the violent behavior that the participants could not manage or cope with. For similar reasons as the formation of sadness after the violence, it was determined that feelings of anger also arose in the healthcare workers. Additionally, not feeling safe at the service and the thought of the probability of being exposed to violence at any time led to fear. Similarly, a study in the literature also reported that anger and fear were among the psychological effects of physical violence against nurses.[23] A study consisting of psychiatrists as the sample determined that emotional exhaustion occurred post-violence.[27] There are studies suggesting that physical violence leads to negative emotions by reducing psychological wellbeing.[12,28] In addition to these, physical violence may lead to more serious mental disorders such as depression, anxiety, and posttraumatic stress disorder.[13,27] In the analysis of this study, it was observed that the feeling of anger experienced by the personnel subjected to violence gave rise to the urge for violence. It was seen that the participants wanted to retaliate with violence against violence, but they were able to control this urge. Continuation of this situation may lead to the formation of hostile environments. This, in turn, may negatively affect the interaction between the healthcare worker and the patient. This is why the personnel's feeling of anger needs to be discussed, and factors that give rise to anger need to be fixed.

It was learned in this study that there were participants who thought of changing their workplace as they were not able to cope with the possibility of being subjected to violence. It is found that this thought occurred to only the nurses and assistive care personnel. The presence of doctors at clinics based on their area of expertise of their own choice may prevent such thoughts from occurring. A study reported that being exposed to violence affects the rates of quitting jobs among nurses.[29] Moreover, another study stated that being exposed to violence caused demands for workplace change.[12] Those studies were in agreement with the results of this study.

It was seen that, based on the characteristics of the violence, the healthcare workers experienced tissue injuries and pain. Physical problems that are experienced cause healthcare workers to interrupt their work for a duration to get better.[13] When studying the welfare of nurses at the workplace, Hüfner et al.[10] discovered that physical and verbal violence increased in work-related health problems and occasions of getting sick reports. It is known that physicians are at great risk regarding exposure to physical violence and experience serious physical loss.[13]

It was found that normalization and getting used to violence increased as the work duration of the healthcare workers increased. It is known that nurses see normalizing physical violence as a cultural part of their job.[23] It is also known that normalization of and getting used to something increase the risk of being subjected to physical violence.[23] For this reason, it is believed that it may be possible to reduce this risk by preventing normalization and getting used to violence.

According to the results of this study, the participants were observed to use stigmatizing expressions while speaking about the violent situation. The participants emphasized that patients with a psychiatric diagnosis are different from other people, violence is expected behavior, and this probability is higher at the psychiatry service. In the study, a clear statement on how stigmatizing the patient affected the probability of physical violence was not reached. Likewise, it has been stated in the literature that psychiatrists and nurses working at psychiatry services have stigmatizing attitudes.[23] It is known that stigmatization affects the perceptions and reactions of nurses against patient violence, but there is no evidence that it increases the probability of violence.[23] It is thought that stigmatization will increase even further as the rate of physical violence increases. It should be kept in mind that, with the therapeutic nature of treatments unique to mental health and the environment, it may become possible to reduce stigmatization by reducing the rate of physical violence.

In the study, it was determined that the therapeutic aspect of the clinical environment was disrupted or reduced. The participants were observed to want to return the clinical environment to its therapeutic state. Moreover, the reestablishment of the therapeutic environment was perceived as an additional responsibility. In the definition of a therapeutic environment, the need for the environment to be safe is emphasized. It is known that the physical environment and social environment, which are among the components of a therapeutic environment, are disrupted by violence, and it is needed to establish the therapeutic environment again as fast as possible. Providing a therapeutic environment quickly is important for the safety of all patients and healthcare workers.[30]

5 | LIMITATIONS OF THE STUDY

The memory factor is a limitation in terms of research, as the experiences of being exposed to physical violence are determined by the participant's statements. To reduce the effect of this limitation, the participants were asked about the last violent act they experienced in the last 1 year. This has provided an advantage for facilitating decision-making and remembering the details of violence in the personnel who have been exposed to violence more than once. However, these criteria also led to the exclusion of participants who had been exposed to violence more than 1 year after their last exposure.

6 | CONCLUSION AND SUGGESTIONS

In contrast to other studies on the effects of physical violence on healthcare workers, in this study, the concepts of wanting to retaliate, invasion of privacy, shame-humiliation, obsession/compulsion, and restructuring of the therapeutic environment were encountered. Furthermore, this study not only covers doctors and nurses but also discusses the experiences of assistive healthcare personnel related to physical violence. Although physical violence has been defined as an occupational danger at psychiatry services, it was seen that there are not enough studies on this topic. For this reason, it is believed that the results of our study may increase awareness. In this study, the physical violence taking place at a psychiatry service was defined and interpreted from the perspective of the healthcare worker. It is thought that the results of this study contribute to a better understanding of the phenomenon of physical violence. Additionally, this study may shed light on future studies to be planned on preventing physical violence and clinical management of violence.

7 | IMPLICATIONS FOR NURSING PRACTICE

For nurses who have the most contact with patients among healthcare professionals, understanding the phenomenon of violence in psychiatry wards will improve their supportive role in the team and the role of caregivers in the therapeutic environment. Knowing what violence means in the psychiatry ward will allow obstacles to preventing and managing violence to be recognized and will enable staff to understand their feelings and the feelings of others subjected to violence. In addition, understanding the effects of aggression is important for diversifying research in this area. This study also reveals the need for effective management of aggression and mental empowerment-recovery training, such as emotional control and anger management against aggression. The anger/fear/sadness occurring during the violence made it known that it was seen not only in the perpetrator but also in the health professionals who were exposed to it. In this way, it may be possible to eliminate the cognitive and emotional compelling points of care for the aggressive patient. Thus, it can be thought that the physical and mental trauma of health workers who are exposed to violence/attack cause damage that must be eliminated by state policies.

CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

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