

**FACTORS THAT INFLUENCE ABUSE OF NURSES BY PATIENTS AND THEIR
RELATIVES IN A TERTIARY HEALTH CARE INSTITUTION IN BENIN CITY EDO
STATE**

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OCTOBER, 2025

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**IN PARTIAL FULFILMENT FOR THE AWARD OF BACHELOR'S DEGREE IN
NURSING SCIENCE (BNsc), UNIVERSITY OF BENIN, BENIN CITY.**

OCTOBER, 2025

DECLARATION

This is to declare that this research project titled “Factors that influence abuse of nurses by patients and their relatives in a tertiary health care institution in Benin city,Edo state” was carried out by Unoka Jessica Chinasa. It will solely be the result of my work except where acknowledged as being derived from other person (s) or resources.

EXAMINATION NUMBER: _____

FACULTY OF NURSING SCIENCE, UNIVERSITY OF BENIN, BENIN CITY.

Signature:

Date:

CERTIFICATION/APPROVAL

This is to certify that this research project was carried by Unoka Jessica Chinasa with Mat No. BMS1900246, Faculty of Nursing Science, under the supervision of PROF.(MRS)R.E. ESEWE .

PROF.(MRS)R.E. ESEWE

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ABSTRACT

Workplace abuse of nurses by patients and their relatives is a growing concern, affecting job performance, mental health, and overall well-being. This study assessed the factors influencing the abuse of nurses at the University of Benin Teaching Hospital (UBTH), Ugbowo, Benin City. The study aimed to determine the prevalence, types, and contributing factors of abuse experienced by nurses. A descriptive cross-sectional survey was conducted among 258 nurses selected through a stratified sampling technique. A structured questionnaire was used to collect data, and 251 responses were deemed valid, giving a response rate of 97.2%. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26.0, with results presented in tables and figures. The study found that verbal abuse was the most common form of abuse, experienced by 71% of respondents. Other reported forms of abuse included emotional distress (59%), workplace bullying (53%), and rude or dismissive behavior (66%). Physical assault (37%), unwanted sexual harassment (42%), and stalking (31%) were less frequently reported. Factors contributing to abuse included patient frustration due to delayed medical attention (mean = 3.1), lack of understanding of hospital policies (mean = 3.0), and emotional distress of patient relatives (mean = 3.2). Patients with psychiatric conditions, those under the influence of drugs or alcohol, and those with severe pain were more likely to abuse nurses. Abuse of nurses in UBTH is prevalent, with verbal and emotional abuse being the most reported. Factors such as patient frustration, unrealistic expectations, and poor communication contribute to these incidents. There is a need for hospital management to implement stricter policies against abuse, provide conflict resolution training for nurses, and improve communication between healthcare workers and patients' relatives. Additionally, security measures should be strengthened to ensure a safer work environment for nurses.

Keywords: assessment, factors, influence, abuse, nurses, patients, relatives, work environment

DEDICATION

This work is dedicated to God Almighty who is providing me with the strength to complete my academic journey.

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CHAPTER ONE

INTRODUCTION

1.1 Background of study

The nursing profession is an essential component of the healthcare system, providing critical care, empathy, and support to patients and their families. Nurses are often the primary point of contact in healthcare settings, and their role extends beyond medical care to include patient advocacy, education, and emotional support. However, despite their vital contributions, nurses frequently encounter workplace challenges, including verbal, physical, and psychological abuse from patients and their relatives (Yesilbas & Baykal, 2021). This abuse not only undermines the dignity of the nursing profession but also threatens the safety, mental health, and job satisfaction of nurses, ultimately affecting the quality of care provided (Li et al., 2022).

Workplace violence is an alarming concern in healthcare settings worldwide, disproportionately affecting nurses who are often at the frontline of patient care. This issue is deeply rooted in systemic challenges, cultural factors and inherent stress of healthcare environments. Studies underscore the multifaceted nature of workplace violence, highlighting its physical and professional repercussions on healthcare workers, particularly nurses (Kim et al. 2021;Hansen et al.,2023). Nurses frequently experience violence from patients, their families, and sometimes even colleagues, contributing to high levels of emotional exhaustion, reduced job satisfaction, and compromised patient care quality (del Carmen Pérez-Fuentes et al., 2021). Factors such as overcrowding, insufficient security, and long wait times in healthcare settings exacerbate these incidents (Bingöl & İnce, 2021). Furthermore, the COVID-19 pandemic intensified these

challenges, with reports of increased bullying, burnout, and violence against nurses (Somani et al., 2022).

Globally, workplace violence against healthcare workers has become a growing concern, with nurses reported to be among the most vulnerable groups (Giménez Lozano et al., 2021). In low- and middle-income countries like Nigeria, the situation is exacerbated by systemic issues such as underfunded healthcare systems, overcrowded facilities, and understaffing. These challenges create a stressful environment for both healthcare workers and patients, potentially escalating tensions and conflicts (Botngård et al., 2021).

In tertiary healthcare institutions, where the complexity of cases and the influx of patients are higher, nurses are particularly susceptible to various forms of abuse (Fu et al., 2021). Benin City, Edo State, Nigeria, is home to several tertiary healthcare institutions that serve as referral centers for a wide range of medical conditions. These facilities are often overstretched due to the large population they cater to and the limited resources available. In such high-pressure environments, nurses may be subjected to abuse stemming from patients' frustrations over delays, perceived negligence, or unmet expectations (Bingöl & İnce, 2021). Similarly, relatives of patients, overwhelmed by anxiety or dissatisfaction with care outcomes, may lash out at nurses, viewing them as the most accessible targets for their grievances (Faghihi et al., 2021).

In many instances, workplace violence is underreported due to fear of retaliation, stigma, or lack of institutional support (Byon et al., 2022). Studies reveal that this violence not only jeopardizes nurses' mental and physical health but also leads to significant workforce turnover and a decline in the quality of care provided to patients (Pang et al., 2023). The psychological toll is especially severe, with nurses reporting anxiety, depression, and feelings of insecurity, all of which impact

their resilience and ability to deliver compassionate care (Xu et al., 2022). Factors contributing to this abuse are multifaceted and include individual, societal, and institutional influences. At the individual level, poor communication skills, stress, or burnout among nurses and patients can lead to misunderstandings and conflicts (Pang et al., 2023). Societal factors such as cultural norms that devalue nursing as a profession, gender dynamics, and a general lack of awareness about the challenges faced by healthcare workers also play a role (Boateng & Brown, 2022). Institutionally, factors such as inadequate security measures, lack of policies to address workplace violence, and poor conflict resolution mechanisms further expose nurses to abuse (Shorey & Wong, 2021).

Cultural and geographical variations also influence the prevalence and forms of workplace violence. For instance, studies in Norway and Canada highlight verbal abuse and neglect, often stemming from systemic biases and racial undertones (Boateng & Brown, 2022). In contrast, in regions like Saudi Arabia and China, physical aggression and fear of future violence are more prominent concerns (Alzailai et al., 2023). The persistence of workplace violence necessitates targeted interventions, such as improving security measures, fostering a supportive work environment, and providing training on conflict resolution (Lim et al., 2022). Additionally, addressing broader organizational issues like toxic leadership and inadequate staffing can mitigate the incidence of violence (Labrague, 2021).

This study focuses on identifying the factors influencing the abuse of nurses by patients and their relatives in a tertiary healthcare institution in Benin City, Edo State, Nigeria. It is unknown what factors influence the abuse of nurses by patients hence this study.

1.2 Statement of problem

Workplace violence against nurses is a serious issue that threatens their safety, mental health, and job satisfaction (Bashir et al., 2023). Nurses frequently face verbal, physical, and emotional abuse from patients and their relatives, especially in tertiary healthcare institutions where workload and stress levels are high (Boateng & Brown, 2022; de Raeve et al., 2023). Such violence often stems from patient frustration, long waiting times, overcrowding, and systemic challenges within hospital administration (Labrague, 2021). The stressful nature of healthcare settings, coupled with emotional distress experienced by patients and their families, frequently escalates into aggressive behaviors (Bingöl & İnce, 2021). Weak institutional support and poor security measures further sustains the problem (Alzailai et al., 2023). Evidence shows that nurses in various clinical settings continue to face aggression from patients and their families worldwide (Saga et al., 2021; Faghihi et al., 2021).

The consequences extend beyond individual nurses, affecting healthcare delivery and institutional efficiency. Nurses who experience violence are more likely to suffer from burnout, anxiety, and depression, leading to increased absenteeism, higher turnover rates, and reduced quality of patient care (Pang et al., 2023; Li et al., 2022). These challenges place additional strain on healthcare institutions, exacerbating staff shortages and lowering overall service quality. Despite growing research on workplace violence in healthcare, there is limited focus on tertiary hospitals in Nigeria. This study seeks to identify the key factors contributing to the abuse of nurses by patients and their relatives in a tertiary healthcare institution in Benin City, Edo State. By examining these factors, the research aims to provide evidence-based recommendations for improving workplace safety, fostering a supportive environment, and implementing policies to protect nurses and enhance healthcare service delivery.

1.3 Aim of the Study

The aim of this study is to assess the underlying factors influencing workplace violence against nurses in a tertiary healthcare institution in Benin City, Edo State, Nigeria.

1.4 Objective of the Study

The specific objective of this study are to:

1. To explore the abuse experienced by nurses in a tertiary healthcare institution in Benin City, Edo State, Nigeria.
2. To identify the factors that influence the abuse of nurses by patients and their relatives in a tertiary healthcare institution in Benin City, Edo State, Nigeria.
3. To investigate the impact of abuse on nurses' well-being in a tertiary healthcare institution in Benin City, Edo State, Nigeria

1.5 Research Questions

1. What is the abuse experiences of nurses in a tertiary healthcare institution in Benin City, Edo State, Nigeria?
2. What are the factors that influence the abuse of nurses by patients and patient relatives in a tertiary healthcare institution in Benin City, Edo State, Nigeria?
3. What is the impact of abuse on nurses' well-being in a tertiary healthcare institution in Benin City, Edo State, Nigeria?

1.6 Research Hypotheses

H_0 (Null hypothesis): There is no significant relationship between patient-family interactions and abuse of nurses in a tertiary healthcare institution.

H_1 (Alternate hypothesis): There is a significant relationship between patient-family interactions and abuse of nurses in a tertiary healthcare institution.

1.7 Significance of the Study

To the Nursing Profession: This study holds significant value for the nursing profession by highlighting factors that influence the experiences of nurses in their workplace. Given the impact of violence, abuse, and neglect on job satisfaction and the quality of patient care, understanding these factors can guide policy and training improvements to create safer environments for nurses. Additionally, insights gained can support nursing leaders and administrators in addressing workplace stressors, potentially reducing burnout and turnover rates within the profession. Implementing strategies based on these findings can also contribute to building a more resilient nursing workforce, fostering a positive work culture, and ensuring high standards in patient care.

To Healthcare Providers: For healthcare providers, this study underscores the critical need for organizational policies that prioritize the physical and psychological well-being of staff. Recognizing the effects of workplace violence, particularly in high-stress environments such as emergency departments, can prompt healthcare providers to adopt preventive measures and promote a supportive atmosphere that reduces conflict. The study's findings may also encourage healthcare organizations to implement comprehensive training programs that equip staff with the tools to handle challenging situations effectively, ultimately improving team dynamics and patient outcomes.

To Society: The societal significance of this study lies in its contribution to safer and more compassionate healthcare environments. When nurses and healthcare providers work in supportive, non-violent settings, patients are more likely to receive high-quality care, which contributes to better health outcomes for society as a whole. The study can also raise public awareness of the challenge's healthcare professionals face, fostering greater empathy and support from communities for frontline workers. Finally, by advocating for improved workplace conditions, the study supports the societal goal of a robust healthcare system that attracts and retains dedicated professionals, benefiting public health overall.

1.8 Scope of study

The scope of this study is delimited to nurses by patients and their relatives in work environment, using University of Benin Teaching Hospital as a case study. The study focused on the abuse of nurses by patients and their relatives.

1.9 Operational Definition of Terms

Workplace: A professional setting where individuals engage in assigned tasks and responsibilities. In this study, the workplace refers specifically to the healthcare environment where nurses provide patient care within a tertiary healthcare institution.

Violence: Any act of physical, verbal, emotional, or psychological aggression directed toward an individual, causing harm or distress. In the context of this study, violence refers to the abuse—whether physical, verbal, or emotional—experienced by nurses from patients and their relatives within a healthcare setting.

Abuse: refers to any intentional mistreatment or harm directed at an individual or group that causes physical, emotional, or psychological damage. In the context of the healthcare setting, abuse can take various forms and typically involves a power imbalance where the abuser seeks to exert control, harm, or distress on the victim.

Patient: A patient is an individual who receives medical care, treatment, or services from a healthcare provider, such as a doctor, nurse, therapist, or hospital staff. Patients may seek care for a variety of reasons, including illness, injury, preventive care, or medical conditions that require monitoring or treatment.

Patients relative: A patient relative refers to a family member, spouse, or other close individual who is related to the patient and is involved in their care, either directly or indirectly. This individual may provide emotional support, assist with decision-making, help with physical care, or interact with healthcare providers on the patient's behalf.

Tertiary Healthcare Institution: A high-level medical facility that provides specialized healthcare services, including advanced medical care, surgical procedures, and intensive patient management. These institutions typically serve as referral centers for primary and secondary healthcare facilities and are often equipped with specialized medical professionals and advanced technology.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter deals with review of relevant literature related to this study under the following headings; conceptual review, theoretical framework, empirical studies and summary of literature review.

2.1 Conceptual Review

2.1.1 Concept of Violence

Violence is generally defined as the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group, which either results in or has a high likelihood of resulting in injury, death, psychological harm, or deprivation (WHO, 2020). It is a social and public health issue that occurs in various settings and forms, often influenced by cultural, economic, and environmental factors. Violence stems from individual, social, and environmental factors such as anger, frustration, mental illness, substance abuse, social inequality, and poor conflict resolution (WHO, 2020; Krug et al., 2022). In institutions, factors like stress, weak support systems, and power imbalances also contribute.

While violence can occur in any setting, it becomes particularly concerning when it takes place within professional environments such as healthcare institutions. Workplace violence broadly refers to any act or threat of physical violence, harassment, intimidation, or other disruptive behavior that occurs at the work site (WHO). It is essential to clarify the specific types of violence relevant to this study, including physical assault, verbal abuse, threats, intimidation, and harassment (Yesilbas & Baykal, 2021). Additionally, related concepts such as job satisfaction,

burnout, turnover intention, and well-being are important to consider, as these are key outcomes influenced by workplace violence (del Carmen Pérez-Fuentes et al., 2021; Kakemam et al., 2021; Pang et al., 2023).

2.1.2 Workplace Violence in Healthcare Settings

Workplace violence in healthcare settings is a pervasive and multifaceted issue that significantly impacts nurses (Lim et al., 2022). Nurses, as frontline healthcare providers, are particularly vulnerable to violence from patients, their relatives, and sometimes even colleagues (Bingöl & İnce, 2021). The unique characteristics of healthcare environments, such as high-stress situations, emotional demands, and close physical contact, contribute to the increased risk of workplace violence (Ayasreh & Hayajneh, 2021). Factors such as patient mental health issues, substance abuse, long waiting times, and dissatisfaction with care can escalate into violent behavior (Hakala et al., 2021; Syed et al., 2022; Bingöl & İnce, 2021). Additionally, organizational factors like inadequate staffing, lack of security measures, and poor management support can exacerbate the problem (Marufu et al., 2021). The consequences of workplace violence in healthcare extend beyond physical harm, leading to psychological distress, burnout, decreased job satisfaction, and increased turnover rates among nurses (Kim et al., 2021; Zhang et al., 2022).

2.1.3 Prevalence and Forms of Workplace Violence Against Healthcare Workers

Workplace violence in healthcare is a significant global concern, posing substantial risks to healthcare workers' safety, well-being, and the quality of care they provide (Lim et al., 2022). This section provides an overview of workplace violence in healthcare settings, outlines the various forms of violence, and discusses global and regional prevalence rates, with a specific focus on workplace violence against nurses.

Healthcare settings, designed to promote healing and well-being, paradoxically can be breeding grounds for violence (Ayasreh & Hayajneh, 2021). The complex and often stressful nature of healthcare work, coupled with factors such as patient mental health issues, long waiting times, and staff shortages, contribute to an increased risk of workplace violence (Bingöl & İnce, 2021; Marufu et al., 2021). Healthcare workers, particularly those in direct patient care roles, are frequently exposed to aggressive and violent behaviors from patients, their relatives, and, in some instances, colleagues (Yesilbas & Baykal, 2021). The consequences of workplace violence extend beyond physical harm, impacting the psychological well-being, job satisfaction, and overall productivity of healthcare staff (Kim et al., 2021; Zhang et al., 2022).

2.1.4 Types of Violence in Healthcare Settings

Violence against healthcare workers, especially nurses, is a major concern worldwide. It manifests in various forms and originates from different sources, including patients, relatives, colleagues, and supervisors. Each type of violence has significant consequences, affecting the well-being, job satisfaction, and overall performance of healthcare workers (del Carmen Pérez-Fuentes et al., 2021). Below are the major types of violence experienced in healthcare settings:

Physical Violence

Physical violence involves direct bodily harm inflicted on healthcare workers. This includes hitting, slapping, punching, kicking, pushing, biting, or even the use of weapons. Nurses are particularly vulnerable to physical attacks from agitated patients, distressed relatives, or even coworkers (Lim et al., 2022). For instance, a frustrated patient may strike a nurse during a procedure, or a relative might physically assault a healthcare provider over delays in treatment (Bingöl & İnce, 2021). In psychiatric and emergency units, where patients may be disoriented or

under the influence of substances, physical aggression is more frequent (Ayasreh & Hayajneh, 2021; Jang et al., 2022). The consequences of physical violence range from minor injuries to severe trauma, which can lead to fear, decreased productivity, and reluctance to work in high-risk environments (Kim et al., 2021).

Verbal Abuse

Verbal abuse is one of the most common forms of workplace violence in healthcare (Yesilbas & Baykal, 2021). It includes insults, shouting, humiliation, threats, and any spoken or written words aimed at intimidating or demeaning a healthcare worker. Nurses often experience verbal abuse from frustrated patients or their relatives, particularly when treatment outcomes do not meet their expectations (Bingöl & İnce, 2021; Boateng & Brown, 2022). A nurse may be yelled at for perceived delays or insulted by a superior or colleague who questions their competence. In some cases, verbal abuse also includes racial or gender-based slurs (Boateng & Brown, 2022; Iheduru-Anderson et al., 2021). Though it does not cause physical harm, verbal abuse leads to emotional distress, decreased job satisfaction, and burnout among nurses, ultimately affecting the quality of patient care (Pérez-Fuentes et al., 2021).

Psychological/Emotional Violence

Psychological violence includes actions that cause emotional distress or mental health challenges without involving physical contact. Intimidation, harassment, manipulation, and threats fall into this category. For example, a nurse may receive threats of harm from a patient's family members after delivering bad news, or a superior may deliberately intimidate a nurse into compliance through persistent criticism (Low et al., 2021; Zhang et al., 2021). Workplace gossip and false rumors also contribute to emotional violence, creating an unhealthy work environment (Shorey

& Wong, 2021). The long-term consequences of psychological violence include anxiety, depression, reduced job performance, and even an increased likelihood of nurses leaving the profession (Pang et al., 2023; Shorey & Wong, 2021).

Sexual Harassment and Assault

Sexual violence in healthcare settings ranges from inappropriate sexual remarks and unwelcome advances to physical assault and coerced sexual activity. Nurses, particularly female nurses, often face unwanted sexual advances from patients, colleagues, or even supervisors. A patient may make inappropriate comments about a nurse's appearance, while a coworker may engage in non-consensual physical contact. In more severe cases, nurses have reported being pressured into sexual favors in exchange for promotions or professional opportunities. The impact of sexual harassment and assault includes psychological trauma, loss of confidence, workplace dissatisfaction, and legal implications for the perpetrators and institutions involved. (Shorey & Wong, 2021)

Workplace Bullying and Mobbing

Workplace bullying occurs when an individual is repeatedly subjected to harmful behaviors such as exclusion, humiliation, or professional sabotage (Shorey & Wong, 2021). Mobbing, a more extreme form of bullying, involves a group of individuals collectively targeting a colleague. In healthcare settings, bullying often occurs when senior nurses deliberately overwhelm junior nurses with excessive workloads or when colleagues isolate a nurse and spread false information about them. Superiors may also undermine a nurse's credibility by criticizing them publicly. The effects of workplace bullying include high levels of stress, low self-esteem, decreased job satisfaction, and, in some cases, resignation from the profession (Somani et al., 2022).

Cyberbullying

With the rise of digital communication, cyberbullying has become a significant form of workplace violence (Farley et al., 2021). Healthcare workers may be harassed through online platforms such as social media, emails, or text messages. Examples include derogatory comments about a nurse's performance posted on social media, threatening emails from patients or their relatives, and the unauthorized sharing of confidential patient or staff information to humiliate or intimidate a nurse. Cyberbullying can have devastating effects, leading to emotional distress, reputational damage, and even legal consequences (Angwaomaodoko, et al., 2024).

Institutional Violence

Institutional violence refers to systemic policies or practices that negatively affect the well-being of healthcare workers. This includes understaffing, excessive workloads, lack of protective policies, and unjust disciplinary actions. Nurses often experience institutional violence when they are forced to work long hours without adequate compensation or when they lack the necessary resources to perform their duties safely (Zhang, et al., 2021). In some cases, hospital management may fail to address complaints of workplace violence, leaving nurses vulnerable to repeated abuse. The consequences of institutional violence include job dissatisfaction, burnout, high turnover rates, and a decline in the overall quality of healthcare services.

Patient-to-Nurse Violence

Patient-to-nurse violence is one of the most common forms of violence in healthcare settings. It often occurs when patients become aggressive due to pain, frustration, mental health conditions, or the influence of drugs and alcohol. Psychiatric nurses, emergency room staff, and those working in intensive care units are at a higher risk of experiencing violence from patients (Jang

et al., 2022). For example, a disoriented elderly patient with dementia may strike a caregiver, or a drug-seeking patient may threaten a nurse who refuses to administer narcotics (Hakala et al., 2021). The consequences of patient-to-nurse violence include physical injuries, emotional trauma, and reluctance to work in high-risk departments.

Relatives-to-Nurse Violence

Family members of patients may also engage in violence against nurses due to stress, frustration, or grief. When patients do not receive immediate attention or when their condition deteriorates, relatives may react aggressively towards healthcare workers (Bingöl & İnce, 2021). A common scenario is a relative shouting at a nurse for perceived delays in care or even physically attacking a nurse after receiving bad news. In extreme cases, relatives may threaten legal action or violence against nurses whom they blame for negative patient outcomes. The emotional toll of this form of violence can lead to anxiety, job dissatisfaction, and increased burnout among nurses.

Peer-to-Peer Violence

Violence between colleagues, known as peer-to-peer violence, can manifest as verbal abuse, discrimination, gossip, or professional sabotage (Shorey & Wong, 2021). Nurses may experience hostility from coworkers in the form of exclusion from team activities, deliberate misinformation, or excessive criticism. A senior nurse may belittle a junior colleague in front of others, or a group of nurses may spread rumors about a colleague to undermine their reputation. Peer-to-peer violence creates a toxic work environment, leading to stress, decreased morale, and increased staff turnover.

Supervisor-to-Nurse Violence

Violence from supervisors or managers occurs when those in leadership positions misuse their power to intimidate, harass, or unfairly treat their subordinates. This may include constant criticism, public humiliation, threats of demotion, or unjust denial of promotions and professional opportunities (Low et al., 2021; Zhang et al., 2022). A nurse may be unfairly reprimanded or subjected to excessive workloads as a form of punishment (Labrague, 2024). The long-term consequences of supervisor-to-nurse violence include stress, reduced job performance, and an increased likelihood of nurses leaving their jobs in search of a more supportive work environment.

2.1.5 Global and Regional Prevalence Rates

The prevalence of workplace violence in healthcare varies across different countries and regions, reflecting diverse cultural, socioeconomic, and organizational contexts. A systematic review by Leźnicka & Zielińska-Więczkowska (2024) highlights the widespread nature of the phenomenon among healthcare workers. In China, a cross-sectional study revealed a significant prevalence of workplace violence against nurses, with specific influencing factors and adverse consequences identified (Li et al., 2022). Studies in other regions, such as Saudi Arabia and Ghana, have also reported high rates of workplace violence against healthcare workers (Alzailai et al., 2023; Boateng et al., 2022). The COVID-19 pandemic has further exacerbated the issue, with reports of increased workplace bullying against nurses (Somani et al., 2022).

2.1.6 Workplace Violence against Nurses Specifically

Nurses, as the largest group of healthcare professionals and those most frequently in direct contact with patients, are particularly vulnerable to workplace violence (Ayasreh & Hayajneh,

2021). They often bear the brunt of patient and family frustration, anger, and aggression. Studies have consistently shown that nurses experience higher rates of workplace violence compared to other healthcare workers (Jang et al., 2022). The specific forms of violence experienced by nurses include physical assault, verbal abuse, threats, and harassment (Yesilbas & Baykal, 2021). Factors such as long working hours, high patient-to-nurse ratios, and inadequate security measures contribute to the increased risk of workplace violence against nurses (Marufu et al., 2021). The consequences of workplace violence on nurses' well-being are profound, leading to emotional exhaustion, burnout, decreased job satisfaction, and increased turnover intention (Pang et al., 2023; Kim et al., 2021).

2.1.7 Factors Influencing Workplace Violence Against Nurses

Workplace violence against nurses is a complex phenomenon influenced by a multitude of interacting factors. Understanding these factors is crucial for developing effective prevention and intervention strategies. This section explores patient-related, organizational, socioeconomic, cultural factors, and the impact of the COVID-19 pandemic on workplace violence against nurses.

1. Patient-Related Factors

Patient-related factors play a significant role in precipitating workplace violence. Mental health conditions, such as psychiatric disorders and cognitive impairments, can increase the likelihood of aggressive behavior (Bingöl & İnce, 2021). Substance abuse and intoxication can also impair judgment and self-control, leading to violent outbursts (Syed et al., 2022; Hakala et al., 2021). Patient dissatisfaction with care, stemming from long waiting times, perceived inadequacies in treatment, or unmet expectations, can also trigger frustration and aggression (Bingöl & İnce,

2021). Saga et al. (2021) highlighted relatives' experiences with abuse and neglect in nursing homes which may contribute to violent reactions as well. The attitudes of patients towards healthcare professionals, influenced by their cultural background and personal experiences, can also impact their behavior (Iheduru-Anderson et al., 2021).

2. Organizational Factors

Organizational factors within healthcare settings significantly contribute to the risk of workplace violence. Inadequate staffing levels and high workloads can increase stress and burnout among nurses, making them more vulnerable to violence (Marufu et al., 2021). Limited resources, such as security personnel and equipment, can also compromise the safety of healthcare workers (Lim et al., 2022). A lack of clear policies and procedures for reporting and addressing workplace violence can create a culture of silence, where incidents go unreported and perpetrators are not held accountable (Zhang et al., 2021). Abusive supervision and toxic leadership styles can foster a hostile work environment, increasing the risk of workplace violence (Labrague, 2021, 2024; Zhang et al., 2022; Low et al., 2021).

3. Socioeconomic and Cultural Factors

Socioeconomic and cultural factors can also influence the occurrence of workplace violence against nurses. Societal norms and expectations regarding healthcare professionals, particularly nurses, can shape patient and family behavior (Boateng & Brown, 2022). Gender biases and power imbalances can contribute to the vulnerability of female nurses to harassment and violence (Faghihi et al., 2021). Socioeconomic disparities and inequalities in access to healthcare can also fuel frustration and anger, leading to aggression toward healthcare providers (Bingöl & İnce, 2021). The perception of nurses from minority ethnic groups can also be influenced by race

and origin and might contribute to violence (Iheduru-Anderson et al., 2021; Boateng & Brown, 2022).

2.1.8 Impact of Workplace Violence on Nurses

Workplace violence exacts a significant toll on nurses' well-being, leading to a cascade of negative consequences that affect their psychological health, physical well-being, professional satisfaction, and the quality of patient care. This section explores the multifaceted impact of workplace violence on nurses, considering the psychological, physical, and professional ramifications, as well as the broader effects on the healthcare system.

Psychological Effects

The psychological impact of workplace violence on nurses is profound and far-reaching. Experiencing violence can lead to heightened levels of stress, anxiety, and depression (Pang et al., 2023). The emotional toll of workplace violence can manifest as burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Kakemam et al., 2021; Giménez Lozano et al., 2021; Alzailai et al., 2023; Chowdhury et al., 2022). In some cases, nurses may develop post-traumatic stress disorder (PTSD), a debilitating condition marked by intrusive thoughts, flashbacks, and avoidance behaviors (Havaei, 2021). Exposure to workplace violence can also erode nurses' self-esteem and confidence, undermining their ability to cope with future challenges (Xu et al., 2022).

Physical Consequences

In addition to the psychological burden, workplace violence can result in significant physical consequences for nurses. Physical assaults can lead to injuries ranging from minor bruises and cuts to more severe fractures and head trauma (Li et al., 2022). The fear of future violence can also lead to increased absenteeism, as nurses may avoid coming to work due to safety concerns (Marufu et al., 2021). Chronic stress and anxiety related to workplace violence can also

contribute to physical health problems such as sleep disturbances, fatigue, and musculoskeletal disorders (Kim et al., 2021).

Professional Consequences

The experience of workplace violence can have a detrimental impact on nurses' professional lives. Workplace violence is associated with decreased job satisfaction, leading to feelings of disillusionment and disengagement from work (del Carmen Pérez-Fuentes et al., 2021; Khan et al., 2021; Caponnetto et al., 2022). Increased turnover intention is also a common consequence, as nurses seek to escape violent work environments (Pang et al., 2023; Park & Song, 2023; Marufu et al., 2021; Boateng et al., 2022). Furthermore, workplace violence can impair nurses' ability to provide high-quality patient care, as their focus shifts from patient needs to personal safety (Kim et al., 2021). Labrague et al. (2021) showed how toxic leadership can influence nurse-assessed adverse patient events and quality of care.

Effects on the Healthcare System

The impact of workplace violence extends beyond individual nurses, affecting the overall functioning of the healthcare system. High turnover rates among nurses increase recruitment and training costs, straining already limited resources (Marufu et al., 2021). Short staffing levels, resulting from absenteeism and turnover, can compromise patient safety and increase the risk of medical errors (Ulrich et al., 2022). A demoralized and disengaged nursing workforce can negatively impact the overall quality of care, leading to decreased patient satisfaction and poorer health outcomes (Kim et al., 2021). Ultimately, workplace violence undermines the integrity and effectiveness of the healthcare system.

2.1.9 Coping Mechanisms and Support Systems for Affected Nurses

Nurses who experience workplace violence require effective coping mechanisms and robust support systems to mitigate the negative impacts on their well-being and professional lives. This section explores individual coping strategies, organizational support mechanisms, the role of healthcare institutions in violence prevention, and relevant legal and policy frameworks.

Individual Coping Strategies

Individual coping strategies play a vital role in helping nurses manage the stress and trauma associated with workplace violence. Resilience, the ability to bounce back from adversity, is a key factor in protecting nurses' mental health (Chitra & Karunanidhi, 2021; Xu et al., 2022). Emotional regulation techniques, such as mindfulness and cognitive reappraisal, can help nurses manage their emotions and reduce the intensity of negative feelings (Xiao et al., 2022). Seeking social support from colleagues, friends, and family members can provide emotional comfort and practical assistance (Lu et al., 2023). Self-care practices, such as exercise, relaxation techniques, and hobbies, can also promote well-being and reduce stress (Xiao et al., 2022).

Organizational Support

Healthcare organizations have a responsibility to provide comprehensive support systems for nurses who experience workplace violence. Clear policies and procedures for reporting and addressing workplace violence are essential for creating a culture of accountability and support (Zhang et al., 2021). Employee assistance programs (EAPs) can provide confidential counseling and support services for nurses struggling with the psychological effects of workplace violence (Zhang et al., 2021). Training programs on violence prevention, de-escalation techniques, and self-defense can equip nurses with the skills and knowledge to manage potentially violent

situations (Lim et al., 2022). Debriefing sessions following violent incidents can provide nurses with an opportunity to process their experiences and receive emotional support (Zhang et al., 2021). Nurse managers also play an important role in fostering a supportive work environment by providing emotional support, recognizing their team's achievements and modelling positive communication (del Carmen Pérez-Fuentes et al., 2021; Modaresnezhad et al., 2021).

2.1.10 Role of Healthcare Institutions in Violence Prevention

Healthcare institutions must take proactive steps to prevent workplace violence. Implementing environmental modifications, such as improved lighting, security cameras, and controlled access points, can enhance safety (Lim et al., 2022). Conducting risk assessments to identify potential hazards and vulnerabilities can inform prevention strategies (Lim et al., 2022). Establishing collaborative relationships with law enforcement and community resources can provide additional support and assistance (Lim et al., 2022). It is also important to address organizational factors that contribute to workplace violence, such as inadequate staffing levels, high workloads, and abusive supervision (Marufu et al., 2021; Labrague, 2021, 2024; Zhang et al., 2022). Younas et al. (2023) highlight barriers to delivery of person-centered care, indicating that the nurses' inability to properly care for the patient can become a stressor that leads to workplace violence.

2.1.11 Legal and Policy Frameworks Addressing Workplace Violence

Workplace violence against nurses requires strong legal and policy measures to ensure their safety and well-being. International bodies such as the International Labour Organization (ILO) and the World Health Organization (WHO) emphasize safe and healthy work environments and encourage governments to adopt policies that prevent workplace violence.

At the national level, occupational safety and health (OSH) laws are designed to protect workers but often lack specific provisions addressing violence in healthcare settings. While criminal and anti-discrimination laws may apply after incidents occur, their enforcement in healthcare workplaces is often weak (Iheduru-Anderson et al., 2021).

Some countries have introduced healthcare-specific policies requiring risk assessments, improved security, and staff training to prevent violence. These also include clear reporting channels and support for affected nurses (Zhang et al., 2021). However, poor enforcement, limited resources, and underreporting of incidents remain major challenges (Byon et al., 2022).

2.2 Theoretical Framework

2.2.1 The Job Demand-Control (JDC) Model (Karasek, 1979)

The Job Demand-Control (JDC) Model, introduced by Robert Karasek in 1979, is a well-established framework for understanding work-related stress and its effects on employees. The model suggests that job strain arises from the interaction between two primary dimensions: job demands and job control. Job demands refer to the workload, time pressures, and psychological stressors an employee faces, while job control reflects the degree of autonomy and decision-making power an employee has over their tasks. According to Karasek's Job Demand-Control model (1979), when job demands are high but control is low, workers experience job strain, which can negatively impact their mental and physical health. However, if employees have high levels of control over their work, they are better equipped to handle stress, even in demanding roles.

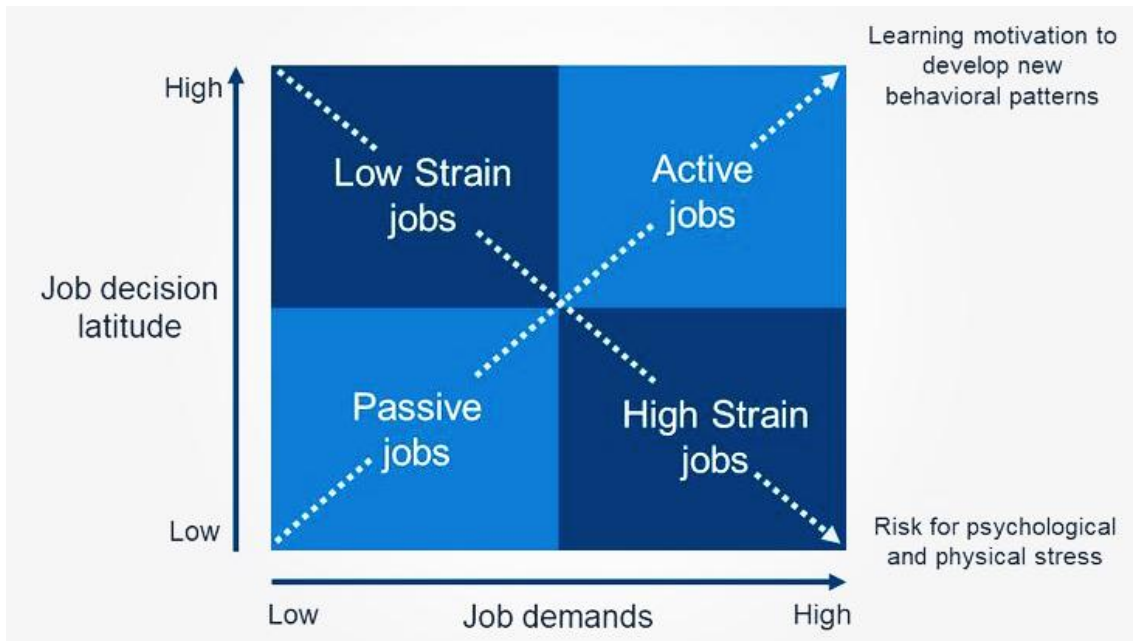


Fig 2.1: Job Demand-Control (JDC) Model By Robert Karasek

2.2.2 Key Components of the JDC Model

Job Demands

Job demands encompass the psychological pressures and responsibilities that come with a particular job. These demands may include a heavy workload, tight deadlines, and high expectations from supervisors or clients. Additionally, factors such as role ambiguity, where job responsibilities are unclear, and role conflict, where employees face competing demands from different sources, contribute to workplace stress. While some level of job demand is necessary for productivity and engagement, excessive demands can lead to burnout, decreased job satisfaction, and health complications.

Job Control

Job control, often referred to as decision latitude, represents the extent to which employees have autonomy over their work tasks and the ability to use their skills effectively. This concept includes two main aspects: decision authority, which involves the freedom to make choices about how work is performed, and skill discretion, which allows employees to apply and develop their abilities in the workplace. High job control enables workers to feel empowered and capable of managing their responsibilities, reducing the negative effects of job demands. Conversely, when employees have little control over their tasks, they may feel frustrated and helpless, increasing their risk of stress-related health issues.

Job Strain and Its Effects

The combination of high job demands and low job control leads to a condition known as job strain, which has been linked to various negative health outcomes. Employees who experience high job strain are at a greater risk of developing cardiovascular diseases, anxiety, depression, and burnout. The prolonged impact of job strain can also result in low job satisfaction, decreased productivity, and increased absenteeism. When workers are unable to influence their work conditions, they may struggle to cope with stress effectively, leading to exhaustion and disengagement from their roles.

2.2.3 The Four Job Categories in the JDC Model

Karasek's model classifies jobs into four distinct categories based on the levels of job demand and job control:

High-Strain Jobs (High Demand, Low Control)

High-strain jobs are considered the most stressful because employees face significant workload pressures while having little control over their tasks. Workers in such roles often experience high levels of stress, exhaustion, and burnout, which can negatively impact their health and job performance. Examples of high-strain jobs include factory workers, call center employees, and frontline service workers, where repetitive tasks and strict supervision limit employees' ability to manage their work environment.

Low-Strain Jobs (Low Demand, High Control)

Low-strain jobs offer employees a relaxed work environment with minimal stressors and high levels of autonomy. Because the workload is manageable and employees have significant control over their tasks, these jobs promote mental well-being, job satisfaction, and creativity. University professors and research scientists are examples of individuals in low-strain jobs, as they often have the freedom to determine their schedules and research focus. This type of job is considered ideal for personal and professional growth without excessive stress.

Active Jobs (High Demand, High Control)

Active jobs involve a high level of responsibility and workload but also provide employees with significant control over their decision-making and skill use. While these jobs can be challenging,

they are often associated with personal growth, motivation, and high engagement. Employees in active jobs, such as surgeons, managers, and engineers, tend to develop problem-solving skills and resilience, which help them handle stress more effectively. Unlike high-strain jobs, active jobs enable workers to exert influence over their work conditions, making stress more manageable.

Passive Jobs (Low Demand, Low Control)

Passive jobs involve minimal job demands and limited opportunities for employees to apply their skills or make decisions. Because these jobs do not challenge workers, they may lead to boredom, disengagement, and a lack of professional development. Employees in passive jobs, such as security guards and some clerical positions, may struggle with motivation and job satisfaction, as their roles do not provide opportunities for learning or growth. Over time, employees in passive jobs may experience a decline in job-related skills and enthusiasm for their work.

2.2.4 Implications for Workplace Well-Being

The JDC model provides valuable insights for organizations seeking to improve employee well-being and productivity. To reduce job strain and create a healthier work environment, employers can implement strategies such as reducing excessive job demands, increasing job control, and fostering skill development opportunities. Providing employees with decision-making autonomy, flexible work arrangements, and supportive leadership can significantly enhance job satisfaction and well-being. Additionally, promoting a workplace culture that encourages collaboration and social support can help employees cope with high job demands more effectively.

2.2.5 Application of the Job Demand Model

Workplace violence is a significant occupational hazard for nurses, particularly in high-pressure environments such as tertiary healthcare institutions. The Job Demand-Control (JDC) Model, proposed by Karasek (1979), provides a theoretical framework for understanding how occupational stressors, such as high job demands and low job control, contribute to workplace violence. This model suggests that the interaction between job demands and job control determines the level of workplace stress experienced by employees, which in turn affects their ability to manage conflict and violence effectively. In the context of workplace violence against nurses in a tertiary healthcare institution in Benin City, Edo State, Nigeria, the JDC model helps explain how excessive work demands, coupled with limited control over their work environment, can increase the risk of violence while also identifying potential interventions to mitigate these risks.

Below is the description of the application of the model;

2.2.5.1 Job Demands and Workplace Violence

Job demands refer to the various physical, psychological, and organizational aspects of a nurse's work that require sustained effort and contribute to occupational stress. In a tertiary healthcare setting, nurses often face extremely high job demands, which increase their vulnerability to workplace violence. These demands include:

Heavy Workload and Staff Shortages: Nurses in tertiary hospitals often handle a high patient load, with many working long hours due to staff shortages. The pressure to attend to numerous patients within limited timeframes increases physical exhaustion and emotional stress, making them more susceptible to aggressive behavior from patients, relatives, and even colleagues.

Emotionally and Physically Challenging Work: Nurses frequently deal with critically ill, psychiatric, or trauma patients, many of whom may exhibit aggressive or violent behavior due to their medical conditions. This is particularly common in emergency departments, psychiatric units, and intensive care units (ICUs), where patients are often in distress or confused.

Exposure to Aggressive Patients and Visitors: Nurses regularly encounter frustrated or hostile relatives who may lash out due to delays in treatment, dissatisfaction with care, or emotional distress over a loved one's condition. Additionally, intoxicated, mentally unstable, or non-compliant patients pose a direct risk of verbal and physical violence against healthcare workers.

Unpredictable Work Conditions and High-Stress Environments: The dynamic nature of a tertiary hospital means nurses must quickly adapt to emergencies, often working under immense pressure with limited recovery time between shifts. This chronic stress impairs their ability to manage conflicts and increases their likelihood of experiencing workplace violence.

Job Control and Nurses' Response to Workplace Violence

Job control refers to the level of autonomy and decision-making power an employee has in their work environment. According to the JDC model, nurses with low job control are at a higher risk of workplace stress and violence because they lack the authority to make decisions regarding patient care, safety protocols, and workload distribution.

Limited Autonomy in Managing Violent Incidents: Many nurses are not empowered to enforce safety measures or de-escalate violent situations effectively. Institutional policies may restrict their ability to refuse unsafe assignments or limit their authority in handling aggressive patients and relatives, leaving them feeling helpless in violent encounters.

Lack of Supportive Institutional Policies: In many healthcare institutions, workplace violence is underreported due to fear of retaliation, lack of managerial support, or a culture that normalizes aggression in healthcare settings. Inadequate reporting systems and the absence of clear violence prevention protocols further weaken nurses' control over their safety.

Job Demand-Control Model and Occupational Stress in Nurses

The JDC model predicts that when high job demands are combined with low job control, it results in high job strain, which increases stress, anxiety, and vulnerability to workplace violence. In the context of nursing, the following outcomes illustrate the impact of high job strain:

Psychological Distress and Burnout: Excessive workload, combined with frequent exposure to violence, contributes to emotional exhaustion, anxiety, and post-traumatic stress disorder (PTSD) among nurses. Many nurses report experiencing fear, helplessness, and demoralization after repeated violent encounters.

Decreased Job Satisfaction and High Turnover Rates: Workplace violence is a leading factor in nurse dissatisfaction and job turnover. Nurses who experience frequent aggression may choose to leave their jobs or the profession altogether, exacerbating staffing shortages and workload burdens on remaining personnel.

Impaired Patient Care and Professional Performance: Chronic stress and fear of violence negatively impact nurses' ability to focus, make critical decisions, and provide compassionate

care. Nurses under stress may also develop avoidance behaviors, leading to delays in patient care, errors, and reduced engagement with high-risk patients.

2.2.6 Implications for Workplace Violence Prevention

To reduce workplace violence, interventions should aim to decrease job demands while increasing job control among nurses. Based on the JDC model, the following strategies can be implemented:

Reducing Job Demands:

1. Ensuring adequate staffing levels to minimize exhaustion and stress.
2. Implementing violence prevention policies, such as security presence in high-risk units.
3. Establishing clear reporting and intervention protocols for violent incidents.

Increasing Job Control:

1. Empowering nurses with decision-making authority in patient care and safety protocols.
2. Providing nurses with self-defense and conflict de-escalation training.
3. Encouraging open communication with hospital management to address safety concerns.

Enhancing Social Support:

1. Creating peer support groups for nurses to share experiences and coping strategies.
2. Offering counseling services to help nurses deal with trauma from violent incidents.
3. Conducting regular training sessions on handling workplace violence effectively.

2.3 Empirical Review

Abuse experienced by nurses

In a study conducted by Yesilbas and Baykal (2021), the causes of workplace violence against nurses from patients and their relatives in Turkish hospitals were explored. This qualitative study used a descriptive design and purposive sampling to select participants from five different hospitals. Thirty-four nurses from various departments participated in semi-structured in-depth interviews, which were audio-recorded and analyzed through content analysis. The study revealed four major themes: health care system, health institutions, health professionals, and patients and their relatives. Each of these themes contained several subthemes, with the "health care system" and "health institutions" encompassing four subthemes, "health professionals" containing five subthemes, and "patients and their relatives" including twelve subthemes. The findings emphasized the multifaceted nature of workplace violence, suggesting that prevention strategies should address these diverse causes comprehensively.

Similarly, Faghihi et al. (2021) aimed to understand the components of workplace violence against nurses from the perspective of female nurses working in a hospital in Tehran. This qualitative study employed purposive sampling to select 21 female nurses with maximum diversity in terms of work experience, age, and ward assignments. Semi-structured interviews were conducted, and the data was analyzed using content analysis. The findings were categorized into two main themes: interpersonal violence and organizational coercion. The study concluded that effective hospital management is needed to reduce violence, emphasizing the importance of raising awareness among staff, patients, and visitors, and creating a supportive environment for reporting incidents.

In another study, Boateng and Brown (2022) explored nurses' experiences of workplace conflict with patients and their family members in two Canadian cities, particularly focusing on how ethnic/racial identity influences these conflicts. The study, which used a qualitative phenomenological approach, included in-depth interviews with 66 registered nurses. The results highlighted the prevalence of horizontal conflicts, including physical assaults, verbal aggression, racial stereotyping, and sexual harassment, especially among ethnic minority nurses. Institutional support, through policies designed to de-escalate aggressive behavior, was found to be critical in mitigating these conflicts. The authors concluded that healthcare institutions must implement policies that hold patients and their families legally accountable for uncivil and aggressive behaviors toward healthcare providers.

Zhang et al. (2021) conducted a systematic qualitative review to identify nurses' experiences of workplace violence and their support needs. Ten studies, conducted in eight countries, were included in the review. Four key themes emerged regarding nurses' experiences: "inevitable and unpredictable trauma," "higher tolerance and understanding of unintentional violence," "positive learning or passive adjustment," and "struggle with role and behavior conflict." Additionally, the review identified two main themes related to nurses' support needs: "informal support" and "formal support." The study highlighted that while nurses often experience significant psychological trauma from workplace violence, the support systems available to them are insufficient, and organizations must prioritize creating robust support structures.

Christensen et al. (2021) reviewed the qualitative literature on emergency department (ED) nurses' experiences of domestic violence (DV) presentations. The review, which focused on papers published between 2000 and 2019, included ten studies. Three themes were identified:

"feeling devastated in a world of helplessness and hopelessness," "anger of indifference," and "grieving the pain and suffering." These themes captured the emotional burden ED nurses face when supporting DV victims, including feelings of anger, sadness, and helplessness. The study concluded that the emotional strain of caring for DV victims often leads nurses to distance themselves emotionally as a coping mechanism, contributing to compassion fatigue and vicarious trauma.

Factors that influence the abuse of nurses by patients and patient relatives

In a study by Bingöl and İnce (2021), conducted in Turkey, the factors influencing violence in emergency departments (EDs) from the perspectives of patient relatives were examined. The study aimed to determine the factors contributing to violence incidents in the ED, focusing on the perceptions of patients' relatives. A total of 520 individuals who brought a relative to the Adult ED at Akdeniz University Hospital participated in the study between April and June 2017. The data was gathered through a two-part questionnaire: the first part contained 15 items on participants' demographic characteristics, while the second part included 20 statements that asked participants to rate the factors that may contribute to violence in the ED. The data were analyzed using percentage and frequency calculations.

The study found that 55.6% of participants were men, and 54.7% were married. Among the incidents witnessed, 27.1% reported verbal violence, 14.6% observed physical violence, and 1.7% noted verbal threats, particularly against nurses. The study concluded that the primary cause of violence in EDs was the lack of adequate information provided to patients and their families regarding the patient's condition. Additionally, over 40% of the relatives of patients indicated that anxiety, nervousness, stress, and sadness contributed to violent incidents. The

authors recommended that informing patients and their relatives about the patient's condition and adopting an empathetic approach from healthcare staff could help reduce incidents of violence in EDs. This study is unique as it gathers the opinions of patient relatives on preventing violence in the ED.

In a study by Li et al. (2022), the prevalence of workplace violence among nurses in China and its association with demographic characteristics, quality of work life, and coping styles was explored. The study aimed to understand the extent of workplace violence, its influencing factors, and its emotional impact on nurses. A cross-sectional design was employed, involving 2,769 nurses in China. The researchers used several questionnaires, including a demographic information questionnaire, the Hospital Workplace Violence Questionnaire, the Chinese version of the Work-Related Quality of Life Scale, and the Coping Style Scale. The data were analyzed using chi-squared tests, Mann–Whitney U tests, and binary logistic regression.

The study revealed that 49.12% of nurses (n = 1360) had experienced at least one type of workplace violence within the past six months. The risk factors for workplace violence included night shifts, specific work departments, chronic diseases, sleep disorders, frequent overtime, adverse nursing events, and passive coping styles. In contrast, working conditions, general well-being, and positive coping were identified as protective factors. The study concluded that workplace violence is a common issue among nurses in China, and improving working conditions, well-being, and coping mechanisms may help reduce its impact. Furthermore, the emotional and psychological consequences of workplace violence were evident, highlighting the need for interventions to address these issues.

Low et al. (2021) aimed to explore the antecedents leading to counterproductive work behavior (CWB) among nurses in Malaysia, focusing on abusive supervision and perceived injustice. The study also examined the moderating effects of power distance orientation and locus of control on CWB. A questionnaire-based approach was used with 337 nurses from six public hospitals in Malaysia. The data were analyzed using structural equation modeling.

The study found that nurses perceive injustice when subjected to abusive supervision, which can lead to CWB. Additionally, nurses with a high level of power distance orientation were less likely to perceive abusive supervision as unjust, while those with an internal locus of control were less likely to engage in CWB. The study highlighted the importance of addressing abusive supervision in the workplace and considered the cultural and individual factors that influence nurses' behaviors at work.

In a study by Kim et al. (2021), the relationship between nurses' experiences of workplace violence, emotional exhaustion, and perceptions of patient safety was explored. The cross-sectional analysis used survey data from a large academic medical center, employing the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture and additional measures related to workplace violence and emotional exhaustion. The results indicated that nurses reported more verbal violence than physical violence, and these experiences negatively affected emotional exhaustion and perceptions of patient safety. Moreover, emotional exhaustion was found to mediate the relationship between verbal abuse and patient safety perceptions. The study concluded that interventions to reduce emotional exhaustion and strengthen resilience among nurses could mitigate the effects of workplace violence.

Lastly, Botngård et al. (2021) examined factors associated with staff-to-resident abuse in nursing homes in Norway, utilizing a cross-sectional exploratory study design. Data was collected from 3,693 nursing staff across 100 randomly selected nursing homes, and multilevel mixed-effects logistic regression analyses were used to explore individual, relational, and institutional factors contributing to psychological abuse, physical abuse, and neglect. The study found that staff who were registered nurses or licensed practical nurses, reported psychological distress, had poor attitudes toward people with dementia, or intended to leave the job were more likely to perpetrate abuse. Additionally, relational factors like care-related conflicts and resident aggression, as well as institutional factors such as lack of managerial support, were linked to abuse. The study emphasized the need for a multifaceted approach to prevent elder abuse in nursing homes.

Impact of abuse on nurses' well-being, including stress levels, anxiety, depression, and job satisfaction

In a study by Pang et al. (2023), the mediating and moderating roles of depressive symptoms in the relationship between workplace violence (workplace violence) and turnover intention among South Korean nurses were investigated. This cross-sectional study employed a survey design to explore how verbal violence and sexual harassment contribute to depressive symptoms, which in turn affect nurses' turnover intentions. The results revealed that both verbal violence and sexual harassment were associated with increased depressive symptoms, which partially mediated their relationship with turnover intention. Furthermore, depressive symptoms were found to moderate the effect of sexual harassment on turnover intention. The study concluded that managing depressive symptoms in nurses who experience workplace violence is essential for reducing turnover intentions, alongside preventing workplace violence.

Kakemam et al. (2021) conducted a cross-sectional online survey among 1,004 Iranian nurses to examine the relationship between burnout and the perceived quality of patient care, as well as the occurrence of adverse events (AEs) during the COVID-19 pandemic. The study found that 31.5% of nurses reported high levels of burnout, and the risk of AEs ranged from 26.1% to 71.7%. Emotional exhaustion and depersonalization were positively correlated with poorer patient care, while personal accomplishment was negatively correlated with adverse events like medication errors. The study concluded that higher burnout levels are linked to a reduction in the quality of care and an increased occurrence of AEs, highlighting the need for interventions to address nurse burnout.

Labrague (2024) explored the impact of toxic leadership on work satisfaction and psychological distress among Filipino emergency nurses, with a focus on work-family conflict as a mediator. The study found that toxic leadership behaviors had a direct negative effect on work satisfaction and a direct positive effect on psychological distress. Work-family conflict was shown to partially mediate the relationship between toxic leadership and both psychological distress and work satisfaction. This study emphasized the need for interventions to mitigate the negative effects of toxic leadership on emergency nurses' well-being and job satisfaction.

Alzailai et al. (2023) examined factors contributing to burnout among intensive care nurses in Saudi Arabia during the COVID-19 pandemic using a constructivist grounded theory approach. Interviews with 22 ICU nurses identified "pandemic pervasiveness" as a central theme, which highlighted the widespread impact of the pandemic on nurses' personal and professional lives. Family, work, and broader societal factors were identified as contributing to nurses' burnout. The

study concluded that addressing these contextual factors, alongside workforce shortages, is critical for preventing burnout in ICU nurses.

Lastly, Chowdhury et al. (2022) investigated the correlation between workplace violence, bullying, burnout, job satisfaction, and depression among Bangladeshi nurses during the COVID-19 pandemic. The cross-sectional survey of 1,264 nurses revealed that depression was positively correlated with workplace violence, bullying, and burnout, and negatively correlated with job satisfaction. Depression was found to be higher among nurses with longer working hours, no timely salary, and no training on workplace violence. The study concluded that addressing workplace violence, improving the work environment, and enhancing job satisfaction are key factors in reducing depression among nurses.

2.4 Summary of Literature review

The literature review explored the issue of workplace violence against nurses in healthcare settings, focusing on its prevalence, impact, contributing factors, and potential strategies for mitigation. Workplace violence in healthcare can be categorized into four types: Type I (criminal intent), Type II (client-related), Type III (worker-on-worker), and Type IV (personal relationships), with nurses often being the primary targets, particularly of Type II and Type III violence.

Globally, workplace violence against nurses is a significant concern, with studies indicating varying prevalence rates depending on the region, healthcare facility type, and patient demographics. Violence often leads to physical injuries (such as cuts, bruises, and fractures), psychological distress (including anxiety, depression, and PTSD), and negative work-related outcomes such as burnout, absenteeism, job dissatisfaction, and decreased patient care quality.

Factors contributing to workplace violence include individual factors (e.g., nurses' demographic characteristics and emotional intelligence), organizational factors (e.g., inadequate staffing, lack of security, and poor leadership), and environmental factors (e.g., overcrowded hospitals, high-stress situations). Patient-related factors, such as aggressive behavior due to medical conditions (e.g., psychiatric disorders, dementia) and substance abuse, also contribute to the likelihood of violence. Furthermore, family members' perceptions of care can escalate conflicts, leading to violent incidents.

Nurses' experiences with workplace violence reveal a sense of fear, helplessness, and powerlessness, but they also employ various coping strategies, including seeking support from colleagues and management. However, the effectiveness of support systems, such as de-escalation training, varies, highlighting the need for more comprehensive and effective interventions.

To mitigate workplace violence, various strategies have been proposed, including improved staff training on conflict resolution and de-escalation techniques, the implementation of zero-tolerance policies, and environmental modifications to enhance safety (e.g., secure spaces, panic buttons). Legal frameworks, along with institutional and psychological support, such as counseling and employee assistance programs, also play a vital role in addressing the issue.

The COVID-19 pandemic has further exacerbated workplace violence, with nurses facing increased aggression from patients and families due to heightened stress, fears of contagion, and overcrowded healthcare settings. This has led to worsening mental health outcomes for nurses, including greater burnout and job turnover intentions.

Despite extensive research, gaps remain in the literature, particularly in understanding the specific role of family members in escalating violence and the long-term effects of workplace violence on nurse retention. Further research is needed to address these gaps and to develop more tailored, effective strategies for preventing and managing workplace violence in healthcare environments.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Overview

This chapter described the research methodology that the researcher adopted in conducting this study. The various components of research methodology was discussed under their respective headings, including research design, study setting, target population, sample and sampling technique, instruments of data collection, validity and reliability of instruments, method of data collection, method of data analysis, and ethical considerations.

3.1 Research design

A cross-sectional research study design was used for this study. Cross-sectional studies are observational studies that analyze data from a population at a single point in time. They are often used to measure the prevalence of health outcomes, understand determinants of health, and describe features of a population (Wang & Cheng, 2020). The study's design comprised a description of the occasions, circumstances, and occurrence rates of particular phenomena over the course of the study period.

3.2 Research Setting

This study was conducted in Edo State, one of the 36 states in Nigeria, located in the South-South geopolitical zone. The state has 18 local government areas and serves as a major administrative and economic hub in the region, with Benin City as its capital. Edo State hosts several healthcare institutions, including the University of Benin Teaching Hospital (UBTH).

The study setting, University of Benin Teaching Hospital (UBTH), is a tertiary healthcare facility established in 1973. It is located in Ugbowo, Ovia North-East Local Government Area of

Edo State. UBTH provides comprehensive healthcare services including clinical, diagnostic, and emergency care. The hospital has an estimated bed capacity of over 910 (UBTH, 2024) and comprises 19 clinical departments, 3 medical laboratory departments, and 3 emergency units, staffed by multidisciplinary health professionals.

3.3 Target Population

The target population comprises of 721 nurses working in the various departments in University of Benin Teaching Hospital (UBTH), Ugbowo, Benin City.

Table 3.1 Number of Nurses in clinical areas at UBTH

Units	Number of nurses
Accident and Emergency Unit A	88
Accident and Emergency Unit B	76
Surgical Unit	92
Obstetrics and Gynecology	90
Medicine Unit A	82
Medicine Unit B	69
Theatre complex	73
Pediatrics	73
Clinic Unit A	45
Clinic Unit B	33
Total	721

(source, Human Resources Department, February 2025).

3.4 Sample Size Determination

The sample size was calculated as indicated below:

Using Taro Yamane's Formula

$$n = \frac{N}{1 + N(e)^2}$$

Where

N= Population under study

E= Constant 0.05%) margin error

$$n = \frac{721}{1 + 721(0.05)^2}$$

$$n = \frac{721}{1 + 721(0.0025)}$$

$$n = \frac{721}{1 + 1.80}$$

$$n = \frac{721}{2.80}$$

$$n = 257.5$$

Therefore, the sample size was 258.

3.5 Sampling Technique

The stratified sampling technique was used in this study. Stratified sampling is a probability sampling technique where the population is divided into homogeneous subgroups or "strata" based on shared characteristics such as gender, age, income, education level or unit

Proportional sampling calculation

Academic level	Determination of sample size in each level	Sample size per level
Accident and Emergency Unit A	88/721X258	31
Accident and Emergency Unit B	76/721X258	27
Surgical Unit	92/721X258	33
Obstetrics and Gynecology	90/721X258	32
Medicine Unit A	82/721X258	29
Medicine Unit B	69/721X258	25
Theatre complex	73/721X258	26
Pediatrics	73/721X258	26
Clinic Unit A	45/721X258	16
Clinic Unit B	33/721X258	12
	Total	258

3.6 Instrument for Data Collection

The instrument for data collection in this study was a self-structured questionnaire. This was developed based on the objectives of the study. The questionnaire was made up of five sections with questions which was carefully drafted, sequenced and constructed in a bid to get in-depth information that was useful and relevant to the study.

Section A: consist of the demographic data of the participants (Age, Marital Status, Current Educational Level, Ethnicity).

Section B: abuse experiences of nurses in University of Benin Teaching Hospital, Benin City

Section C: factors that influence the abuse of nurses by patients and patient relatives

Section D: Impact of abuse on nurses' well-being

3.7 Validity of the Instrument

The instrument's validity pertained to its capability to accurately measure the intended construct or concept (Surucu & Maslakci, 2020). Researchers assessed various validity types such as content, construct, criterion, and face to evaluate the instrument's accuracy. For this research, face and content validity were utilized to validate the research tool. The questionnaire was validated by both the project supervisor and a field expert, and necessary adjustments were implemented by the researcher.

3.8 Reliability of the Instrument

The reliability of an instrument referred to its stability and consistency in delivering uniform outcomes when assessing the same criteria under identical circumstances (Surucu & Maslakci, 2020). It essentially gauged how consistently the instrument produced similar results across multiple trials. A reliable instrument is one that could produce the same results if the behavior was measured again by the same scale. The Cronbach's alpha reliability technique was employed in this study. This researcher conducted reliability testing on the instrument by distributing 26 questionnaires, which constituted 10% of the total sample size of 258, to working nurses of Faith MediPlex (which are outside the sampled population). A coefficient of 0.71 was obtained and the instrument was considered reliable.

3.9 Method of Data Collection

A well-structured questionnaire was administered to the nurses until the required sample size of 258 is achieved. The nurses was approached at the University of Benin Teaching Hospital. The purpose of the study was explained to them, and the instrument for data collection was

administered. Data collection was conducted by the researchers. The data collection took place during break periods, and on-the-spot retrieval of the administered copies of the questionnaire ensured that all copies were collected on the same day. Data collection lasted for about two weeks.

3.10 Method of Data Analysis

The data collected were analyzed using the Statistical Package for the Social Sciences (SPSS) version 27.0. Descriptive statistics such as mean, frequency, and percentages was computed to summarize the data. Hypothesis testing was conducted using the Chi-square test of association, with the level of significance set at $p < 0.05$. The results of the analyses was presented using tables, graphs, frequencies, and percentages to provide a clear overview of the findings.

3.11 Ethical Considerations

Ethical approval was obtained from the Health Research Committee, University of Benin Teaching Hospital, Benin City. Permission was obtained from the various ward managers before proceeding with the research. Before data collection begins, participants received detailed explanations about the research's purpose, content, and implications. They were assured of confidentiality, ensuring the protection of their personal and private information. Throughout the research, ethical guidelines was strictly adhered to, including the following considerations:

- 1. Confidentiality:** Respondents' information was treated confidentially, with no request for names or addresses in the questionnaire. Participants understood that their responses are confidential and solely used for research purposes. No personal identifiers was used in any document or questionnaire to maintain anonymity.

2. Voluntary Participation: Participants were informed of their right to voluntary participation without facing penalties or bias. They can choose to withdraw or decline to provide information at any point if they feel uncomfortable or unsure.

3. Avoidance of Plagiarism: Proper citation of all authors used in the study was ensured, both within the content and in the reference page.

CHAPTER FOUR

RESULT AND FINDINGS

This chapter deals with the representation of data collected regarding assessment of factors that influence abuse of nurses by patients and their relatives in work environment in University of Benin Teaching Hospital. A total of 258 questionnaires were distributed to nurses working in the various departments in University of Benin Teaching Hospital (UBTH), Ugbowo, Benin City, 251 were properly filled and valid for data analysis, giving a response rate of 97.2%.

Table 4.1: Socio-Demographic Characteristics of Respondents

Variable	Frequency (n = 251)	Percent (%)
Age		
20-30 years	47	18.7
31-40 years	87	34.7
41-50 years	61	24.3
50 and above	56	22.3
Gender		100
Male	23	9.16
Female	228	90.8
Years of nursing experience		100
0-5 years	68	27.1
6-10 year	72	28.7
11-15 years	64	25.5
16 and above	47	18.7
Highest level of educational		100
RN/RM	50	19.9
Bsc	73	29.1
Msc	65	25.9
Phd	63	25.1
Ethnicity		100
Edo	133	53
Igbo	27	10.8
Hausa	13	5.18
Yoruba	35	13.9
Others	43	17.1
Religion		100
Christian	208	82.9
Muslim	24	9.56
Traditional	8	3.19
Others	11	4.38

Table 4.1 presents the socio-demographic characteristics of the respondents (n = 251). The majority (34.7%) were aged 31-40 years, followed by 41-50 years (24.3%), while 22.3% were 50 years and above, and the least represented group was 20-30 years (18.7%). Most respondents were female (90.8%), while 9.16% were male. In terms of nursing experience, 28.7% had 6-10 years of practice, followed by 0-5 years (27.1%), 11-15 years (25.5%), and 16 years and above (18.7%). Educational attainment varied, with 29.1% holding a BSc, 25.9% an MSc, 25.1% a PhD, and 19.9% possessing RN/RM qualifications. Ethnically, the majority were Edo (53%), followed by Yoruba (13.9%), Igbo (10.8%), and Hausa (5.18%), while 17.1% belonged to other ethnic groups. Christianity was the predominant religion (82.9%), followed by Islam (9.56%), traditional worship (3.19%), and other religions (4.38%). This data provides insight into the composition of the nursing workforce, highlighting its predominantly female representation, varying levels of experience, and diverse educational backgrounds.

4.2 The abuse experiences of nurses in University of Benin Teaching Hospital, Benin City.

Table 4.2: Abuse experiences of nurses

ITEMS	YES	NO	Mean	Remark
Have you suffered from verbal abuse from patients before?	178 (71)	73 (29)	1.7	High
Have you been physically assaulted by patients, visitors, or colleagues before?	92 (37)	159 (63)	1.4	Low
Have you experienced unwanted sexual harassment, advances, comments, or physical contact from patients, visitors, or colleagues?	105 (42)	146 (58)	1.4	Low
Have you witnessed verbal or written threats to cause harm, either directly or indirectly, by patients, families, or other staff members before?	164 (65)	87 (35)	1.7	High
Have you been bullied by colleagues or superiors that are meant to intimidate, degrade, or humiliate a nurse before?	133 (53)	118 (47)	1.5	High
Have you witnessed persistent and unwanted following, monitoring, or communication, typically by patients or ex-colleagues in times past?	79 (31)	172 (69)	1.3	Low
Have you been a victim of actions or words that cause emotional distress, such as manipulation, intimidation, or humiliation in times past?	147 (59)	104 (41)	1.6	High
Have you been a victim of discriminatory comments or actions that target a nurse's race, gender, religion, or other personal characteristics before?	122 (49)	129 (51)	1.5	Low
Have you experienced a rude, dismissive, or disrespectful behavior by colleagues or supervisors that creates a hostile work environment?	166 (66)	85 (34)	1.7	High
Have you been a victim of intentional destruction or theft of personal belongings or hospital property by disgruntled patients, visitors, or colleagues as a form of intimidation or retaliation before?	88 (35)	163 (65)	1.4	Low
			Grand mean	1.5

Mean Cut-off = 1.5

Table 4.2 shows that the highest mean (1.7) was recorded for verbal abuse from patients, with 178 (71) respondents affirming this experience, followed by witnessing verbal or written threats, reported by 164 (65) respondents. Experiencing a rude, dismissive, or disrespectful workplace environment also had a mean of 1.7, with 166 (66) respondents confirming this. Emotional

distress due to manipulation, intimidation, or humiliation had a mean of 1.6, with 147 (59) affected. Bullying by colleagues or superiors and discriminatory comments or actions had means of 1.5, with 133 (53) and 122 (49) respondents, respectively. Lower means were observed for physical assault (1.4) with 92 (37) respondents, unwanted sexual harassment (1.4) with 105 (42), and intentional destruction or theft of belongings (1.4) with 88 (35). The lowest mean (1.3) was recorded for persistent unwanted following or monitoring, experienced by 79 (31) respondents.

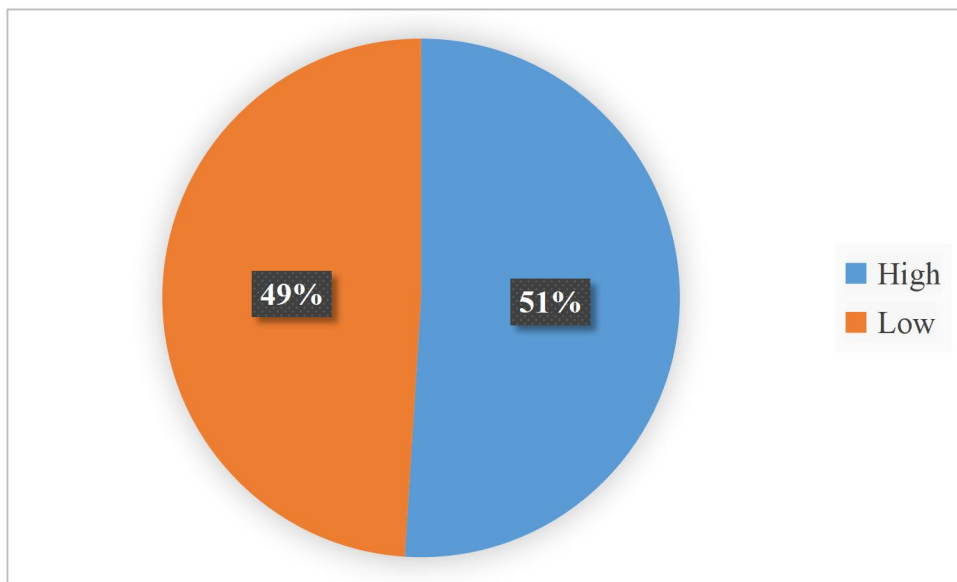


Figure 4.1: Pie chart showing abuse experiences of nurses

Figure 4.1 illustrates the abuse experiences of nurses, revealing that a slight majority (51%) reported a high level of abuse, while 49% experienced a low level of abuse.

4.3 Factors that influence the abuse of nurses by patients and patient relatives in University of Benin Teaching Hospital, Benin City

Table 4.3: Factors that influence the abuse of nurses by patients and patient relatives

ITEMS	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
Patients often become abusive due to frustration from delayed medical attention.	104 (41)	89 (35)	39 (16)	19 (8)	3.1	Influential
Lack of patient understanding about hospital policies contributes to abuse towards nurses.	98 (39)	87 (35)	45 (18)	21 (8)	3	Influential
Patients with severe pain or distress are more likely to verbally or physically abuse nurses.	110 (44)	92 (37)	31 (12)	18 (7)	3.2	Influential
Patients with psychiatric conditions tend to be more abusive toward nurses.	117 (47)	86 (34)	29 (12)	19 (7)	3.2	Influential
Drug or alcohol-influenced patients are more likely to abuse nurses.	126 (50)	77 (31)	30 (12)	18 (7)	3.2	Influential
Patient relatives often become abusive when they perceive that their loved one is not receiving adequate care.	102 (41)	93 (37)	35 (14)	21 (8)	3.1	Influential
Relatives' unrealistic expectations about treatment outcomes lead to nurse abuse.	113 (45)	85 (34)	37 (15)	16 (6)	3.2	Influential
Lack of proper communication between nurses and patient relatives contributes to abuse.	108 (43)	90 (36)	34 (14)	19 (7)	3.1	Influential
Relatives who do not understand medical procedures are more likely to abuse nurses.	111 (44)	91 (36)	32 (13)	17 (7)	3.2	Influential
Emotional distress of patient relatives increases the likelihood of abuse toward nurses.	109 (43)	94 (37)	30 (12)	18 (7)	3.2	Influential
			Grand Mean		3.2	Influential

Mean Cut-off = 2.5

Table 4.3 reveals that several factors were perceived by respondents as influential in contributing to the abuse of nurses by patients and their relatives. Among the top-rated factors, patients in

severe pain or distress, those with psychiatric conditions, and individuals under the influence of drugs or alcohol were seen as particularly likely to exhibit abusive behavior towards nurses, all scoring a mean of 3.2. Similarly, the unrealistic expectations of patient relatives regarding treatment outcomes, their lack of understanding of medical procedures, and emotional distress were also identified as key contributors to abusive incidents, each also receiving a mean score of 3.2. Additionally, frustration stemming from delayed medical attention (mean = 3.1), lack of understanding of hospital policies (mean = 3.0), and poor communication between nurses and patient relatives (mean = 3.1) were recognized as significant influencers of nurse abuse. These findings highlight a combination of clinical, emotional, and communication-related factors that collectively increase the risk of abusive encounters within healthcare settings. The consistently high mean scores suggest a pressing need for targeted interventions to address patient and relative expectations, improve communication strategies, and enhance the management of high-risk patients to protect nursing staff from abuse.

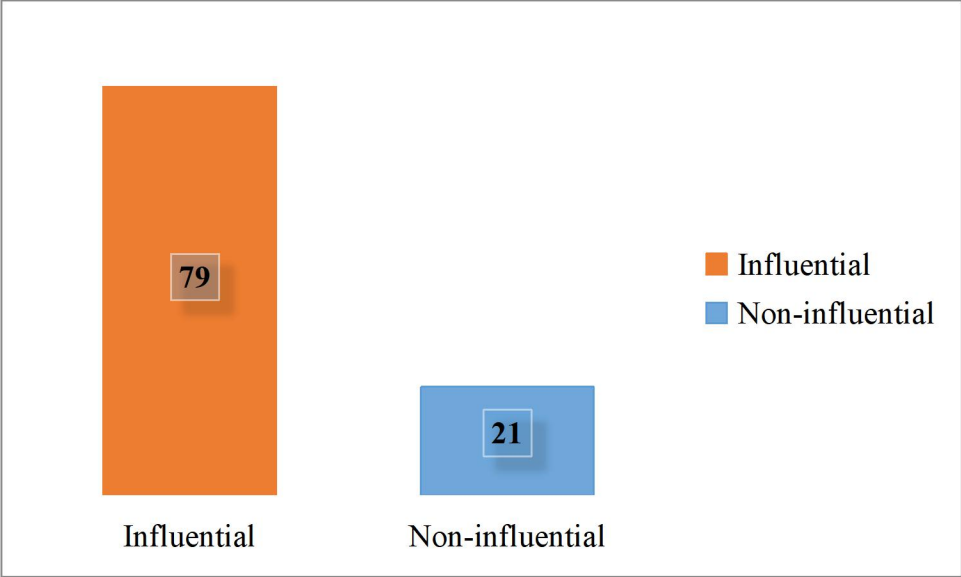


Figure 4.2: Bar chart showing factors that influence the abuse of nurses by patients and patient relatives

Figure 4.2 presents the factors influencing the abuse of nurses by patients and their relatives, showing that the majority (79%) found these factors influential, while 21% considered them non-influential.

4.4 The impact of abuse on nurses' well-being in University of Benin Teaching Hospital, Benin City

Table 4.4: Impact of abuse on nurses' well-being

ITEMS	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Remark
Experiencing abuse from patients or relatives has increased my stress levels.	113 (45)	89 (35)	31 (12)	18 (7)	3.2	High
Workplace abuse has caused me to feel anxious before coming to work.	109 (43)	91 (36)	37 (15)	14 (6)	3.2	High
I often feel emotionally drained due to abuse from patients or their relatives.	118 (47)	85 (34)	34 (14)	14 (6)	3.2	High
I experience sleep disturbances due to stress caused by workplace abuse.	104 (41)	90 (36)	36 (14)	21 (8)	3.1	High
Verbal or physical abuse at work has contributed to feelings of depression.	111 (44)	87 (35)	38 (15)	15 (6)	3.2	High
I have developed a fear of interacting with certain patients or their relatives due to past abuse.	108 (43)	92 (37)	35 (14)	16 (6)	3.2	High
I feel a sense of helplessness when I experience abuse in my workplace.	115 (46)	86 (34)	32 (13)	18 (7)	3.2	High
Workplace abuse has made me less satisfied with my nursing profession.	107 (43)	93 (37)	30 (12)	21 (8)	3.1	High
I feel less motivated to perform my duties due to frequent abuse.	110 (44)	91 (36)	33 (13)	17 (7)	3.2	High
I have considered leaving the nursing profession due to the abuse I experience at work.	99 (39)	98 (39)	29 (12)	25 (10)	3.1	High
Grand Mean					3.2	High

Mean Cut-off = 2.5

Table 4.4 illustrates the significant impact that abuse from patients and their relatives has on the well-being of nurses. A substantial number of nurses reported that experiencing abuse has led to increased stress levels (mean = 3.2) and feelings of anxiety before coming to work (mean = 3.2). Emotional exhaustion was also widely reported, with many nurses feeling emotionally drained due to repeated exposure to abuse (mean = 3.2).

Sleep disturbances linked to stress were highlighted (mean = 3.1), as were feelings of depression resulting from verbal or physical abuse at work (mean = 3.2). Moreover, a considerable number of respondents admitted to developing fear when interacting with certain patients or relatives based on prior abusive encounters (mean = 3.2), and many expressed a sense of helplessness when subjected to workplace abuse (mean = 3.2). The abuse also negatively affected job satisfaction (mean = 3.1), motivation (mean = 3.2), and professional commitment, with some nurses even considering leaving the profession altogether due to these negative experiences (mean = 3.1).

Overall, the findings emphasize that workplace abuse is not just an isolated incident but a persistent threat to nurses' well-being, affecting their mental health, job satisfaction, and willingness to remain in the profession. These results underscore the need for urgent institutional support systems, mental health interventions, and strict anti-abuse policies to protect nurses and preserve the integrity of the healthcare workforce.

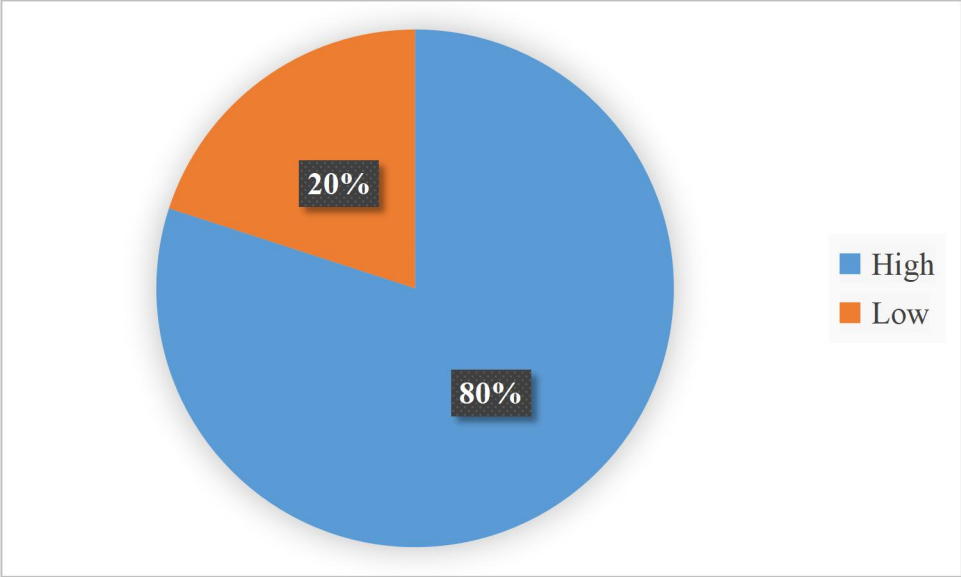


Figure 4.3: Pie chart showing impact of abuse on nurses' well-being

Figure 4.3 illustrates the impact of abuse on nurses' well-being, revealing that 80% experienced a high impact, while 20% reported a low impact.

Test of Hypothesis

Table 4.5: Relationship between abuse experiences by nurses and the impact of abuse on nurses' well-being in University of Benin Teaching Hospital, Benin City

Abuse Experience	Impact of abuse on nurses' well-being		Test Statistics (χ^2)	df	P value	Decision
	High	Low				
High	26(39.6)	98(83.4)	4.682	1	0.03	Rejected
Low	99 (66.8)	16 (24.2)				

Table 4.5 presents the relationship between nurses' abuse experiences and the impact on their well-being at the University of Benin Teaching Hospital. The chi-square test ($\chi^2 = 4.682$, $df = 1$, $p = 0.03$) indicates a significant association, leading to the rejection of the null hypothesis.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter discusses the major findings of the research compared with the literature reviewed, the implication for nursing, summary, conclusion, Recommendations and Suggestions for further Studies.

5.1. Discussion of major Findings

The study assessed the factors that influence abuse of nurses by patients and their relatives in work environment in University of Benin Teaching Hospital. The socio-demographic characteristics of the study participants reveal important patterns that both align with and differ from previous research samples. The age distribution shows a predominance of nurses in the 31-40 years' bracket (34.7%), followed by 41-50 years (24.3%), suggesting a relatively experienced workforce. This age distribution differs somewhat from studies like Li et al. (2022) and Pang et al. (2023), which often featured younger nursing populations. The gender distribution, with 90.8% female and 9.16% male nurses, reflects the typical gender imbalance in nursing noted across multiple studies. This aligns with Faghihi et al.'s (2021) study, which specifically focused on female nurses' experiences, acknowledging the gender-skewed nature of the profession.

However, the inclusion of male nurses in the current study provides a broader perspective on abuse experiences across genders. Regarding professional experience, there's a relatively even distribution among the 0-5 years (27.1%), 6-10 years (28.7%), and 11-15 years (25.5%) categories, with slightly fewer nurses having 16+ years of experience (18.7%). This experience distribution provides a comprehensive view across career stages, similar to Boateng and Brown's (2022) approach of including nurses with diverse work experiences. The educational profile of

respondents shows a high level of qualification, with 80.1% holding degrees beyond RN/RM certification. This educational distribution is notably higher than most previous studies and may influence the reporting and perception of abuse experiences, though this relationship wasn't specifically examined in earlier research.

The ethnic composition, predominantly Edo (53%), with representations from other major Nigerian ethnic groups, provides a unique perspective compared to previous studies, which were largely conducted in different geographical and cultural contexts. This ethnic diversity, combined with the religious distribution (82.9% Christian, 9.56% Muslim), offers insights into how cultural and religious factors might influence abuse experiences and responses, an aspect that wasn't prominently featured in the reviewed literature except for Boateng and Brown's (2022) examination of ethnic/racial identity influences on workplace conflicts. These demographic characteristics provide important context for understanding the study's findings, particularly how different demographic factors might influence experiences of abuse, coping mechanisms, and impact on well-being.

Abuse experienced by nurses

The findings from the current study align significantly with previous research while offering some unique insights into the patterns of abuse experienced by nurses. The data shows that 51% of nurses reported high levels of abuse, which is comparable to Li et al.'s (2022) finding of 49.12% of nurses experiencing workplace violence in China. Verbal abuse emerged as the most prevalent form of mistreatment, with 71% of nurses reporting such experiences. This aligns with Kim et al.'s (2021) observation that nurses reported more verbal violence than physical violence. The high prevalence of verbal abuse also corresponds with Bingöl and İnce's (2021) findings,

where 27.1% of observed incidents in emergency departments were verbal violence. Physical assault rates (37%) in the current study were notably lower than verbal abuse but still significant. This pattern is consistent with Bingöl and İnce's (2021) study, which reported 14.6% physical violence incidents, though our study shows a higher prevalence.

The current study's finding of 42% experiencing sexual harassment adds an important dimension that was also highlighted in Boateng and Brown's (2022) Canadian study, particularly affecting ethnic minority nurses. Workplace bullying and hostile work environment experiences (66% reporting rude or disrespectful behavior) align with Low et al.'s (2021) findings regarding counterproductive work behavior and abusive supervision in Malaysian hospitals. The current study's revelation that 59% of nurses experienced emotional distress through manipulation or humiliation corresponds with Zhang et al.'s (2021) theme of "inevitable and unpredictable trauma" in their systematic review.

Discriminatory behavior (49%) and stalking/unwanted monitoring (31%) represent areas less extensively covered in previous studies, though Boateng and Brown (2022) did address racial stereotyping in their Canadian study. The relatively high rate of witnessing threats (65%) adds to our understanding of the indirect exposure to violence that nurses face, which was not prominently featured in the reviewed literature. The current findings both reinforce and expand upon existing research, particularly by providing specific percentages across a broad spectrum of abuse types, offering a more comprehensive picture of the various forms of abuse nurses encounter in their professional lives.

Factors that influence the abuse of nurses by patients and patient relatives

The current study's findings regarding factors influencing nurse abuse demonstrate significant parallels with previous research while providing additional quantitative insights. The overall finding that 79% of respondents considered these factors influential underscores the significance of various contributing elements to nurse abuse. Regarding patient-related factors, the study found that patients under the influence of drugs or alcohol were most likely to be abusive (81% agreeing/strongly agreeing), followed closely by patients with psychiatric conditions (81%). This aligns with Botngård et al.'s (2021) findings about care-related conflicts and resident aggression, though their study focused specifically on nursing homes.

The high agreement about psychiatric patients' tendency toward abuse (47% strongly agreeing) adds a specific dimension not extensively covered in the reviewed literature. Delayed medical attention as a trigger for abuse (76% agreement) corresponds with Bingöl and İnce's (2021) Turkish study, which identified lack of adequate information as a primary cause of violence in emergency departments. Similarly, the current study's finding that 74% agreed that lack of understanding about hospital policies contributes to abuse reinforces their conclusions about the importance of informing patients and families about procedures and conditions. The role of patient relatives' emotional state and expectations emerged strongly in the current findings, with 80% agreeing that emotional distress increases abuse likelihood. This aligns with Bingöl and İnce's (2021) finding that over 40% of patient relatives indicated anxiety, nervousness, stress, and sadness as contributors to violent incidents.

The current study's identification of unrealistic expectations about treatment outcomes (79% agreement) as a factor adds a specific dimension to understanding relative-initiated abuse.

Communication issues featured prominently, with 79% agreeing that lack of proper communication contributes to abuse. This corresponds with Li et al.'s (2022) findings about working conditions and their impact on workplace violence. The high agreement (80%) about relatives' lack of understanding of medical procedures leading to abuse provides quantitative support for previous qualitative findings about the importance of clear communication and education. Pain and distress as abuse triggers (81% agreement) aligns with previous studies' findings about situational factors, though the current study provides more specific quantification of this relationship. This adds to Li et al.'s (2022) findings about risk factors for workplace violence, particularly regarding specific patient conditions and circumstances

. The findings extend beyond previous research by providing detailed percentages for specific contributing factors, offering a more nuanced understanding of their relative importance. The consistently high agreement rates (ranging from 74% to 81%) across different factors suggest that nurse abuse is influenced by a complex interplay of patient, relative, and communication-related factors, supporting the multifaceted approach to prevention suggested in previous studies.

Impact of abuse on nurses' well-being, including stress levels, anxiety, depression, and job satisfaction

The current study's findings regarding the impact of abuse on nurses' well-being reveal striking parallels with previous research while providing detailed quantification of these effects. The overall finding that 80% of nurses experienced a high impact from abuse demonstrates the severe toll of workplace violence on nursing professionals. The high prevalence of stress (80% agreeing/strongly agreeing) and anxiety (79%) aligns with Pang et al.'s (2023) findings regarding the relationship between workplace violence and psychological distress among South Korean

nurses. The current study's specific finding that 81% of nurses feel emotionally drained adds quantitative support to Zhang et al.'s (2021) theme of "inevitable and unpredictable trauma." Sleep disturbances, reported by 77% of respondents, correlate with Li et al.'s (2022) identification of sleep disorders as a risk factor in workplace violence, suggesting a cyclical relationship between abuse and sleep problems. The high rate of depression-related feelings (79%) supports Chowdhury et al.'s (2022) findings about the positive correlation between workplace violence and depression among Bangladeshi nurses. The development of fear in patient interactions (80% agreement) and feelings of helplessness (80%) echo Christensen et al.'s (2021) themes of "feeling devastated in a world of helplessness and hopelessness." This psychological impact extends to job satisfaction, with 80% reporting reduced motivation, supporting Labrague's (2024) findings about the negative effect of toxic workplace environments on work satisfaction. Particularly concerning is the finding that 78% of nurses have considered leaving the profession due to abuse, which aligns with Pang et al.'s (2023) research on turnover intention among nurses experiencing workplace violence. The current study's high rate of job dissatisfaction (80%) corresponds with Kakemam et al.'s (2021) findings about the relationship between burnout and quality of patient care. The findings extend beyond previous research by providing specific percentages across multiple dimensions of well-being impact. The consistently high agreement rates (ranging from 77% to 81%) across different impact measures suggest that abuse affects nurses comprehensively, touching on psychological, emotional, and professional aspects of their lives. This supports Alzailai et al.'s (2023) findings about the pervasive nature of workplace stress and its impact on nurses' personal and professional lives. The current study's detailed quantification of well-being impacts provides stronger evidence for the severe psychological toll of workplace abuse, reinforcing the urgency of implementing

protective measures and support systems. The findings suggest that the impact of abuse is not only immediate but potentially long-lasting, affecting both individual nurse well-being and broader healthcare delivery quality, as suggested by previous studies.

5.2 Implications for Nursing practice

The findings of this study have significant implications for nurses, particularly in terms of awareness, communication, emotional well-being, and workplace safety. The high prevalence of abuse, including verbal harassment (71%), physical assault (37%), and sexual harassment (42%), highlights the urgent need for nurses to be more vigilant and prepared for potential risks in their work environment. Recognizing common triggers, such as patient distress, unrealistic expectations, and poor communication, can help nurses anticipate and manage difficult situations more effectively.

Effective communication plays a crucial role in mitigating abuse, as 79% of nurses agreed that misunderstandings and lack of information contribute to violent incidents. Training in clear, compassionate communication can help nurses convey medical procedures, hospital policies, and patient care expectations more effectively, reducing frustration and conflict with patients and their relatives. Additionally, emotional and psychological support is essential, given the high levels of stress (80%), anxiety (79%), and depression (79%) reported by nurses. Hospitals should provide access to counseling services, peer support programs, and stress management training to help nurses cope with the emotional burden of workplace violence.

Workplace safety policies must also be strengthened to protect nurses from abuse. Since 79% of respondents identified patient-related factors as major contributors to violence, hospitals should enforce stricter security measures and develop clear protocols for handling aggressive behavior.

Encouraging nurses to report incidents without fear of retaliation is also critical. Establishing a confidential and supportive reporting system can ensure timely interventions and policy improvements to create a safer work environment.

Moreover, training programs focused on conflict resolution, self-defense, and de-escalation strategies can empower nurses with the skills needed to navigate difficult situations while maintaining their own safety. Addressing workplace violence is not only essential for protecting nurses but also for improving job satisfaction and retention. The emotional toll of abuse can lead to burnout, reduced productivity, and increased turnover rates, ultimately affecting the quality of patient care. By implementing comprehensive strategies to prevent and manage workplace violence, healthcare institutions can create a safer, more supportive environment where nurses feel valued, protected, and motivated to perform their duties effectively.

5.3 Summary

This study examined the factors influencing the abuse of nurses by patients and their relatives in the work environment at the University of Benin Teaching Hospital. The findings reveal that abuse is a prevalent issue, with 51% of nurses experiencing high levels of mistreatment. Verbal abuse (71%) was the most common form, followed by workplace bullying (66%), emotional distress (59%), physical assault (37%), and sexual harassment (42%). These findings align with previous studies on workplace violence in nursing, highlighting the widespread nature of the problem. The study also identified key factors contributing to the abuse of nurses, including patient-related elements such as drug or alcohol influence (81%) and psychiatric conditions (81%). Additionally, delayed medical attention (76%), unrealistic expectations from patient relatives (79%), and poor communication (79%) were significant triggers of violence. Emotional

distress among patient relatives further contributed to hostile interactions, emphasizing the complex nature of abuse in healthcare settings.

Furthermore, the impact of abuse on nurses' well-being was profound, with 80% of respondents reporting high levels of emotional exhaustion, stress, and anxiety. Workplace violence also affected job satisfaction, sleep quality, and overall mental health, reinforcing the urgent need for intervention. The study underscores the importance of improved workplace policies, enhanced communication strategies, and psychological support systems to mitigate abuse and promote a safer, healthier work environment for nurses.

5.4 Conclusion

This study has highlighted the significant issue of nurse abuse in the workplace, particularly at the University of Benin Teaching Hospital. The findings reveal that a substantial proportion of nurses experience various forms of mistreatment, with verbal abuse, workplace bullying, and emotional distress being the most prevalent. The study also identified critical factors contributing to nurse abuse, including patient-related conditions, unrealistic expectations from patient relatives, and poor communication. These elements create a hostile work environment that negatively affects nurses' well-being, leading to heightened stress, anxiety, and emotional exhaustion.

The study underscores the urgent need for targeted interventions to reduce workplace violence in healthcare settings. Addressing communication gaps, improving patient and family education on hospital policies, and implementing stronger workplace policies to protect nurses are essential steps toward mitigating abuse. Additionally, providing psychological support and stress management programs for nurses will be crucial in fostering a healthier work environment. By

acknowledging and addressing these issues, healthcare institutions can create a safer, more supportive atmosphere that enhances nurses' well-being and overall job satisfaction.

5.5 Limitations of the Study

Despite the valuable insights provided by this study, several limitations must be acknowledged. First, the study was conducted within a single healthcare institution, the University of Benin Teaching Hospital, which may limit the generalizability of the findings to other hospitals or healthcare settings with different organizational structures and patient demographics. A broader study across multiple institutions would provide a more comprehensive understanding of nurse abuse in Nigeria.

Second, the study relied on self-reported data, which is subject to recall bias and potential underreporting or overreporting of abuse experiences due to fear, stigma, or personal perceptions. Some nurses may have chosen not to disclose certain abusive encounters due to concerns about workplace repercussions or the sensitivity of the topic.

5.6 Recommendations

Based on the findings of this study, the following recommendations are proposed to address the issue of nurse abuse in healthcare settings:

1. Healthcare institutions should develop and enforce clear policies on workplace violence, including zero-tolerance measures against verbal, physical, and emotional abuse. These policies should outline specific reporting procedures and consequences for abusive behavior.

2. Hospitals should enhance security by deploying trained personnel, installing surveillance systems, and establishing emergency response protocols to ensure the safety of nurses and other healthcare workers.
3. Efforts should be made to educate patients and their relatives about hospital procedures, treatment expectations, and nurses' roles to reduce misunderstandings that may lead to conflicts. Hospitals should also implement structured communication training for nurses to handle difficult interactions effectively.
4. Given the significant emotional and mental toll of workplace abuse, healthcare institutions should offer counseling services, peer support groups, and stress management programs to help nurses cope with their experiences.
5. Nurses should receive periodic training on conflict resolution, de-escalation techniques, and handling aggressive behavior from patients and their relatives. This will equip them with the skills to manage tense situations and minimize the risk of violence.
6. Hospital management should foster a culture of respect and support by addressing nurses' concerns, promoting teamwork, and recognizing the efforts of healthcare workers. Leadership should take active steps to ensure that nurses feel valued and protected in their roles.

5.7 Suggestions for Further Study

To build upon the findings of this study, future research should explore the following areas:

1. Conducting research across multiple hospitals, including private and rural healthcare facilities, will provide a broader understanding of the prevalence and patterns of nurse abuse in different work environments.

2. Future studies should assess the long-term effects of workplace abuse on nurses' mental health, job performance, and career progression over an extended period.
3. Research should evaluate the impact of various intervention programs, such as conflict resolution training, security measures, and mental health support, in reducing abuse incidents and improving nurses' well-being.
4. Further investigation is needed into how cultural norms, societal attitudes, and patient expectations influence the frequency and severity of nurse abuse in different regions

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APPENDIX
QUESTIONNAIRE
DEPARTMENT OF NURSING SCIENCE,
UNIVERSITY OF BENIN,
BENIN CITY, EDO STATE

Dear Respondent,

I am a 500 level student of the department of Nursing in the above-named institution. I am carrying out a research study on the topic; “Factors that influence abuse of nurses by patients and their relatives in a tertiary healthcare institution”. Please kindly assist me by indicating your opinion where necessary

Yours faithfully,

Instruction: please do not write your name, provide and tick the appropriate answer.

Section A: Socio-demographics of respondents

1. Age: 20-30 31-40 41-50 51 and above
2. Gender: Male Female
3. Years of nursing experience: 0-5 6-10 11-15 16 and above
4. Highest level of education: RN/RM BSc MSc PhD
5. Ethnicity: Edo Igbo Hausa Yoruba Others
6. Religion: Christian Muslim Traditional Others

Section B: Abuse experiences of nurses

Tick as applicable the correct answers.

S/N	ITEMS	YES	NO
1	Have you suffered from verbal abuse from patients before?		
2	Have you been physically assaulted by patients, visitors or colleagues before?		
3	Have you experienced unwanted sexual harassment, advances, comments or physical contact from patients, visitors or colleagues?		
4	Have you witnessed verbal or written threats to cause harm, either directly or indirectly, by patients, families, or other staff members before?		
5	Have you been bullied by colleagues or superiors that are meant to intimidate, degrade, or humiliate a nurse before?		
6	Have you witnessed persistent and unwanted following, monitoring, or communication, typically by patients or ex-colleagues in times past?		
7	Have you been a victim of actions or words that cause emotional distress, such as manipulation, intimidation, or humiliation in times past?		
8	Have you been a victim of discriminatory comments or actions that target a nurse's race, gender, religion, or other personal characteristics before?		
9	Have you experienced a rude, dismissive, or disrespectful behaviour by colleagues or supervisors that creates a hostile work environment?		
10	Have you been a victim of intentional destruction or theft of personal belongings or hospital property by disgruntled patients, visitors, or colleagues as a form of intimidation or retaliation before?		

Section C: Factors that influence the abuse of nurses by patients and patient relatives

Tick the most appropriate.SA=4, A=3, DA=2, SD=1

ITEMS	4	3	2	1
Patients often become abusive due to frustration from delayed medical attention.				
Lack of patient understanding about hospital policies contributes to abuse towards nurses.				
Patients with severe pain or distress are more likely to verbally or physically abuse nurses.				
Patients with psychiatric conditions tend to be more abusive toward nurses.				
Drug or alcohol-influenced patients are more likely to abuse nurses.				
Patient relatives often become abusive when they perceive that their loved one is not receiving adequate care.				
Relatives' unrealistic expectations about treatment outcomes lead to nurse abuse.				
Lack of proper communication between nurses and patient relatives contributes to abuse.				
Relatives who do not understand medical procedures are more likely to abuse nurses.				
Emotional distress of patient relatives increases the likelihood of abuse toward nurses.				

Section D: Impact of abuse on nurses' well-being

Tick the most appropriate.SA=4, A=3, DA=2, S=1

ITEMS	4	3	2	1
Experiencing abuse from patients or relatives has increased my stress levels.				
Workplace abuse has caused me to feel anxious before coming to work.				
I often feel emotionally drained due to abuse from patients or their relatives.				
I experience sleep disturbances due to stress caused by workplace abuse.				
Verbal or physical abuse at work has contributed to feelings of depression.				

I have developed a fear of interacting with certain patients or their relatives due to past abuse.				
I feel a sense of helplessness when I experience abuse in my workplace.				
Workplace abuse has made me less satisfied with my nursing profession.				
I feel less motivated to perform my duties due to frequent abuse.				
I have considered leaving the nursing profession due to the abuse I experience at work.				

RELIABILITY OF INSTRUMENT ON FACTORS THAT INFLUENCE ABUSE OF NURSES BY PATIENTS AND THEIR RELATIVES IN A TERTIARY HEALTH CARE INSTITUTION IN BENIN CITY, EDO STATE

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.81	0.80	30

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Have you suffered from verbal abuse from patients before?	53.4931	15.077	-.047	.701
Have you been physically assaulted by patients, visitors or colleagues before?	54.1111	15.302	.204	.210
Have you experienced unwanted sexual harassment, advances, comments or physical contact from patients, visitors or colleagues?	53.4167	15.126	-.061	.185
Have you witnessed verbal or written threats to cause harm, either directly or indirectly, by patients, families, or other staff members before?	87.3188	27.590	-.123	.099
Have you been bullied by colleagues or superiors that are meant to intimidate, degrade, or humiliate a nurse before?	87.4813	26.138	.053	.092
Have you witnessed persistent and unwanted following, monitoring, or communication, typically by patients or ex-colleagues in times past?	53.4931	15.077	-.047	.565
Have you been a victim of actions or words that cause emotional distress, such as manipulation, intimidation, or humiliation in times past?	53.2986	14.141	.055	.196
Have you been a victim of discriminatory comments or actions that target a nurse's race, gender, religion, or other personal characteristics before?	53.4167	15.126	-.061	.185
Have you experienced a rude, dismissive, or disrespectful behaviour by colleagues or supervisors that creates a hostile work environment?	87.3188	27.590	-.123	.099
Have you been a victim of intentional destruction or theft of personal belongings or	87.4813	26.138	.053	.092

hospital property by disgruntled patients, visitors, or colleagues as a form of intimidation or retaliation before?				
	53.4931	15.077	-.047	.165
Patients often become abusive due to frustration from delayed medical attention.	87.4500	25.582	.125	.071
Lack of patient understanding about hospital policies contributes to abuse towards nurses.	87.3188	27.590	-.123	.099
Patients with severe pain or distress are more likely to verbally or physically abuse nurses.	87.4813	26.138	.053	.092
Patients with psychiatric conditions tend to be more abusive toward nurses.	87.3188	27.590	-.123	.099
Drug or alcohol-influenced patients are more likely to abuse nurses.	87.4813	26.138	.053	.092
Patient relatives often become abusive when they perceive that their loved one is not receiving adequate care.	87.3188	27.590	-.123	.099
Relatives' unrealistic expectations about treatment outcomes lead to nurse abuse.	87.3188	27.590	-.123	.099
Lack of proper communication between nurses and patient relatives contributes to abuse.	87.4813	26.138	.053	.092
Relatives who do not understand medical procedures are more likely to abuse nurses.	86.3125	25.587	.034	.056
Emotional distress of patient relatives increases the likelihood of abuse toward nurses.	87.6438	27.325	-.076	.081
Patients often become abusive due to frustration from delayed medical attention.	87.5938	26.658	.058	.077
I seek guidance from a dietitian or healthcare professional when unsure about my diet.	87.3188	27.590	-.123	.099
I prepare home-cooked meals that align with my diet plan.	87.4813	26.138	.053	.092
I read food labels to check for sugar content before consuming packaged foods.	86.2813	26.719	-.064	.095
I take my meals in accordance with my insulin schedule.				
I have enough knowledge about diet therapy to follow my recommended meal plan.	86.3125	25.587	.034	.056
The cost of healthy food options affects my ability to comply with diet therapy.	87.6438	27.325	-.076	.081
Limited availability of diabetes-friendly foods influences my diet choices.	87.5938	26.658	.058	.077
Family and social support encourage me to follow my dietary recommendations.	87.3188	27.590	-.123	.099
Lack of time to prepare healthy meals affects my compliance with diet therapy.	87.4813	26.138	.053	.092
I find it difficult to resist unhealthy foods, even though I know they affect my blood sugar levels.	86.2813	26.719	-.064	.095
Cultural food preferences make it hard for me to strictly follow my diet plan.	86.3125	25.587	.034	.056
Healthcare professionals provide adequate guidance on how to manage my diet effectively.	87.6438	27.325	-.076	.081
I feel motivated to comply with diet therapy because of the health benefits.	87.5938	26.658	.058	.077
Stress and emotional factors make it difficult for me to maintain a healthy diet.	87.3188	27.590	-.123	.099

The support of my healthcare provider positively influences my adherence to diet therapy.	87.4813	26.138	.053	.092
Confusion about food portions and meal planning affects my compliance with diet therapy.	86.2813	26.719	-.064	.095
I believe strict adherence to diet therapy significantly improves my health outcomes.	86.3125	25.587	.034	.056
Peer pressure and social events make it challenging to stick to my diet plan.	87.6438	27.325	-.076	.081
My level of physical activity influences my dietary choices.	87.5938	26.658	.058	.077

Comment: The reliability analysis using Cronbach's Alpha, yielding a result of 0.80, for the overall scale. Additionally, the Cronbach's Alpha of 0.52 when the items are standardized. These values suggest a good level of internal consistency among the items in this scale.