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'It comes with the territory' - Staff experience with violation and humiliation in mental health care - A mixed method study

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HIGHLIGHTS

- A high amount of MHC staff report experiences of being violated and humiliated during work.
- The participants' perceptions of the users and their behaviour seem to influence their experience.
- Male workers were more often victims of serious physical violence, and women were more often targets for sexual harassment.
- Participants considered being exposed to violence and humiliation to be part of the job when working in mental health care.

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ABSTRACT

Background: The aim of this study was to investigate staff's experiences with violation and humiliation during work in mental health care (MHC). A total of 1160 multi-professional MHC staff in Norway responded to an online questionnaire about their experiences with different kinds of violation and humiliation in the MHC setting. In addition, a sample of professionals (eight MHC nurses) were recruited for in-depth individual interviews.
Method: The study used an explorative mixed method with a convergent parallel design; this included a web-based questionnaire to MHC staff in combination with individual interviews. The sample is considered to be equivalent to staff groups in MHC in Norway.
Results: Between 70 and 80% of the staff reported experiencing rejection, being treated with disrespect, condescending behaviour or verbal harassment. Male workers were significantly more often victims of serious physical violence, and women were significantly more often targets for sexual harassment. In interviews, participants said they considered being exposed to violence and humiliation to be part of the job when working in MHC, and that experience, as well as social support from colleagues, helped MHC practitioners to cope better with violent situations and feel less humiliated at work.
Discussion: A high amount of MHC staff report experiences of being violated and humiliated during work. The participants' perceptions of the users and their behaviour seem to influence their experience of feeling violated and humiliated. Knowledge about the dynamics of aggression between staff and users in MHC may be used in safeguarding staff and users, prevent coercion and heighten the quality of care.

1. Background

Violence and humiliation toward staff is one of the major concerns in mental health care (MHC) services (Atawneh, Zahid, Al-Sahlawi, Shahid, & Al-Farrah, 2003; Magnavita & Heponiemi, 2012; Rippon, 2000). As a consequence, attention has been given to the topic of risk-assessment (O'Rourke, Wrigley, & Hammond, 2018). Safety at work promotes good health and work satisfaction for employees. Staff security is also an important factor in providing good service to users during MHC. Further staff are more productive in an environment where they feel safe from violence and threats (Soares, Lawoko, & Nolan, 2000; Svalund, 2009), which, may have a negative impact on both the work environment and quality of care (Svalund, 2009).

Violence and humiliation come in many forms and variations, and handling aggression is a major challenge in MHC and a primary reason for applying coercive measures (Anderson & West, 2011; Haugvaldstad & Husum, 2016; O'Rourke et al., 2018); it includes acts of physical, verbal and sexual violation and harassment. The World Health

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Organisation divides violent acts into four groups: physical, sexual, psychological and emotional (Butchart & Mikton, 2014). Hartling and Luchetta (p. 264) have provided a definition for the concept of humiliation: 'The internal experience of humiliation is the deep dysphoric feeling associated with being, or perceiving oneself as being, unjustly degraded, ridiculed, or put down—in particular, one's identity has been demeaned or devalued' (Hartling & Luchetta, 1999). Another concept that need to be defined are 'debriefing'. Staff debriefing is a rigorous event analysis of each incident to address practice issues, identify system problems with the intentions to prevent staff burn-out and, heighten quality of care and prevent recurrences (Sutton, Webster, & Wilson, 2014).

The phenomenon of violence and humiliation in MHC is complex, so this study has an explorative design and uses mixed methods (Creswell & Plano Clark, 2011), addressing both MHC staff experiences of humiliation and violation at work and their perception of these experiences. Users' experiences of humiliation were also investigated and have been published in a previous article (Husum, Legernes, & Pedersen, 2019). The study is part of a larger study at the Centre for Medical Ethics (University of Oslo, Norway) investigating different ethical challenges in relation to MHC, especially the use of coercion and experiences of violation and humiliation.

1.1. Research on violence and humiliation in the MHC setting

Previous research shows that violence against health care staff is common (Gates, 2004; Kuehn, 2010). The European Commission defines workplace violence as 'Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.'

The Norwegian labour inspection authority (Arbeidstilsynet, 2009) have reported that 5–6% of Norwegian employees are exposed to violence at least once a month. However, research shows that as many as 50–85% of MHC staff have experienced different kinds of violence during their career (Al-Azzam, Tawalbeh, Sulaiman, Al-Sagarat, & Harb, 2017; Atawneh et al., 2003; Nolan, Soares, & Arnetz, 1999; Svalund, 2009). Violence against employees has been claimed to increase in frequency and severity in the MHC setting (Nolan et al., 1999; Rippon, 2000; Soares et al., 2000; Taylor & Rew, 2010), and there is also reason to believe that violence against employees is under-reported (Atawneh et al., 2003; Nolan et al., 1999; Rippon, 2000; Taylor & Rew, 2010). Some consider violence and threats as part of the work in MHC, and as a consequence, the problem has not been taken seriously enough (Anderson & West, 2011; Rippon, 2000; Svalund, 2009). Reporting violent behaviour has been inhibited by the stigma of victimisation, such as shame, threat of further violence, isolation and fear of judgement (Rippon, 2000). Peer pressure and limited support from supervisors have made some health care staff unwilling to report incidents of violence. Under-reporting may also be due to uncertainty about what should be reported as violence (Anderson & West, 2011; Rippon, 2000).

Organisational challenges, such as staff shortages, low social support, time pressure, overtime work, high job demands, heavy workload, lack of time to carry out one's duties, interactional atmosphere, role conflict and lack of predictability at work, are reported as contributing risk factors to violence (Arbeidstilsynet, 2009; Johannessen, Gravseth, & Sterud, 2015). Furthermore, younger employees with limited experience of health care seem more vulnerable than older employees (Gerberich et al., 2004; Nolan et al., 1999).

Health care staff exposed to violence may experience both short- and long-term consequences (Gates, Gillespie, & Succop, 2011; Rippon, 2000). How employees cope with violence is both individual and dependent on the severity and frequency of episodes and how the organisation deals with it afterwards (Atawneh et al., 2003). For some employees, there will be no consequences of violence and humiliation beyond the actual episode, whereas others will experience persistent physical and mental problems that might lead to sick leave, higher staff turnover, poor staff morale and absence from work (Schnieden, 1993, cited in (Atawneh et al., 2003)). MHC staff who are frequently exposed to violence and humiliation tend to develop depressive symptoms, are reluctant to be closely involved with users and experience guilt, self-doubt, helplessness and work dissatisfaction (Atawneh et al., 2003; Gerberich et al., 2004; Rippon, 2000; Soares et al., 2000).

MHC users sometimes reject help and are considered a threat toward themselves and others. The user group also includes users who may struggle with emotional, relational and drug challenges, which may predispose them to display aggressive behaviour (Anderson & West, 2011; O'Rourke et al., 2018). Users' perception of limits and restrictions also plays a part. The goal of this study was to investigate experiences with violence and humiliation during work in a Norwegian sample of multi-professional staff working in MHC. The research questions to be answered were:

1. What kind of violation and humiliation have MHC staff experienced at work?
2. How common is the experience of being subjected to violation and humiliation during work in this sample?
3. How do staff perceive experiences of violation and humiliation during work?
4. How do staff think that they can be safeguarded during work in MHC?

2. Method

This is an exploratory study using mixed methods. A convergent parallel mixed-method design has been used (Creswell & Plano Clark, 2011), where qualitative and quantitative data are collected in parallel, analysed separately and then merged and interpreted together. Quantitative data were collected in collaboration with several professional organisations through a web-based questionnaire. In addition, semi-structured individual interviews with eight MHC nurses were performed to complement the questionnaire-based data (Fig. 1).

2.1. Study population and procedure/sampling

The Norwegian health care system is organised through four regional and 26 local specialist health care authorities, along with 356 municipalities with responsibility for primary health care. We performed an anonymous electronic survey among professionals and treatment staff from all parts of the Norwegian psychiatric and addiction treatment system, including hospital-based wards, outpatient clinics and municipal services. For optimal dissemination of the electronic questionnaires, we contacted the five most relevant professional organisations: Norwegian Medical Association (psychiatrists or doctors training in psychiatry); Norwegian Psychological Association (psychologists working in mental health and substance abuse treatment settings); Norwegian Nurses Organisation (nurses working in mental health and substance abuse treatment settings); Norwegian Union of Social Educators and Social Workers (social workers, child welfare officers and social educators working in mental health and substance abuse treatment settings); Norwegian Union of Municipal and General

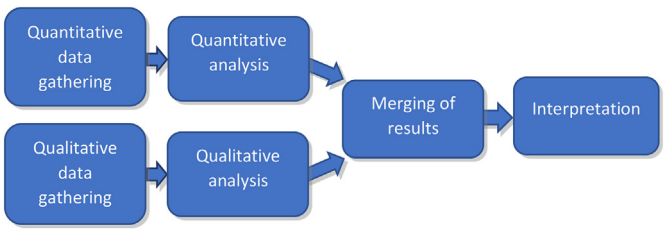

Fig. 1. Phases in the convergent parallel mixed-method design.

Employees (auxiliary nurses and others working in mental health and substance abuse treatment settings). Each organisation sent an email with a link to the electronic questionnaire to their members, a total of 15,576 professionals. With this procedure, it was not possible to send individual reminders, but the respondents seemed fairly representative for Norwegian MHC staff. The questionnaire link was open between 16 June and 17 December 2014. The survey was anonymous, and the web-based tool Questback® was used.

2.2. Web based questionnaire to staff

Variables consisted of information about the profession (psychiatrist/MD, psychologist, nurse, other profession) along with the following categorical variables: sex, age group and years of experience. Variables also included where the respondents were working (regional health authority) and the type of treatment setting (psychiatry, addiction treatment, municipality service). The respondents were asked whether they had experienced:

- Rejection
- Being treated with disrespect
- Condescending behaviour
- Threats
- Verbal harassment
- Neglect
- Shoving, spitting, things thrown at them
- Physical violence
- Physically rough treatment
- Lack of privacy
- Verbal sexual harassment
- Physical sexual harassment
- Sexual assault

The questionnaire asked about to what degree the staff had experienced the mentioned behaviour 'in the last 14 days', 'often', 'rarely' or 'not' during the last year. In the analysis, it was not perceived as meaningful to keep this division, and the categories were therefore put together and dichotomised into whether the staff had experienced the particular behaviour or not. The reason that it was not considered meaningful to keep the division in four categories was that few staff had experienced the mentions behaviours during the last 14 days, and the other categories was also often small. So, to get more robust analysis we chose to dichotomize staff experiences in having experienced the mentioned behaviour or not. Hereby the categories 'in the last 14 days', 'often', 'rarely' was put together to one category and named 'have experienced' the particular behaviour. The questionnaire also contained an 'open answer field' where the staff could describe their experience in their own words. A quote from the open answer field are presented on page 18 in the 'Discussion' section.

2.3. Analysis of quantitative data

The quantitative data was analysed with descriptive analyses and F-test. Statistically significant differences between groups of professionals are shown with *p*-values; significant level was set at 0.001. SPSS version 24 was used for all analyses. The results of the quantitative data answer the first two research questions and are presented under the first two headings in the results section.

2.4. Interviews with staff

In addition, eight MHC nurses were recruited for in-depth individual interviews by the two first authors. The recruitment method was strategic, and participants were recruited in different ways: advertising through the web page of a mental health organisation and by contacting the school for education of social workers (OsloMet). In addition, the research network was used to recruit staff for interviews. The inclusion criteria were 'mental health nurse with experience from mental health care'. Only female nurses contacted to be interviewed. The majority chose to be interviewed at their workplace, and one was interviewed at the University of Oslo. All interviews took place in suitable rooms, and the qualitative semi-structured interviews covered a variety of topics:

- Experience of being humiliated or exposed to violence at work
- How they had been exposed
- Personal impact of being exposed
- If their opinions have changed over time
- Contributing/risk factors
- How to prevent violence in the workplace and safeguard staff

When approaching eight interviews, saturation was considered reached and inclusion ended. This means that the last interviews provided little new information in relation to the research questions and we stopped including more nurses in the sample.

2.5. Qualitative analysis

Eight interviews were transcribed, made anonymous and analysed according to Giorgi's principles for phenomenological analysis (Giorgi, 1997). The four analysis steps were: (1) read entire transcript of the interview for a sense of the whole; (2) delineate the meaning units; (3) transform the meaning units into representative and meaningful categories; (4) put together and conceptualise the findings. Condensed descriptions of the findings are used here and presented according to the research questions. Three of the authors have (TLH, VT and RP) have been involved in the analyses to strengthen the reliability of the findings. Result of the quality data answers the two last research questions and are presented under the last two headings in the results section.

2.6. Ethics

The web-based questionnaire was anonymous, and participants were requested not to write information that could compromise the confidentiality of institutions, wards, staff or users. The participants who were interviewed were given written and verbal information about the study and gave written consent to apply. To maintain anonymity, information about the participants was kept to a minimum. Participants were encouraged to contact the main researcher in case of distress after the interviews. None of the participants made contact. The Norwegian National Data Directorate approved the study (receipt number: 27.08.2014, Ref.: 39196/3/AMS).

2.7. Patient and public involvement statement

Representatives from Norwegian MHC user-organisations were involved as a reference group in planning of the overall design of the study, development of research questions and outcome measures construction of the online questionnaire. The project was funded by the Norwegian ExtraFoundation for Health and Rehabilitation, a voluntary health and rehabilitation organisations (NGOs) based in Norway.

3. Results

3.1. Sample

Altogether 15,576 questionnaires were sent out through the professionals organisations and a total of 1160 MHC staff responded to the questionnaire about their experiences with different kinds of violation and humiliation in the MHC setting. This gives an overall response rate of 7.5% (1160/15,576), varying from 5% of the nurses to 12% of the psychiatrists and members of the Norwegian Union of Social Educators and Social Workers in this organisations in Norway. The respondents

worked in all four Norwegian regional health authorities and are a multi-professional group, with all professional groups in MHC represented in the sample. The sample consisted of 66% women and 34% men. Of these, 25% were social workers (n = 286), 22% psychologists (n = 258), 20% nurses (n = 233), 18% psychiatrists or psychiatrists in training (n = 211) and 15% assistant nurses or other (n = 172). Additional information about the sample is presented in previous articles from the study (Aasland, Husum, Førde, & Pedersen, 2018; Husum, Hem, & Pedersen, 2017).

The eight participants recruited for in-depth interviews were experienced female MHC nurses aged 40–50 years who worked in MHC specialty services. Based on an open invitation to participate in the study, only female nurses volunteered. The gender bias will be further discussed in the discussion and in the 'limitation' section. Results will be presented according to the four research questions.

3.2. What kind of violation and humiliation in work had MHC staff experienced?

The majority of the participants in the web-based survey had broad experience with different kinds of humiliation and violation during work. Between 70 and 80% of the staff members reported experiencing rejection, being treated with disrespect, condescending behaviour or verbal harassment. Male workers were more often victims of serious physical violence (physically rough treatment, physical violence and being subjected to shoving, spitting and things thrown at them) and women were significantly more frequent targets for sexual harassment. The nurses who were interviewed had also experienced violation and humiliation during work. A majority of the eight nurses told about experiencing violence and humiliation during work in MHC, but also said that the words 'humiliation' and 'being exposed to violence' were rarely used at work regarding the behaviour they were exposed to from the users.

3.3. How common was the experience of being subjected to violation and humiliation during work in this sample?

The columns in Fig. 2 show the proportion of participants in the sample who experienced the behaviour mentioned after the answers had been dichotomised. There were significant gender differences in some types of experiences, as shown by the p value on the columns. Significant findings with p-values are shown beside the columns. The whole sample consists of 66% women/34% men.

There were also differences between the professional groups with regard to how many had experienced the behaviour mentioned. There were significant differences on all variables except for 'sexual assault' (F test). Staff working in the units 'on the floor' had experienced more of all kinds of humiliation and violence than staff working at a greater distance in offices. Psychologists had experienced less of all kinds of the negative behaviours mentioned (Fig. 3).

3.4. How do staff perceive experiences of violation and humiliation during work?

The nurses interviewed said that they had experienced being verbally scolded and felt afraid when being a victim of violence, but they said they had not felt humiliated by the behaviour. They thought of the experiences as *'Part of the job, which had to be tolerated' and, as one said, 'It comes with the territory'*. Some of the nurses had experienced verbal violence, and a minority said they had experienced physical violence. One of the participants said that she had experienced sexual assault. Some of the nurses had experienced threats, and a minority mentioned that their family or someone they cared about had been threatened or humiliated. A sample quote: *'I have not experienced much violence. I have experienced more threats. When my family are being threatened, I experience it as especially intimidating. It makes me scared'*.

Further, some of the participants mentioned feeling vulnerable as a result of feeling humiliated at work. Among other things, the participants mentioned that all staff members have good and bad days when they are more vulnerable because of stress or fatigue. Being tired or stressed could make the experience of humiliation worse. The

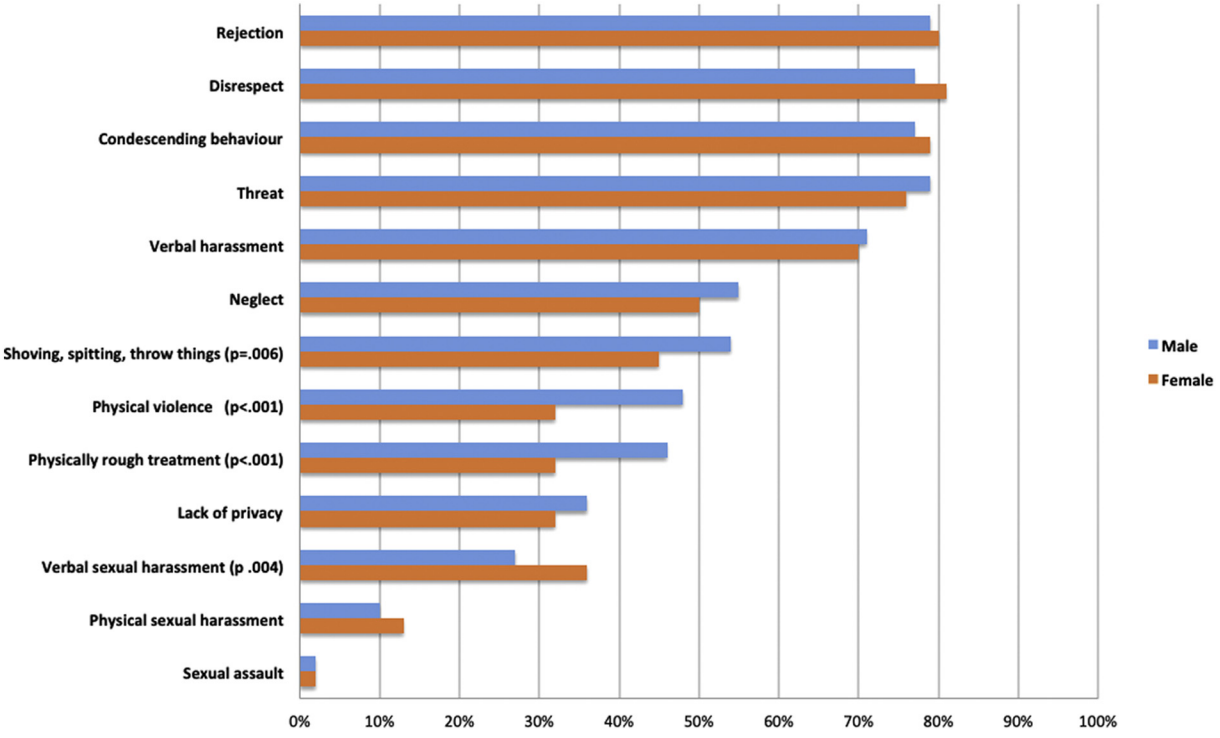

Fig. 2. Proportions of female and male staff's experience with violations and humiliations during work.

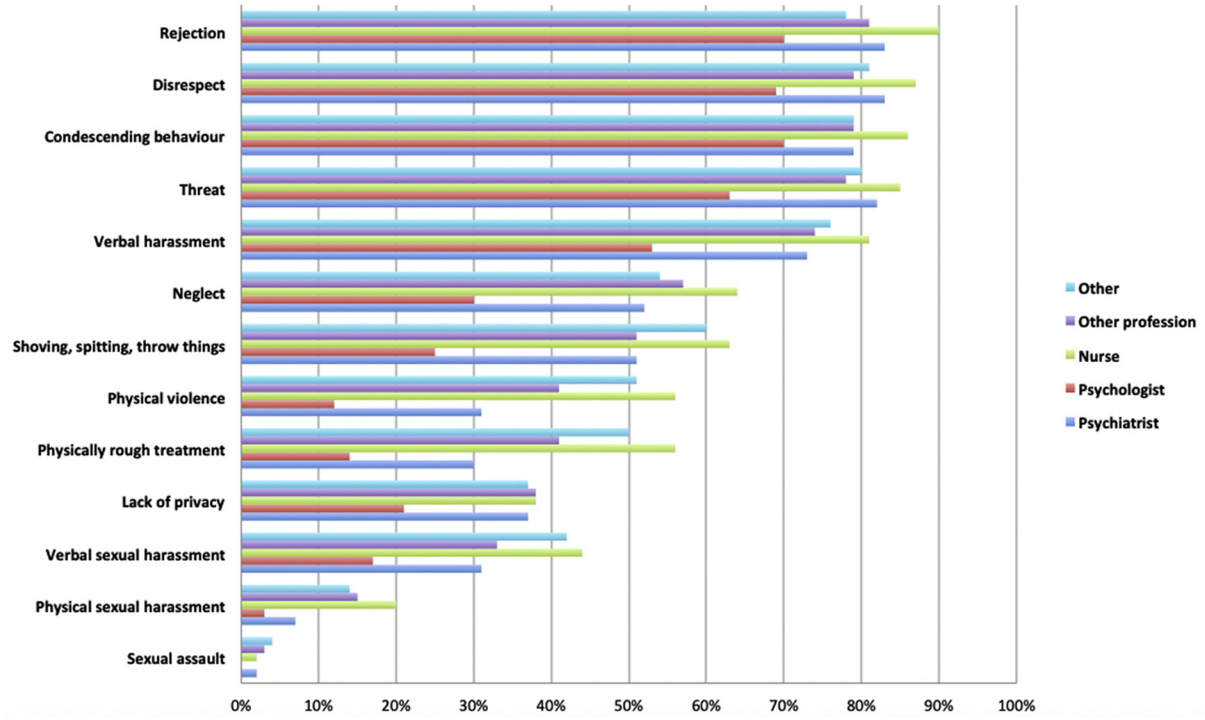

Fig. 3. Different professions' experiences with violation and humiliation during work. For all differences (except sexual assault) the F-tests are significant.

participants explained this as one reason for feeling humiliated on some days: *'Something may be experienced as a humiliation one day; but maybe not another day when one maybe is feeling stronger'*. However, they said they often did not feel personally offended. They said they regarded the negative experiences as part of their job, caused by the users' mental illness: *'I have to say that I see that these users are very sick, and that the threatening behaviours are part of their defence mechanisms. I don't get intimidated by that'*. The participants mentioned that they did not think that the users humiliated them intentionally or were violent deliberately; they considered their behaviour as part of their mental illness.

The participants said that being exposed to violence affected their self-esteem. They said that in the long term, violence and humiliation could change you if you did not do anything about it. Some of the participants said they were more vulnerable before, compared to now. What they defined as humiliating or violent had changed. What they perceived as humiliating or violent before was not necessarily humiliating and violent now, as things did not get to them as easily. Being more self-assured and gaining knowledge and experience were mentioned as contributing factors. Furthermore, they said that even if they did not take it personally, it could make an impact: *'I think I have gotten thicker skin and got more robust now. I stand stronger as a nurse. It needs more to change my view of myself as a nurse'*. However, getting used to being humiliated was also mentioned as a possible risk factor for burnout.

3.5. How do staff think that they can be safeguarded during work in MHC?

According to the participants, knowledge and experience determine whether employees feel humiliated or not. The participants believed that new and young staff members had less competence and experience than those who had worked in MHC for a while: *'When you are older and more experienced, you feel safer. You are maybe better able to predict when situations develop'*. Gaining work experience would make employees able to tolerate more. The participants reported that they had more knowledge and became more reflective when they gained more work experience. The majority of the nurses believed that their perceptions of humiliation and violation were habituated. By habituation, they meant that when you get used to being exposed to threats and violations over time, you feel less humiliated. The threshold for feeling humiliated is heightened: *'I have worked here a while, and I guess you get used to it. Things I maybe would feel humiliated by if I were new here, or not used to them (the users). There are things I don't consider as a humiliation now'*.

Furthermore, participants said that their experience and knowledge taught them how to interact with users. They learned how to behave, how to deal with the users and how to communicate and perceive situations before they escalated. By always being one step ahead, employees can avoid situations that may lead to humiliation or violation. Several of the participants mentioned that being young and inexperienced was a risk factor for being vulnerable to humiliation and violation: *'You come proud. You have come to help people. And then you are degraded and rejected instead. You are told (by users) you are not worth anything. That you don't know anything and that you are a bad person. That isn't a good feeling'*. All participants mentioned that experience was a contributing factor for how employees cope with humiliation and violence. More experience and knowledge made them less vulnerable.

Several of the nurses being interviewed believed that social support from colleagues helped in coping with humiliation and violation. Social support gained through debriefing helped employees to cope with difficult situations. Among other things, the participants mentioned follow-up and/or de-briefing, good interaction, reflection and information from colleagues as preventive factors for being exposed to humiliation and violence. According to the participants, individual employees are responsible for informing other employees if things get out of control or if they are not able to manage difficult happenings at work. Furthermore, employees mentioned that it is important for colleagues to look after each other: *'It's important to talk to someone afterwards. We cannot protect ourselves from feeling humiliated. We are humans after all. But it is part of the work when working with people. We humiliate and are humiliated in different situations. But we could probably be more aware and ask ourselves if this was ok. We try to talk together at work and talk through episodes. It's something about trying not to take home too much'*.

The informants also said that different work factors could increase the risk of being a victim of violence and humiliation at work. Time

pressure, stress, heavy workloads, staff shortages, poor capacity and colleagues' competence are some of these factors. Furthermore, those who had worked with users in their homes said that they felt more exposed to threats and violence. In the users' own homes, they often worked alone and therefore did not have immediate help and support from colleagues, unlike in the mental health institutions. Working part time gave employees the opportunity to get away and reflect on their work, and therefore it was perceived to make it easier to cope with humiliation and violence. On the other hand, working full time or more could make staff more tired and therefore more prone to be humiliated in relation to episodes that involve aggression and/or violation.

4. Discussion

In this discussion, results from the quantitative and qualitative inquiry will be interpreted together in order to provide a deeper and better understanding of the topic. The distribution of staff in the quantitative sample resembles the population of staff working in MHC in Norway; therefore, the sample is considered to be fairly representative of staff in MHC services in Norway.

4.1. Violation and humiliation: A common experience during work

Between 70 and 80% of the mental health workers in the sample who answered the questionnaire in the quantitative part of this study reported experiences of humiliation and violation during work. This is a disturbingly high percentage, which suggests that conflict and aggression between service users and staff are part of daily life in mental health services. This percentage is also in line with previous international findings, which confirm that as many as 50–85% of mental health staff have experienced violation and humiliation during work (Anderson & West, 2011; Atawneh et al., 2003; Campbell et al., 2011; Jonker, Goossens, Steenhuis, & Oud, 2008; Nolan et al., 1999; O'Rourke et al., 2018; Soares et al., 2000). However, due to different definitions of terminology and settings, it is difficult to assess and compare the prevalence of violence and humiliation in MHC (Anderson & West, 2011; O'Rourke et al., 2018).

Because it may be considered shameful to be victimised at work, experiences of humiliation and violations may be under-reported (Anderson & West, 2011; Atawneh et al., 2003). The issue of shame was possibly less challenging for the participants who answered the anonymous questionnaire. Even so, the professionals may label their experiences in different ways. One of the main findings from the interviews was that participants were hesitant to use the terms 'humiliation' and 'violation' for their experiences. Some of the nurses interviewed said that they did not use these words in their daily talk at work, which may be another reason for under-reporting violence and humiliation at the workplace in MHC (Ferns, 2006). When users behaved in a threatening manner, staff seemed to perceive this as part of the mental illness and not as behaviour that the users should be held accountable for.

Previous research also suggests that the issue of violation and humiliation toward MHC staff has not been given enough attention or treated seriously, because it is considered to be 'part of the job' (Anderson & West, 2011; Rippon, 2000). This may also be due to the stereotype that users with mental illnesses are considered to be violent and dangerous (Anderson & West, 2011; O'Rourke et al., 2018).

Male workers seem to be more exposed to the most serious kind of violation in the form of physical violence, physical rough treatment and shoving, spitting and having things thrown at them. This may be due to the fact that it is the male workers who are often given the task of handling aggression in the wards. A Norwegian study supports the findings that male workers may be expected to handle aggression and situations that may develop into physical aggression (Sommerseth, 2008). Female staff, on the other hand, seem to be more exposed to verbal sexual harassment. Some researchers claim that nursing is the profession with the highest rate of sexual harassment (Madison & Minichiello, 2001; Robbins, Bender, & Finnis, 1997). This study indicates that nurses experience all kinds of humiliation and violation more often than other professionals. This is presumably because nurses work close to the users in the ward, unlike psychiatrists and psychologists, who generally have offices outside the ward and meet the users more rarely. Psychologists, in fact, experienced less violation and humiliation during work in MHC than other professionals. This may be due to their handling of aggression in a more therapeutic way, but it may also be influenced by other factors and should be investigated further through research. Another part of this study, which investigated attitudes and opinions on coercion among professionals, also found that psychiatrists were more authoritarian and prone to use paternalistic interventions than psychologists (Aasland et al., 2018). The difference between professions should be investigated more thoroughly. Staff with experience working outside the hospital setting and at the user's own home also said they felt particularly exposed and vulnerable.

4.2. 'It comes with the territory'

The qualitative data support the perception that being exposed to humiliation and violation is part of the work and *'comes with the territory'* (quote from open answer field in the questionnaire). One explanation could be that being defensive and prone to aggression is part of users' mental disorder, and that user aggression and violence is part of their symptomatology. In this way, the users are not held responsible for their actions and the topic may be downplayed. The relationship between aggression and mental health challenges is complex, and some researchers claim that 'mental disorders are neither necessary, nor sufficient causes of violence' (Stuart, 2003). User aggression may also be viewed as a response to 'normal' interaction processes (Haugvaldstad & Husum, 2016). Aggressive interaction may be influenced by the users' and staff members' characteristics and experiences, as well as factors arising from the interaction between them (Holmqvist & Armelius, 1996). Traditionally, violent behaviour among users has been viewed as a symptom of mental illness (Anderson & West, 2011; O'Rourke et al., 2018). There is, however, a growing body of empirical evidence suggesting that user/staff interaction may exert important influences on users' aggression and violence (Duxbury, 2002; Gadon, Johnstone, & Cooke, 2006; Hamrin, Iennaco, & Olsen, 2009). This indicate that there is need for a more interactional view on the topic of aggression in MHC (Haugvaldstad & Husum, 2016).

If staff perceive aggressive outbursts as part of the illness and try to act professional by keeping at a distance from the user, this may lead users to perceive themselves as not being treated with authenticity. A contemporary study on interaction between staff and users highlights the importance of ordinary and authentic relationships between staff and users in psychiatric care from the users' perspective (Molin, Graneheim, & Lindgren, 2016).

Being 'professional' is sometimes associated with being invulnerable and able to cope without feeling humiliated, and staff claim that training and experience give them such competence. Vulnerability to humiliation is also associated with being young and inexperienced. Defining humiliation and violent behaviour as part of the users' illness may be a strategy to cope better with the challenges of work. This finding is in line with previous research, which also found that more experienced staff felt less humiliated than less experienced staff (Gerberich et al., 2004; Nolan et al., 1999; Rippon, 2000). A theoretical framework useful for interpreting this finding is social learning theory and the perception of self-efficacy. In line with this theory, more experience, knowledge and perception of control may prevent feelings of humiliation—for example, by perceiving aggression as a trait of the user, instead of viewing it as a result of interaction or as a challenge at work (Bandura, 1977; Lazarus & Folkman, 1987).

4.3. How to create safer environments and staff

The participants mentioned several possibilities for safeguarding staff before and after episodes that include experiences of humiliation or violence. This is in line with previous research (Anderson & West, 2011; O'Rourke et al., 2018). Support from other staff, the possibility of talking to and getting input from supervisors and a debriefing routine are also all known to prevent staff burnout (Bang, 2003). Another study of violence in acute psychiatric units found that nurses endorsed the need for improved education and debriefing following an incident and a supportive work environment to prevent user violence (Stevenson, Jack, O'Mara, & LeGris, 2015). Several of the participants mentioned the importance of feeling safe at work, with emphasis on safe colleagues, a safe physical environment and staffing levels that provide safety. This may especially be a challenge when MHC staff work increasingly in outpatient settings.

The importance of making staff feel safe and be safe at work is an important question and is also highlighted in literature reviews examining how staff factors may influence the escalation of aggression and threatening episodes (Anderson & West, 2011; Haugvaldstad & Husum, 2016; O'Rourke et al., 2018). Staff insecurity may lead to the development of dangerous situations and the use of involuntary means (Haugvaldstad & Husum, 2016). Organisational factors mentioned by the participants that may enhance staff security include appropriate staffing levels, the prevention of crowded wards, high competence of staff and a good therapeutic environment for users. This is also in line with previous research and recommendations.

4.4. Strengths and limitations of the study

A particular strength of the present study is that it contains a comprehensive nationwide and multi-professional sample of MHC staff in Norway. All health regions in Norway are represented. The anonymous web-based questionnaire may have encouraged the participants to give frank and honest answers. The mixed-method design is also a strength, as the quantitative and qualitative data complement each other and provide a deeper, more comprehensive understanding of staff experience with humiliation and violation during work.

However, there are also some limitations to this exploratory study, such as the low response rate for the quantitative part, which comprised the online questionnaire. Despite this, the sample is fairly large, which to some degree compensates for the low response rate. Previous research confirms that online questionnaires often show low response rates, lower than traditional questionnaires (Crouch, Robinson, & Pitts, 2011).

Another limitation of this study is the possibility of self-selection bias when the participants filled out the questionnaire. Staff with the most comprehensive experience of violation and humiliation may have volunteered to participate in the study. Therefore, this sample of staff may include more staff who have more experiences of violation and humiliations than a representative sample of staff would have had. Talking about experiences with humiliation may be perceived as shameful and non-professional, leading participants to conceal such experiences, especially in the interviews. Furthermore, staff may escape from feeling vulnerable by avoiding talking or thinking about experiences of humiliation.

Further, only female nurses were recruited for interviews. This may create a gender bias. Male nurses and mental-health workers may have other experiences of being victimised at work, and this question should be investigated further. Differences in experience and perception between professional groups should also be investigated more thoroughly in future studies.

5. Conclusion

A high number of MHC staff in this sample reported experiencing rejection, disrespect, condescending behaviour or verbal harassment during work. The majority of participants had experienced humiliation and violation during work. There were significant differences between genders and among the different professions. Male workers were more often victims of serious physical violence (physically rough treatment, physical violence and being subjected to shoving, spitting and things thrown at them) whereas women were more often exposed to sexual harassment. Staff working in the units 'on the floor' experienced more humiliation and violation than staff who generally have offices outside the ward. Psychologists, in fact, experienced less violation and humiliation than the other groups. The interviews revealed, however, that the nurses did not feel personally offended because they often perceived the experiences as part of their job and a consequence of the users' mental illness. Experience and knowledge seem to reduce the perception of humiliation and violation. Furthermore, the nurses said that being tired or stressed made the experience of humiliation worse. Getting used to being humiliated was mentioned as a possible risk factor for staff burnout.

To give users high quality care, staff need both skills and support in dealing with humiliation and violation. In particular, staff need skills in de-escalation techniques and prevention of aggression on MHC wards. Experiences with humiliation and violation may have a negative effect on staff, both psychologically and physically, thus compromising the quality of care; therefore, efforts should be made to prevent and reduce such experiences.

Contributorship statement

All authors have been involved in planning the study. The first and second authors conducted interviews and qualitative analysis, together with the last author. The first, third and last authors analysed the quantitative analysis. The first author is responsible for the mixed method analysis, together with the last author, and the last author conducted the quantitative analysis. All authors contributed to writing the manuscript.

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Data sharing statement

Data belong to the University of Oslo. The study has a mixed method design and consists of quantitative and qualitative data. Study protocol, statistical analysis, and interview transcripts may be presented upon request.

Declaration of Competing Interest

The authors have no competing interests.

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