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# Perceptions of workplace violence among victimized nurses: A phenomenological study in a remote island of Indonesia

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## ABSTRACT

**Background**: Workplace violence (WPV) is a serious occupational hazard that can undermine nurses' professionalism, increase stress, and contribute to a toxic work environment. Repeated exposure to WPV is particularly concerning as it can diminish motivation, reduce job satisfaction, and negatively affect the quality of care. In hospitals located on remote small islands, where frequent interpersonal encounters are inevitable due to limited staffing and close community ties, the challenges faced by WPV-victimized nurses can be even more complex.
**Objective**: This study aimed to explore how nurses working in a remote island hospital perceive and experience WPV
**Methods**: A descriptive phenomenological approach was employed to capture the lived experiences of nurses at Sabang City Hospital who had experienced WPV. Participants were selected purposively. Data were collected using demographic questionnaires, semi-structured in-depth interviews, field notes, and audio recordings. The interviews explored the nature of WPV incidents, emotional and psychological impacts, and expectations for organizational support. Data were analyzed thematically to identify patterns and shared meanings.
**Results**: Three key themes emerged: (1) perceiving WPV as a source of sadness, distress, and long-lasting trauma; (2) recognizing WPV as encompassing both verbal (insults, threats) and non-verbal (intimidation, neglect) forms; and (3) expecting more active roles from superiors and hospital management, including prevention, immediate intervention, and post-incident support.
**Conclusion**: Nurses' varied perceptions of WPV reflect the urgent need for structured prevention strategies and responsive management interventions. Strengthening organizational policies and support mechanisms is critical to safeguarding nurses' well-being and fostering a safe, respectful workplace.

**Keywords**: workplace violence; violence; nurse practitioners

## INTRODUCTION

Nurses are among the healthcare professionals most vulnerable to Workplace violence (WPV), which can originate from patients or their family members (Liu et al., 2019). The prevalence of WPV is notably higher in developing countries, where inadequate healthcare infrastructure and poor working

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- *This study reveals how WPV is perceived by nursing staff, demonstrating that such experiences can cause traumatic feelings while they continue to provide patient care in environments where they unavoidably encounter the perpetrators on a frequent basis.*
- *The findings underscore the importance of the expected roles of healthcare leaders—particularly nurse managers—in effectively responding to incidents of WPV.*
- *Hospital management and nursing leaders should adopt a proactive approach to recognizing, addressing, and mitigating WPV by ensuring the provision of emotional support, establishing clear and accessible reporting systems, and implementing consistent follow-up measures for affected staff.*

conditions exacerbate the risk (Njaka et al., 2020). Evidence from a cross-sectional study in a university hospital in Saudi Arabia indicated that 30% of nurses had experienced verbal abuse (Hill et al., 2022). Similarly, studies in China report that nearly all nurses have encountered at least one episode of WPV, encompassing both physical and non-physical forms. In Malawi, WPV prevalence among nurses reaches 80%, while in India, rates are comparably high. Even in high-income countries, WPV remains a concern, with approximately 36% of nurses in Australia reporting such experiences (Banda et al., 2016).

In Indonesia, WPV remains a significant occupational hazard for nurses. A multicenter study involving six hospitals reported that 54.6% of nurses—particularly those working in emergency departments—had experienced WPV (Zahra & Feng, 2018). In Aceh, research conducted in mental health facilities found that 79.3% of nurses had encountered aggressive behavior from patients, with 48.9% reporting mild stress as a consequence (Azalia et al., 2017). The Executive Board of the Indonesian National Nurses Association (PPNI) for the Aceh Region documented two legal cases of violence against nurses since 2019 (PPNI, 2019). Further, a study by Faidhil et al. (2022) revealed that 59.8% of nurses experienced some form of WPV, with 7.9% reporting physical violence and 56.7% reporting non-physical violence. Verbal abuse was the most common non-physical form (52.8%), followed by bullying (34.7%) and racism (5.6%). These findings underscore the persistent and multifaceted nature of WPV in healthcare settings. Preliminary online data collection in Sabang City identified 11 nurses who had experienced WPV, raising concern over the normalization of violence in the workplace. Such conditions can diminish nurses' motivation and perpetuate a false sense of safety, even as WPV incidents occur daily (Copeland & Henry, 2017). Therefore, this study aims to explore the experiences of nurses who have been exposed to WPV, with the goal of informing strategies to enhance workplace safety and nurse well-being.

## METHODS

### Design

This study employed Husserl's descriptive phenomenological approach to explore nurses' lived experiences and perceptions of WPV. Rooted in Edmund Husserl's philosophical tradition, this approach seeks to uncover and describe the essence of a phenomenon as experienced by individuals, free from preconceptions or theoretical bias. It emphasizes bracketing (epoché), whereby researchers deliberately set aside personal assumptions and prior knowledge to view the phenomenon solely from the participants' perspectives. Data collection typically involves in-depth, open-ended interviews, enabling participants to share detailed and authentic accounts of their experiences. The analytical process involves identifying significant statements, clustering them into themes, and synthesizing these into an exhaustive description that captures the phenomenon's essential structure. In this study, Husserl's descriptive phenomenology provided a rigorous framework to faithfully represent the lived experiences of nurses who have been victims of WPV, thereby offering valuable insights into its impact on their professional and personal lives.

## Ethical Consideration

Ethical approval for this study was obtained from the Nursing Research Ethics Commission, Faculty of Nursing, Universitas Syiah Kuala (IRB No. 112006301023). Prior to data collection, participants received comprehensive information about the study's objectives, procedures, and potential benefits, ensuring informed decision-making. Participation was entirely voluntary, with no risk of disadvantage or harm. The principles of autonomy, anonymity, and confidentiality were strictly upheld throughout the research process. Participants were assured of fair and respectful treatment, non-discrimination, and the right to withdraw from the study at any stage without penalty. All personal information was handled with strict confidentiality to protect participants' privacy.

## Participants and Setting

This descriptive phenomenological study involved eight nurses who had experienced WPV. Purposive sampling was employed to select participants who could provide rich, in-depth descriptions of their experiences. The inclusion criteria were as follows: (1) having experienced verbal WPV, (2) being available for face-to-face interviews, (3) willingness to participate as a respondent, and (4) having experienced at least one form of WPV, either physical or non-physical. Exclusion criteria included nurses who were on extended leave during the study period, those currently undergoing psychological treatment for trauma related to WPV, and those unwilling or unable to provide informed consent. These criteria were established to ensure that participants could engage meaningfully in the interview process while safeguarding their well-being during data collection.

## Data Collection

Data collection for this study was conducted at Sabang City General Hospital between December 19, 2023, and February 13, 2024. Sabang City General Hospital was selected as the research site due to its strategic role as the primary healthcare facility in the region, serving a diverse patient population across various clinical departments. The decision to focus on this setting was informed by preliminary data indicating notable issues related to WPV against nurses. Initial assessments revealed that several nurses in this hospital had reported direct experiences of WPV, both physical and non-physical, creating an urgent need to explore the phenomenon in greater depth. Conducting the study in this setting provided an opportunity to capture context-specific experiences and contributing factors to WPV, thereby generating insights that could inform tailored prevention and intervention strategies within the hospital environment.

Semi-structured, in-depth interviews were conducted in a quiet and private room within the hospital to ensure participant comfort and confidentiality. Each interview began with open-ended questions to encourage participants to share their experiences freely, followed by probing questions to explore emerging themes in greater detail. Interviews lasted between 45 and 75 minutes and were audio-recorded with participants' consent. Data collection and analysis were conducted concurrently, allowing the researcher to identify when no new themes or insights were emerging, indicating that data saturation had been achieved. This approach ensured that the findings comprehensively reflected the breadth and depth of nurses' experiences with WPV in this setting.

## Data Analysis

Data were analyzed using Miles and Huberman's interactive method (Miles et al., 2014), which involves three interconnected processes: data condensation, data display, and conclusion drawing/verification. In the data condensation phase, the researcher organized and reduced the raw data by compiling interview transcripts, writing summaries, assigning codes, developing themes, generating categories, and preparing analytical memos to capture emerging insights. The second phase, data display, involved presenting the organized data in visual formats—such as tables containing coded text and thematic flow diagrams—to facilitate systematic examination. Codes were subsequently grouped into subthemes and overarching themes to reflect the essence of participants' experiences. In the final phase, conclusion drawing and verification, the researcher synthesized the findings to answer the study's guiding questions, continuously revisiting the data to confirm the accuracy and credibility of the interpretations. This iterative and rigorous process ensured that the analysis remained grounded in participants' narratives while capturing the complexity of WPV as experienced by nurses.

## Trustworthiness

To ensure the trustworthiness of the data, this study applied the four criteria proposed by Lincoln and Guba: credibility, transferability, dependability, and confirmability. Credibility was established by engaging deeply with the participants and the data, ensuring that the findings accurately reflected the truth of participants' accounts and the research context. Transferability was addressed by providing rich, detailed descriptions of the study setting, participants, and findings, enabling readers to determine the applicability of the results to other contexts. Dependability was ensured through a structured and systematic data analysis process grounded in the principles of qualitative research, allowing for consistency and reliability in the interpretation of findings. Confirmability was achieved by maintaining transparency in data presentation and analysis, ensuring that the results were grounded in participants' narratives rather than researcher bias, and allowing external evaluation by other researchers. Collectively, these strategies strengthened the rigor of the study and minimized potential bias in the findings.

# RESULTS

The participants in this study were nurses who had experienced WPV. They were aged between 25 and 40 years, predominantly female, and all served as executive nurses. Most participants held an associate degree as their highest level of education and were employed under non-civil servant status. The majority had a working tenure of approximately ten years. Detailed demographic characteristics of the participants are presented in Table 1.

The data analysis on the perception of nurses who have experienced violence in the workplace (Figure 1) emerged three themes, which are described below:

## 1. Perceiving WPV as the cause of feelings of sadness, distress, and trauma

This theme describes what nurses who experience WPV perceive can cause feelings of sadness, pressure, and traumatic feelings, which include four subthemes, namely (1) Victim's feelings: sad, (2) Victim's feelings: under pressure, (3) Nurse's feelings: Traumatized, and (4) Nurses' comfort at work.

### *1) Victim's feelings: sad*

The perception of nurses is that experiencing WPV can cause feelings of sadness. Some participants expressed their experiences as follows:

> *It feels sad; at first, I cared about the patient. He was very kind and friendly, but his family seemed indifferent. The family should be the first to care about the patient because the nurse only provides care. However, what happened was the opposite. After they said things that were unpleasant to hear, I paid less attention to the patient. I care, but it feels less (P7).*
>
> *It hurt at the time. When a family breaks the rules, such as stretching the mat on the floor, I am too lazy to remain because I am afraid that the incident (the family is angry) will be repeated, and it will make an impression on my heart. Therefore, the rules that should be carried out were not to be appropriately run (P8).*

### *2) Victim's feeling: under pressure*

Perceptions of nurses who experienced WPV about their feelings of working under stress when the violence occurred

> *The first thing is our feelings; we work under pressure. Even though we have done our best, it is still wrong (P2).*

### *3) Nurses' feelings: Trauma*

Perceptions of nurses who experienced WPV about their feelings of being traumatized at work when the violence occurred.

> *Perhaps as the days pass, my trauma can disappear because their words do not mean to hurt. They could mean not to interfere in my family's affairs. I think so; I have no right to interfere in his affairs. However, I did it because I care about the patient. If I do not care about him, I will immediately sign the form (a form of the patient's request for discharge) for the patient to go home (P7).*
>
> *Of course, I feel too lazy to work and talk if I go on shift with her. When I remind her about mistakes, she becomes angry. So, I also became too lazy to do it. Yes, I feel lazy to work with her (P8)*

### *4) Nurses' comfort in the workplace*

Nurses who experienced WPV perceived their comfort in the workplace when the violence

**Table 1**. Characteristics of Participants (n=8)

| Age | Gender | Position | Employment Status | Educational background | Working Period |
|---|---|---|---|---|---|
| 38 | Female | Emergency Nurse | Civil servants | 3-years-diploma | 11 Years |
| 28 | Male | Inpatient Nurse | Non-Civil servants | 3-years-diploma | 2 Years |
| 36 | Female | Inpatient Nurse | Non-Civil servants | 3-years-diploma | 10 Years |
| 37 | Female | Emergency Nurse | Civil servants | Bachelor | 13 Years |
| 36 | Male | Emergency Nurse | Non-Civil servants | 3-years-diploma | 11 Years |
| 33 | Female | Intensive care Nurse | Non-Civil servants | 3-years-diploma | 8 Years |
| 35 | Female | Inpatient Nurse | Non-Civil servants | 3-years-diploma | 10 Years |
| 32 | Female | Intensive care Nurse | Civil servants | Bachelor | 2 Years |

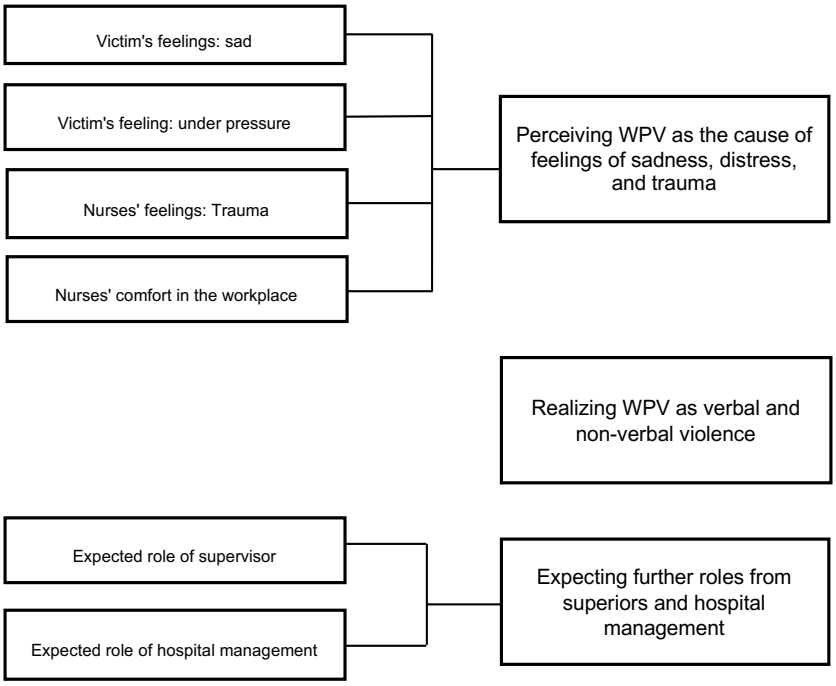


**Figure 1**. Themes and subthemes

occurred. Nurses perceived that there was a lack of comfort in the workplace.

*The first thing is that we are no longer comfortable with the patient because his mood is unstable. He overreacted to his illness. Then, the communication between us is not good; that is why sometimes I am too lazy to visit him to give him injections (P2)*

*I do not think it has any effect, but I feel uncomfortable, annoyed, and embarrassed after being scolded (P3)*

## 2. Realizing WPV as verbal and non-verbal violence

This theme explains how the violence

experienced by nurses both verbally and non-verbally. Verbal abuse is still the most common thing that can reduce motivation and cause fear for nurses on duty. The following is the content of the conversation expressed by the nurse, namely:

*The patient's family speaks rudely, angry, and threateningly with backing and knocks us down with their speech (P2)*

*The verbal abuse is throughout the speech; his tone is high, he yells at us, and he tells us not to follow the SOP. Unlike non-verbal means of physical harm, such as slapping, threatening, and carrying sharp objects (P2).*

*Violence in the workplace can be verbal or nonverbal. Verbally, it is ridicule or insults from friends and other people in the work environment. Perhaps verbal violence occurs because of the difference in status between employees and civil servants. However, it can also happen because of differences in educational background, so our communication is often underestimated (P4).*

### 3. Expecting further roles from superiors and hospital management

This theme explains the role of superiors and hospital management in dealing with WPV, which can occur at any time. These roles are significant in overcoming this problem so that it does not worsen in the future.

#### *1) Expected role of supervisor*

This sub-theme illustrates that nurses need a further role from superiors so that if there are problems experienced by nurses in the hospital, they have a protector and liaison between the nurse or WPV victim and the patient's family or patient as the perpetrator of violence. Explanations from participants are as follows:

*Yes, usually, we are together with the patient's family, sitting in a discussion to solve the problem with the head of the room. Then, the head of the room straightened out and explained what the SOP should be carried out in the hospital (P2).*

*The response was immediately reported to the POM (military police). Based on our experience, the nurse, accompanied by the head of the room and the head of the field, initially reported the case to the police. Still, the police directed her to report it to the POM because the perpetrator of the violence was TNI (P3).*

#### *2) Expected role of hospital management*

This sub-theme illustrates that nurses need a further role from hospital management so that if nurses experience problems, the hospital can bridge between the two parties, namely nurses and abusers. Explanations from participants are as follows:

*Yes, as a hospital, we want to protect our staff, whatever happens (P3).*

*Hospitals should be able to protect the nursing staff as a workplace; we must be protected no matter what happens there (P7).*

## DISCUSSION

Although WPV has been recognized for decades, it remains a pervasive yet often underestimated problem in healthcare settings. While public awareness exists, concern and proactive engagement in addressing WPV remain limited. The International Labour Organization's (ILO) first report on WPV, published in 1998, was a pivotal moment in highlighting the issue globally. Since then, awareness and scholarly attention have increased, yet recent evidence suggests that what is visible may represent only the "tip of the iceberg," with the true prevalence likely underreported due to normalization of violence, fear of retaliation, or lack of reporting mechanisms. The far-reaching consequences of WPV are now more clearly understood—not only affecting the physical and psychological well-being of healthcare workers but also compromising workplace morale, staff retention, and the quality of patient care.

Creating a safe and supportive work environment is fundamental to preventing WPV. Essential components of an effective prevention strategy include strong management commitment demonstrated through clear organizational policies, active employee participation in policy development, and comprehensive job hazard analyses that assess risks across all work areas. Preventive measures should incorporate hazard control strategies and be reinforced through both pre-employment orientation and ongoing professional education tailored to WPV prevention (Huber, 2018). Such education

should address early recognition of potentially violent situations, de-escalation techniques, and procedures for incident reporting.

Equally critical is the post-incident response. Immediate follow-up after a WPV incident ensures the safety of all staff, patients, and visitors, while also facilitating early intervention to address both physical and psychological harm. Recommended steps include providing prompt medical attention for injured employees, initiating formal accident and incident reporting, and ensuring injured workers receive appropriate compensation and follow-up care. Engaging occupational safety authorities, determining the need for law enforcement involvement, and maintaining ongoing communication with affected staff are also essential for fostering trust and demonstrating organizational commitment to staff welfare (Balogun et al., 2016).

Nurse managers play a pivotal role in both prevention and response to WPV. Their responsibilities extend beyond immediate crisis management to include establishing and enforcing safety protocols, supporting injured staff through access to healthcare and counseling services, and ensuring incidents are promptly reported and reviewed by hospital administration. Furthermore, nurse managers must advocate for systemic changes—such as improved staffing ratios, environmental modifications, and zero-tolerance policies—to address the root causes of WPV and prevent recurrence (Sullivan, 2019). Collectively, these measures emphasize that addressing WPV requires a multifaceted and sustained approach involving policy, education, hazard control, and leadership engagement. Beyond safeguarding staff, such efforts contribute to a safer and more therapeutic environment for patients, ultimately enhancing the quality and safety of healthcare delivery.

## Strengths and Limitations

This study offers valuable insights into the lived experiences of nurses facing WPV, particularly within the context of a regional hospital in Indonesia, a setting where qualitative evidence remains limited. By employing Husserl's descriptive phenomenological approach and using in-depth interviews, the study was able to capture rich, nuanced narratives that reflect the complexity of WPV in nursing practice. The purposive sampling and achievement of data saturation further enhance the credibility and transferability of the findings. However, several limitations should be acknowledged. The study was conducted in a single hospital setting, which may limit the generalizability of the results to other healthcare environments. Additionally, self-reported data are subject to recall bias and the possibility of underreporting due to the sensitive nature of the topic. Despite these limitations, the findings contribute significantly to the understanding of WPV in nursing and highlight the urgent need for comprehensive prevention and intervention strategies.

## Implications for Practice

The findings from Sabang City General Hospital underscore that WPV is not only a pervasive challenge in global healthcare but also a pressing local issue with profound implications for nurse well-being and patient care. Participants' narratives revealed that incidents of verbal abuse, bullying, and physical aggression were often normalized and insufficiently addressed, fostering a workplace climate that compromised safety and morale. These experiences highlight the urgent need for hospital leadership to implement structured WPV prevention and response protocols tailored to the local context. Such measures should include comprehensive staff training in violence recognition and de-escalation, establishment of clear reporting and follow-up procedures, provision of psychological support for affected staff, and integration of WPV prevention into organizational policy. Strengthening interprofessional collaboration, improving staffing ratios, and fostering a culture of mutual respect are also critical to mitigating the risk of violence. By addressing WPV proactively, Sabang City General Hospital can enhance nurse retention, improve the quality of patient care, and serve as a model for other healthcare facilities in Indonesia facing similar challenges.

# CONCLUSIONS

WPV remains a critical issue that demands urgent and sustained attention from healthcare leaders, policymakers, and nursing managers. Immediate action is essential to prevent its escalation and to safeguard the physical, psychological, and professional well-being of healthcare workers, particularly nurses who are frequently at the frontline of patient care. Creating a safe and supportive work environment not only protects nurses from

harm but also fosters comfort, confidence, and motivation, enabling them to deliver high-quality nursing services. Addressing WPV requires a multifaceted approach that includes clear organizational policies, effective prevention and response protocols, staff education, and a workplace culture grounded in respect and zero tolerance for violence. This must be a priority for healthcare institutions to ensure that acts of violence—whether perpetrated by colleagues, patients, or visitors—are promptly identified, effectively managed, and ultimately reduced. By doing so, organizations can enhance nurse retention, promote patient safety, and strengthen the overall quality of care.

### Declaration of Interest

*The authors declare no conflicts of interest.*


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### Data Availability

*None*

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