Exploring the Effects of Patients' Violence on Mental Health Practitioners in Nigeria

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ABSTRACT

This article examined patient violence on mental health practitioners, the experiences and the unique effects of these encounters among practitioners in the mental health setting, as well as the ways of minimizing these discomforting circumstances to enable a conducive atmosphere for the practitioners and their patients. The study created an in-depth understanding of the practitioners' experiences, using a phenomenological design on 28 participants from three mental health settings in Nigeria. Data was transcribed word for word and analyzed and then displayed using matrix, quotations, and causal networks. Findings from the study indicated that violence against practitioners included physical attacks, lockups in the office, threats, abuses and insults, and accusations. Consequently, practitioners experienced fear, injury, distress, fatigue, reduced concentration and brain function, inadequate performance and poor general well-being. These patient attacks lead to disturbing experiences that are capable of causing pain and affecting the practitioner's ability to handle patients and other duties. Nonetheless, patient hostility could be minimized by training the practitioners for a positive mindset, recruiting more practitioners, increasing security and providing rescue doors to every building in the psychiatric hospitals for easy escape.

Keywords: mental health practitioners; mentally ill patients; violence; disturbing experiences; psychiatric hospitals

INTRODUCTION

The violence faced by practitioners in the mental health setting is worrisome and cannot be disregarded (Van-Leeuwen & Harte, 2017) since mental health patients, the world over are tagged with some form of violence at some point of their illness (Brophy et al., 2018). This violence is either verbal or physical (Jakobsson et al., 2020), depending on the attack meted out to the mental health practitioners who are responsible for giving treatment and care to mentally ill patients. Day in and out, practitioners are exposed to this violence since the patients are unpredictable and have mood swings intermittently (Oluwole et al., 2019). There is, however, no amount of carefulness that can escape these unpredicted attacks (Khait et al., 2022; Välimäki et al., 2022), so practitioners have come to believe that patient violence is normal and cannot be avoided (Kennedy & Julie, 2013; Samouei et al., 2018). This fate is disheartening and means that practitioners have no choice but to expect such attacks from patients (Kennedy & Julie, 2013).

Many times, even patients under treatment and thought to be improving could suddenly become violent and attack the practitioners without having a pre-knowledge of such attacks at that particular moment. These

attacks cause fear, anxiety, frustration and regrets among practitioners in psychiatric hospitals (Yang et al., 2017). Patients' attacks have disoriented and disfigured many practitioners; to some, damages to their property (Baby et al., 2014; Khait et al., 2022; Schablon et al., 2018), and a few, death (Mento et al., 2020). Efforts such as barricading the hospital wards and offices and chaining and tranquillizing patients to curb this menace have been unsuccessful. Since humans attend to these patients, the point of discharging duty or treatment becomes the contact of expression of patients' aggression toward practitioners (Olashore et al., 2018; Onyia et al., 2019; Samouei et al., 2018). This is because so many of the mentally ill hallucinate and are informed by those voices emanating from their thought to act aggressively before the practitioners hurt them (Khait et al., 2022).

Many young mental health practitioners do not wish to continue working in the psychiatric environment for fear of the unknown, and some refuse to specialize in psychiatry after their internship or residency at the psychiatric hospitals due to their experiences with hostile patients (Oluwole et al., 2019; Tonso et al., 2016). This branch of health has suffered so much inattention from the government and nongovernmental organizations. As such, practitioners go through a lot, yet their sad experiences are not recognized/appreciated and compensated by concerned authorities (Turk et al., 2018). This branch of healthcare is relegated to the background compared to the area of physical and general medicine. The relegation clearly shows a lack of knowledge of the increasing cases of mental illness. Hence, the increase in mental health illness calls for attention to address patients' attacks on mental health practitioners in these settings.

LITERATURE REVIEW

Global Experience of Violence

Globally, some discussions regarding violence against mental health practitioners in psychiatric hospitals have been linked to attacks from the patient and their relatives (Cranage & Foster, 2022; Ham et al., 2021; Hiebert et al., 2022). Specifically, 61% of the practitioners have been exposed to insult, swearing, threat, humiliation, verbal and sexual harassment, pushing, slapping, and punching by aggressive patients and their relatives, thus affecting their performance. Despite these effects, institutions remained unresponsive to issues of patient violence and no actions were taken to contain the menace in Turkey (Turk et al., 2018). In Taiwan, these practitioners experience patient hostility in psychiatric hospitals, mostly at the point of examination and restraining the psychiatric patients. These patients are unpredictable; as such, they bite and beat up the practitioners, making them afraid of the patients even when they are supposed to give adequate treatment and care, and this affects the morale and enthusiasm to carry out their tasks (Chou & Tseng, 2020).

Additionally, mental health practitioners in Iran reported 58.9% physical violence, 81.4% verbal violence, 32.4% bullying, and 7.3% racial harassment when in contact with patients and their relatives; nonetheless, issues of racial harassment and bullying were committed by the practitioners. In the event of attacks, some practitioners attempt defence while others don't. Some reported to their family and manager. Besides, no filed complaints cases of violence on mental health staff were evident, and this was due to feelings of guilt, shame, fear of negative consequences, not being aware of reporting processes, believing that it is of no use as such would not be given adequate attention resulting to feelings of anxiety, insecurity and work difficulty (Samouei et al., 2018).

Furthermore, 69.8% of mental health practitioners in Botswana experienced physical violence that included hitting, kicking, pushing, and shaking. Patients committed the attacks in the wards and outpatient departments due to their mental state and practitioners' attempts to calm patients, resulting in injuries and job dissatisfaction compared to those with no violence experience. Yet, practitioners reported that this violence could have been predicted and prevented. Besides being on the job for more than 4 years, they

were exposed to physical attacks more than their counterparts with fewer service years. That being so, victims of patient attacks received support from the psychiatric work setting through medical treatment, emotional and financial help, and sick leave (Olashore et al., 2018).

In Nigeria, patient aggression toward mental health practitioners poses a serious concern in psychiatric hospitals (Akanni et al., 2019; Olabisi et al., 2019). Regarding this, 67% of practitioners had verbal or physical attacks from patients and their relatives in the wards, outpatient, and emergency departments, resulting in injury, worry and shame, and 62.4% could not foresee the attacks. This aggression was due to delayed service, loss of patients, inadequate staff, insults, attackers' personalities and mental states, and poor hospital facilities, but the practitioners sometimes provoked patients. Besides, these victims were those on shift duty, younger and under 10 years on the job, and. attacks could be prevented by walking away from patient hostility. Besides, 58.8% of practitioners did not report violence to the management due to their insensitive and unresponsive attitude to patient attacks. Nonetheless, attending anger management workshops enhanced tolerance in handling patients to minimize violence (Oluwole et al., 2019).

In addition, practitioners worry about patient violence since it occurs when they come in contact with patients. The attacks were with weapons, and practitioners could not defend themselves; only 26.9% of cases were reported, and no action was taken in 51.9% of violence, but action was taken in 40.4%. Patients were given verbal warnings and prosecuted in a few instances. Still, no consequences were attached to most attacks on practitioners, given that they sought an opportunity to share their experiences for counselling (Onyia et al., 2019).

Different Types of Patient Violence on Mental Health Practitioners

The violence experienced by practitioners is disturbing and of different degrees and types (Dean et al., 2021; Holmberg et al., 2020). Furthermore, emotional abuse and intimidation were the types of violence the practitioners experienced, and these were associated with years of experience, indicating that more years of experiencing patient hostility resulted in higher stress than fewer years (Yao et al., 2021). Additionally, 62.3% of practitioners in Japan reported verbal violence, 60.4% were physically attacked, and 2.6% experienced sexual assaults, which occurred more in the acute wards and with younger nurse practitioners by patients and their relatives, supervisors and work colleagues (Kobayashi et al., 2020). Accordingly, 90% of practitioners experienced verbal aggression, 53% were verbal threats, 82% were object aggression, and 50% were physical aggression, which patients and their relatives committed. Moreover, practitioners in acute inpatient psychiatric units experienced more violence than their counterparts in other units. Though practitioners received training on aggression management, patient hostility has continued in psychiatric hospitals (Aguglia et al., 2020).

Causes of Patients' Violence on Practitioners

Several factors, such as patient's health condition, denial of patients' admission, delays in nursing and medical care, patients' requests and care dissatisfaction, violation of visiting hours, smoking prohibition, inadequate staff, poor organization and support, and psychological problems contribute to patient hostility (Basfr et al., 2019). Some causes were overcrowding, long waiting time (Basfr et al., 2019), denial of patients' requests, compulsory admission, enforcement treatment, discharge refusal, poor communication (Bowers, 2014), underlying aetiological factors (Kennedy & Julie, 2013), and less working experience increased the risk of being a victim (Van-Leeuwen & Harte, 2017).

Effect of Patients' Violence on Practitioners

Practitioners' experience with aggressive patients is devastating. It affects them physically and emotionally through mere thoughts of being at risk, compromised patient care, being argumentative and aggressive with

family members (Kennedy & Julie, 2013), and innocent patients and colleagues. Besides, exposure to patient violence led to substance abuse and anger, and the effect resulted in psychological distress, burnout, secondary traumatic stress experiences, poor well-being and compassion satisfaction among mental health nurses (Kobayashi et al., 2020), and high financial cost (McIvor et al., 2023). Besides reporting burnout, patient hostility affected individual well-being and patient care in psychiatric hospitals (Aguglia et al., 2020). Additionally, the descriptions of psychiatric units as torture chambers and accusations of violation of human rights were also experienced as difficult and upsetting experiences which resulted in fear and frustration among mental health practitioners, hence making the realization of patient treatment and care unsuccessful (Jansen et al., 2022).

Theory of violence

Frustration-aggression hypothesis: This theory states that the occurrence of aggression always presupposes the existence of frustration and, contrary, that the existence of frustration always leads to some form of aggression. The potential to aggress is inborn, but it necessitates frustrating stimuli (like the individual's mental state and other surrounding circumstances) to initiate a response, thereby designating aggression as a reactive phenomenon. Aggression is thus the reaction to frustration, and other reactions to frustration are also possible, but aggression is the fundamental reaction (Dollard, Doob, Miller, Mowrer & Sears, 1939; Miller, 1941 as cited in Drndarević, 2021). Aggression results from frustration, such as patient mental state and long waiting hours, poor working conditions, lack of support and unresponsive attitude of psychiatric hospital management in handling violence, and inadequate staffing. The mental health patients, their relatives and practitioners react to the challenging circumstances because they are uncomfortable and frustrated; any little trigger unveils their anger as an expression of dislike.

Research Question

How does patient violence influence mental health practitioners in the mental health settings in Nigeria?

METHOD

The study used a phenomenological research design on 28 participants (doctors, nurses, pharmacists, psychologists, social workers, and occupational therapists) purposefully selected for in-depth interviews because they were mental health practitioners working in the mental health setting and who have interacted with treated and cared for mentally ill patients.

Interviews were conducted using an interview guide and an audio recorder. Afterwards, the audios were carefully listened to and transcribed word for word by the authors to ensure accuracy in the data-gathering process. Data was analyzed using case and content analysis, data display methods, problem/cause and solution methods, direct quotations, and thematic analysis. Using the ideas of Braun and Clarke (2006), we familiarized ourselves with the data, generated initial codes, searched for themes, reviewed themes, defined and named themes, and produced reports. Also, data display methods, such as quotation, matrix and causal network (Miles & Huberman, 1994), have been used in this study.

Ethical approval letters were obtained from the three data collection locations with reference: FNPH/A.864/Vol.XVII/133 for Benin, FNPH/HTR/REA/VOL.11/482 for Enugu, and FNPH/122020/REC062 for Maiduguri federal neuropsychiatric hospitals. Participants were informed of the purpose of the study, and participation was voluntary; thus, they had the right to refuse participation at any point of the interview. After a detailed explanation, participants signed consent before the in-depth interviews. Confidentiality was assured, participants' information was codified, and transcriptions were not identifiable. There was no conflict of roles between the participants and the researchers.

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RESULT

The impact of patients' violence on mental health practitioners in Nigerian psychiatric hospitals was examined based on practitioners' lived experiences with aggressive patients. These experiences were constructed around physical attacks, lockups in offices, threats, abuses and insults, and accusations. The results are in Table 1 and Figure 1.

Table 1 A Matrix Showing How Patient Violence Influences Mental Health Practitioners in Nigeria

Latent Variable	Experiences	Causes	Effects	Coping strategies	Proposed solutions	Responsible actors
Violent Patients	1. Physical attacks 2. Lockups in office 3. Abuses & insults 4. Threats to kill practitioner 5. Accusations	· Patient tactic to refuse treatment · Patient Mental State · Patients long waiting hours · Patients escape plans	· Injury · Property damage · Fatigue · Aggression · Fear · Poor concentration	· Continuous injury treatment · Borrow uniforms · Security intervention · Tranquilize pts · hazard allowance Payment	· Increase security · Provide rescue doors · Recruit more Mental Health Practitioners · Offer adequate treatment/care to patients	· Management · Mental Health Practitioners

As shown in Table 1, physical attacks are characterized by fighting, hitting, slapping, attempted strangulation, beating and pulling the practitioners by the necktie and destruction of the hospital tables, ceiling, chairs, television and fans, and personal items of the practitioners. These attacks are due to patients' mental states, impatience as they wait for treatment and care, and leaving in a state of denial about their health condition. Consequently, practitioners are exposed to property damage (e.g., uniforms, windscreens, laptops), injury, pain, constant fear, reduced concentration level, diagnostic and prescription errors and poor well-being. Participants suggested that management should increase security, provide rescue doors and recruit more mental health practitioners to ensure adequate patient treatment and care. Below are some of the narratives illustrating the experiences of five mental health practitioners:

At our emergency, they brought in this violent patient who brought down the fan and was breaking television and the doors. Everybody ran out of that place, and we started calling for help, and they were able to sedate that patient. Working here is stressful, and we need to be very conscious of safety. There should be a rescue door because a patient might enter with a weapon in his bag, and even harm us. It was a negative experience, and I don't know whether I will continue with this place. ***(EPh50F05)***

Another practitioner from a different profession but in the same hospital narrated a similar experience as follows;

Some patients are aggressive both verbally and physically, so it creates fear and tension. A patient was admitted against his wish and when he wanted to abscond, the caregiver raised alarm, so the people around with the security men at the gate held him back, but he was able to break through. Unfortunately, a female practitioner was coming to work as she was entering the gate; the patient raised a very big brick, so the

security personnel fled. Before the practitioners could realize the situation, her head was smashed with that brick, and the patient escaped. The woman collapsed and was rushed to the hospital; though she was medicated and discharged, she still lives with the scales; even the outcome of those injuries may hamper her performance in her job. ***(EOt49M07)***

As indicated in Table 1, lockups in offices and threats are characterized by locking of doors, mal-handling and choking, name-calling, and threats to inflict injury and kill. The fundamental causes of aggression include patients' mental state, refusal to accept health conditions, and unwillingness to discharge patients by practitioners. Because of that, mental health practitioners are fatigued, depressed, distressed and live in constant fear and dissatisfaction. The participants suggested that the management should improve security in strategic places and all the offices and intervene swiftly in issues of violence. Below are some narratives illustrating the experiences of two mental health practitioners:

I was rough-handled by a patient who came in and requested treatment. He came to the office and locked the door, then said, "You brag one that is always injecting me, you people always tell me at ward rounds that I do not want to come for injection; you think it is easy for me to take treatment? I want to inflict injury on you so that you too will be taking treatment and find out whether it is easy." The patient hooked me close to the protector and said, " I want to kill you here. I was Stressed out and highly depressed. This patient wanted to kill me because I work for them. So those are what we have been experiencing and will be experienced as long as mental health institutions are concerned. ***(BSW46M03)***

Another practitioner from a different profession but in the same hospital narrated a similar experience as follows.

A patient came here, broke bottles and was about to assault practitioners who were there to help him. Most of the patients think this is a facility where no one is proud to be; for that reason, the patient became very violent and said, "Nothing is wrong with me; leave me alone. I should not be here". The patient felt that he should not be here and that they forcefully brought him to the hospital. It took much physical effort to calm him down and the intervention of our health attendants to rescue that situation. From that moment, henceforth, we forbid anybody from bringing in any form of bottle in this facility. ***(BPh40M02)***

As illustrated in Table 1, abuse and insult are characterized by rudeness, insulting words, noise, name-calling, and sexual harassment. The fundamental triggers of hostility include patients' tactics to refuse treatment and mental state of patients. In consequence, practitioners experience tension, fear, dissatisfaction and reduced functioning. Some practitioners suggested that the management should train practitioners in positive mindsets and anger management to enable practitioners to handle patients appropriately. Some of the narratives explaining the experiences of two mental health practitioners are as follows:

I was abused by a patient who was pressing me to the wall, but another practitioner hit him hard, he left me and ran away. I don't know what he said, and you know, being a woman, some of them will make advances and say, I love you! You are beautiful. ***(MPs41F05)***

Another mental health practitioner from a different profession and hospital narrated a similar experience as follows;

Sometimes, I get abused and verbally harassed, but that is part of the job. I feel dissatisfied with my work, but some other time, I take it as one of the hazards of the job. ***(EOt49M07)***

As shown in Table 1, accusations are characterized by false allegations, lies, shouting and rudeness. These attacks are due to patients' mental states, patients' long waiting hours, practitioners' poor communication skills, lack of understanding and impatience by the patients and inability to meet patients' demands.

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Accordingly, practitioners were exposed to fear, anxiety, increased blood pressure, confusion and poor well-being. When the participants were asked about ways to reduce patient violence, they suggested that the management and practitioners should ensure they receive detailed information about patients and recruit more practitioners to handle patients' concerns to reduce aggression. Find below some narratives showing the experiences of two mental health practitioners:

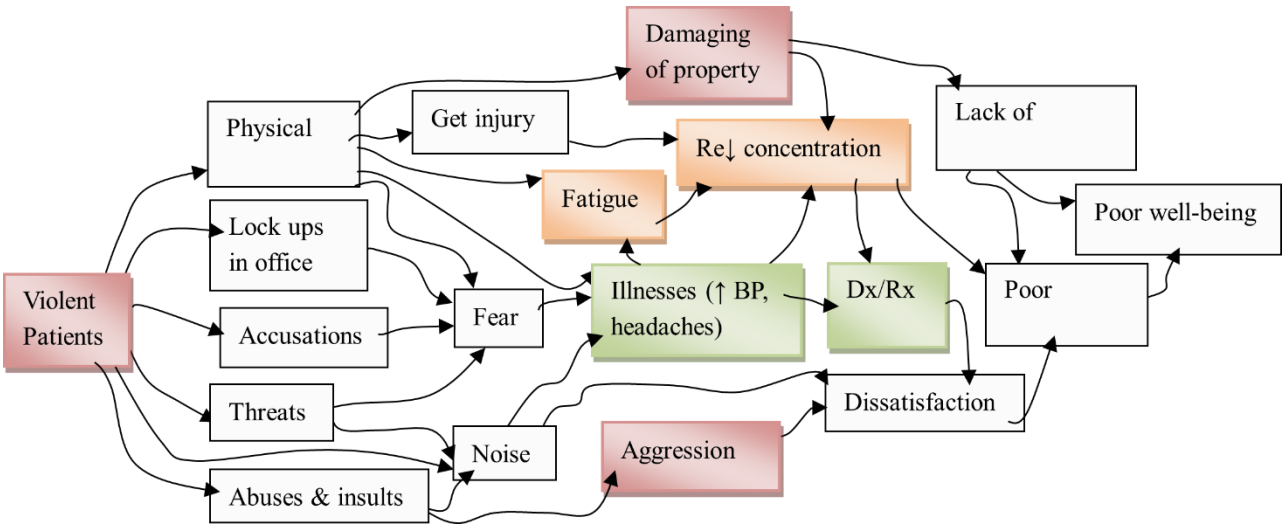
Patients want you to attend to them so that they can leave. We try to meet their demand because they become more violent if that is not met. A patient dealt with one of us; he said that "the practitioner is his problem and the one troubling him and that the staff was sent to kill him", so he held on to the practitioner, dragging his tie around his neck, and it took the intervention of some men to rescue him from that patient. Patients do not want to waste time, and because of their state, most of them do some things to throw you off balance. So that is enough stress for us too. We need more security to work here. ***(BPh40M02)***

Another practitioner from a different profession but in the same hospital narrated a similar experience.

We were repatriating patients, and at the time, we could not locate the address; we told the patient that we were going back to the hospital and bed again. So the patients were annoyed, and started shouting kidnappers! help me! in the vehicle, so people will say leave this guy alone; he is well. I was scared that people might lynch us or inflict injury on us; our lives were at risk because people look at everybody as ritualists. People were trying to raise alarm without listening to what we were saying, so fear came into us at that time. It was stressful for us, but we overcame by making them understand that these were our patients because their files were with us. So, I said please, sir, we are not kidnappers; we are psychiatric professionals, taking care of the patients and now taking them home. The experience was very positive because we could repatriate and get the loved ones to cater for the patients. ***(BSW46M03)***

The circumstances above are discomforting and disturbing and bring about poor well-being, as illustrated in Figure 1

Figure 1 Causal Networks Showing How Patient Violence Influences Mental Health Practitioners in Nigeria



Key: BP-Blood Pressure, Dx-Diagnostic, Rx-prescription, ↑- Increased, Re↓─Reduced

Figure 1 illustrates how patients' violence (see details in Table 1) can affect mental health practitioners.

Given this, practitioners are exposed to patients' attacks, such as physical attacks (e.g., fighting, beating, and tearing of uniforms), lockups in office, abuses and insults, threats to kill practitioners, and accusations resulting from patients' mental state, long waiting hours, escape plans, and tactics to refuse treatment

indicates that practitioners face issues of violent patients in their day-to-day tasks. This unfavourable experience results in injuries, properties (e.g., uniforms, ceiling, tables, chairs, fans, windscreen, laptops) being damaged, fatigue, lack of concentration, constant fear and feelings of dissatisfaction; this makes the practitioners unproductive in their duties.

DISCUSSION

Patients' violence influenced mental health practitioners in so many ways, thereby causing devastating effects on their performance and well-being. Mainly, practitioners in the mental health setting experienced physical attacks such as fighting, beating, biting, slapping, and breaking of laptops, fans, doors, chairs, and television, pulling practitioners' neckties and tearing of uniforms. These exposed practitioners to injury, fracture, property damage, fatigue, aggression transference, feelings of insecurity, fear, poor concentration, and leading to diagnostic and prescription errors, pain, increased blood pressure, headaches, lack of motivation, poor functioning, and dissatisfaction thus affecting the practitioners' general well-being. This is in line with the studies of (Kobayashi et al., 2020) that physical attacks on mental health nurses resulted in distress, poor well-being and dissatisfaction. In a similar experience, Olashore et al. (2018) reported that physical violence (like hitting, kicking, pushing, and shaking) resulted in injuries and job dissatisfaction among mental health practitioners. Consistent with these findings, Chou and Tseng (2020) found that biting and beating up mental health practitioners results in fear and reduced eagerness to carry out their duties.

Furthermore, some practitioners were exposed to lockups in offices and threats to kill and harm them in psychiatric hospitals. Due to these, practitioners were fatigued, depressed, distressed, dissatisfied and were constantly in fear of the unknown since the patients could attack them at any time in the hospital; they could not concentrate and function adequately in their duties. This finding is consistent with those of Van-Leeuwen and Harte (2017), who found physical threats with weapons, lockups and attempted strangulation as leading to pain, injuries, fear, anger, stress and reduced alertness among practitioners. Turk et al. (2018) also indicated that threats and humiliation by aggressive patients affects performance in the psychiatric setting. Similarly, verbal threats increase mental health practitioners' stress levels (Aguglia et al., 2020).

Moreover, many practitioners experienced abuse and insults like rudeness, offensive words, name-calling, and sexual harassment from patients in psychiatric hospitals. Given these, practitioners experienced tension, fear, dissatisfaction, lack of motivation and reduced functioning in the psychiatric hospital. This result is in agreement with those of Turk et al. (2018), who found verbal violence in the form of insult, swearing, verbal and sexual harassment by hostile patients to affect practitioners' performance. In agreement with Tonso et al. (2016), verbal abuse and sexual harassment by patients resulted in distress and frequent sick leave, staff leaving the profession and unwillingness of future generations to specialize in psychiatry. Similarly, Samouei et al. (2018) indicated that verbal violence resulted in feelings of anxiety, insecurity and work difficulty. Besides, verbal aggression resulted in higher levels of burnout (Aguglia et al., 2020). Consistently, practitioners who experienced verbal abuse were stressed, anxious and depressed (Basfr et al., 2019).

In addition, accusations in the form of false allegations, lies and rudeness to increased tension, illness, fear, dissatisfaction, reduced functioning and poor well-being among practitioners. This finding agrees with Jansen et al. (2022), who found accusations against mental health nurses to have resulted in fear and frustrated the achievement of treatment goals. Similarly, mental health staff who were faced with false accusations of sexual assault experienced fear about their safety (Morton et al., 2022)

This study's result is also in line with the frustration-aggression hypothesis, which indicates that aggression is the reaction to frustrating stimuli such as disturbing circumstances that leads to negative effect on the individual (Dollard, Doob, Miller, Mowrer & Sears, 1939; Miller, 1941 as cited in Drndarević, 2021). The

researchers, therefore, concluded that patient violence poses a great risk to the practitioners' performance, manner of handling the psychiatric patient and other duties/tasks, as well as their mental health and general well-being.

Practical Implications

This study indicated that mental health practitioners who are charged with the responsibility of helping mental health patients are physically attacked, threatened, accused wrongly, abused and insulted at the point of giving care to their patients. The study reveals that practitioners constantly live in fear with feelings of insecurity and dissatisfaction in their day-to-day tasks in the mental health setting. Consequently, our findings specified that increasing security and personnel with specialized mental health training and placing them strategically to handle patients will minimize violence in psychiatric settings. Also, employing more practitioners with positive mindsets and anger management skills will probably enable practitioners to handle patients appropriately. Moreover, creating rescue doors to every structure by the hospital's management would enable easy escape when they envisage patient attack thereby reducing injuries and other illness conditions, which has practical implications for the health and well-being of practitioners.

Limitation

The phenomenological design offers rich and detailed information on the human experience, and result emerges from the data. However, it depends upon the subjects' articulateness and requires the researcher's interpretation. In phenomenological designs, gathering data and data analysis is time-consuming and tasking. Besides, the qualitative sample for this study was mental health practitioners who work in federal neuropsychiatric hospitals only. As such, because qualitative samples are smaller, findings from the study may not represent the experiences of other mental health practitioners working in general medicine settings.

Future Research

Future research should explore underlying personality issues associated with patients' violence on practitioners in mental health settings using focus group discussions.

It would be of great interest to examine the impact of patients' violence on mental health practitioners using a mixed-method design.

CONCLUSION/RECOMMENDATION

This study showed that mental health practitioners experience much violence from patients. The violent encounters are devastating and harmful, affecting their general performance and well-being. The study's supporting literature showed that practitioners are exposed to patients' violence in various degrees, specifying that this violence is distressful and discomforting. Nonetheless, these can be reduced if psychiatric hospitals are given adequate attention by the government, management, and practitioners, who can ensure an encouraging atmosphere for the practitioners and their patients. Furthermore, due to the practitioners' experiences of violence in the psychiatric hospitals, the management should increase security that will help to ensure proper organization of patients, rescue practitioners and intervene in issues of patient violence. Also, to ensure that every building in the hospital has a rescue outlet where practitioners can easily escape in instance of violence. Given the large number of patients and patients' long waiting hours, the government should recruit more practitioners in psychiatric hospitals and ensure better conditions of service that will encourage their performance and enhance their general well-being in an environment of violence. In addition, engaging practitioners in training on how to manage situations of violence will reduce anger and build a positive mindset about the mental health setting, hence changing the perspective that violence in the mental health setting is normal. That will reduce practitioners' fear, property damage, injuries, and fatigue

and improve their concentration and functioning in these settings.

COMPLIANCE WITH ETHICAL STANDARDS

All procedures performed involving human participants were in accordance with the ethical standards of federal neuro-psychiatric hospitals and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

INFORMED CONSENT

Informed consent was obtained from all individual adult participants included in the study.

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