



Violence, *burnout* and minor psychiatric disorders in hospital work*

Violência, *burnout* e transtornos psíquicos menores no trabalho hospitalar
Violencia, *burnout* y trastornos psíquicos menores en el trabajo hospitalario

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ABSTRACT

Objective: Identifying the violence suffered by the health team workers and their association with Burnout and minor psychiatric disorders. **Methods:** Cross-sectional study with 269 health team professionals of a public hospital in southern Brazil. Data were collected through the use of the *Survey Questionnaire: Workplace Violence in the Health Sector*, *Maslach Inventory Burnout* and *Self-Report Questionnaire*. **Results:** Workplace violence struck 63.2% of workers, prevailing mostly in women ($p = 0.001$), among nursing auxiliaries/technicians ($p=0.014$) and was associated with minor psychiatric disorders ($p<0.05$), as exposure to different forms of violence increased the chances of these disorders by 60% (CI 95%: 1.2-2.1). The three Burnout dimensions were also associated to violence at work ($p<0.05$). **Conclusion:** Health workers experience violence in the workplace and this exposure is associated with Burnout symptoms and minor psychiatric disorders.

DESCRIPTORS

Workplace Violence; Occupational Health; Health Manpower; Nursing Staff.

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INTRODUCTION

Workplace violence is considered a growing phenomenon in the world and a major public health problem, and has been appointed by the health sector as a prevalent field for the occurrence of attacks on workers⁽¹⁻²⁾. Therefore, violence at work has gained international prominence in discussions on the challenges related to human resources for health⁽³⁻⁵⁾. Prevalence rates show that the problem of violence in health services range from 17 to 94%, and frequently exceeds 50% of workers⁽²⁻⁶⁾.

The potential for this exposure can be attributed to the characteristics of performed activities by health professionals, which involves constant physical contact and intense interaction with people who receive their care, as well as their families and caregivers^(3,6). Still, the unfavorable conditions for the provision of care can be understood as disagreements which generate barriers that can easily evolve into assaults between patients and health professionals, or among the professionals themselves, since both have infringed on their expectations and desires⁽⁷⁻⁸⁾. In this context, it is understood that workplace violence is in the form of aggression stemming from labor relations and is presented in the form of threats, abuse or attacks⁽¹⁾, having its origins directly related to the conditions and organization of work.

In the international scenario, studies have revealed concern about violence in health services^(2,5-6). However, in Brazil the problem still needs to be studied further⁽⁸⁻¹⁰⁾, since the invisibility of its occurrence and consequences contributing to the attacks are treated as "natural" in many work environments and the magnitude of the problem is underestimated.

The negative consequences of violence on the health of workers and the assistance provided have been evidenced by symptoms of stress, low self-esteem and the demotivation of the victims^(5,10-12). These symptoms, which have been linked to the exposure of workers to violence and are characteristic of *Burnout*, a prevalent syndrome in health workers and characterized by high levels of emotional exhaustion, depersonalization, and low job satisfaction⁽¹³⁾.

In addition, minor psychiatric disorders have also been linked to the victims of violence at work⁽⁹⁾, which are described as non-psychotic psychiatric symptoms⁽¹⁴⁾, such as anxiety, insomnia, sadness, fatigue, forgetfulness, difficulty in concentrating, irritability, somatic complaints and neurasthenia. Thus, in addition to the interest in identifying the violence suffered by workers of the health team, this study questioned its association with *Burnout* and minor psychiatric disorders. Given the above, the objective was to identify the violence suffered by the health team workers and its association with *Burnout* and minor psychiatric disorders.

METHOD

This is a cross-sectional study in a public referral hospital for trauma care in southern Brazil. This service has 139 beds and provides more than 900 daily visits, starting at emergency rooms with inpatient units, surgery and

intensive care. The professionals work in the position of effective provision and are governed by municipal statute.

The study sample consisted of 269 subjects, defined according to sample calculation on the population of 1,025 health team professionals. The sample size calculation was performed with the aid of software *WinPepi* version 9.4, assuming a confidence level of 95%, 5% error estimate, 80% power and prevalence of 50%.

The random selection of subjects was performed by a draw, stratified according to the proportion of professional categories over the whole of 349 doctors, 103 nurses, 482 nursing auxiliaries/technicians and 91 professionals from other health team categories (social workers, psychologists, physiotherapists, dentists, nutritionists and radiology technicians), regardless of shift or sector. We selected the subjects from a list of employees provided by the hospital's human resources sector, and we set a year of service in the hospital as the minimum time for inclusion criteria and that they had to be active in the period of data collection, which occurred during the months of June–August 2011. In the case where someone refused to participate in the study (n=7), they were replaced by people from within the same category and following the same type of draw.

For the data collection, participants answered questions that verified demographic and labor information. To evaluate the occurrence of violence in the last 12 months, we used the *Survey Questionnaire Workplace Violence in the Health Sector*⁽¹⁵⁾, proposed by the World Health Organization, International Labour and Public Services Organization, and International Council of Nurses, and it was translated and adapted to Portuguese⁽¹⁶⁾. For professionals who also worked at other institutions, the focus of the research was clarified as the episodes of violence that only occurred at this study site.

Burnout was assessed by the *Maslach Burnout Inventory* (MBI)⁽¹⁷⁾, which detects a syndrome characterized by high emotional exhaustion, depersonalization, and low professional efficacy. These dimensions make up the scale of 22 questions used to identify *Burnout*. The MBI was translated into Portuguese and validated in Brazil, with a Cronbach's alpha of 0.86 in the subscale of emotional exhaustion, 0.69 for depersonalization and 0.76 in professional efficacy⁽¹³⁾.

To track Minor Psychiatric Disorders, we used the Self-Report Questionnaire (SRQ-20) recommended by the World Health Organization and validated for the Brazilian population in 1986 with 83% sensitivity and 80% specificity⁽¹⁴⁾. The SRQ has 20 questions that assess non-psychotic psychiatric symptoms.

We coded and tabulated data with the aid of *Microsoft Windows Excel*, and performed statistical analysis using the *Statistical Package for Social Sciences software (SPSS)*, version 18.0. For sociodemographic and labor variables, we calculated relative and absolute frequencies when categorical, and measures of central tendency and dispersion when continuous. The factor studied (workplace violence) was analyzed with dichotomous categories (victims and non-victims of violence) and considered being exposed to different forms

of perpetration of physical, verbal, moral, racial and/or sexual violence as a continuous variable.

We treated the SRQ-20 scores and MBI dimensions as scalar variables, obtaining a mean and standard deviation. The cutoff point in the SRQ-20 scale was seven positive responses for both genders, thereby constituting the groups with and without Minor Psychiatric Disorders⁽¹⁴⁾. To identify levels (high, moderate and low) of *Burnout* dimensions, we selected the higher or equal scores to the 75th percentile on the subscales of emotional exhaustion and depersonalization, and up to 25th percentile in the professional efficacy subscale. The categorical variable of *Burnout* (yes or no) was observed in subjects with high emotional exhaustion and depersonalization, and low professional efficacy⁽¹³⁾.

We found associations between the groups using the chi-square test. The differences between mean scores of MBI and SRQ-20 were then analyzed using the *t*-test (for variables with normal distribution) and Mann-Whitney test (for variables with asymmetric distribution). The correlations with exposure to different forms of violence were carried out using Spearman and Kruskal-Wallis tests.

In multiple logistic regression analysis, the influence of independent variables on the outcomes (*Burnout* and Minor Psychiatric Disorders) were verified first, in order to select variables with $p < 0.15$ to be included in the analytical model. We considered the results statistically significant if $p \leq 0.05$ values in Poisson multiple regression analyzes (Minor Psychiatric Disorders) and multiple linear regression (*Burnout* dimensions).

The study met the ethical prerequisites of research involving human beings, according to Resolution 196 of 1996 of the National Health Council and was approved by the Research Ethics Committee, under number 001.014667.11.8. All subjects signed a two-way Consent Form.

RESULTS

The study was conducted with 269 health workers, of which 157 (58.4%) were female, with an average of 49 (+7.4) years of age, who had companions (63.9%, $n = 172$), median of two (1-2) children, education median of 17 (14-21) years of education, average professional experience of 24.8 (+7.8) years of experience in health and 16.2 (+7.7) years at the institution.

Regarding the professional category, the sample consisted of 122 (45.4%) nursing auxiliaries/technicians, 27 (10%) nurses, 90 (33.5%) physicians and 30 (11.1%) other health professionals. Most worked in critical care units (44.2%, $n = 119$), such as intensive care units and an operating room, followed by emergency rooms (21.9%, $n = 59$), inpatient units (17.8%, $n = 48$) and other sectors (16%, $n = 43$), which included the blood bank units, radiology, physiotherapy, psychology and social work.

Sample distribution into work shifts revealed that 39.4% ($n = 106$) of participants worked during the day and 27.9% ($n = 75$) at night. Long shifts (with periods including day and night) were reported by 32.7% ($n = 88$) of the sample. The weekly workload of workers had a median of 40 (30-40) hours per week. Most subjects (63.2%, $n = 170$) reported not working at other institutions and 8.9% ($n = 24$) of the workers had some kind of leading responsibility.

In the sample, 63.2% ($n = 170$) of the subjects were exposed to violence, with a prevalence of female victims ($p = 0.001$), younger ($p = 0.044$), lower education ($p = 0.036$) and belonging to the professional category of nursing auxiliaries/technicians ($p = 0.014$) (Table 1). Among the victims, we found that 35% ($n = 94$) experienced one type of violence, while 28.2% ($n = 76$) of the sample had been exposed to two or more forms of violence perpetrated at work.

Table 1 – Distribution of workers exposed and not exposed to violence at work, according to sociodemographic and labor characteristics - Porto Alegre, RS, Brazil, 2011.

Sociodemographic and Labor Variables	Workplace Violence		P
	Yes (n = 170)	No (n = 99)	
Gender*			0.001^s
Female	112 (71.3)	45 (28.7)	
Male	58 (51.8)	54 (48.2)	
Age[†]	48.5 (± 6.9)	49.8 (± 8.2)	0.044
Education level (years of study)[‡]	17 (14-20)	18 (14-23)	0.036[†]
Average hours of sleep[†]	6.4 (± 1.4)	6.6 (± 1.1)	0.373
Smokers*			0.488 ^s
Yes	22 (68.7)	10 (31.3)	
No	148 (62.4)	89 (37.6)	
Experience time in healthcare[†]	24.6 (± 7.4)	25.2 (± 8.5)	0.331
Experience time at the institution[†]	15.9 (± 6.9)	16.6 (± 8.9)	0.275
Work sector*			0.104 ^s
Emergency rooms	43 (72.9)	16 (27.1)	
Critical Units	67 (56.3)	52 (43.7)	
Inpatient units	34 (70.8)	14 (29.2)	
Other	26 (60.5)	17 (39.5)	
Professional category*			0.014^s
Nursing auxiliaries /technicians	88 (72.1)	34 (27.9)	
Nurse	19 (70.4)	8 (29.6)	
Doctor	47 (52.2)	43 (47.8)	
Others	16 (53.3)	14 (46.7)	

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Sociodemographic and Labor Variables	Workplace Violence		P
	Yes (n = 170)	No (n = 99)	
Work shift*			0.110 [§]
Day time	70 (66.0)	36 (34.0)	
Night time	52 (69.3)	23 (30.7)	
On shift	48 (54.5)	40 (45.5)	
Week workload*	40 (30-40)	36 (30-40)	0.012[†]
Working at another institution*			0.145 [§]
Yes	57 (57.6)	42 (42.4)	
No	113 (66.5)	57 (33.5)	
Work accidents*			0.009[†]
Yes	96 (69.1)	43 (30.9)	
No	74 (56.9)	56 (43.1)	
Nº of Accidents[†]	1 (0-2)	0 (0-1)	0.045[§]
Days missed from work last year[†]	0 (0-10)	0 (0-3)	0.018[§]
Satisfied with their work*			0.026[†]
Yes	92 (58.2)	66 (41.8)	
No	78 (71.6)	31 (28.4)	
Interpersonal relationships review[†]	4 (4-4)	4 (4-4)	0.058 [§]
Job recognition*			0.001[†]
Yes	82 (54.3)	69 (45.7)	
No	87 (74.4)	30 (25.6)	
Concern about violence*	4 (3-5)	2 (1-3)	<0.001[§]

n (%); †Average (±Standard Deviation); §Medium (interquartile intervals); §Chi-square; †t-Student; *Mann-Whitney.

Note: Work accidents included typical accidents, the most reported were biological and ergonomic accidents, human aggressions were not included in this variable. Interpersonal relationships review was assessed on a 5 point scale: (1) very bad; (2) bad; (3) regular; (4) good; (5) great. Concern about violence was assessed on a 5 point scale: (1) not worried; (2) slightly worried; (3) moderate concern; (4) concerned; (5) very concerned

We identified 46 (17.1%) workers with Minor Psychiatric Disorders (MPD), of which 38 (82.6%) reported exposure to violence (p = 0.003) (Table 2).

In the same table significant correlation between MPD and exposure to multiple forms of violence can be seen. From the selection of labor and sociodemographic variables

associated with MPD, the strength of association was analyzed using Poisson regression model (Table 3).

From the prevalence ratio, it was possible to establish that exposure to different forms of perpetrated violence compounded the chances of these disorders by 60% (95% CI: 1.2-2.1).

Table 2 – Distribution of workers according to the presence of Minor Psychiatric Disorders and scores of the SRQ-20 according to total sample, victims of violence and exposure to different forms of violence suffered at work - Porto Alegre, RS, Brazil, 2011.

	Total sample (n = 269)	Violence		p	Different forms of violence (n = 269)	P
		Yes (n = 170)	No (n = 99)			
MPD[†]				0.003[§]		<0.001
Yes	46 (17.1)	38 (82.6)	8 (17.4)		2 (1-2)	
No	223 (82.9)	132 (59.2)	91 (40.8)		1 (0-1)	
MPD scores[†]	2 (1-5)	3 (1-6)	2 (0-4)	<0.001	0.330	<0.001[†]

n (%); † Medium (interquartile intervals); § Correlation coefficient; § Chi-square; || Mann-Whitney; *Spearman.

Legend: MPD – Minor Psychiatric Disorders

Table 3 – Poisson Regression Model for variables associated with Minor Psychiatric Disorders - Porto Alegre, RS, Brazil, 2011.

Variables	PR (95% CI)	P
Nº of children	0.7 (0.5-0.9)	0.016
Years of experience in healthcare (every 5 years)	1.3 (1.1-1.6)	0.015
Professional Category		
Nursing auxiliaries /technicians	3.5 (0.8-15.3)	
Nurse	2.5 (0.4-13.8)	0.095
Doctor	2.9 (0.6-13.8)	0.303
Other	1.0	0.165
Nº of professionals present	1.0 (0.9-1.1)	0.064
Satisfaction with work place		
Yes	0.6 (0.3-0.9)	
No	1.0	0.032
Nº of work Accidents	1.2 (0.9-1.4)	0.100

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Variables	PR (95% CI)	P
Days missed from work		
None	1.0	
≤1 week	1.6 (0.8-3.4)	0.205
1 week to 2 months	1.8 (0.9-3.4)	0.087
≥2 months	3.5 (1.5-8.1)	0.004
Exposure to different forms of violence	1.6 (1.2-2.1)	0.001

Legend: PR = Prevalence Ratio; CI = Confidence Interval.

The application of MBI confirmed *Burnout* in 18 (6.7%) workers, among which 13 had experienced violence at work (p=0.411). The high levels of emotional exhaustion and depersonalization, and low professional efficacy were associ-

ated with violence (Table 4).

Linear regression was conducted from the selection of demographic and labor variables associated with each of the dimensions that make up *Burnout* (Table 5).

Table 4 – Distribution of means and levels of *Burnout* dimensions and *Burnout* syndrome, according to the exposure of workers to violence and the different forms of violence. Porto Alegre, RS, Brazil, 2011.

	Total (n = 269)	Violence		P	Different forms of violence (n = 269)	P
		Yes (n = 170)	No (n = 99)			
<i>Burnout</i>^{†*}						
Yes	18 (6.7)	13 (72.2)	5 (27.8)	0.411	1 (0-2)	0.196 [†]
No	251 (93.3)	157 (62.6)	94 (37.4)		1 (0-2)	
<i>Burnout Dimensions</i>^{†§}						
Emotional exhaustion	28.2 (±11.6)	30.3 (±11.2)	24.5 (±11.6)	<0.001 ^{**}	0.322	<0.001 ^{**}
Professional efficacy	47.2 (±7.1)	46.7 (±6.8)	48.1 (±7.5)	0.099 ^{**}	-0.150	0.014 ^{**}
Depersonalization	10.6 (±5.8)	11.3 (±6.2)	9.2 (±4.8)	0.002 ^{**}	0.164	0.007 ^{**}
<i>Burnout Levels</i>^{†*}						
Emotional exhaustion				<0.001		<0.001
Low	68 (25.3)	32 (47.1)	36 (52.9)		0 (0-1)	
Moderate	133 (49.4)	84 (63.2)	49 (36.8)		1 (0-2)	
High	68 (25.3)	54 (79.4)	14 (20.6)		1 (1-2)	
Professional efficacy				0.017		0.011 ^{**}
Low	73 (27.1)	54 (74.0)	19 (26.0)		1 (0-2)	
Moderate	122 (45.4)	78 (63.9)	44 (36.1)		1 (0-1.3)	
High	74 (27.5)	38 (51.4)	36 (48.6)		1 (0-1)	
Depersonalization				0.014		0.053 ^{**}
Low	78 (29.0)	46 (59.0)	32 (41.0)		1 (0-2)	
Moderate	123 (45.7)	71 (57.7)	52 (42.3)		1 (0-2)	
High	68 (25.3)	53 (77.9)	15 (22.1)		1 (1-2)	

n (%); †Medium (interquartile intervals); ‡Average (±Standard Deviation); §Correlation coefficient^{||}Chi-square; †Mann-Whitney. ††t-Student; ††Spearman; ††Kruskal-Wallis.

Table 5 – Multiple linear regression model to the dimensions of *Burnout* - Porto Alegre, RS, Brazil, 2011.

Dimensions	Variables	B	p	r ²
Emotional exhaustion	White	-2.574	0.081	0.306
	Number of children	-0.961	0.055	
	Interpersonal relationships review	-1.513	0.084	
	Job satisfaction	-5.502	<0.001	
	Recognition at work	-5.432	<0.001	
	Concern about violence	0.924	0.048	
	Different forms of violence	2.019	0.003	
Professional efficacy	Age	0.124	0.028	0.157
	Number of children	0.763	0.029	
	Professional Category			
	Nursing auxiliaries/technicians			
	Nurse	1.805	0.193	
	Doctor	1.154	0.512	
	Other	2.901	0.043	
	Hours of sleep	-0.598	0.056	
Interpersonal relationships review	1.137	0.053		
Job recognition	3.388	<0.001		

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Dimensions	Variables	B	p	r ²
Depersonalization	Number of children	-0.684	0.012	0.122
	Work sector			
	Urgency or Emergency rooms			
	Critical Units	-1.572	0.159	
	Inpatient units	-2.909	0.003	
	Other	-2.866	0.014	
	Working at another institution	1.574	0.025	
	Job recognition	-2.054	0.003	
	Different forms of violence	0.930	0.010	

Legend: B – angular regression coefficient; r² – determination coefficient.

On the variables of influence on the dimensions of *Burnout*, there is a correlation between increased exposure to different forms of perpetrated violence and Emotional Exhaustion ($p = 0.003$), as for every increase in violence that the worker suffered, there was an average increase of two points in that dimension. Workplace violence remained in the final regression model of professional efficacy. Increased exposure to different forms of perpetrated violence at work was correlated with depersonalization ($p = 0.003$).

DISCUSSION

The percentage of victims of violence at work (63.2%) exceeds the statistical studies that used the same investigation strategy in the health services of Bahia⁽¹⁸⁾, of Rio de Janeiro (46.7%) and in countries such as Portugal (37%), Thailand (54%) and South Africa (61%)⁽¹⁵⁾. However, it was lower than the prevalence in Australia (67.2%) and Bulgaria (75.8%)⁽¹⁵⁾.

In Australia, another study found that 52% of health professionals were victims of some form of violence at work in the last four weeks⁽⁴⁾. Similar findings were seen in a Swiss university hospital, with 50% of violence in the last 12 months and 11% in the last week⁽⁶⁾. These data reveal the prevalence of victims in a recent period, featuring workplace violence as a phenomenon occurring in labor every day. Brazilian studies have identified a prevalence of 25-65% for some kind of violence in the last 12 months^(9,18).

The prevalence of the auxiliary/practical nurse category among the victims of violence in the study setting, as well as workers with less education was also predominant among the victims, reinforcing the higher exposure of nursing professionals with a medium level in this study. Brazilian studies have highlighted the exposure of these professionals^(16,18).

Some authors state that nursing is more exposed to violence from both the profile of their direct care activities to the patient^(5-6,11) and the predominance of female workers⁽⁵⁾, placing particular emphasis on the implications of gender being aggravating. A longitudinal study pointed to the exposure of nurses to gender violence, finding that in this class there was an increased risk of violence due to the overlap of labor abuse to domestic violence, and an increase in the chances of stress and depression⁽¹⁹⁾. The implication of gender on the understanding of violence should consider the historical cultural and economic inequality between genders, for which women have been in unfavorable

conditions. Females having the largest distribution in the group of workers exposed to occupational violence has been recurrent in the health sector^(5,9,12).

Victims of violence at work in the past year had lower average age than those not exposed to violence in the last year, reinforcing findings of other studies^(5,9,12,18,20-21). This result can be explained from the perspective of young professionals who have less expertise in the development of their work activities and thus would have less ability to prevent attacks. However, the differences related to professional practice time do not reinforce this fact.

The exposure of health workers to violence at work has been linked to higher workloads in labor^(12,20), according to results of this study. In addition to concluding that the increase of the incidents stems from the increase in exposure time to the phenomenon, it is considering the possibility that overload is reflected in behaviors that add risk, such as less attention to detail or greater irritability. Other Brazilian studies^(9,16) describe the precariousness of employment contracts as an aspect that focuses on the vulnerability of workers.

The shift of the victims had no significant prevalence. These findings differ from other studies^(5,12,16,20), which indicated increased exposure for professionals who work at night.

Workplace violence may reflect on different aspects of working life; in this study we highlight the negative relationship on satisfaction and recognition at work. Other studies showed association to employee dissatisfaction⁽⁹⁻¹⁰⁾, demotivation to work⁽¹⁰⁾, decreased professional commitment⁽⁵⁾, damage to teamwork, experiences working under pressure and physical overload⁽¹²⁾.

A study also found that violence interferes on adverse events in nursing care⁽²²⁾. However, we found no studies to confirm the data from this research on the prevalence of occupational accidents among workers exposed to violence, but it is understood that accidents are representations of emotional and cognitive impairments brought about by the experience of violence. Workplace violence was associated with worker's absences, complementing findings in the literature that indicate this phenomenon as the cause of absence^(3,9). However, we note that in addition to the underreporting of violence in health services⁽⁸⁾, it has not been registered as cause of removal, which may result in the same occurring in health services.

Victims of workplace violence have been concerned about this issue^(10,16), which is linked to the discontent from

their experiences and to consequences of worker safety. Victims of workplace violence have experienced feelings of fear and insecurity⁽¹⁰⁾, suggesting damage to workers' health.

In this sense, the results of this study show the association between the experience of violence and the prevalence of MPD, confirming other findings⁽⁹⁾. Regression analysis has highlighted that exposure to different forms of perpetrated violence is a high probability factor for developing MPD, confirming data from other studies about the negative influence of exposure to more types of violence on the mental health of workers^(19,23).

The association between violence at work and depression, anxiety and post-traumatic stress disorders has already been discussed⁽²⁴⁾. In these conditions, feelings such as sadness, anger, shock, confusion and shame were associated with violence at work⁽⁵⁾.

A longitudinal study of 176 nurses from two American hospitals revealed the effects of exposure to physical violence on health in the form of somatic symptoms and musculoskeletal injury⁽²⁵⁾. Another pointed out that the violence suffered by hospital workers can lead to increased use of psychotropic drugs, particularly antidepressants, but also anxiolytic⁽²⁶⁾.

Regarding *Burnout* measured by the MBI, data from this study demonstrated that emotional exhaustion and depersonalization were higher for the victims of violence, therefore the dimensions of the scale were associated with workplace violence. Corroborating these data, a study of nurses from 11 public hospitals in Spain found that increased exposure to violence at work is associated with greater emotional exhaustion and depersonalization, and a lower level of psychological well-being⁽²⁷⁾. Another Spanish study confirms the association of violence with the dimensions of emotional exhaustion and depersonalization⁽²³⁾. Research conducted with nurses from 10 European coun-

tries showed that the highest frequencies of violence were associated with higher levels of *Burnout*⁽¹²⁾, which was also concluded from a systematic review⁽⁵⁾.

CONCLUSION

Health workers experience violence in the workplace and this exposure is associated to symptoms of *Burnout* and MPD. Workers subjected to different forms of perpetrated violence experience these conditions even more.

The victims were predominantly women, younger workers, working more hours and having less education, and working as auxiliary/practical nurses. In addition to the *Burnout* symptoms and minor psychiatric disorders, the cruelties of violence proved to be linked to typical complications of labor, such as accidents and absenteeism, reflecting the complexity of the elements involved in the suffering and illness of workers. Exposure to violence also has a negative impact on job satisfaction and worker recognition.

These results have implications for the field of study and practice in occupational health, revealing the need for protective measures on the occurrence of violence and harm to the mental health of health care professionals, especially nursing. We must invest in monitoring systems for the incidents in order to identify measures that contain aggressors and to track the victims, thereby minimizing the damage of violence. This issue needs to have institutional guidelines, seeking to understand its origins and invest in a zero tolerance culture of violence at work.

Regarding the limitations of the study, the bias of reverse causality between the variables studied factor and outcomes should be considered. Given these speculations, we see the need for further studies, and recommend longitudinal designs seeking more evidence related to health and worker safety and the impact on patient care.

RESUMO

Objetivo: Identificar a violência sofrida pelos trabalhadores da equipe de saúde e a sua associação com *burnout* e transtornos psíquicos menores. **Método:** Estudo transversal, realizado com 269 profissionais da equipe de saúde em hospital público da região sul do Brasil. Na coleta de dados foram utilizados o *Survey Questionnaire Workplace Violence in the Health Sector*, *Maslach Inventory Burnout* e o *Self-Report Questionnaire*. **Resultados:** A violência no trabalho acometeu 63,2% dos trabalhadores, prevaleceu no sexo feminino ($p=0,001$), entre auxiliares/técnicos de enfermagem ($p=0,014$) e foi associada aos transtornos psíquicos menores ($p<0,05$), sendo que a exposição a diferentes formas de violência acresceu em 60% as chances desses transtornos (IC95%:1,2-2,1). As três dimensões do *burnout* também se associaram à violência no trabalho ($p<0,05$). **Conclusão:** Os trabalhadores de saúde sofrem violência em seu ambiente de trabalho e a essa exposição associam-se os sintomas de *burnout* e transtornos psíquicos menores.

DESCRITORES

Violência no Trabalho; Saúde do Trabalhador; Recursos Humanos em Saúde; Recursos Humanos de Enfermagem.

RESUMEN

Objetivo: Identificar la violencia sufrida por los trabajadores del equipo de salud y su asociación con *burnout* y trastornos psíquicos menores. **Método:** Estudio transversal, realizado con 269 profesionales del equipo de salud en hospital público de la región sur de Brasil. En la recolección de datos se utilizaron el *Survey Questionnaire Workplace Violence in the Health Sector*, el *Maslach Inventory Burnout* y el *Self-Report Questionnaire*. **Resultados:** La violencia laboral comprometió al 63,2% de los trabajadores, fue prevalente en el sexo femenino ($p=0,001$), entre auxiliares/técnicos de enfermería ($p=0,014$) y estuvo asociada con los trastornos psíquicos menores ($p<0,05$), siendo que la exposición a distintas formas de violencia añadió en el 60% la probabilidad de ocurrir dichos trastornos (IC95%:1,2-2,1). Las tres dimensiones del *burnout* también se asociaron con la violencia laboral ($p<0,05$). **Conclusión:** Los trabajadores de salud sufren violencia en su ambiente laboral y con esa exposición se asocian los síntomas de *burnout* y trastornos psíquicos menores.

DESCRIPTORES

Violencia Laboral; Salud Laboral; Recursos Humanos en Salud; Personal de Enfermería.

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