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Psychological violence in nurses' professional practice*

VIOLÊNCIA PSICOLÓGICA NA PRÁTICA PROFISSIONAL DA ENFERMEIRA

VIOLENCIA PSICOLÓGICA EN LA PRÁCTICA PROFESIONAL DE LA ENFERMERA

Rute Barbosa[1], Liliana Maria Labronici[2], Leila Maria Mansano Sarquis[3], Maria de Fátima Mantovani[4]

ABSTRACT

April to June 2008, at Universidade Federal do Paraná, in three hospitals, one higher education school and one secondary education school. The objectives were: to analyze the presence of psychological violence in the professional practice of nurses; to characterize the type of violence and the aggressor; to identify the victim's reactions after the aggression. Interviews were performed with 161 nurses, whose ages ranged between 22 and 57 years, and most of white ethnicity. It was found that psychological violence occurs at both the hospital and academic settings; most aggressors are women, particularly colleagues, followed by physicians and other health team professionals; nurses with less than one year since their graduation were those who suffered the highest degree of aggression and of greatest intensity. The factors that resulted from the aggression included irritability, which ranked first place, followed by anger, sorrow, and reduced self-esteem.

KEY WORDS

Violence against women.
Nurses.
Women, working.
Professional practice.

RESUMO

Pesquisa descritiva realizada de abril a julho de 2008, na Universidade Federal do Paraná, em três instituições hospitalares, uma unidade acadêmica de ensino superior e uma de ensino médio. Os objetivos foram: analisar a presença da violência psicológica na prática profissional da enfermeira; caracterizar o tipo de violência e o agressor; identificar as reações da vítima após a agressão. Foram entrevistadas 161 enfermeiras, com idade entre 22 a 57 anos, prevalecendo a raça branca. Constatou-se que a violência psicológica acontece no ambiente hospitalar e acadêmico; os agressores em sua maioria são mulheres, com destaque para as colegas de trabalho, seguido do médico e outros profissionais da equipe de saúde; as enfermeiras com menos de um ano de graduação foram as que sofreram maior grau de agressão e com maior intensidade. Entre os fatores resultantes da agressão, a irritabilidade está em primeiro lugar, seguida da raiva, tristeza e diminuição da auto-estima.

DESCRITORES

Violência contra a mulher.
Enfermeiras.
Trabalho feminino.
Prática profissional.

RESUMEN

Investigación descriptiva realizada de abril a julio de 2008 en la Universidad Federal de Paraná, en tres instituciones hospitalarias, una unidad académica de enseñanza superior y una de enseñanza media. Los objetivos fueron: analizar la presencia de la violencia psicológica en la práctica profesional de la enfermera, caracterizar el tipo de violencia y al agresor, identificar las reacciones de la víctima después de la agresión. Fueron entrevistadas 161 enfermeras, con edad entre 22 y 57, prevaleciendo la raza blanca. Se constató que la violencia psicológica acontece en el ambiente hospitalario y académico, los agresores en su mayoría son mujeres, destacándose las colegas de trabajo, seguidas por los médicos y otros profesionales del equipo de salud, las enfermeras con menos de un año de graduación fueron las que sufrieron mayor grado de agresión y con mayor intensidad. Entre los factores resultantes de la agresión, se ubica en primer lugar la irritabilidad, seguido de la rabia, tristeza y disminución de la autoestima.

DESCRIPTORES

Violencia contra la mujer.
Enfermeras.
Trabajo de mujeres.
Práctica profesional.

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INTRODUCTION

Psychological violence is a complex phenomenon comprehended as a multidimensional psychosocial syndrome. Psychosocial because it affects the individual, the work group and the organization, producing dysfunctions at individual and collective levels, generating important external repercussions; and multidimensional as it is commonly presented with a range of physical and psychic symptoms, specific and nonspecific, not reducible to a typical and easily diagnosed configuration[1].

The Law Maria da Penha defines psychological violence as:

> any behavior that causes emotional harms and lowers the self-esteem, harms one's full development or aims to degrade or control one's actions, behaviors, beliefs and decisions through threats, embarrassment, humiliation, manipulation, isolation, constant surveillance, disobedient persecution, insult, blackmail, ridiculing, exploitation and limitation of the locomotion right or any other means that causes harms to one's psychological health and self-determination[2].

The psychological violence affects the multidimensionality of the woman, since its invisibility leaves marks caused but its frequency, and the triviality involved in its treatment eliminates the structure of the individual identity[3].

The possibility of women being victims of psychological violence in the several sectors of the public space takes place due to their presence in the working world, which reflected in the increase of the statistics of this working class. Studies show that verbal abuse, intimidation and moral harassment are more frequent than physical aggressions, and from 40 to 70% of the victims show symptoms of substantial stress, as shown by the labor overview report of the International Labor Organization - ILO[3-4].

Records of the ILO[3] show that health professionals suffer violence at work. In Bulgaria, 76% suffered some sort of violence at work, in South Africa, 61%, in Thailand, 54%, and 46.7%, in Asia.

In Brazil, there are records of incidents of physical or psychological violence at work, however, there is the undernotification as fulcrum to rethink it. Statistics reveal that the violence in the health area goes beyond individual insults and aggressions, since it jeopardizes the productivity, the care quality and the development of the daily and professional activities, women are especially vulnerable. The possibility of the nurse suffering it in the development of her activities is three times higher than that of other health professionals, since it is an essentially female profession[3]. In this context, it is necessary to study it in order to prove its existence both in the public and in the private settings, as well as to develop strategies for facing it, since it leaves invisible marks, and may propitiate the development of diseases, besides harming not only the individual who suffers it, but the collective, and reflecting in the quality of the developed work.

OBJECTIVES

- Analyzing the psychological violence in the professional practice of the nurse;
- Characterizing the type of psychological violence suffered by the nurse and the aggressor;
- Identifying the main reactions of the victim after the aggression.

METHOD

This is a descriptive study developed at the Federal University of Paraná in three hospital institutions, a university unit and a high school unit. Data were collected from April to July of 2008, with 161 nurses, 138 from hospital institutions and 23 professors. The structured instrument used was divided into two parts: the first contained multiple choice questions with alternatives identified to characterize the study subjects, and the second part presented two Likert-type sociopsychological scales to describe the aggressor, the aggression and to identify the victim's reaction after the aggression. Despite of being self-explanatory, it was personally delivered to each one of the participating nurses, who were then instructed about how to fill them out, and a date and time were set for their collection. The scales were validated by specialist judges, as recommended by the literature[5].

The 1st scale was built with statements based on the Law no. 11.340 - (Law Maria da Penha) which defines the psychological violence against women, and 12 items from the list of hostile behaviors elaborated by Heins and Leymann, which were modified and adapted in order to enable the characterization of the aggressor and the psychological violence suffered. The 2nd scale was elaborated based on the literature[6-7] and concerns the effects of violence in the victim's professional practice and life.

After being modified and validated by the specialist judges, the instrument was tested with 6 nurses, 3 nursing professors and 3 clinical nurses, who were not part of the sample. After the test, the instrument was reformatted in order to facilitate the subject's comprehension and answers.

Regarding the ethical aspects, the project was sent to the Committee of Ethics of the Health Sciences Department and approved on 12/12/2007 (CAAE: 0087.091.000-07). The anonymity of the subjects participating in the study was guaranteed with the use of a code instead of their names.

Data were typed into an electronic sheet with the software applications Excel and SPSS (Statistical Package for the Social Sciences). Before starting the statistical analysis, the population was divided into classes: employment bonding, nursing practice time, income, marital status, race and age.

The intensity level of the violence suffered was evaluated according to the frequency of the answers and the aggression level was calculated through the arithmetical mean of the 15 factors evaluated in the second scale of Likert, as they were considered relevant in the measurement of the psychological violence suffered, which were: irritability; lowered self-esteem; professional insecurity; sadness; loneliness; crying crisis; anger; lack of motivation; difficulties in relationships at work; wish to change to a different department; wish to quit the job; wish to change to a different profession; difficulties in the relationship with the family; physical and mental illnesses.

The level of aggressiveness was considered high when most of the statements above were answered with the frequencies: *always* and/or *several times*. It was considered an average level when most of the statements were answered with the frequencies: *only once* and *more than once* (3 times a year). The low level of aggressiveness considered: *never* or *only once*, and at the most *more than once*. Therefore, it was possible to calculate the arithmetical mean and the standard deviation of the answers according to the level of aggressiveness.

RESULTS

The participants were between 22 and 57 years old; among those, 82 (51%) were between 40 and 57 years old; 141 (88%) were white-skinned, 82 (51%) married, 95 (58,8%) clinical nurses, 32 (20%) from the administrative area, 23 (16%) professors, and only 4 (3%) were area managers.

Salaries varied from R$ 1,500.00 to R$ 2,500.00 for 62 (39%). 51 (32%) had graduated over 20 years ago, and 57 (35%) worked in the nursing area for over 20 years. 119 (74%) were nurses approved by a federal public examination, and most of them, 105 (65%), did not have another employment bonding.

By evaluating the income of the Nursing Professors (NP) separately, it was evidenced that none of them earned less than R$ 2,500.00, and 19 (12%) had salaries over R$ 3,500.00, whereas 19 (12%) Nurses from Hospital Institutions (HN) earned up to R$ 1,500.00, and only 17 (10%) had salaries over R$ 3,500.00.

The characterization of the level of aggression suffered, by workplace, evidenced that the Arithmetical Mean (AM) among the NP (n = 23) is 3.67; among the HN (n = 138) AM = 3.85 and regarding all participants (n = 161) AM = 3.82. In face of the similarity of the results, these were presented without a differentiation of workplace.

Table 1 presents the characterization of the psychological violence, suffered by the participants of this study, during their entire professional practice.

Table 1 - Characterization of the psychological violence during the professional practice of the nurse - Curitiba, PR - 2008

Frequency of aggression	N	%
Not applicable and/or indifferent	7	4.3
Never	18	11.1
Only once	10	6.2
More than once	70	43.4
Several times	45	28.0
Always	11	7.0
Total	161	100.0

Note: (n=161)

Table 2 refers to the suffered violence in a recent perspective, during the year of 2007.

Table 2 - Characterization of the psychological violence suffered by the nurse during the year of 2007 - Curitiba, PR - 2008

Frequency of aggression	N	%
Not applicable and/or indifferent	25	16.0
Never	41	25.0
Only once	14	9.0
More than once	48	30.0
Several times	31	19.0
Always	2	1.0
Total	161	100.0

Table 3 presents the characterization of the aggressor's gender.

Table 3 - Characterization of the frequency of aggression according to the aggressor's gender - Curitiba, PR - 2008

Frequency of aggression	Female aggressors		Male aggressors		Sum	
	N	%	N	%	N	%**
Not applicable and/or indifferent	35	21.7	44	27.3	79	24.5
Never	28	17.4	48	29.8	76	23.6
Only once	11	6.8	16	9.9	27	8.4
More than once	41	25.5	34	21.1	75	23.3
Several times	17	10.5	12	7.4	29	9.0
Always	29	18.1	7	4.5	36	11.2
Total	161	100.0	161	100	322*	100

*Total number of aggressions (the same person may have suffered aggressions from different aggressors and from both genders).
** Percentage calculated based on the total number of aggressions (n=322).

Table 4 - Characterization of the aggressor - Curitiba, PR - 2008

Aggressor	Not applicable and/or indifferent		Never		Only once		More than once		Several times		Always		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Co-worker from the same category	35	21.8	34	21.2	7	4.3	53	32.9	17	10.5	15	9.3	161	100
Doctor	60	37.3	24	14.9	10	6.3	39	24.2	17	10.5	11	6.8	161	100
Other professional from the multidisciplinary team	39	24.3	40	24.8	18	11.2	34	21.2	17	10.5	13	8	161	100
Student	52	32.3	89	55.2	5	3.1	10	6.3	5	3.1	-	-	161	100
Patient ad/or patient's relative	40	24.8	70	43.5	15	9.3	20	12.5	15	9.3	1	0.6	161	100

Note: The data presented above are grouped and one nurse may have experienced aggression from different aggressors, in different categories, during the exercise of her practice.

Table 5 characterizes the frequency of the aggression.

Table 5 - Characterization of the frequency of the aggression - Curitiba, PR - 2008

Aggressor	Not applicable and/or indifferent		Never		Only once		More than once		Several times		Always		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
I was assaulted by my superior	45	28	44	27.3	5	3.1	33	20.5	21	13	13	8.1	161	100
I was assaulted by my subordinate	46	28.6	56	34.8	12	7.4	35	21.8	9	5.6	3	1.8	161	100
The aggressions practiced against me came from different aggressors	38	23.6	29	18	9	5.6	57	35.3	18	11.2	10	6.3	161	100
The aggressor had a different skin color from mine	70	43.5	66	41	3	1.8	9	5.6	4	2.5	9	5.6	161	100
The agressor belonged to adifferent social class from mine	70	43.5	37	23	3	1.8	26	16.2	14	8.7	11	6.8	161	100
The agressor was from a different generation from mine	60	37.3	38	23.6	7	4.3	22	13.7	14	8.7	20	12.4	161	100

Note: The data presented above are grouped and one nurse may have experienced aggression from different aggressors, in different categories, during the exercise of her practice.

The doctor was represented independently in the instrument, apart from the variable *other professional from the multidisciplinary team*, since the health team generally has one doctor and one nurse. However, the other professionals, such as physiotherapists, social workers, psychologists and others are not often involved in the routine of the activities of all participants in the study.

Results evidenced that the highest arithmetical mean related to the level of aggression suffered was found among the 19 (11.8%) nurses who earned the lowest salaries, and that this index proportionally decreased as the salary increased.

The age groups that suffered more aggressions are those close to 57 years old, with AM = 5.60, and between 34 and 39 years old with AM = 4.54. It was observed that the longer the period since the graduation the lesser the level of aggression suffered, with a poor negative correlation (-0.49), even with higher AM of aggression (5.60).

Nurses who had graduated less than a year ago were the ones who suffered the highest level of aggression and with the highest intensity. The participants who had graduated over 20 years ago were the main victims (n= 50 = 31%), with lower intensity, revealing the AM = 3.34 regarding the aggression level.

It was evidenced that the nurses submitted to a high level of aggression presented high AM of 15.63 for irritability, 11.85 for anger, 10.98 for sadness, 10.49 for low self-

esteem, 8.45 for crying crisis, 8.11 for loneliness, 7.69 for the wish to change to a different job, 3.93 for the wish to change to a different profession, 3.11 for physical illnesses and 3.27 for mental illnesses. Thus, even when submitted to a low level of aggression, they presented 6.85 for irritability, 5.7 for anger, 4.76 for sadness, 3.41 for low self-esteem and 3.17 for crying crisis.

It was observed that the verbal mistreatment and the actions that discredit the identity of the nurses are the most common. The most frequently indicated items in the frequency *more than once* were: interrupting the speech before the thought conclusion and restricting their professional actions so as to interfere in their practice (n = 52), making malicious comments about the victim (n = 50), ignoring her existence (n = 38), making depreciative insinuations about her competence (n = 35), criticizing her private life (n = 30). Sexual harassment was mentioned by two nurses.

DISCUSSION

The literature confirms that nurses are the main victims of psychological violence at the workplace, and this occupational risk against nursing is disturbing and cannot be compared to that in other professions[5]. In this study, 11 participants answered they *always* suffer this type of violence, and this may be related to the poor social value of the nursing profession, which is socially less visible[8] and eminently female. Therefore, it carries the cultural legacy of subordination that complicates the exercise of the profession.

According to a study developed by the International Labor Organization, the psychological violence is present all over the world in the work environment in different sectors, however, health professionals are those who face the highest risk, and women are especially vulnerable. Consequently, the possibility of a nurse suffering violence at her workplace is 3 times higher than that of any other health professional[3].

A study developed in Chile evaluated the perception of 210 nurses about the labor violence and revealed that 94.3% (n = 198) of them identified the psychological violence as the main type in their professional practice, and that it was manifested through degradation (48.0%), denial (29.0%) and terrorizing (23.0%)[9].

In the Chilean study, the nurses who were close to 57 years old were the main victims. These data are similar to those of the University of Granada, in Spain, with a sample of 325 professors, and evidenced that the labor harassment was concentrated, in 76.4% of the cases, among professionals who were between 36 and 55 years old[10].

A study developed at the Regional Hospital of Bragança, in Portugal, with a sample of 70 nurses, between 24 and 67 years old, evidenced that those who were older than 40 years old were not only the main victims of psychological violence but also experienced the phenomenon with higher intensity[11].

Table 3 shows that 41 (25.5%) nurses stated they were assaulted by another woman *more than once* and 29 (18.1%) reported their aggressors were *always* women, whereas only 34 (21.1%) were assaulted by men *more than once*. This study shows that, at the studied work environment of the studied nurses, women are the main aggressors. This violence may be related to the competition among them, since they continuously seek public acknowledgement at work.

The Association of Canadian Nurses (Associations des Infirmeières et Infirmiers du Canadá - AIIC) shows that the violence among peers has happened with more frequency because the nurses have a difficulty to discuss the violence given and/or received among colleagues, and this lack of visibility increases the possibility of aggression occurrence[12]. The invisibility of the action reinforces the aggressor, thus favoring her persistence in this intent.

A study developed in 1996, in Sweden, with workers in general and from both genders, evidenced that 45.0% of the men suffered labor harassment against 55.0% of the women[12]. The difference was not considered significant, and the conclusion was that both men and women are victims of this phenomenon in the same proportion there. Nevertheless, 76.0% of the assaulted men were harassed by other men, only 3.0% by women, and the others were assaulted by people from both genders. Among the women, 40.0% of the assaulted women were harassed by women, 30.0% by men, and the others were assaulted by people from both genders. This study concluded that aggression is more common among people from the same gender[13].

Another study carried out in France, with 350 subjects, evidenced that 70.0% of the women were victims of labor violence against 30.0% of the men, attributing this difference between the genders to the sociocultural context[7].

The analysis of the aggressor's characterization in Table 4 evidenced a frequency of 53 (32.9%) as victims of colleagues from the same professional category, characterizing the nurse as main aggressor. In the sequence, the frequency found was 39 (24.2%) for *doctor*, and 34 (21.2%) for *other professional from the multidisciplinary team*. The nurses stated that aggressions suffered *more than once* were practiced by their subordinates. However, it is possible to highlight that the nurses suffered violence from all the mentioned aggressors, and, in a sum disregarding the absolute frequency, 67 (40.9%) stated the aggressor was their superior. It was possible to evidence that regardless the hierarchy, the psychological violence in the work environment is present among the participants.

The result indicating that the main aggressor of the nurses (n = 92) was a colleague from the same professional category is similar to that found by a study developed by the International Council of Nurses[5], in which the psychological violence in the professional practice of the nurse takes place mainly horizontally. It is practiced by a colleague from the same hierarchical level and/or professional category[7], and it is constituted by an aggressive behavior that a member of the same profession, or a peer of any level, manifests against the other at work[12].

The horizontal violence, when perpetuated for a long time, may become mixed. This means that depending on the omission and/or consent of the superior hierarchy, which becomes, therefore, accomplice, it is characterized as descending vertical violence[7]. In face of the event, the victim's subordinates become disrespectful towards her, and this generates the ascending vertical violence. Therefore, whenever there is no confrontation and/or support, the victim will experience different types of violence, because one triggers the other, which characterizes the mixed violence.

The answers found in this study show that the same person experienced different types of violence, caused by different people, and which may be characterized as mixed violence. This violence is composed by minor incidents, apparently benign, in which the accumulation and the convergence, supported by an absent and negligent hierarchy, reinforce the conflicts of values, complicating the confrontation of the situations. It is the lack of support that generates occupational damage[13-14].

The results found differ from a study developed with nursing professionals (n = 210) at a Hospital from the Eighth Region, in Chile, in which 76.2% (n = 160) of the interviewees indicated the doctor as the main aggressor, followed by the relatives of the patients, with 58.1% (n = 122)[8]. Another study in Chile shows that the most frequently identified aggressors were the patients and/or their relatives, followed by the nurses[15].

According to table 5 it is possible to evidence that 57 (35.3%) nurses stated that the aggressions came from different aggressors *more than once*, and 39 (24.2%) stated *the aggressor was usually the same person*. Repeated aggressions from the same aggressor, according to the literature, configure moral harassment and not simply psychological violence[16-17]. Although most aggressions came from different aggressors, the variable *the aggressor was usually the same person* demands attention due to its frequency, since it suggests that among the participants there are those who are suffering moral harassment and not simply psychological violence.

The ILO refers that harassment is one of the aspects of the labor violence, constituted by aggressive, cruel, threatening and humiliating behaviors, practiced by an individual and/or group against one person, in order to destabilize her[2,17]. The aggressor calls into question the capability and competence of the victim and, at times, when there is reaction, insinuate they are overreacting[14]. Those who do not take part in the harassment prefer to remain neutral as they fear to become the next victim[14]. This phenomenon was observed in France by companies that suffered a process of organizational restructuring. In the hospital context, the lack of space for the worker's manifestation causes a loss of values for her regarding what the work represents, which decreases their level of satisfaction and pleasure[13].

It is necessary to consider that the repetition and persistence of violent actions at a work environment may serve as indicators to establish the origin of the violence, which may be identified as a phenomenon promoted by the administrative organization of the institution, and not necessarily by a person[14].

The presence of different aggressors also suggests the gender violence, and as nursing is a predominantly female profession, female nurses suffer the consequences of the subordination experienced by women since the beginning.

The subordination configured by the question of gender aggravates the situation of violence against women, and may be related to their capability of sexual and social self-determination[18]. In this context, a new professional attitude is necessary, based on the reflection about the social relations of gender, and on the complexity of the domestic violence against women.

Perhaps it is the moment for a new professional attitude that considers the gender issue related to the violence against women[18], and for restructuring the administrative models aimed at restraining any type of labor violence.

The lack of structure of the hierarchy or its omission and the lack of solidarity at work compose a higher exposure to the violence that does not find protection barriers. This means that the victim is completely exposed and at the mercy of a destructive phenomenon. The maintenance of a united team, represented by a present hierarchy, is essential to maintain the mental health of the health professionals[14].

CONCLUSION

The studied group was composed by nurses aged between 27 and 57 years old (n=161), with the highest number being between 40 and 45 years old (n=53), most being white-skinned (n=141) and married (n=82). The nurses were clinical professionals (n = 92), administrative (n=32), professors (n=23), and their income varied from R$ 1,500.00 to 2,500.00 (n=62). The study had the participation of nurses who had graduated over 20 years ago (n=51), who had worked in the area for over 20 years (n=57), who were civil servants approved in public exams (n=119) and, most of them, did not have another employment bonding (n=105).

The study showed that the psychological violence is a reality in the professional practice of the nurses, both in the hospital and in the academic environment, and that most of them stated they have suffered it *more than once* (n = 70).

Most of the aggressors were women, *more than once* (n = 41), with highlights to co-workers, *more than once* (n = 53), followed by the doctor, *more than once* (n = 39) and other professionals from the team, *more than once*(n = 34).

The study also revealed that the lower the salary and the shorter the time since the graduation, the higher the level of aggression suffered. The nurses who suffered more aggressions were over 34 years old (Arithmetical Mean - AM = 4.54), with the highest AM among those who were closer to 57 years old (AM = 5.60). Among the factors resulting from the aggression, it is important to highlight the irritability (AM = 10), followed by anger (AM = 7.7), sadness (AM = 7.0) and decrease of the self-esteem (AM = 6.4), configuring the psychological violence.

Psychological violence is one of the occupational risks for aggravating health, to which the nurses participating in this study were subject in their work environment. Giving visibility to it at the work environment depends on the individual and collective participation of the nurses, in terms of reporting power abuse, discrimination, and avoiding the trivialization of the injustice. In this context, nurses must be the main characters for the prevention of this complex and old phenomenon in the labor world, but recently studied in the nursing context.

It was also evidenced that the nurses suffered repeated aggressions from the same aggressor, which may characterize cases of moral harassment and not simply psychological violence. Therefore, new studies are suggested in order to identify the presence of moral harassment in the work environment of the nurse, the used confrontation mechanisms, as well as the determinant factors of the psychological violence. Perhaps, the answer may provide subsidies for the implementation of measures for preventing, fighting the psychological violence and protecting the worker's health.

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