

**“AN INVESTIGATION INTO PATIENTS’  
PERCEPTIONS OF CONTRIBUTING FACTORS  
TOWARD THEIR AGGRESSIVE AND VIOLENT  
BEHAVIOUR AFTER ADMISSION TO A MENTAL  
HEALTH FACILITY”.**

**By**

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**An investigation into patients' perceptions of contributing factors toward their aggressive and violent behaviour after admission to a mental health facility.**

**KEYWORDS**

Mental Health Care Act

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## **ABSTRACT**

Aggressive and violent behaviour in inpatient mental health facilities is found world-wide and is a frequent and serious clinical and nursing care problem (Duxbury, 2002:325). Despite the importance of international research findings and recommendations, it appears that patients' perceptions of the possible contributing factors toward aggressive and violent behaviour in mental health facilities is an area of enquiry that has not been widely explored in South Africa in general, or in the Western Cape, in particular.

It is against this background, using the theoretical framework of Duxbury (2002), that this study endeavoured to investigate the external and situational contributing to patients' aggressive and violent behaviour in mental health facilities in Cape Town, as seen from patients' perspectives.

A qualitative research design was used in this study as it focused on patients' perceptions of possible contributing factors toward their aggressive and violent behaviour. A sample of 40 patients was selected from eligible patients admitted to the pre-discharged wards of Lentegeur and Valkenberg mental health facilities between January 2004 and June 2004.

Data was collected by tape-recording interviews using a semi-structured interview schedule at a time acceptable to the patients. A thematic analysis was utilized according to the theoretical framework of external and situational models of possible contributing factors of inpatient aggressive and violent behaviour.

The study concluded that the occurrence of aggressive and violent behaviour disrupts the therapeutic alliance. If mental health facilities want to be of optimal benefit to patients, it is required that activities should be restructured and certain nursing staff should change their attitudes. Planning and upgrading efforts require a holistic approach, obtaining and integrating input from a wide range of sector, as well as ensuring nursing staff compliance with suggested changes. Moreover, preventing and

controlling aggressive and violent behaviour amongst inpatients should be a key innovation in the operation of all mental health facilities. Results of this study indicated that there is a need for interventions that will enable staff to deal effectively with situations that may precipitate anger and assault.

## DECLARATION

I declare that:

“An investigation into patients’ perceptions of contributing factors toward their aggressive and violent behaviour after admission to a mental health facility”.

is my own work, that it has not been submitted before for any degree or examination at any other university, and that all the sources have been indicated and acknowledged by complete references.

Evalina van Wijk

October 2006.

Signed:                     *EVWIJK*

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# **CHAPTER ONE**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

This chapter is concerned with an orientation to the study in which the formulation of the research problem, significance of the study, research methodology, ethical consideration and limitations of the study are described. At the end of this chapter, an outline of the study is presented.

### **1.2 FORMULATION OF THE PROBLEM**

#### **1.2.1 Background of the problem**

The increasing interest in inpatient violence and aggressive behaviour found in the literature is due to the common occurrence of such incidents in mental health facilities, with 75% of mental health nurses being physically threatened at some stage (Munro, 2002:38). In a study conducted in 1997 in a closed mental health admission ward, as noted by Nijman, áCampo, Ravelli and Merckelbach (1999), one aggressive incident per day was reported. Literature reviews pertaining to violence in institutional settings generally report on violence towards staff members, and the risk posed by patients to other patients (Morrison, 1990:32). For the past twenty-five years numerous attempts have been made worldwide to identify why mental health facilities are disrupted by the occurrence of aggressive and violent behaviour, and why such incidents are often under-reported (Owen, Tarantello, Jones & Tennant, 1998:1456).

A Science and Human Rights Coalition (SHRC/AAAS, 1998) analysis confirmed this perception by highlighting a number of difficulties relating to the general conditions and violence in mental health facilities, e.g. Weskoppies Hospital and recommended that follow-up research studies be conducted (SHRC/AAAS, 1998). It appears, however, that these recommendations for studies examining violence within the mental health facilities have not been followed in the Western Cape. Motivation to pursue an investigation into the occurrence of aggressive and violent behaviour in mental health facilities was further prompted by the concerns of Bothwell (2001:321) who also found that there is a dearth of literature in South Africa relating to the possible contributing factors towards violent and aggressive behaviour in patients with mental illness. It is

the view of the researcher that there is a need to determine how various external and situational factors might predispose patients to aggression or violent behaviour at psychiatric inpatient facilities.

A clinical psychologist, based at Valkenberg mental health facility, indicated that there is widespread concern about the increase of aggressive and violent behaviour after admission to the mental health inpatient facilities in the Western Cape (personal communication, 2 June 2003). Two new admission wards are currently being built on the premises of the Valkenberg mental health facility in order to alleviate some of the perceived causative factors of violence such as lack of privacy. Provision will be made for more space, more privacy and protected open areas to avoid the current overcrowding which is thought to contribute to aggression and violent behaviour. Three video cameras will be installed not only for nursing staff to observe patients, but also to protect patients and staff (personal communication, 2 June 2003).

Aggressive and violent behaviour in inpatient mental health facilities is found worldwide and is a frequent and serious clinical and nursing care problem (Katz & Kirkland, 1990:262; Shah, Fineberg & James, 1991:305; Davis, 1991:585; Palmstierna, Borje & Wistedt, 2000:79 and Duxbury, 2002:325). Aggressive and violent behaviour causes severe disruptions of occupational, societal, familial and other social functions (Palmstierna & Wistedt, 1995:32; Carlsson, Dahlberg & Drew, 2000:545 and Sjöström, Eder, Malm, & Beskow, 2001:459). Sclafani (2000:2) indicated that mental health facilities are disrupted by incidents of violence and aggression and that these acts are inevitable, it should not be accepted passively with a "business as usual" attitude. Sclafani (2000:3) states that it is no longer appropriate for mental health service providers to focus on this issue from the passive perspective that "violence is part of the job". These issues should be addressed from a documented, comprehensive, and proactive perspective. This approach of violence prevention and intervention should be reflected in three major areas: administrative/managerial leadership and support, clinical inquiry, and staff development and training initiatives.

Katz and Kirkland (1990:262); Lanza, Kayne, Hicks and Milner (1994:319); Kho, Sensky, Mortimer and Corcos (1998:38) and Rabinowitz and Mark (1999:341) conducted studies to identify the possible contributing factors towards aggressive and

violent behaviour in mental health facilities in Western countries. Bothwell (2001:321) reported that there is little sound empirical knowledge regarding the relationship between aggression and violent behaviour and environmental and situational factors in mental health facilities in South Africa. However, no evidence could be found of any prior nursing studies in the Western Cape that have explored these issues, hence this study appears to be the first one of this nature.

Despite the importance of international research findings and recommendations, it appears that patients' perceptions of the possible contributing factors towards aggressive and violent behaviour in mental health facilities is an area of enquiry that has not been widely explored in South Africa in general, or in any of the four associated mental health facilities in the Western Cape, in particular. The researcher's personal experience while working in mental health facilities in the Western Cape confirms that these disturbing phenomena of violence and aggression also occur locally. In South Africa, the respective demands of mental health nursing, legislation and the prevalence of aggressive and violent behaviour in mental health in-patient facilities, place tremendous pressure on the nursing management responsible for the planning and implementing of nursing care. According to the World Health Organisation, such care should be provided in a therapeutic environment, yet due to financial and human constraints it is improbable that new, high-quality state facilities will be provided in the immediate future (WHO Report, 2001). It would therefore be pertinent to identify possible contributing factors to aggressive and violent behaviour in the Western Cape mental health facilities in order for appropriate responses to be formulated.

### **1.2.2 Problem statement**

During 2003, the management of the Valkenberg mental health facility asked patients who had been admitted previously, and who were at that stage attending the out patient department (OPD), to complete an evaluation questionnaire. The responses of those who completed the questionnaire indicated general satisfaction with treatment in the OPD, but considerable dissatisfaction with inpatient services. Unsatisfactory or negative ratings were recorded in the categories of boredom, privacy, cleanliness, the quality of bedding and toilets in the admission wards, food quality, visiting hours, safety issues, and lastly the availability and listening skills of nurses. Personnel have

expressed increasing concern about inpatient violence. The January 2002 report of the Director of the associated mental health facilities in Cape Town noted that violent incidents in the psychiatric services are increasing, and recognised the need for protocols regarding the safe and acceptable management of patients in order to prevent violence and aggression (personal communication, 27 February 2003).

While the poor state of the facilities and staffing shortages are disturbing, it does not provide sufficient explanation for the current situation (injury to patients) in the mental health facilities. From personal experience the researcher gathered that factors such as low staff morale, a lack of adequate training, a lack of leadership in certain areas, poor communication, administrative inefficiencies, hostility, and divisions between different nursing categories and wards (for example: acute admissions and pre-discharge wards) contribute to the current situation.

### **1.3 Significance of the study**

Owen, et al. (1998:1456) reported that research from a nursing perspective on factors relating to mental health inpatient violence is lacking. These authors support the urgent need for research to identify nursing issues, which may contribute to inpatient aggression and violence. Blair and New (1991:25) state that violence in our society is an increasing national concern and that the occurrence of violence in mental health facilities reflects this trend. Abundant international epidemiological evidence exists which support interplay between patient, environmental and situational factors that contribute to the prevalence of aggressive and violent behaviour in mental health facilities (Cooper & Mendonca, 1991:163; Morrison, 1994:245 and Schanda & Taylor, 2001). Due to the complexity of violent behaviour, it is vital to develop interventions that cover the range of causative factors. Palmstierna and Wistedt (1995:32) and Love and Hunter (1996:30) caution, however, that the phenomenon of aggressive and violent behaviour does not lend itself easily to measurement.

The findings and recommendations of this study could prompt mental health providers, service managers and mental health nurses at these facilities to share their experiences and perspectives with each other, with a view to addressing the areas of concern around the possible contributing factors towards violent behaviour in inpatient facilities.

## **1.4 AIM AND OBJECTIVES OF THE STUDY**

### **1.4.1 Aim**

To investigate the factors contributing to patients' aggressive and violent behaviour in mental health facilities in Cape Town, as seen from patients' perspectives.

### **1.4.2 Objectives**

The study focused on the following objectives:

1. to explore patients' perceptions of the environmental factors that possibly contribute to their aggressive and violent behaviour;
2. to explore patient's perceptions of the situational factors that possibly contribute to their aggressive and violent behaviour; and
3. to identify possible interventions to reduce aggressive and violent behaviour of patients in the acute wards of mental health facilities in the Western Cape.

## **1.5 OPERATIONAL DEFINITIONS**

For the purpose of this study the following definitions apply:

**Aggression** any verbal behaviour that comprises insulting, threatening or disruptive and abusive language directed towards the self or others that upset the communication.

**Violence:** violence occurs when physical force is used that results in harm of the self, others or property.

**Internal factors:** the role of patient variables, such as the specific mental health diagnosis, as risk factors for aggressive and violent behaviour.

**External factors:** the impact of environmental factors on the incidence of patient aggression such as hygiene of ward environment, ward atmosphere, living conditions and nursing staff/patient ratio.

**Situational factors:** the impact of patient and nursing staff interactions on the incidence of patient aggression.

## **1.6 STUDY OUTLINE**

**Chapter One** introduces the study, the background statement, problem statement, aim, objectives and significance of the study, and operational definitions. **Chapter Two** presents literature on the contributing variables (pertaining to environmental and



situational factors) which may influence patients' aggressive and violent behaviour after admission to a mental health facility. **Chapter Three** presents the research design and methodology process, while **Chapter Four** is a presentation and discussion of the research findings. **Chapter Five** provides a summary of the findings, recommendations, problems experienced during the research and conclusions.

This chapter has given a description of the problem being studied, aims and objectives of the study, an introduction to the literature review and as well as definition of terms. **Chapter Two** comprises a presentation of the literature reviewed.

# CHAPTER TWO

## LITERATURE REVIEW

### 2.1 INTRODUCTION

This chapter is concerned with a review of the literature relating to factors contributing to aggressive and violent behaviour in mental health inpatient facilities.

Carnwell and Daly (2001:57) state that the purpose of a literature review is to “critically appraise and synthesize the current state of knowledge relating to the topic under investigation as a means of identifying gaps in the knowledge”. Necessary steps in this process include a definition of the scope of the review, identifying sources of information, reviewing the available literature, and conducting the review. The purpose of this review was to survey available electronic databases (eg PubMed) and the English language psychiatric and nursing peer reviewed journals in order to identify, firstly, the general scope of research reports on contributing factors to violence and aggression in mental health facilities, and secondly, theoretical reviews of the subject. Lastly, since a stated purpose of this study is to try and identify interventions to reduce violence and aggression, a review of management principles is given at the end of this chapter.

During the literature search it was established that research reports generally centred around patient-related factors, environmental factors and staff-patient interactions as contributing factors toward patients’ aggressive and violent behaviour after admission to a mental health facility. Indeed, Duxbury (2002) identified three models which incorporate explanations for the causes of such behaviour. Although Duxbury’s framework includes patient factors (Internal model) as important contributing factors toward aggressive and violent behaviour, it is not a focus area for this study. The objectives of this study are the environmental and situational factors which will be discussed, respectively, under Duxbury’s External and Situational models (Duxbury, 2002).

## **2.2 THEORETICAL FRAMEWORK**

Duxbury (2002:325) identified three models, which incorporate explanations for the causes of such behaviour. Each model highlights areas of concern, including patient variables (Internal model), environmental variables (External model), and deficiencies within staff-patient interactions (Situational model). It was found to be a useful construct for this study, and to formalise the literature review. Since patient factors do not form part of this study, the Internal model will not be discussed further.

The following sections describe the possible factors associated with aggressive and violent behaviour in mental health facilities, as found in the literature, and grouped according to the remaining two models.

### **2.3 EXTERNAL MODEL (ENVIRONMENTAL FACTORS)**

This model focuses on the impact of environmental factors upon the incidence of patient aggression, including building deficits (limited physical space, overcrowding, poor provision of privacy), hospitalization, hospital shifts, the timing of assaults, staff gender, experience, grade and training, as well as other poor environmental provisions (Johnson, Martin & Guha, 1997 and Nijman & Palmstierna, 2002).

#### **2.3.1 Hospitalization**

According to Letendre (1997:285), patients subjected to involuntary commitment have a more negative perception of mental health facilities than those admitted on a voluntary basis. Patients in mental health facilities also mentioned some restrictive practices, namely doors that are locked, and personal belongings being confiscated, which is consistent with findings from Kho, et al. (1998). In addition, patients have to submit to the regulations of daily ward life imposed by staff. Users find these rules oppressive and feel that they are being reduced to an infantile status. Patients describe the wards as places of locked doors and heavy sealed windows, which give the impression of being imprisoned, small beds and limited space that has to be shared with several others, a space where staff members simply walk in as if they were in their own home.

Gruenberg, et al. (1967) cited in Rabinowitz and Mark (1999) noted that previous studies suggested that the hospital environment can lead to social breakdown and thereby affect the behaviour of institutionalised individuals.

### **2.3.2 Ward atmosphere**

The necessity of a safe environment is evidenced in at least two domains, namely physical safety (Megaree, cited in Lanza, et al. 1994) and the therapeutic ward climate, also known as social safety (Moos, Shelton & Petty, 1973).

Katz and Kirkland (1990) and Holmqvist and Fogelstam (1996) also confirmed the importance of the ward milieu in the treatment of psychiatric patients, and noted that this has been emphasised for many years. Many psychiatric institutions, in accordance with therapeutic milieu principles, have had the goal of changing the traditional custodial and hierarchical wards to more democratic organisations, where patients have a greater influence on ward decisions and where the rules are open to negotiation (Katz & Kirkland, 1990).

Closely related to the above, the evaluation of a patient's potential for violence is an important component of care in mental health inpatient settings. Beauford, McNiel and Binder (1997) reported that the therapeutic alliance is an important predictor of the effectiveness of inpatient treatment. It was found that if the therapeutic alliance during the initial evaluation is ineffective, the risk of the patient exhibiting physical attacks or inducing fear during the first week of hospitalisation will be higher.

An element of the milieu which has been overlooked is the intensity of environmental stimulation, because right from the beginning, patients are forced into all sorts of group meetings where communication is often complex. Several members may speak simultaneously and statements are often wordy, long and abstract. Meetings are often lively with laughter and, especially in the more analytically orientated milieus; there is a search for hidden meanings. Melle, Friis, Fauff, Island, Loretzen & Vaglum (1996) noted that the therapeutic atmosphere might contain an overdose of environmental stimulation for some. Factors such as loud music, the inability to distinguish staff from patients by dress and discouragement of the sick role all contribute to patients acting aggressively and violently because the circumstances are bewildering.

According to Miller, Zadolinnyj and Hafner (1993); Van der Slot (1998) and Gunderson (1983), cited in Gebhardt and Steinert (1999), ward atmosphere, whether it is peaceful and supportive, or hostile and disturbing, is an important factor in psychiatric inpatient treatment. Nijman, Merchelbach, Allertz and aCampho (1999) reported that the most unfavourable impact on ward atmosphere is due to severely disturbed patients who are loud, humiliating, disorganised and violent.

A study done by Middelboe, Schjodt, Byrstring and Gjerris (2001) investigated the relationship between patients' perception of the real ward atmosphere and their satisfaction. They used the Ward Atmosphere Scale (WAS) and a satisfaction questionnaire, and reported that patients in locked wards perceive more anger and aggression, whereas patients subjected to coercive measures perceived less autonomy and practical orientation. Patient satisfaction was predicted by higher scores on the WAS dimensions. In particular, support, order and organisation predicted satisfaction, except from the areas of anger/aggression and staff control. Patients gave the "ideal" ward higher ratings on all scales. The perceived gap between the ideal and real ward explained 45% of variance in satisfaction. Their findings support the idea that patients' perception of the ward atmosphere is a meaningful measure and this perception appears to be a strong predictor of satisfaction (Middelboe, et al. 2001).

Evans (1992) strongly supports the fact that patients' satisfaction with treatment has to be taken into account in order to improve psychiatric inpatient services.

Katz and Kirkland (1990:272) noted that social mechanisms that can control or limit violence could alleviate patients' feelings of vulnerability, reduce the threat level they perceive in the environment, and support in them a growing sense of being in control.

### **2.3.3 Living conditions**

According to Lanza, et al. (1994:320), living conditions are important determinants of aggressive and violent behaviour. These include various forms of restraint and seclusion, the influence of the physical environment such as colours, arrangements of

rooms, furniture and crowding (Bensley, Nelson, Kaufman, Silverstein & Shields, 1995).

#### **2.3.4 Activities of the day**

Lanza, et al. (1994) and Owen, et al. (1998) noted that violence has been known to increase around meal times, or during times that are allowed to patients to walk around freely. Results of similar studies done by Bradley, Kumar, Ranclaud and Robinson (2001) found that incidents of aggressive and violent behaviour were most likely to occur during the afternoon shifts when there is a lack of structured interaction and socialisation such as ward outings, therapeutic groups and interviews.

Tardiff and Sweillam (1982) cited in Rabinowitz and Mark (1999), also found that there were fewer incidents when there was more structured interaction and socialisation such as occupational and industrial therapy. These authors indicated that the potential for violent incidents is greater in periods when patients move or gather in groups, for example, when they walk together from the ward to the dining room.

Health care givers and managers have the responsibility to monitor the frequency and types of untoward incidents that occur concerning patients in their care (Fairlie & Brown, 1994:864). These authors identified that the highest risk period for the occurrence of aggressive and violent incident is 16:00 to 19:00 and up to 22:00. One possible explanation is that frustration and tension build up during the day among some residents and occasionally crossing some kind of threshold in the late afternoon. A further explanation is that by 16:00 patients are leaving the structured environment of various therapy departments. The availability of staff to respond to patients' incidents of aggressive and violent behaviour is variable - between 8:00 and 9:00 patients are being washed and dressed before going to the various therapy departments. Staff members are involved in these activities, which enable them to assess potentially aggressive behaviour in order to intervene before violence occurs.

Study findings from Owen, et al. (1998:1455) and Rabinowitz and Mark (1999:343) have found that violence increases during less structured ward activities. Those studies on the timing of violence in mental health wards indicate that it is most likely to occur during times of transition or uncertainty, such as when staff shifts change, or when the

usual schedule of regular, repetitive activities is not implemented (Owen, et al. 1998:1455 and Rabinowitz & Mark, 1999:343). Differences in violent behaviour, even when patients have the same diagnosis, are often a result of the different social structure between wards.

In summary, the studies reviewed conclude that violence increases during less structured ward activities - during times of uncertainty or transition, such as when staff shifts change, or when the usual schedule of regular, repetitive activities is not implemented (Owen, et al. 1998; Rabinowitz & Mark, 1999; Nijman & aCampo, 2002).

### **2.3.5 Density (crowding), privacy and control**

Density, privacy and control are three interrelated variables described in the literature that may help in understanding the relationship between crowding and violence when investigating the impact of architecture on human mood and behaviour (Spencer & Baum, 1997 cited in Kumar & Bradley, 2001:434). Baum and Koman (1976), cited in Kumar and Bradley (2001:434), defined *density* “as the number of individuals per unit of space.” Drinkwater and Gudjonsson (1989), cited in Kumar and Bradley (2001:434), reported that one review has identified two types of density in relation to crowding and violence in psychiatric wards: *social density*, or number of people in a given area, and *spatial density*, or size of an area used by a given number of individuals. Spencer and Baum 1997, cited in Kumar and Bradley (2001:434), further noted that when there is an increase in social density, stress will increase, and the individual’s actual and perceived privacy and control, will decrease. In addition, social interactions are often imposed in such situations and can occur at inconvenient times, which may have an adverse effect on individual frustration tolerance (Spencer & Baum, 1997 cited in Kumar & Bradley, 2001:434). The adverse effect on individual frustration tolerance can lead to fewer or even improper social interactions (Baum & Valius, 1977 cited in Kumar & Bradley, 2001:434). Domachowski (1980), cited in Kumar and Bradley (2001:434), defined *privacy* as “an individual’s ability to protect interpersonal space – the space in which two or more people come into any type of interaction.” In support of Domachowski (1980) and Codol (1978), cited in Kumar and Bradley (2001:434), comments that when equally accessible to all

parties, interpersonal space is thought to protect against stress and violence. Individual strategies for maintaining personal space depend on culture, room size, level of acquaintance, and other social and psychological variables. Nijman, et al. (1999:391) reported that when social density increases, there is a decrease in the individual's control over the environment, which is in turn associated with self-reported, behavioural, and biochemical indices of stress. These authors further noted that when more people are forced to interact and share a communal space, as is the case in a crowded psychiatric ward, their privacy, the social density of the ward, and the control they have on the environment are all easily disrupted with the result that when patients experience increased stress levels, it precipitates violence (Nijman, et al. 1999:391).

Nijman, et al. (1999:391) found that in "environments where density, privacy, and control are in optimal balance, violence is less likely to occur, e.g. through such simple environmental strategies as allocating individual rooms to patients, preventing crowding, and matching the ward activities to the needs and capacities of the patients."

According to Kumar and Bradley (2001:434), the role that the architecture of acute-care psychiatric wards plays in the occurrence of violence needs to be examined, because if architecture is taken into consideration, factors such as privacy, density, and control can be manipulated.

Gulak (1991), cited in Kumar and Bradley (2001:434), found that due to a lack of communication between hospital architects, patients, and staff working on acute-care psychiatric wards, they overlook the impact of density and the loss of patients' privacy and control over their environment. Furthermore, the design of these wards may partially contribute to the occurrence of violence, given the significant discrepancy between living conditions in the community and those of a psychiatric ward - the patient in a psychiatric ward is faced with sharing communal rooms (Shrivastava, Kumar & Jacobson, 1999, cited in Kumar and Bradley, 2001:434). Areas perceived to be private, such as bedrooms are smaller or shared, and there is less objective area that the patient can define as his or her own. Not only are patients objectively crowded, they may also experience



subjective crowding in such high-density situations. Shrivastava, et al. (1999) cited in Kumar and Bradley (2001:434), postulated that a sense of frustration and anger are expected outcomes, especially when patients feel they have lost control over their environment.

Haller and Deluty (1988), cited in Kumar and Bradley (2001:434), emphasize that “psychiatric wards are there to encourage patients to socialize and to participate in activities, which increases intrusion upon the patients’ personal living area and activities.” The authors also noted that nursing staff who do routine observations and dispense medications, frequently enter the patients’ bedrooms or personal space, and patients might perceive staff as forcing them to socialise. Other patients may also intrude, and this may be more apparent in communal rooms. The authors further noted that the concentration of more severely ill patients in shrinking inpatient facilities and frequent rehospitalisation of severely disturbed patients who spend shorter periods outside hospitals collectively lead to social disruption and ward turmoil – predisposing to violence in acute-care inpatient wards (Haller and Deluty, 1988 cited in Kumar and Bradley, 2001:434).

### **2.3.6 Limit setting**

Bjorkley (1993) used a scale comprising of seven categories for the prediction of aggression and dangerousness in psychiatric patients, and came to the conclusion that limit setting was the category that represents the highest risk for dangerous behaviour. Soloff and Turner (1994) found that patients who were committed had a higher frequency of seclusion and restraint than voluntary patients did.

Patients who viewed restraints negatively or as a punishment, or who perceived restraints as aggression against them would be more likely to maintain or increase their aggressive behaviour (Sheridan, Henrion, Robinson & Baxter, 1990:778; Fuller-Torrey, 1994:407 and Bensley, et al. 1995:443).

### **2.3.7 The influence of external factors on patient/ nursing staff interaction**

The results of a study by Bensley, et al. (1995) showed that patients and staff had many concerns in common, including restrictions on patients smoking, access to

outdoors, clinical skills of nursing staff, the use of seclusion and restraint on the wards, and rules that were not explained. Talbot (1990:721); Palmstierna, et al. (2000:79) and Blaum (2002:1) suggested that all nursing staff should be properly trained in control and restraint techniques in order to reduce the number of aggression related incidents.

Early research speculated that responses to patients' requests would affect the outcome of mental health care (Winstanley & Whittington, 2002:144). It was postulated that if patients feel that staff members have acknowledged their requests, the relationship would be improved, which would ultimately increase the effectiveness of treatment. Studies identified a positive relationship between a negotiated approach and patient satisfaction (Noble, Douglas & Newman, 1999:325).

Ekland and Hansson (1997:330) found that patients who are exposed to treatment programmes based on principles from milieu and occupational therapy demonstrate a lower level of anger. This is because all staff members are female, and programmes are organised as a group treatment, with flexible arrangements to fit the individual needs. The emphasis is therefore on the patients' strengths instead of their weaknesses.

At the staff level, communication stress may be diminished by providing patients with better information about treatment goals, investing more time in explaining why certain restrictions during treatment are necessary, and training staff to prevent and manage aggression. Increasing the number of skilled nursing staff members in order to meet the demands of patients may be helpful to reduce aggression and to increase appropriate behaviour amongst patients (Rabinowitz & Mark, 1999:344).

An organisation that clearly defines boundaries of time, space and staff responsibilities, and that is standardised, routine and predictable, is conducive to preventing or controlling violent behaviour (Katz & Kirkland, 1990:268).

Negative nursing staff-patient interactions may be associated with violence. Patients' levels of anger are higher in response to non-therapeutic limit setting styles, and very low for therapeutic styles (Lancee, Gallop, McCay & Toner, 1995:724). The frequency and characteristics of aggressive and hostile behaviour in a psycho-geriatric unit was investigated using the Staff Observation Aggression Rating Scale (SOASR). It was

found that most aggressive acts were directed towards nursing staff when providing help with activities of daily living (Nilsson, Palmstierna & Wistedt, 1998:172).

Cheung, Schweitzer, Tuckwell and Crowley (1996:260) also used the SOASR scale to measure aggressive behaviour in a psychiatric ward, and found that physical assaults occurred at a rate of 97.6 per 100 patients per year. About 40% of all incidents appeared to be unprovoked. Most physical incidents involved the use of body parts and aggression was mostly directed at staff members. Serious injuries were rare. James, Fineberg, Shah and Priest (1990:846) reported a high correlation between an increase in violent incidents and an increased use of temporary staff. However, Cleary, Edwards and Meehan (1999:110) found that an increase in the number of staff on psychiatric wards did not increase the number of incidents, but that the severity of the incidents decreased. It is clear that factors such as staff gender, experience, grade and training impact upon the incidence of patient aggression and violence (Duxbury, 2002).

### **2.3.8 Nursing staff/patient ratio**

Maier (1996) examined staff factors and found that the incidence of violence was higher in wards where staff members were uncertain of their roles or where a larger proportion of shifts were replaced by non-permanent nursing staff. A higher nursing staff to patient ratio has been found to be related to increased violence. Fewer incidents occurred when the staff-patient ratio approached 1:1. Lanza, et al. (1994:325) prospectively studied the relationship between the staff to patient ratio and the number of assaults. The authors support the idea of an inverse relationship between the number of staff members, and the frequency of assaults.

Way, Braff, Hafemeister and Banks (1992:363) found that most violent incidents occurred when the nursing staff to patient ratios was high. Bradley, et al. (2001:5) hypothesised that if there is an increase in the number of violent incidents, it will be highly correlated with a high staff to patient ratio, and with high ward occupancy. However, Way, et al. (1992) could not find any association between staff-patient ratio and the occurrence of aggressive and violent behaviour in psychiatric facilities.

A study by Patel and Hope (1992) also investigated the interplay between the patient-staff ratio and aggressive and violent behaviour and reported that a small increase in the number of staff may not reduce the number of patient incidents. According to Maier (1996) an increase in assaults and violent behaviour have been found to be associated with lower level of experience among nurses, new employee status or lack of staff training in aggression control techniques. Nursing assistants were assaulted more often, than were registered nurses; although the assistants had considerable contact with patients despite their "lack of training." Carmel and Hunter (1989) as cited in Davis (1991), found that more recently hired, inexperienced staff was more likely to be injured from assault. They also found that nurses were by far the most frequent victims among professional staff and that male nurses were injured more often than females. Male nurses may be expected to be more involved in physical incidents because mostly they made use of physical force when manage aggressive patients.

Owen, et al. (1998) finding that non-mental health trained staff are more at risk of being assaulted may be significant, but it is not easily reconciled with the fact that these staff members have more contact with patients than mental health trained staff, suggesting that staff attitudes provoke violence and refer to it as a case of "blaming the victim." Owen, et al. (1998) also emphasised the implications of using female staff and staff members who do not have mental health or aggression training.

### **2.3.9 Reporting of incidents**

Studies by Way, et al. (1992); Morrison (1993); Shah and Tamalde (1998) and Iverson and Hughes (2000) were reviewed regarding the issue of official reporting of violent incidents - under-reporting of such incidents was the common finding. Blomhoff, Seim and Friis (1990:774) indicated that the seriousness of an incident does not guarantee that it will be reported. James, et al. (1990:849); Blair and New (1991:96); Bradley, et al. (2001:6) and Nijman and Palmstierna (2002:101) also indicated that the prevalence of aggressive and violent behaviour is often underreported in daily nursing reports. These authors also assert that the increasing number of incidents is an obstacle to effective treatment and rehabilitation.

Palmstierna and Wistedt (1995) reported that the study of violence in psychiatric wards presents several problems, for example, the under-reporting of violence and inadequate documentation make it difficult to draw conclusions. The number of unreported incidents such as assaults might exceed that of reported assaults. Bradley, et al. (2001) experienced the same problems during their study - patients and staff may become aware that they are being studied, and therefore alter their behaviour.

A study done by Chou, Lu and Mao (2002:190) used structured instruments such as the SOARS and an environmental assessment questionnaire in order to minimise this trend of under-reporting. It may also be possible to collect additional data related to staffing variables and activity levels of the wards, which may be associated with the incidence of aggression (Crowner, Peric, Stepic & Van Oss, 1994). Winstanley and Whittington (2002) support the notion that during research studies an unknown proportion of incidents will always be lost due to non-reporting.

Despite an awareness of the problem of aggressive and violent behaviour in mental health facilities, little is known about the true prevalence of these incidents, mostly due to inconsistent reporting methods by staff (Munro, 2002:38). In a study by Zernike and Sharpe (1998:126), 68 aggressive incidents took place over a five-month period, and the staff reported all incidents.

Several types of measurement approaches have been used to predict aggressive and violent behaviour better, for example self reports, which were consistent with the frustration-aggression hypothesis (Dolard, cited in Morrison, 1993:263). Various problems were experienced by the theoretical approaches and self-report measures.

#### **2.4 SITUATIONAL MODEL**

This model focuses specifically on the deficiencies within staff-patient relationships and interactions (Duxbury, 2002:327). Outcomes of studies done by Garrison 1984, cited in Davis (1991:585); Blair (1991) and Bjorkley (1993:1365) showed that violence tends to be interactive. Aspects of immediate physical proximity as well as the presence of staff and other patients have a negative influence on the individual's behaviour. A common theme in studies explaining situational factors is that incidents are usually provoked, and they are not simply the spontaneous manifestations of

underlying pathology. Aggressive and violent behaviour in mental health facilities is a continuing problem that affects staff and patients physically and emotionally and it is a principal cause of injury (i.e. harm to body parts) (Bensley, et al. 1995:440). The contributing factors include negative interactions (Sheridan, et al. 1990:779 and Bensley, et al. 1995:443) and power issues (Morrison, 1994:247; Crouner, et al. 1995:615).

Although interpersonal interaction is the heart of mental health nursing, some criticisms were reported in the past few years (Cleary, et al. 1999:110). Lancee, et al. (1995:609) explain “that nurse-patient interaction has a significant impact on the patients’ well being, and the quality and outcome of nursing care,” though claims have been made that psychiatric nurses do not always interact in a therapeutic manner (Davis, 1991:587).

The need to maintain ward order, to manage patients, other staff and the environment, places pressure on nursing staff who cope by utilising a custodial model of care, and thereby creating barriers to effective therapeutic interaction. Katz and Kirkland (1990) indicated that fearful staff attitudes might lead to assaultive behaviour by patients. Sheridan, et al. (1990) noted that when staff members became overly confrontational in their interactions with psychiatric patients, the patients might perceive this as an authoritarian attitude and react violently to it. Whittington and Wykes (1994) reported that a confrontational attitude displayed by male nurses enhanced the likelihood of patient violence. Rosenbaum (1990) illustrated that a staff member’s efforts to over-control patients and displaying an authoritarian posture may increase these staff members vulnerability to future assaults. External locus of control, anxiety, as well as rigid and authoritarian behaviour of staff members seem to be relevant to the occurrence of patient assault in mental health facilities (Solof, 1983, cited in Bjorkly, 1993:1364; Ray & Subich, 1998).

Holmqvist and Fogelstam (1996:290) reported that acute ward patients received negligent attention from nurses in terms of staff-patient interaction in the first ten days of admission, and this may result in an increase in aggressive and violent behaviour amongst patients with mental illness.

Letendre (1997:285) and Duxbury (2002:327) indicated that patients feel frustrated or angry because of staff attitudes which focus on applying rules and controlling symptoms through medication, while excluding any possibility of establishing a therapeutic relationship. In another study done by Shah, et al. (1991:305), it is stated that the presence of more nursing staff do not necessarily lead to fewer assaults, but these authors also indicated that other factors such as staff commitment to their patients and staff ability to manage such incidents are more important. Owen, et al. (1998:1456) found a positive relationship between violence and a number of nursing staff members, and linked the violent behaviour with female staff and staff members who have no training in mental health or training how to prevent aggression and violent behaviour. Davis (1991:587) reviewed the issue of patient-staff interaction - staff provocation of aggressive behaviour may result in negative counter-transference reactions among staff members, creating additional problems in therapeutic communication. Two distinct points of view on this matter were identified: patients usually claimed that teasing by other patients or provocation by staff initiated the assault, whereas the staff typically claimed that there was no reason for the action. The idea that staff in some way provokes assaults may be supported by two pieces of evidence. Firstly, staff members may be assaulted at a higher rate than other patients. Secondly, nursing staff are not always assaulted at a uniform rate; that is, some seem to be attacked repeatedly. Ultimately, a certain amount of physical "provocation" by staff may be unavoidable because the attacks often occur when they are administering medication or leading or restraining agitated patients.

Davis (1991:588) postulated that staff members tend to displace feelings of anger and aggression on to the patient. Nursing staff members have been described as rigid, intolerant, authoritarian (Fisher, 1993:634 and Neale & Rosenheck, 1995:721). Bothwell (2001:321) speculated that a "norm of violence" contributes to ward assaults. Thus, there is an expectation that violence is acceptable and will be tolerated. As noted before, other factors that could contribute to patient violence were anxiety and counter-transference among staff members (Katz & Kirkland, 1990:276). These assumptions are firmly supported by Bensley, et al. (1995:444). Similarly, Blair (1991:25) found that staff members who do not feel secure with helpless and frightened patients may reflect their own helplessness and fear in hostile counter-

transference. These feelings may inhibit a staff member's ability to recognise incipient violence and help the patient to control it (Linaker & Busch-Iversen, 1995:252).

Duxbury (2002) indicated that the violent patient's biggest fear is to lose self-control, and such patients appreciate therapeutic efforts that restore a sense of control, which can prevent them from acting on their urges. The caregiver should explore all avenues of aggression with the patient, pointing out that the goal of this exploration session is to prevent the aggression. The caregivers should be aware of their own fear and anger, and of the effect of their feelings might have on the patients who are already dangerous and disturbed.

## **2.5 GENERAL PRINCIPLES OF MANAGING AGGRESSION AND VIOLENT BEHAVIOUR**

According to Lanza, et al. (1991:253); Davis (1991:587) and Ilkiw-Lavalle and Grenyer (2003) there are significant differences between patient and staff perceptions of the causes of aggressive incidents on inpatient mental health units, and the different ways to reduce it. This observation is supported by Beck and Roy (1996:3) who suggested that both patients and staff play an important role in causing, and preventing violence.

Menninger (1993:208) suggested that the provision of mental health services in mental health facilities is an organisational undertaking, and it involves a trust relationship between service providers and service users. The management of aggression and violent behaviour amongst mentally ill inpatients has become a topic of increasing concern. Thus, prevention of aggression in mental health facilities should have a high priority (Lanza, et al. 1991).

Beck and Roy (1996) suggested that prevention of aggressive and violent behaviour is always preferable to cure. Although it is difficult to predict violent behaviour in a reliable and systematic way, it is possible to assess the risk potential through the evaluation of patients' history and background with an appreciation of external and situational factors, which are commonly associated with the increased likelihood of aggressive behaviour (Beck & Roy, 1996:3 and Kho, et al., 1998:39).



Nursing staff should be properly organised to provide a secure environment in which violent or potentially violent behaviour is unlikely to occur, or it should be rapidly detected and controlled if it does occur. In this regard, Blaum (2002) suggested the development of training programmes for nursing staff. The following topics should be included in such a program:

- the development of communication skills; and
- de-escalation of situations by verbal means that will allow nursing staff to talk to the aggressive patients instead of touching them, which might precipitate an anger outburst from frightened and frustrated patients.

Injuries resulting from patient violence are perceived as an occupational hazard in mental health settings, both to the staff, patients and the therapeutic milieu (Carmel & Hunter, 1990:558). According to Carmel and Hunter (1990) it is important to reduce staff injuries that result from violence. Training of staff members to manage violent behaviour needs to be a high priority in all mental health inpatient facilities (Harris & Rice, 1997:1168).

Philips and Rudestam (1995:164) support the above suggestion and reported that male staff members, after completing a program in non-violent self-defence skills behaviour, said that fear and aggression among staff members was significantly reduced, and that fewer assaults and outbreaks of aggressive and violent behaviour among patients were reported. Therefore, the development of skills in non-violent physical techniques of self-defence strongly correlates with an increase in the value that was placed on using these skills and non-violent outcomes (Philips & Rudestam, 1995). Hansson, Bjorkman and Berglund (1993) found that the development of quality assurance programmes for psychiatric care showed an increase in the quality of care and accountability from the patients' perspective.

According to Hunter and Love (1996) and Duxbury (2002), general approaches to management of aggression and violent behaviour include preventative measures, de-escalation and reactive, "traditional" methods such as restraint medication and seclusion.

A careful reassessment of the patient's mental status should be carried out in every case of aggressive or violent behaviour, including the possibility of further violent behaviour (Wilder & Sorensen, 2001:31). The multidisciplinary team should review the patient's treatment plan, as well as security measures, and for continuous care with precautions to prevent the reoccurrence of aggressive or violent behaviour. Although patients have the right to receive the care and protection required for their condition, staff and other patients also have the right to feel safe and secure. It is suggested that all nursing staff working in the unit should have an opportunity to work through their feelings and reactions surrounding aggressive or violent behaviour.

Management decisions should be based on patients' perceptions of the interplay between the internal, external and situational factors that might contribute to their aggressive and violent behaviour. Katz and Kirkland (1990) and Duxbury (2002) suggested that nursing staff should be more sensitive to patients' needs, and they should encourage patients to express their feelings.

Mental health nurses in inpatient settings play a critical role in the management of potentially violent patients. One of their primary objectives is to ensure the safety of patients and staff 24 hours a day. This requires the skilful observation of patients' motor behaviour, verbal clues, and change in mental status, which may indicate an increase in agitation or possible aggression behaviour. It requires experience in prevention strategies and skill in aggressive intervention techniques (Silver, 2002). To intervene effectively with potentially violent patients, psychiatric nurses should be able to work well under stress and be able to organise and execute a plan of immediate action. After the acute stage of the patient's illness, nurses should focus their work on assisting patients to manage their own behaviour and supporting their newly acquired skills. Nursing staff therefore, should have confidence in dealing with aggressive patients (Stuart & Laraia, 1999; McGowan, Wynadden, Harding, Yassine & Parker, 1999:104).

Various multidimensional models have been developed in an attempt to apply research findings to the proactive setting. Morrison (1990:33) and Schanda and Taylor (2001), for instance, identified a coercive interaction style in violent patients, which together with a history of violence and length of hospitalisation could predict 55% of all

aggression and violent behaviour. Such conceptualisations could allow new interventions to be developed which take into account the social interactive nature of violence (Talbot, 1990:721 and Roper & Anderson, 1991). Winstanley and Whittington (2002:146) indicated that social mechanisms can control or limit violence, alleviate patients' feelings of vulnerability, reduce the threat level they perceive in the environment, and support them in a growing sense of being in control. Barlow, Grenyer & Ilkiw-Lavalle (2000:971) reported that methods to reduce aggressive and violent behaviour include the improvement of security. In this regard, Bensley, et al. (1995:444) recommended the following:

- an increase in the number of nursing staff
- improved interpersonal skills training
- modification of the environment and
- an increase in patients' medication.

Barlow, et al. (2000:971) and Arnetz and Arnetz (2001:418) emphasised the importance of debriefing after an aggressive or violent episode, because these forms of behaviour have an emotional impact on staff and patients. Carlsson, et al. (2000:535) found that caregivers sometimes experience fear and feel threatened, and recommend that staff members should be aware of the emotion that might be evoked in themselves by violent patients because it can make the management of already problematic patients very complicated.

Ekland and Hansson (1997:330) found that patients prone to violence found female nurses and aides less provocative than male staff, and when such female staff was confronted with threatening patients in the absence of male staff and aides, the female staff tended to be more apt to rely on non-aggressive manners and feminine intuition instead of resorting to police-like measures. The authors also found that the exclusive use of female aides may keep the incidence of violence in a psychiatric hospital to a minimum.

Talbot (1990:721); Palmstierna and Wistedt (1995:34) and Baumann (2001:284) have said that it is required of staff to have a safe and practical approach to manage aggressive and violent behaviour in mental health facilities effectively, and specific

guidelines should be established in the multidisciplinary team and administration with respect to legal actions. The latter author emphasises the importance of assessment of the aggressive or potentially violent patient in order to identify the causes of his/her behaviour.

Baumann (2001:284) noted that the basic principles of restraint are to use the minimum force to restore order and to avoid harm to the patient, the staff, or others. Raja, Azzoni and Lubich (1997:428) suggested that a non-restraint policy might reduce violent behaviour amongst psychiatric inpatients. Bjorkly (1993:1374) has a different opinion and proposes “open-area seclusion” as an alternative treatment modality for psychiatric patients with aggressive and disturbed behaviour.

In the South African context, the South African Nursing Council Regulations 2598 and 378 provide clear guidelines on how to provide safe nursing care. Staff should be proficient in the use of physical and pharmacological restraints and proper training should be given to these nursing staff to manage anger, interpersonal conflict and stress (Palermo, Liska, Palermo & Dal Forno, 1991:1441).

Nurses should use the multidisciplinary team as a treatment tool and as a vital resource in the management of difficult or dangerous situations - nurses should respond to aggressive patients in a creative way that allows them to encounter their clients as unique individuals (Carlsson, et al., 2000:538). Nursing staff should set clear and explicit limits for patients at the beginning of their treatment, and all members of the treatment team should ensure fair and consistent enforcement of limits.

## **2.6 CONCLUSION**

This chapter has focussed on the literature concerning possible contributing factors to aggressive and violent behaviour in inpatient mental health facilities, utilising the External and Situational models as described by Duxbury (2002). It is nevertheless recognised that considerable overlap, and possibly complex interactions, exist between the various factors.

For the purpose of this study the data will be analyzed in accordance with the theoretical framework of Duxbury (2002), focussing on the External and Situational models.

The next chapter will focus on an overview of the research methodology applied in the study.

# **CHAPTER THREE**

## **RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

The purpose of this Chapter is to provide an overview of the research methodology applied in this study. It focuses on the following: the research design, theoretical framework, research settings, the study population and sampling procedure, data collection methods, data analysis, ethical considerations and limitations of the study.

### **3.2 RESEARCH DESIGN**

For this study a qualitative approach was used. A qualitative research design focuses on the subjective experiences or views of the individuals involved about the specific topic being examined (Mouton, 2001).

Qualitative methods are used where there is little known about phenomena (Brink, 1996). The phenomenological design seemed to be the most appropriate method to obtain the necessary information because the researcher sought to explore what was significant from the perspectives of the patients in terms of the factors contributing to their aggressive and violent behaviour after admission to a mental health facility. These insights are obtained not through improving comprehension of the whole, but it is a means of exploring depth, richness and complexity inherent in the phenomena (Burns & Grove, 1993).

Furthermore, exploratory research focuses on a specific area of interest or concern - in this study, patients' perceptions of the environmental and situational factors that could possibly contribute to their aggressive and violent behaviour and aims to obtain new knowledge by describing, comparing and classifying observations. It does not attempt to manipulate or control the environment or to test interventions. According to Seaman (1991) it may be advantageous for the researcher to use the collected data to formulate nursing questions or problems for later investigation.

### **3.3 THEORETICAL FRAMEWORK**

For the purpose of this study, Duxbury's external and situational theoretical models of 2002 were selected as the framework for data analysis. This author identified three models highlighting the areas of concern, namely the Internal, External and Situational models which refer to patient variables, environmental factors and staff/patient interactions respectively. As stated in Chapter 2, factors relating to the Internal model, such as patients' age, gender and diagnoses were not a focus area of this study, as the stated objectives of the study focus on environmental factors and staff/patient interactions, as perceived by patients participating in the study.

### **3.4 RESEARCH SETTINGS**

The two selected study sites, Lentegeur hospital and Valkenberg hospital, are mental health facilities situated in the Western Cape Province, South Africa. The referral areas for these two hospitals are mostly the urban and rural areas of the Western Cape Province.

The basic reason for selecting these two study sites was that the researcher, being a nursing tutor in psychiatric nursing science, is familiar with these facilities from conducting regular visits to nursing students. More specifically:

- logistical accessibility for the researcher: as part of her normal duties, the researcher has to visit students at both facilities several times a week,
- a working relationship between the researcher and health service staff already exist,
- incidents of aggressive and violent behaviour appear to be commonplace at these two facilities.

At these mental health facilities different types of wards are classified as "open" and "closed" wards. An "open" ward refers to unrestricted movement of patients, while a "closed" ward refers to one which does not allow patients to move in and out of the ward freely, generally because they are not in contact with reality and have poor insight and judgement.

### **3.5 STUDY POPULATION AND SAMPLING PROCEDURE**

For the purpose of this study, the study population was patients from two pre-discharge wards at Lentegeur hospital and two pre-discharge wards at Valkenberg hospital between January and June 2004. These pre-discharge wards are “open,” which allow patients unrestricted movement in and out of the ward. The participants reflect the racial groups of the referral areas, namely from Coloured, African (Xhosa), and White communities. At the time of the interviews (January – June 2004), all the patients were receiving medication.

Purposive sampling was used. According to Brink (1996:141), purposive sampling is based on the judgment of the researcher regarding participants who are especially knowledgeable about the question that is being investigated. To assist this process, the consulting psychiatrist was approached to identify possible participants for inclusion into this study. Participants were selected according to the following inclusion criteria:

- patients 18 years or older;
- patients who have been admitted for at least 7 days;
- patients who expressed an interest in the study topic, and a willingness to share their views and experiences by means of an audio-taped interview;
- patients from any cultural background;
- patients who were not psychotic but in touch with reality and understanding the purpose of the study (deemed to be functioning at the level of a voluntary patient); and
- patients who signed informed consent for study participation.

Qualitative studies typically focus in depth on relatively small samples selected purposefully because they are concerned with information richness and not representativeness (Patton, 1990). In this study the intended sample size was 25 patients, however the researcher ended up interviewing 40 patients, 20 patients at each of the research settings, until in her opinion, saturation has been reached. The reason for this is that although some patients showed interest to participate and signed informed consent, participation was poor during the interview. They decided not to continue with the interview after approximately ten minutes, with the result that these interviews lack depth.



The selection process was done as follows: the consulting psychiatrist(s) in charge of a selected ward was requested to identify all the patients who, in his/her opinion, would meet the criteria for participation, for example patients who are not psychotic but in touch with reality and understand the purpose of the study. The researcher interviewed the patients deemed eligible by the psychiatrist at a time convenient for the patient and researcher. If the researcher had two hours available, she would interview the number of patients who could be fitted in during that period irrespective of the number of patients identified by the psychiatrist.

### **3.6 DATA COLLECTION**

#### **3.6.1 Procedure**

Before commencing with any interviews with the patients at the study sites, separate introductory and informative meetings were held separately with the psychiatrists, the nursing staff and managers responsible for the selected wards. The rationale for these meetings was for the researcher to explain the purpose of the investigation, to clear up potential areas of misunderstanding, and to gain the cooperation of the nursing staff members who are familiar with the patients and the wards. Time was allowed for discussion and questioning.

After signed consent was obtained from the patient, the researcher made an appointment for an interview at a time that suited each patient and the researcher. The primary source of data acquisition was through face-to-face audio-taped interviews with patients, using semi-structured interview schedules (see Appendix A) conducted by the researcher.

According to Mouton (2001), utilising a qualitative interview approach ensures active participation of the interviewer and gives the interviewee a voice. The researcher was aware that true expressions could only be reflected in the mother tongue language, and therefore allowed Xhosa-speaking patients to express their views and perceptions in Xhosa. The researcher does not speak or understand Xhosa and therefore had to use an interpreter to sit in during the interview and to transcribe the audio-taped recording. At each of the two research settings the researcher used one interpreter. Both interpreters met the following criteria:

- fluent in speaking and understanding both English and Xhosa;
- familiar with the field of mental health nursing;
- have extended knowledge of interviewing and the application of interviewing techniques like questioning, probing, clarifying, responding, paraphrasing and non-verbal communication techniques including silence, nodding;
- they were not involved with the nursing care of the patients.

Furthermore, preparation of the interpreters included the following:

- they received information with regard to the background, aims and purpose of the study;
- they received copies of the interview schedule, the permission letters and the operational definitions;
- expectations regarding confidentiality and validity were explained to them as follows:
  - ask the questions exactly the way the researcher communicated it;
  - clarify the patient's perception of a word/sentence before interpreting and translating;
  - never ask any additional questions other than communicated by the researcher;
  - interpret and translate the exact meaning of the patient's response.

### **3.6.2 Instrument**

A semi-structured individual interview was conducted, as described by Mouton (2001). The interview schedule (see appendix A) contained fixed questions in order to minimize improper recording of answers and potential bias by the interviewer. The questions were formulated to explore the patient's perceptions of the environmental factors and of the deficiencies within staff/patient interactions which could possibly contribute to their aggressive and violent behaviour, based on the External and Situational models of Duxbury (2002). Another question was formulated to identify possible interventions to reduce patients' aggressive and violent behaviour in acute wards in mental health facilities by asking them "how do you think similar kinds of incidents can be avoided in future?"

The researcher was free to formulate probing questions as deemed appropriate for the given situation. Patients were asked to describe their feelings, perceptions, thoughts,

and views of the factors which may contribute towards patients' aggression and violence in the ward. They were also asked how they thought similar kinds of incidents could be avoided in future.

The researcher then explored specific responses, which lead to further discussion until the patient had nothing further to say. According to Murrell (1998), this provides an opportunity to gain maximum information and to clarify responses.

### **3.7 DATA ANALYSIS**

Polit and Hungler (1999) described data analysis as the process of bringing order, structure and meaning to the mass of collected data. Qualitative data analysis involves "breaking up" the data into manageable themes, patterns, trends and relationships. The aim of analysis is to integrate the various constitutive elements of one's data through an inspection of the relationships between concepts, constructs or variables, and to observe whether there are any patterns or trends that can be identified or isolated, or to establish themes in the data. During the interpretation of the data, the researcher indicates the levels of support the data provides for the preferred interpretation (Mouton, 2001).

In this study, thematic data analysis was carried out in a series of steps. Marshall and Rossman (1999) describe the process of data analysis and interpretation according to steps in a linear form, however, often some of these steps overlap.

The first step in the process of data analysis was to organize the data. The audiotapes were clearly marked with the date, name of the patient and a number, should it be necessary to verify recorded data with the patient. In order to uphold the confidentiality of the patients' identities, the audiotapes were kept under lock and key. A file was opened for each patient, identified only by the number allocated to the specific patient's audiotape. Each interview was transcribed verbatim. The audiotapes were listened to repeatedly in order to verify that the interview had been transcribed in full. The Xhosa language interviews were translated and transcribed into English verbatim by the interpreters.

The second step in the process of data analysis was to generate categories, patterns and themes. According to Marshall and Rossman (1999), this is the most difficult and creative phase and it represents the heart of qualitative data analysis. To be able to get a feeling for the whole data set, it was necessary to follow the advice of Marshall and Rossman (1999) - by reading, reading and reading once again through the data, it forced the researcher to become familiar with the data in intimate ways.

The sorting of the categories, patterns and themes was done manually according to the theoretical framework of Duxbury (2002:327) by using the External model (environmental factors) as the one category and the Situational model (factors relating to staff/patient interaction) as the second category. The responses to the questions asked during the interviews were categorised either as environmental factors or factors relating to staff/patient interaction. Colour-coding was used to highlight the emerging patterns. According to De Vos, Strydom, Fouche and Delpont (2002:344), this process of “identifying recurring ideas or language, and patterns of belief that link people and settings together, is the most intellectually challenging phase of data analysis and one that can integrate the entire endeavour.”

Throughout this process the researcher discussed the emerging patterns and themes with her research supervisor to identify possible gaps and with a view to final approval and verification. The categories, patterns and themes can be illustrated as follows:

**CATEGORY 1: Environmental factors (External Model)**

Patterns	Themes
<ol style="list-style-type: none"> <li>1. Unhygienic surroundings such as bedrooms, bathrooms, seclusion room</li> <li>2. Dirty bedding</li> <li>3. Quality and quantity of food and food preferences</li> <li>4. Inadequate resources for daily needs such as bedding, facecloths, towels</li> <li>5. Lack of privacy</li> <li>6. Noise levels</li> <li>7. Seclusion</li> </ol>	<ol style="list-style-type: none"> <li>1. Living conditions</li> </ol>

8. Crowding 9. Limit setting 10. Ward activities 11. Disrespect toward culture, religion and right 12. Nursing staff/patient ratio	
13. Safety in the ward 14. Attitude and behaviour of staff influencing the ward atmosphere 15. Smoking habits of patients	2. Ward Atmosphere

**CATEGORY 2: Factors relating to staff/patient interaction (Situational Model)**

<b>Patterns</b>	<b>Theme</b>
1. Staff attitude 2. Patient dissatisfaction 3. Patient satisfaction	Staff/patient interaction

The final step according to Marshall and Rossman (1999), cited in De Vos, Strydom, Fouche and Delpont (2005:339), focuses on the writing of the report.

**3.8 VALIDITY**

The validity of the findings of social research is important, as it will indicate whether the collected data can be trusted. According to Merriam (1998:198), the purpose of research is to produce valid and reliable knowledge in an ethical manner. In order to reduce bias, controls were employed to minimise error at all levels of the research process. Before selecting the study sample, the responsible ward psychiatrists were asked to identify those patients that met the selection criteria.

Any form of bias, which could be introduced by unresponsive patients because of their fears of providing false or incorrect information, or due to mistrust and pressure from ward staff, was curtailed by using a semi-structured interview schedule in the interviews. The use of audio-tapes during the semi-structured interviews was a reliable method of data collection, as the researcher could go back to the raw data when uncertain about a phrase used by the patients.

### **3.8.1 Credibility**

Credibility refers to the truth and believability of findings that have been mutually established between the researcher and the patients as a true reflection with regard to their perceptions and experiences of phenomena. Through interviews the patients were given an opportunity to describe their perceptions and experiences while the researcher listened and audio taped, and thereafter validated the recorded information with the patients themselves. According to Lincoln and Guba (1985) cited in De Vos, et al. (2002:290), credibility is the alternative to internal validity.

### **3.8.2 Transferability**

This is the alternative to external validity or generalisability (De Vos, et al., 2002:352). The purpose of qualitative study is not for generalisation, but to obtain in-depth knowledge. For the purpose of this study, the researcher used Duxbury's models as a theoretical framework which showed that data collection and analysis can be guided by concepts and models (De Vos, et al., 2002:352). Literature has revealed that it is possible and therefore the researcher hopes that the findings of this study could be used in similar research contexts.

### **3.8.3 Confirmability**

According to De Vos, et al. (2002:352), this captures the traditional concept of objectivity. This means confirming what the researcher has heard and observed with respect to the phenomena under study. For this study the researcher listened to the audio tapes repeatedly before data was analysed.

## **3.9 CONTENT VALIDITY**

“Content validity is the extent to which the instrument samples the factors or situations under study. The content of the instrument must be closely related to that which is to be measured” (Treece & Treece, 1986:262). Content validity is an important characteristic of inventories, checklists, evaluation instruments, questionnaires and interview schedules. Every question in the interview schedule and response by the patients related to the focus of this study, since the questions in the interview schedule were linked to the aims of the study. The semi-structured interviews and audio-tapes of the patients' responses, validate the content of this study. The tape recordings are an

exact reflection of the data collected. The patients' responses were discussed with them for final clarification and confirmation of its accuracy.

It is also important that someone else judges whether the content of the study is a true reflection of the information gathered by the researcher. This means that the raw data collected should at any time stand up for perusal by the supervisor or the interviewees. In this study the transcribed data, including the data transcribed by the interpreters, was verified by the supervisor.

### **3.10 TRUSTWORTHINESS OF THE DATA**

According to Guba and Lincoln (1991) cited in De Vos, et al. 2002:290), trustworthiness is a method of ensuring rigor in qualitative research without sacrificing relevance. Burns and Grove (1993:64) state that rigor is reflected in qualitative research as openness, adherence to the philosophical perspective and thoroughness of collecting data.

During the interviews the researcher allowed sufficient time to establish a good rapport with the patient. In the presence of an interpreter, the interpreter was introduced to the patient and the function of the interpreter explained to the patient. The patients were allowed ample time during the interview to respond and to verbalise their perceptions. In this study, the tape recordings were an exact reflection of the data collected. The patients' responses were discussed with them for final clarification and confirmation of its accuracy.

### **3.11 REFLEXIVITY**

As a researcher reflexivity assisted me in the ability to formulate an integrated understanding of my own perceptions and ideas, especially understanding my role in a set of human relations (De Vos, et al., 2005:363). The approach to reflexivity assisted me to become self-conscious and self-questioning to enable me to reflect on my actions during the study. It allowed me as the researcher to see how I can contribute to the construction of social and organisational realities and how to relate to others.

### **3.12 BRACKETING**

Bracketing means that researchers explore their own assumptions in order to set them aside rather than to conceal them so that they do not interfere with the information given by the respondents (Holloway & Wheeler, 1996:190). The researcher is a lecturer in Psychiatric Nursing and is responsible for the accompaniment of students during their placements in the clinical areas at the mental health facilities. The researcher has regular and close contact with the management structures of the facilities and the students regularly reflects on their experiences in the wards. Bracketing requires the researcher to remain neutral with respect to belief or disbelief in the existence of the phenomenon. The researcher first had to identify any preconceived ideas about contributing factors toward patient' aggressive and violent behaviour after admission to a mental health facility. Then the researcher had to suspend any knowledge she might have about the factors that may contribute toward patient' aggressive and violent behaviour, to prevent this information from interfering with the investigation of a pure description of the phenomenon. This would allow trustworthiness of the results.

### **3.13 ETHICAL CONSIDERATIONS**

Seaman (1976) recognizes that in the case of abuse, "intensely emotional life experiences" need to be sensitively dealt with by researchers since the research process can evoke emotional reactions in both the participant and the researcher.

According to Wilson (1989), the most crucial aspect of ethical practice with the research paradigm is to describe the experiences of others in the most faithful way possible. Mouton (2001) stated that the following considerations should be included: "confidentiality, privacy, achieving accurate portrayals and inclusion and exclusion of information."

#### **3.13.1 Permission to conduct the study**

Before embarking on the research, a letter was written to the medical superintendents and deputy directors of the nursing services of the two associated mental health facilities to brief them on the purpose of the study, and to request permission to perform the study. Permission to conduct this study was obtained from the ethical and research committees of both hospitals and the responsible university, University of



Cape Town (Appendix H). The Ethics Committee of the Faculty of Community and Health Sciences at the University of the Western Cape also granted approval for this study.

### **3.13.2 Informed participant consent**

Patients were informed about the potential benefits of and the reasons for undertaking a study of this nature. Patients were further informed about the duration of the study and for how long their cooperation would be required. Patients were informed that if necessary, the researcher can make use of an interpreter. Confidentiality in this regard was confirmed by informing the patients about the criteria used in the selection of the interpreters. As the researcher did not want to invade the patients' privacy, they were assured that their participation in the research study was voluntary, and they were free to withdraw from the study at any time. The patients were informed that the researcher was being supervised. The assurance was given that all information would be treated confidentially and that it would only be used for the purpose of the research. The audiotapes would be kept at the researcher's home, marked with the date of the interview and the name or pseudonym of the patients. On completion of the study, these tapes would be erased. The reporting of sensitive information that could possibly be disclosed was negotiated with the patients. Patients gave voluntary written consent (Appendices B,C,D,E,F,G) only after they were assured about the above conditions (Mouton, 2001). Thereafter patients were asked to provide information as honestly as possible.

### **3.14 LIMITATIONS OF THE STUDY**

This study was limited to only one ward category (pre-discharge wards) in two inpatient mental health facilities in Cape Town because of time constraints and the requirements of a mini thesis. The results are based on the expressed views of 40 patients, which may not be representative of the views of the patients in general.

The researcher was aware that true expressions could only be reflected by the mother tongue language, and therefore allowed Xhosa-speaking patients to express their views and thoughts in Xhosa. The researcher does not speak or understand Xhosa and therefore had to use an interpreter to sit in during the interview and to transcribe the

- ❖ Describe your feelings, perceptions, thoughts and views of the factors which may contribute towards aggression (any verbal behaviour that comprises insulting, threatening or disruptive and abusive language directed towards the self or others that upset the smooth running of the ward) and violence (when physical force is used resulting in harm to the self, others or property) in the ward.

Patients' responses on the final question "How do you think similar kinds of incidents can be avoided in future" addressed the third objective of the study, namely to identify possible interventions to reduce patients' aggressive and violent behaviour in mental health facilities in the Western Cape.

The presentation and discussion of findings will elaborate on the two categories and the patterns and themes which emerged from the collected data. Verbatim quotations from the transcribed interviews are included as well as relevant data from the literature.

#### **CATEGORY 1: ENVIRONMENTAL FACTORS (EXTERNAL MODEL)**

This model focuses on the impact of environmental factors upon the incidence of patient aggression, including building deficits (limited physical space, overcrowding, poor provision of privacy), hospitalization, hospital shifts as well as poor environmental provisions (Nijman, Merchelbach, Evers, Palmstierna & aCampo, 2002).

In this category, fifteen (15) patterns emerged from the responses and from these patterns the researcher identified two (2) themes, namely living conditions (patterns 1-12) and ward atmosphere (patterns 13-15). The findings of these themes will be presented and discussed by elaborating on the patterns which emerged from the responses.

audio-tape recording. The selection and preparation of the interpreters were dealt with in the discussion of the data collection procedure (3.6.1).

Furthermore, the Internal model (patient factors) Duxbury (2002) was not a focus area for this study and therefore not investigated as a contributing factor toward patients' aggressive and violent behaviour after admission to a mental health facility.

However, the findings of this study could contribute to knowledge worth exploring through follow-up studies.

The following chapter comprises the research findings and a discussion of the results.

# **CHAPTER FOUR**

## **RESEARCH FINDINGS AND**

### **DISCUSSION**

#### **INTRODUCTION**

In the previous chapter the research design and methods were discussed. In this chapter the results of this study will be presented and discussed according to identified categories, patterns and themes that emerged from the semi-structured interviews conducted from January-June 2004.

A qualitative research design, which was used for this study, focuses on the subjective experiences or views of the individuals involved about the specific topic being examined (Mouton, 2001). It was found to be an appropriate design to investigate the external and situational factors contributing to patients' aggressive and violent behaviour in mental health facilities in the Western Cape, as seen from the patients' perspectives.

For the purpose of this study, Duxbury's model (2002) was selected as a framework for the data analysis and presentation of the results. Duxbury (2002) identified three models highlighting the areas of concern, namely the internal, external and situational models which refer to the patient variables, environmental factors and factors relating to staff/patient interactions. For the purpose of this study, patient variables (internal model) were omitted because this was not a focus area for this study, as the objectives of the study focus on exploring patients' perceptions of the environmental factors (external model) that could possibly contribute to their aggressive and violent behaviour and exploring patients' perceptions of the staff/patient interactions (situational model) that could possibly contribute to their aggressive and violent behaviour. In exploring the above objectives, patients responded to the following questions:

- ❖ How do you experience the atmosphere in the ward (whether it is peaceful and supportive or hostile and disturbing)?
- ❖ Can you describe the attitudes of staff towards their patients?

**KEY:**

**Resp.            Respondent**

**THEME 1: LIVING CONDITIONS**

**Pattern 1: Unhygienic surroundings**

When respondents were asked to describe their perceptions, experiences, views and thoughts of the factors which may contribute towards aggression and violence in the ward, it was found that the ward environment were perceived as a contributing factor. They expressed feelings of anger and frustration because they did not see any improvement after they verbalised their unhappiness about unhygienic ward conditions at various climate meetings. Respondents responded as follows:

Although the cleaners try to keep the toilets and bathrooms neat, patients with no insight are messy and use the toilets and washbasins as ashtrays (Resp:10).

Sometimes the floors in the bathrooms were covered with urine and faeces, with much delay before it was cleaned up (Resp:06).

All the patients in this ward are unhappy with the dirty bathrooms and in spite of the fact that we raised this on climate meetings nothing has being done about it (Resp:03).

To prevent unhappiness around unhygienic surroundings, respondents commented as follows:

In order for me and all the other patients to feel not so depressed it will be good if the whole environment can be clean, especially the bathrooms and the area in front of the ward (Resp:07).

The ward rules should be clearly spelled out to all new comers that they must not use the wash basins and toilets as ashtrays or through their chips bags on the floor (Resp:22).

The nurses must call the cleaners to clean the bathrooms and toilets if they see it is dirty (Resp:05).

Valfre, (2001:91) stated that the physical surroundings of a therapeutic environment have an effect on the people who live within that space and it include temperature, lightning, sound, cleanliness, and aesthetics. It is the responsibility of nurses to monitor how each of these aspects affects clients.

Hygiene needs are important in the therapeutic environment because clients are occasionally admitted in various states of cleanliness which range from tidy to extremely neglected. Valfre (2001:90) noted that it is therefore important to encourage good hygiene habits.

### **Pattern 2: Dirty bedding.**

Respondents shared their experiences, saying:

The state of the bedding is pathetic and sometimes the blankets are smelly and torn (Resp:26).

I reported in a climate meeting that my blanket is covered with dry vomit, while from the other patients reported that their blankets smells of urine”(Resp:02)

We raise our unhappiness regarding the state of the linen in the ward to the ward staff but they are not interested (Resp: 01).

The general feeling from respondents were that it is better to keep quiet during climate meetings due to the fact that certain nursing staff members respond with sarcasm to their concerns and complaints. However, “an environment that is tidy and in good condition sends a message of caring and pride in appearance” (Valfre, 2001:92).

### **Pattern 3: The quality and quantity of food.**

Wilson and Kneisl (1996), cited in Lobelo (2004), postulated that interferences with basic human needs, such as food, can lead to fear and anxiety. This is evident from the following accounts:

I am not satisfied with the hospital food, it is often served cold and late (Resp:32) The quality of the food is poor and it is very little (Resp:03 ).

The kitchen did not make provision for the food preferences of our different cultures and it annoyed me and some of the other patients to eat Western food (Resp:02).

To prevent this from happening a respondent suggested:

Nurses must take notice of the different cultures in their wards and should ensure that the kitchen now it when they send the food to the wards (Resp:31).

Other comments were:

When we ask for a second helping of food, it is refused with rebukes, while we noted afterwards that some staff members eat from the kitchen, or take from the leftovers home for themselves or their dogs (Resp:34)

When patients mentioned at a climate meeting that they observe how some of the nursing staff and the cleaners eat the patients' food, the nursing staff told us that some of us are already too fat and we must go and check ourselves in the mirror (Resp:16).

However, some respondents voiced their satisfaction as follows:

I cannot complain about the quality of the food, but it is very little (Resp:06).

Food is enough and it taste nice, but is very little" (Resp:08).

I am satisfied with the amount of food (Resp:22).

According to Altschul and McGoven (1985) cited in Lobelo (2004), it is crucial that nurses should attend patients' mealtimes because it can convey an attitude of relaxation and enjoyment. Searle, Brink & Grobbelaar (1989) cited in Lobelo (2004), also noted that if the atmosphere is relaxing, the nurses will be able to attend to problems that crop up, such as those of patients receiving too little, or cold food.

#### **Pattern 4: Inadequate resources for daily needs.**

Respondents' perceptions reveal that a lack of face cloths, towels, toilet paper, deodorants, razors and toothbrushes for personal hygiene contribute to their anger and dissatisfaction with their stay in the ward. This is evident from the following responses:

We are angry because we expressed our anger about the shortages more than once on the climate meeting, but every time the ward staff have an excuse such as: "the government cannot provide more blankets and pillows due to budget constraints and that if you are not happy with the way it is here you must go to private hospital"(Resp:02).

Sometimes there is no toilet paper or towels available and when we asked our families to bring some from our houses, the staff reacted with anger and some mornings we had to use our clothing of the previous day to dry ourselves (Resp:17).

Patients will not be so angry if there are enough face cloths-at least we should have our own and also our own tooth brushes (Resp:12).

Respondents responded to the shortage of linen, saying:

Some evenings there are not enough blankets and pillows for all of us (Resp:07).

More than one night while I was in the closed ward, the ward have so many patients that me and some of the other patients have to find a place for ourselves to sleep with the other patients in their bed (Resp:10).

**Pattern 5: Lack of privacy.**

Respondents explained that they are angry and dissatisfied with the conditions in the ward. This is evident from the following accounts:

Privacy in bedrooms and bathrooms is limited, and we have to share it with several other patients (Resp: 14).

Staff members do not respect our privacy in bedrooms and bathrooms, and walked in without knocking (Resp:18).

Little provision is made for private space where patients and their relatives may sit and talk (Resp:33).

One day, I said to the nurse I am a very private person, can I not bath later, after everybody are finished and the nurse then said: "You are not in a private hospital, the government pays for your stay and furthermore that I want to finish in order to go and drink my coffee" and then I was pushed under a cold shower and told to keep my mouth (Resp:04).

According to some respondents, anger and aggression can be prevented and suggested the following:

We will appreciated it if the nurses can ensure more privacy in the toilets, bedrooms and bathrooms (Resp:11).

It will be of great help if the hospital can provided us a space where we can sat privately with our visitors (Resp:36).

Valfre (2001:82) explain that the "foundation of the therapeutic relationship are trust, empathy and caring and a client need to trust that they will be cared for in a safe and supportive manner." A respondent commented in this regard:

How can I trust the nursing staff with my problems when I heard how they discuss our problems loudly in front of other patients and some times they even make jokes of our illnesses (Resp:02).

Morrison (1993) cited in Valfre (2002:28), stated that "the right to privacy refers to privacy to the body, confidential personal information and the right to be left alone,



and an invasion of privacy occurs when a client's space, belongings or body are violated."

Goren and Orion (1994) cited in Valfre (2001:92), reported that mentally ill clients claim their rooms and sleeping areas as their own and it important that all staff working with these clients should be aware of invading clients' territories. Knocking and announcing themselves before entering clients' rooms demonstrate respect for personal space.

### **Pattern 6: Noise levels**

Respondents verbalised the following regarding noise levels:

I cannot stand the screaming and shouting of the nurses and patients any longer (Resp:01.)

The constant screaming and fighting between patients and certain nurses and amongst patients make me sicker as when I came here (Resp:33).

Valfre (2001: 91) and Rawlins, Williams & Beck (1998: 512) noted that people experiencing mental illness are commonly hypersensitive to sounds and that when noise levels become too intense, clients become distracted and agitated.

### **Pattern 7: Seclusion**

Respondents reported that they were sent back to seclusion for displaying aggressive behaviour, while others indicated that they had been in seclusion, or locked up, by reason of being acutely ill, not necessarily because they were a danger to themselves or others. This is evident from the following responses:

I was completely disorientated about the time and day while I was in there (Resp:17).

You feel humiliated when the nurses take all your personal belongings, and you never know when you will see the outside world ever again. Seclusion damage a person more emotionally as before you are going in there (Resp:07). You feel so helpless and frustrated when the nurses take you to seclusion (Resp:16).

You feel so frightened and unsafe when the nurses put you in a seclusion room (Resp:08).

Seclusion make a person just more aggressive, because when you are in there, the nurses do not bother to talk to you (Resp:31).

We are put in seclusion without an explanation of the ward rules, which caused that some patients get very frustrated (Resp:29).

We were taken back to seclusion without being given a proper reason what we did wrong (Resp:03).

Respondents commented that much of their feelings of anger and violent actions could be prevented and suggested that:

If the nurses visited us more often, it will let us not feel so lonely and it will show us that they really care about us (Resp:12).

It will be helpful if a room with a punch bag can be provided in order for us to get rid of our frustrations and anger (Resp:36).

While most respondents voiced feelings of anger, one respondent commented:

I enjoy it in there, because it is quiet in the room and I have not to listen to the nurses and the other patients' screaming (Resp:05).

Several instances of physical manhandling were reported such as:

We, patients are kicked in the face and stomach (Resp:08).

I was thrown down with my face on the floor while I was naked, with my arms forced behind my back (Resp:21).

Nursing and security staff threaten us with seclusion to punish us, especially if we refuse treatment, or have different opinions about things than the nurses (Resp:03).

The above responses correlate with the findings of Bower, McCullough and Timmens (2000) and Meehan Vermeer and Windsor (2000), who also found that most patients in psychiatry settings have negative perceptions of seclusion. Valfre (2001:416) defines seclusion as: "removal of a client to an area of decreased stimulation: isolation of one person from others."

### **Pattern 8: Crowding**

During the study period the respondents felt that the wards were crowded most of the time and commented as follows:

... damaged some of the property in the ward, but it drives us crazy when we are all in one small place where it is dark from all the cigarette smoke, and the patients who are very sick constantly bother us when we want to be alone (Resp:32).

Yes, some of us were sent back to the acute wards to be secluded because we were aggressive or violent and sometimes injured ourselves or others (Resp:03).

The above responses are consistent with findings by researchers such as Palmstierna, Huitfeldt and Wistedt (1991) and Kumar and Bradley (2001) who found that overcrowding in the wards has been linked with violence because they become over-stimulated due to the ward turmoil.

A response with regard to crowding in the bathrooms was as follows:

In the mornings, all of us stand like sheep in a row waiting for our turn to have a shower or a bath and sometimes we are 3- 4 patients who have to shower together; otherwise if you maybe get permission to shower alone, you have to endure the cold water (Resp:28).

In the same context with regard to bedrooms, Kumar and Bradley (2001:434) indicated that when areas perceived to be private, such as bedrooms, are small or shared, then there is less objective area that the patient can define as his or her own. Not only are patients objectively crowded, they may also experience subjective crowding in such high-density situations. (Kumar and Bradley, 2001:434). Shrivastava et al. (1999), cited in Kumar and Bradley (2001:434), postulated that a sense of frustration and anger are expected outcomes, especially when patients feel they have lost control over their environment.

Valfre, (2001:37) also noted that mental health clients have different perceptions of space which include: personal, social and intimate space and it is important that everybody working with these clients should respect their client's degree of comfort at each distance, and their use of surrounding space. In this regard a respondent said:

Patients will be less aggressive and frustrated if the ward makes provision for more space in our bed rooms and the smoking areas (Resp:37).

While patients enjoy the time spent outside doing exercises, a respondent said:

In summer there is no provision made for shady areas, with the result that most patients sit inside in front of the television all day which cause a lot of friction between us because we are to many patients in one room (Resp:11).

### **Pattern 9: Limit setting**

While conducting the interviews it was detected from respondents perceptions that limit setting and certain “unfair” rules in the ward contribute to their aggressive and violent behaviour. It is evident from the following accounts:

Most of the rules are fair, but we are unhappy with the rules pertaining to the times we have to get up and go to bed (Resp:08).

Other respondents indicated that they tried to voice their dissatisfaction in a climate meeting, but were told:

Keep with the rules or face going back to the locked wards, or get injections”(Resp:36).

Another respondent commented:

I feel very angry and upset with the unfair and inconsistent manner in which nursing staff carry out limit setting (Resp:18).

These perceptions are consistent with findings of Lancee, et al. (1995:724) who found that negative nursing staff-patient interactions may be associated with violence since patients’ levels of anger are higher in response to non-therapeutic limit setting styles, and very low for therapeutic styles. Rawlins, Williams and Beck (1998:470) stated that any threat may increase anxiety and cause regression to maladaptive coping mechanisms.

Other negative experiences revealed the following:

Nursing staff did not want to be bothered by patients if patients were a little bit too noisy or talkative; they would enforce limit setting e.g. staying alone in the bedroom, or being put into seclusion without being talked to (Resp:23).

Limit setting is not always consistent, and in most cases it is used as a threat (Resp:33)

When patients are too talkative or if they asked for medical attention, they are threatened with seclusion or injections (Resp:38).

Staff members’ different limit setting styles were found to be highly provocative. These ideas correlate with the findings by Sheridan, et al. (1990), Fuller-Torrey (1994)

and Bensley, et al. (1995) who found that patients viewed restraints negatively or as a punishment or perceived restraints as aggression against them.

Although respondents admit that limit setting has to be implemented in order to avoid chaos in the wards, they perceived the way it is being done as negative and unacceptable. Valfre (2001:93) commended that limit setting allows the therapeutic environment to be consistent and predictable because clients know that external controls will be enforced, however many mentally ill clients have difficulty to behave within these limits (Valfre 2001:97). Therefore according to this author, it is vital that all team members working with clients should understand the purpose of each limitation and the methods for enforcing them (Valfre, 2001:85).

#### **Pattern 10 : Ward activities**

Some respondents felt that their aggression and violent behaviour was aggravated by the lack of structured activities in the wards. Although each ward has a different ward program and times of activities, the perceptions of the respondents were:

Our day starts at 07:00 and breakfast is served from 08:00 onwards, after which certain aspects of the ward programme is implemented (Resp:18).

We get up at 6 have our breakfast at 9 and lunch at 12 (Resp:14).

Lunch is served anytime from 12:00, after which we are forced to lie on our bed until 14:00. Supper is served at 16:45, then we are sent to bed and lights out is at 21:00(Resp:12).

Rawlins et al. (1993), cited in Lobelo (2004), asserted that the focus of ward activities should be on the benefits to the client rather than to the institution.

During the interviews, the researcher established that most of the respondents perceived an increase in boredom over week-ends, due to the fact that the ward programme is not always implemented and secondly only certain nursing staff members implemented the ward programme from Monday to Friday from 08.00 to 16.00 hours, which resulted in more patients than usual being present in the day rooms. Rawlins, et al. (1993), cited in Lobelo (2004), explain boredom as a lack of adequate stimuli which resulted in feelings of fear, apathy, resentment, depression and hostility.

Those respondents who spent their days in the ward felt that most aggressive incidents occurred between 7:00 and 09:00 and between 17:00 and 19:00. Only a few incidents were reported between 19:00 and 07:00. A response was:

Some patients are likely to become more hostile and aggressive after visiting times because those who did not get any visitors, begged drinks and cigarettes from the patients who did receive visitors and this often caused friction amongst us (Resp:18).

Results of studies done by Bradley, et al. (2001) found that incidents of aggressive and violent behaviour were most likely to occur during the afternoon shifts when there is a lack of structured interaction and socialisation such as ward outings, therapeutic groups and interviews. It is during the above times that there is less supervision, and the effects of the morning medication could possibly play a role.

Ekland and Hansson (1997:330) state that patients who are exposed to treatment programmes based on principles from milieu and occupational therapy demonstrate a lower level of anger. The reason for this was because programmes were organised as a group treatment, with flexible arrangements to fit the individual needs. The emphasis is therefore on the patients' strengths instead of their weaknesses. Respondents in this study were frustrated by restrictions on their freedom, with very few alternatives but to sit around and doing nothing. Especially those who do not attend occupational therapy described the ward environment as "*boring with nothing to do*" which caused much frustration. These thoughts are in line with the findings by Nijman, et al. (2002), who said that under-stimulation from a lack of activities might also lead to disruptive behaviour. Rawlins, et al. (1993), cited in Lobelo (2004), noted that the bored client needs a balance between routine activities and novel activities as well as a change in the predictability of his situation.

Respondents admitted that group activities were included in their treatment but sometimes they did not emotionally feel well enough to attend it. They are, however forced to attend these irrespective of their feelings, which lead to conflict situations with inflexible nursing staff members. In addition, some respondents felt that they are frustrated because of being treated like children at group activities, but rather than

being punished or threatened, they just attended these activities. Some representative responses were as follows:

It is only when the student nurses asked us to participate in groups that the activities are nice (Resp:37.)

It is only some of the nurses that keep us busy with painting, playing of cards or dominoes (Resp:34).

Weekends are boring; here are no students or anyone that can talk to us except for the security guard (Resp:40).

Patients are frustrated because there are not enough activities (Resp:21).

I am so fed-up with dominoes, I do not want to see it ever again after I leave this place (Resp:16).

Other concerns voiced by the respondents are around meal times as follows:

The most incidents that take place in the dining room are mostly verbal differences between patients, or patients and nursing staff (Resp:02).

During the administration of medication in the dining room, certain staff members scream at the patients if they not fetch their medication quickly enough (Resp:34).

Many of patients' aggressive outbursts are provoke during meal times by the presence of other patients' with severe side-effects from the medication (Resp:35).

These perceptions are supported by the authors Lanza et al. (1994) and Owen et al. (1998) who noted that violence has been known to increase around meal times.

Seeing that these wards intend to rehabilitate patients for discharge in order for them to function optimally in the community, the researcher shares Talbot's (1990) concern about the apparent lack of a structured program for the patients and for those that do not attend occupational therapy.

### **Pattern 11: Disrespect towards culture, religion and rights**

Although the Mental Health Care Act 17 of 2002 noted that every mental health care user has the right to be respected and that no discrimination in terms of person, dignity, illness, culture, religion or nationality is acceptable, respondents in this study have different experiences, such as:

We felt dehumanized because our religions are not being respected and we are forced to dance together with our fellow inmates because staff members expect us to do so (Resp:20).

I am annoyed by the loud music from the television that we are forced to endure (Resp:18).

Certain race groups were favored by staff members of the same race concerning issues of seclusion, after being involved in an aggressive incident and we were very unhappy about this (Resp:12).

A Muslim respondent verbalized her experience as follows:

One day when I read the Koran and prayed, the nurse said that I am stupid and Allah will not forgive me (Resp:08).

Respondents expressed feelings of anger, because the ward program make provision for regular climate meetings in the ward, but:

The aim of the climate meetings in this ward is often ignored and I feel the patients in this ward are grossly disadvantaged in terms of our democratic rights, nursing staff force us to attend climate meetings, but we are excluded when it came to the making of decisions (Resp:01).

Nursing staff did not always allow us to highlight our problems but told us to hurry up, because they did not 'have time or were in the mood to listen to our nonsense stories (Resp:04).

One day, just because I opened my mouth the nurse told the doctor I am difficult and must be refused weekend leave and it is sad that the doctor listened to her (Resp:14).

However, one response differed from the others:

When certain nursing staff members were on duty, climate meetings were held on a regular basis, activities/rules were explained and daily activities scheduled according to the ward program with the result that patients of these wards are much calmer during those shifts because a supportive therapeutic environment is provided (Resp:22).

In support of these statements, Joivisto, Janhonen & Vaisanen (2002), cited in Lobelo (2004), noted that disempowerment is partly due to the failure of others to afford a proper hearing to the person's story of his/her experiences and problems in life. Patients have the right to participate in decision-making on matters affecting their health as stipulated in the Mental Health Care Act 17 of 2002. Tadd (1998), cited in Lobelo (2004:38), strongly agrees with this notion, and noted further that patients



should be given freedom of expressing decisions on matters which affect them. If this becomes a reality in care settings, fewer problems may ensue.

### **Pattern 12: Nursing staff/patient ratio**

When respondents were probed whether they thought that the nursing staff/patient ratio is a contributing factor towards their aggressive and violent behaviour, respondents commended as follows:

Certain staff members provoked anger in patients irrespective of the number of staff on duty (Resp:05).

At times there were only a few permanent staff on duty, and although there were some small fights amongst the patients, the patients were much calmer due to the fact that these nursing staff have a supportive attitude (Resp:22).

I can see no difference in the amount of fights or aggressive behaviour amongst patients when the permanent or the agency nurses work (Resp:15).

The number of nurses on duty, whether they are many or few, tend to rather sit in staff rooms or in their offices instead of spending time with us (Resp:01).

From these comments, the ratio of patients to nursing staff was therefore not positively identified as contributing to aggressive outbursts. These findings are supported by findings from Way, et al. (1992) who also found no association between staff-patient ratio and the occurrence of aggressive and violent behaviour in psychiatric facilities.

On the other hand, Morrison (1990) suggested that higher patient/staff ratios would lead to less violence because of decreased opportunities for stressful interactions.

Moos, cited in Rawlins, et al. (1993:514) found that the more clients per staff member on a psychiatric ward, the more emphasis was placed on staff control and the less on support and spontaneous communication. However, the author also stated that a decreased number of staff members and an increased number of clients have also several negative effects such as a greater pressure to develop a more rigid structure, fewer spontaneous interactions between clients and staff and staff members' need to control and manage is increased.

## **THEME 2: WARD ATMOSPHERE**

For the purpose of this study, ward atmosphere was explained to the respondents as either being peaceful and supportive or hostile and disturbing. A safe environment refers to physical safety (Megaree cited in Lanza, et al., 1994) and the therapeutic ward climate, also known as social security (Moos, et al., 1973).

This theme was identified from the following three patterns which emerged from the responses.

### **Pattern 13: Safety in the ward**

Respondents expressed concerns about their safety and mentioned mixing of patients with different mental illnesses, homosexuality and disrespect toward their personal belongings as their main concerns. Respondents said:

I blame the hospital for putting all types of patients together and I fear for my safety in the ward, all types of patients are put together like depressed and manic patients (Resp:05).

I did not want to be mixed with people who are running up and down (Resp:32).

Certain male patients insist on homosexual advances and the night staff was usually not around during these times and when they were informed about these incidents, they were not interested (Resp:22).

Respondents were agitated about their personal belongings which have been stolen since they were admitted at the hospital. Stolen items mentioned by patients included cigarettes, money, clothing and a watch. A respondent said:

One doesn't sleep well at night because you never are sure whether your personal belongings will still be on your locker when you get up in the morning. I feel very angry towards the patients in the ward and the nurses who are not respecting our personal belongings, because when I reported that my jacket disappeared from my locker, the nurse was not supportive and said that the dirty linen have already being taken away (Resp:33).

In order to prevent aggression in this regard respondents suggested:

Every effort should be made to reduce our anxiety by creating a more homely atmosphere (Resp:16).

Much of our frustration can be prevented if we have a place to keep our personal things and clothes (Resp:28).

Valfre (2001:92) asserted that safety and security needs within the therapeutic environment include the feeling of physical safety, the security of limit setting, freedom of hazards and the ability to feel secure with others. The latter refers to limits should be placed on the actions of clients who are a danger to themselves or others.

#### **Pattern 14: Attitude and behaviour of staff influencing the ward atmosphere**

When respondents were asked to describe their perceptions of the ward atmosphere, some of the patients described certain staff members as being pleasant, helpful and therapeutic. According to one respondent:

The atmosphere on the wards when these nursing staff were on duty was pleasant, there were enough activities to relieve boredom, rules were explained, there were consistency and incidents of aggressive and violent behaviour were rare (Resp:01).

However, when the shifts changed, patients experienced the opposite as reflected by respondents:

When a certain shift worked, we are so afraid because they are rude and told us to shut our mouths but when the opposite shift works we are treated with respect (Resp:04).

On certain shifts the nurses are more flexible with visiting hours and they allow your family who came from far to come earlier as what is allowed, where as the other shift work they will stick with visiting time (Resp:18).

It was also established that the general feeling was that the wards reflected an atmosphere of distrust, tension, unhappiness, frustration, depressing, anger, confusion, fear and disorganisation. This was revealed from the following responses:

We are frustrated because when we want to discuss our problems with the nurses, they are always too busy to attend to our problem and we do not want to be left alone with a security guard the whole day who sits and sleep (Resp:36).

It is not nice here, it feels depressing (Resp:14).

The presence of aggression in the pre-discharge wards is quite low because we have more freedom here thus if we feel agitated, we can go outside away from those things that irritate us, but when I was a patient in the locked ward, there the patients were so aggressive that they damaged sometimes things from the

ward or themselves (Resp:11). When asked to clarify the meaning of “things and themselves,” his response was: doors, tables and sometimes patients hurt themselves with anything that is sharp.

The acute closed ward is described as a prison because:

The doors of the wards are locked doors which give the impression that you are in a prison (Resp:34).

Kho, et al. (1998) maintain that while patients have to submit to the regulations of the daily ward life imposed by staff, they often find these rules oppressive and feel they are being reduced to an infantile status.

### **Pattern 15: Smoking habits of patients**

Whilst smoking in public places is restricted by law, it is common knowledge that most mentally ill clients smoke. Issues around tobacco and smoking seemed to cause much frustration and is related to aggression amongst patients. Respondents responded as follows:

Although the new tobacco smoking laws do not make any special provision for mentally ill patients, each ward has a space where patients and visitors can smoke, but it is very small and a person cannot enjoy your cigarette (Resp:14).

Many of the aggressive outbursts in this ward occurred while some of the nursing staff was trying to set limits regarding smoking. The reason for this is because the hospital only provides a limited amount of cigarettes and tobacco, and not all of us have our own cigarettes or tobacco (Resp:15).

Patients begging for cigarettes, which cause that we become aggressive with each other (Resp:24).

One day I refused to give one of the patient's cigarettes, he followed me to the toilet and hit me for my cigarettes (Resp:26).

Non-smoking respondents said:

Most patients in this ward smoke, and those who do not are very agitated and sometimes get aggressive because they have to sit with those who smoke (Resp:03).

I am concerned about dagga that is smoked inside and outside these wards which the patients obtain from outside visitors. There are times when I feel nauseated when I have been sitting next to a person who smokes (Resp:33).

I am not a smoker and to sit the whole day between smokers drives me crazy, I become a passive smoker and it affects me (Resp:4).

I feel that nonsmokers should not be mixed with smokers(Resp:22).

Concerns about smoking include fire setting, aggression towards other clients and staff during attempts to produce smoking material and the ethical dilemma of using tobacco as a reinforcer for behavioural change (Rawlins, Beck and Williams, 1993 cited in Lobelo, 2004).

## **CATEGORY 2: FACTORS RELATING TO STAFF/PATIENT INTERACTION (SITUATIONAL MODEL)**

This model focuses specifically on the deficiencies within staff/patient relationships and interactions (Duxbury, 2002:327). A common theme in studies explaining situational factors is that incidents are usually provoked, and they are not simply the spontaneous manifestations of underlying pathology. The contributing factors include negative interactions (Sheridan, et al. 1990) and power issues (Morrison, 1994).

Respondents have different perceptions of the contributing factors toward aggression compared to their recommendations for reducing it; some perceived their illness as the main contributing factor toward aggression and believed that in order to manage aggression, their medications have to be changed. In contrast, others perceived their illness, interpersonal factors, and environmental factors as being almost equally responsible for their aggression. Some respondents experienced satisfaction with staff/patient interaction, however during the interviews it became evident from respondents' experiences that they also feel disappointed, angry and frustrated about the staff/patient interaction during their stay in hospital and perceive their interaction with the nursing staff as negative.

In this category three patterns emerged from the responses and the researcher identified one theme, namely staff/patient interaction. As with the first two themes, the findings of this theme will be presented and discussed by elaborating on the patterns which emerged from the responses.

### **THEME 3: STAFF/PATIENT INTERACTION**

#### **Pattern 1: Staff attitude**

Responses on the attitude of the nursing staff indicated positive as well as negative perceptions.

Aspects that consistently received negative ratings from respondents included the quality of care, staff attitudes and their feelings of anger and fear of being abused and threatened with a longer stay, seclusion or injections. The nurses failed to provide an attitude of personal worth of respecting an individual, irrespective of culture or creed. The perception of nurses treating patients as if they are criminals appeared repeatedly during the interviews with responses as follows:

I once asked a nurse why are you people treating us like we are in prison? (Resp:16).

We do not deserve to be treated like criminals (Resp:02).

What I have observed is that most of the nursing staff has a tendency of treating us like prisoners as if we have committed crimes (Resp:11).

A few respondents commented that they become violent and that the assaults were directed at those staff members who provoked anger, shouted at them and who were abusive, bullying or inflexible. Respondents described their experiences of a nursing staff members' attitude as follows:

I voiced my unhappiness and complaints in a letter to the superintendent of the hospital via the nursing staff. After three weeks, I enquired whether the letter was indeed sent to the superintendent. The nurse verbally and physically abused me and sent me back to the closed ward without any explanation. Afterwards I suffered bruising and when I told this nurse that I am aware of my rights, she further abused me (Resp:09).

I observed an incident where a patient refused to take her oral medication because it made her drowsy. The nursing and security staff member then threw her on the floor and forced water and the tablets down her throat. The patients who observed the incident were terrified and distressed because the patient nearly choked (Resp:24).

It was established that patients are afraid to differ from certain staff members because of their fear for victimization and intimidation. Respondents commented as follows:

When we did not co-operate and behaved according to the staff's expectations, the security and nursing staff members over-reacted with bossy, punitive behaviour, which triggered aggressive and violent behaviour (Resp:25).

The attitude and behaviour of staff members made us terrified (Resp:14).

Certain staff members are intolerant, rigid and autocratic (Resp:19).

Staff members threatened patients with seclusion or delayed discharge if we talk too much and such threats often elicited anger and assaults amongst patients (Resp:03).

Patients are often left alone with nursing students, or a security officer, with whom they cannot discuss their problems. Respondents felt that it was unacceptable that security staff has to look after them most of the day, and in addition these security staff do not listen to them, and are watching television the whole day. Respondents said:

The permanent nursing staff members are rarely visible or available – they tend to sit in the offices chatting on telephones or in the tearoom (Resp:02).

The security officers mostly sit and sleep, or watch TV, and if you dare disturb them they scream at you to leave them alone and to speak to your doctor (Resp:11).

They did not hide the fact that they are really tired and fed up with us and a person can hear from their voices and just by looking at their body languages, we get the message that they are not in a mood to listen to us and that they are frustrated (Resp:15).

Some of the nursing assistants are rude, agitated and intolerant and nursing staff often had no time, or are not in the mood to listen to us, and when we approached these staff, they become very irritated and verbally abusive (Resp:24).

Other responses were:

The negative attitudes from nurses add more stress to the already stressed patient (Resp:02).

One night a male nurse came drunk on duty, and I am sorry to say that... he was very agitated with us and I could see that this man was definitely not in a mood to talk to us, I felt so agitated and helpless, because on that specific evening, I had a desire to talk to a nurse (Resp:24).

Overall, these perceptions are consistent with the findings by Letendre (1997) and Duxbury (2002) who indicated that patients feel frustrated or angry because of staff

attitudes, which focus on applying rules and controlling symptoms through medication, while excluding any possibility of establishing a therapeutic relationship. However, although it was established that certain of the respondents were at some stage during their current admission physically and emotionally abused by both nursing and security staff, it is difficult to verify this information, which is in line with findings of Sundram (1984).

## **Pattern 2: Patient dissatisfaction**

Respondents felt that:

Myself and all the other patients here are angry because we had to endure daily the threats and abuse of certain of the nurses (Resp:09).

Patients do not want to feel that when they verbalised their feelings to the nurses, they would immediately be threatened with restraint or medication (Resp:36).

A general response was that if staff members have acknowledged their requests, the relationship between patients and nursing staff would be improved, which would ultimately increase the effectiveness of treatment. This is evident from the following comment:

One morning I asked the nurse to be excused from the occupational therapy because what we do there is from no help to me. I told her that the hospital must rather teach me better ways to cope with my stressors that cause my illness. By that time the nurse was very agitated and said: 'You will go because I get fed up of your nagging to go home and I cannot take it any longer to listen to your weenie voice any longer (Resp:15).

When nursing staff do spend time with patients, there is little interaction - staff watch television or read magazines. Respondents explain their dissatisfaction as follows:

We are too scared to bother the nursing staff out of fear of a rebuke (Resp:19). It will be possible for staff to predict violence if they listened to what patients were saying to them - instead of complaining about their bosses or low salaries amongst one another (Resp:23).

Staff could be more available for patients (Resp:07).

Nurses ignore us and will only listen to what our family tell them, they should give us also time to explain ourselves and not make their own judgements (Resp:25).



We would love to take more walks with nursing staff members, but the latter are always either too busy with their own things, they talking for hours on telephones, discussing their personal matters with other staff members, and having very little time to spend with patients (Resp:32).

Although interpersonal interaction is the heart of mental health nursing, some criticisms were reported in the past few years (Cleary, et al., 1999:110). Lancee, et al. (1995:609) explain that “nurse-patient interaction has a significant impact on the patients’ well being, and the quality and outcome of nursing care.”

### **Pattern 3: Patient satisfaction**

Two respondents voiced their satisfaction as follows:

The nurses in this ward are supportive and they listen to us when we have complaints (Resp:30).

What surprised me was that when I was in seclusion one of the nurses visits me often to talk to me which let me not feel so lonely and neglected (Resp:14).

Stuart and Sundeen (1991) cited in Lobelo (2004), stated that by listening to patients and by giving them the support they need, is an important aspect in the nurse patient relationship.

Kreigh & Perko (1988) cited in Lobelo (2004), indicated that a positive attitude which is a necessary foundation in the nurse’s practice, will promote her appropriate and meaningful intervention with patients. Personal worth, open-mindedness, advocacy, hopefulness and involvement are attitudes that enable the nurse to provide the best possible nursing and a personal worth attitude is when nurses respect, tolerate and understand other peoples’ culture (Kreigh & Perko, 1988 & Tadd, 1998 cited in Lobelo, 2004).

## **CONCLUSION**

This chapter has covered the respondents’ perceptions of possible contributing factors toward aggression and violence in mental health inpatient facilities. The supporting literature focused on the external and situational models identified by Duxbury (2002:327) as a theoretical framework for this study.

When respondents were asked to describe their perceptions, experiences, views and thoughts of the factors that may contribute toward aggression and violence in the ward, it was found that the following environmental factors were perceived as contributing factors: firstly, living conditions pertaining to unhygienic surroundings, dirty bedding, quality and quantity of food, inadequate resources for daily needs, lack of privacy, noise levels, seclusion, crowding, limit setting, ward activities and disrespect toward culture, religion and rights and secondly, ward atmosphere pertaining to safety in the ward, attitude and behaviour of staff which influence ward atmosphere and smoking habits of patients.

During the interviews it became evident from respondents' experiences that they also perceive the staff/patient interaction as a contributing factor toward aggressive and violent behaviour in the ward. While some patients were satisfied with the manner in which aggressive and violent incidents were handled, the general perception was that the management of such behaviours was deficient. As a result, patients felt insecure because their needs were not being addressed which in return aggravated the aggressive outbursts. These perceptions are supported by researchers such as Rabinowitz and Mark (1999) whose findings confirmed that increasing the number of nursing staff members in order to meet the demands of patients, might reduce aggression more adequately. Studies done by Noble, et al. (1999) also indicated that there is a positive relationship between a negotiated approach and patient satisfaction.

Nursing staff working with patients with a mental illness should consistently be aware of the recognition, prevention and therapeutic management of aggressive and violent behaviour in mental health facilities. A theoretical understanding of violence will help staff to design management strategies for the management of patients displaying aggressive and violent behaviour. The researcher supports the recommendations by Blair and New (1991) and Wilder and Sorenson (2001) that staff can reduce incidents of assault by recognizing the risk factors and designing styles of interventions with these factors in mind.

Comprehensive assessment and treatment planning can decrease the likelihood of violent behaviour among psychiatric in-patients. This study found, however, that

nursing and security staff do not always manage patient aggression and violence in a constructive manner e.g. they threaten patients with seclusion or shout at patients. It was felt by study patients that if communication between staff and patients could improve. This in turn would give patients more confidence and freedom to discuss their problems, needs and frustrations with the staff. These assertions correspond with the findings by Whittington and Wykes (1996); Nijman, et al. (1999) and Duxbury (2002) that negative nursing staff attitudes and poor communication styles contribute to aggressive and violent behaviour in mental health in-patient facilities.

This study reveals that the occurrence of aggressive and violent behaviour in the two psychiatric in-patient facilities concerned is of great concern. It appears that patients' psychopathology (internal factors) is not solely responsible for their aggressive and violent behaviour; environmental (external) and nursing staff (situational) factors also play an important role.

In general, the results of this study are in most areas consistent with findings of previous research concerning the variables associated with aggressive and violent behaviour. The next chapter summarizes the findings and the conclusions arising from this study

## **CHAPTER FIVE**

# **A SUMMARY OF FINDINGS, RECOMMENDATIONS, THE PROBLEMS EXPERIENCED DURING THE RESEARCH, AND CONCLUSIONS.**

### **5.1 INTRODUCTION**

This chapter presents a summary of the major findings. It should be recognized, however, that while the theoretical framework (External and Situational models) employed was useful in separating contributing factors towards patients' aggressive and violent behaviour, considerable overlap and interplay between these factors exist. The problems experienced during this research will be described.

The recommendations and conclusions reached from this research study are based on findings of the investigation conducted at Lenteguur and Valkenberg hospitals regarding patients' perceptions of contributing factors toward their aggressive and violent behaviour after admission to a mental health facility.

The final results and recommendations of this study will be sent for perusal to the relevant management structures of the two institutions where the study was conducted. The recommendations can possibly contribute to the improvement of mental health nursing care practices in order to prevent and manage aggressive and violent behaviour in mental health facilities. Recommendations are made for further research.

### **5.2 SUMMARY OF FINDINGS**

From the results of this study, it is abundantly clear to the researcher that patients' mental illnesses are not the sole causes of aggressive and violent behaviour in mental health institutions. After admission to hospital, several environmental and staff/patient interaction factors also play a role.

Patients' perceptions of the environmental and situational factors that contribute toward their aggressive and violent behaviour are summarized under the following categories and themes:

### **5.2.1: CATEGORY 1: ENVIRONMENTAL FACTORS (EXTERNAL MODEL)**

#### **Theme 1: Living Conditions**

The respondents verbalized that they are frustrated with the unhygienic conditions of the bathroom, toilets, seclusion room and kitchen which is described by patients as "*filthy and messy*". Respondents were unhappy about the state of the bedding because it "*smell of urine and vomit*" is "*filthy and torn,*" while others said there was sometimes not enough bedding for all the patients.

Most respondents experienced considerable dissatisfaction with inconsistent or rigid limit setting practices, as well as inflexible implementation of ward rules, restrictions on smoking, refusal to participate in required activities, or when they do not get immediate attention, as one of the respondents stated: "*if we are noisy or have different opinions, we are threatened with seclusion*". The majority of respondents expressed that they are forced, 24 hours a day, to be in close proximity of other patients and staff with whom they did not choose to be (lack of privacy). Respondents voiced their frustration with regard to the lack of space and crowding. Other living conditions which were perceived as contributing factors toward their aggressive and violent outbursts were too few recreational activities which result in boredom, poor quality and inadequate bedding, too few toothbrushes, and food which is often too little and served cold, nursing staff members whom are not always consistent with visiting hours, lack of space in smoking areas, excessive noise levels, no provision to accommodate the needs of different cultures, and overtones of racism.

#### **Theme 2: Ward atmosphere.**

According to the respondents, physical environment and ward atmosphere often felt "*threatening, disorganised and frightening*". Patients with different mental health problems e.g. bipolar (both manic and depressive phases) are often confined simultaneously in a ward, which cause tension and frustration amongst patients.

Much frustration was verbalised from issues around smoking. The non-smokers have to endure the smokers, and the smokers feel unhappy because those smokers who do not have their own cigarettes continuously *“beg from them, or steal their stuff”*. Respondents also verbalised their frustration with the nursing staff who *“do little about these problems”*.

Some of the respondents felt unsafe in the ward for various reasons, such as their personal belongings getting lost or stolen, which cause friction between the patients, nursing staff and their families, and the fact that some male nursing staff came on duty under the influence of alcohol which scared them.

## **5.2.2: CATEGORY 2: FACTORS RELATING TO STAFF/PATIENT INTERACTION (SITUATIONAL MODEL)**

### **Theme 3: Staff/patient interaction**

Most of the respondents verbalised that they feel neglected, frustrated, angry and dissatisfied with the behaviour of most of the nursing staff: *“They do not listen to us when we expressing our feelings, or they are just not available, especially in times of crisis”*. Furthermore the responses can be summarised as follows:

- nursing staff are not always able to detect the warning signs of potential violence e.g. increasing irritability, verbal outbursts against staff, fellow patients and other types of behaviour which can be interpreted as “testing” or acting out;
- unsympathetic, rude, and verbally aggressive communication styles between staff members and patients, little respect shown to the patients;
- failure of nursing staff to communicate positive expectations to their patients,
- failure or excessive delay in assisting the potentially violent patient to explore alternative methods of expressing their feelings;
- factors such as low staff morale, a lack of adequate training, a lack of leadership in some areas, poor communication, administrative inefficiencies and hostile divisions between nursing sectors all contribute to the escalation of patient frustration and
- security staff, with no training in patient care, is often left alone with patients.

### **5.3 RECOMMENDATIONS.**

Based on the findings of this study, and following the themes identified, the following recommendations can be made of how nursing staff can create a therapeutic environment and reduce, or eliminate certain of the factors that may contribute towards patient's aggressive and violent behaviour:

According to Rawlins, et al. (1998) a therapeutic milieu is an environment that promotes optimal health and the well being of patients with mental illness in a safe and non-threatening environment. To ensure that this statement becomes a reality, the Mental Health Care Act was promulgated in 2002 to protect patients with mental illness and their belongings. Based on these principles, the following can be done with regard to the living conditions, ward atmosphere and staff/patient interaction:

#### **Theme 1: Living Conditions**

##### **1.1 Hygiene of ward environment and bedding**

- All areas including bedding should be clean and tidy;
- Ensure that routine cleaning procedures are carried out according to the hospital routine and when necessary;
- Floors should be washed with water and soap daily and kept dry and clean at all times;
- Patients should be educated not to smoke or eat in the bathrooms;
- A rubbish bin should be placed in the bathrooms.

##### **1.2 Quality and quantity of food**

Although it is not always possible to serve meals as scheduled, ensure that patients be informed if there are any delays. Steps should also be taken to ensure that:

- the kitchen will be informed of the exact number of patients to be fed;
- food should be served warm warm;
- no staff member should be allowed to eat patients' food;
- the kitchen staff responsible for the preparation of food should be informed about patients' complaints regarding the quantity and quality of food and
- kitchen staff should be informed of patients food preferences and special diets of patients, wherever possible.

### **1.3 Availability of resources for daily needs**

- Ensure availability of daily personal care such as shampoo, face clothes, towels and toilet paper in order to encourage good hygiene habits and reduce frustration levels.

### **1.4 Privacy**

- Privacy in toilets, bedrooms and bathrooms should be provided and respected;
- An area where private telephone conversations are possible should be provided;
- An area where patients can choose to be alone;
- Areas where patients can have private conversations with relatives and friends.

### **1.5 Noise levels**

- Noise levels should be controlled. Ensure that patient's culture and music preference should be taken into consideration when playing TV and music;
- Take notice of patients' complaints regarding the intolerable loudness of the TV and music;
- Patients who are not in control of their emotions should be therapeutically managed in order to prevent that they disturb other patients which might provoke anger.

### **1.6 Seclusion**

This study revealed that the majority of the patients have negative viewpoints regarding seclusion. However, it is impossible to manage severely emotionally disturbed patients with aggressive or violent behaviour without some form of seclusion, physical or mechanical restraint. These techniques not only help to control patients, but it is also effective to prevent injuries and to reduce agitation. All nursing staff should however, be aware of the legal and ethical issues related to physical management strategies. As noted in the Mental Health Care Act 17 of 2002, any staff member can face charges of misconduct if a patient is neglected while in his/her care. Another helpful technique is to provide a "time out" room which provides a quiet space and a cooling - off period for emotionally disturbed patients. In addition, a room with a punch bag can be provided in order for them to get rid of their frustrations and anger.



### **1.7 Crowding**

- Ensure adequate body space;
- Ensure adequate space in bed rooms, smoking rooms and daily living areas;
- Increase the number of nursing staff to supervise patients;
- Adequate natural lighting and ventilation;
- Temperature and ventilation should be adequately controlled.

### **1.8 Limit setting**

- Reducing threatening communication styles by nursing staff;
- Nursing staff should change their attitude and limit setting strategies;
- Nursing staff should be more aware of patients' fear, anxiety, frustration, feelings of intimidation and victimization;
- Whenever possible, patients should be able to leave the ward (in non-secure units) as physical restriction is counterproductive to the reduction of violence. Similarly, wherever possible, service users should have access to open space, for example somewhere to walk around and exercise and to get fresh air;
- Involve patients with the formulating of new ward rules e.g. smoking and visiting times ;
- Ensure that ward rules and the purpose therefore are well understand by all patients;
- Increase communication between patient/staff e.g. explaining expectations and rules while in the ward through reinforcing the established structure such as routine rules of the therapeutic environment.

### **1.9 Ward activities**

- To provide safe, adequate, more regular and realistic activities inside and outside the ward;
- Every ward to ensure that a structured program, according to patients' needs, exists.

### **1.10 Respect toward patients' culture, religion and rights**

- Accept patients unconditionally-irrespective of their behaviour;
- Establish how respect is conveyed in different cultures;
- Be aware of a patient's cultural background when care is planned;
- Avoid circumstances that humiliate patients by forcing them to do anything that is against their religion e.g. dance;

- Inform patients on admission of their human rights;
- The rights and integrity of patients of all patients must be protected at all times.

### **Theme 2: Ward atmosphere**

Every effort should be made to reduce anxiety by creating a more safe and homely atmosphere, including 24- hour access to facilities, such as the television room (many service users have sleeping problems), having the facility to keep one's own clothes, access to private telephones, etc. Also, patients' personal belongings should be keeping safe and accessible, patients should be encourage to respect each other's privacy, and to treat other patients' property as private. To ameliorate the issues around smoking:

- Consideration should be given to improve the environment of smoking rooms, which should be of adequate size;
- To strictly implement the laws pertaining smoking, providing smoke-free zones;
- Increase the amount of nursing staff to supervise patients in the smoking area,
- Listen empathically to patient's complaints and do not threaten them with medication, injections or seclusion;
- Encourage patients to express their feelings in a non-threatening environment.

### **Theme 3: Staff/patient interaction**

The Nursing Act 50 of 1978 and Regulations 2598, 378 and 1206 regulate the nursing profession and exercise control over the nursing profession, nursing education, and determine the scope of practice of the registered and auxiliary nurse (South African Nursing Council, 1994). It is therefore critical for health care providers and training institutions of all categories of nursing to ensure that the training, education curricula for health workers and the supply of nurses form an integral part of the transformation of health services in South Africa. Therefore, it should be a priority at all the training institutions and of all employers to ensure the highest standards of practice for psychiatric nurses in South Africa.

Nursing staff working with patients with mental illness should constantly be aware of the prevention, recognition and therapeutic management of aggressive and violent

behaviour in mental health facilities. Organizations therefore need to ensure that appropriate training and ongoing education for all nursing staff are in place regarding this issue, and to periodically reassess the level of risk for the patient, fellow patients and nursing staff periodically. This information should be based on the results of regular audits of the problem and a comprehensive review of current hospital policies regarding the management of patients presenting with aggressive and violent behaviour, as well as seclusion. Interventions such as medication, physical restraint and seclusion should never be used as a punishment or threat. Nursing managers should actively involve nursing staff when planning in-service training programmes which will keep them on track with what has to be done to ensure the smooth running of a ward.

The primary goal of mental health nursing care is based on a humanistic approach namely, the client's physical, emotional, intellectual, social and spiritual dimension (Rawlins, et al. 1998). However, according to this study, patients' perceptions are that nursing staff do not deal adequately and professionally with the aggressive patient, neither do they have the skills on how to prevent aggressive and violent behaviour in wards. The respondents' recommendations can be summarised as follows:

- Reducing threatening communication styles by nursing staff and to change their attitude and limit setting strategies;
- Nursing staff should be more aware of patients' fear, anxiety, frustration, feelings of intimidation and victimization;
- Increasing communication between patient/staff e.g. explaining expectations, privileges and rules while in the ward;
- Spending more time with nurses, in a structured way, to allow patients to ventilate their feelings;
- To be honest with them about the side effects of medicines instead of making jokes of their complaints.

The researcher agrees with the following recommendations, based on research done by Beck and Roy (1996); Harris and Rice (1997); Gournay (1997); Wick (1998); Van Der Slot (1998); Noble, et al. (1999) and Palmer (s.a.) which could serve as universal

guidelines for aggression management training programmes for nursing staff working in mental health facilities:

- Support research on the experiences of nursing staff regarding violence in the workplace as a basis for developing strategies to address the problem;
- Generate policies and procedures to articulate the hospital's commitment to a humane response when staff or patients are injured in the workplace;
- Organize a series of workshops for all levels of nursing staff to discuss individual and organizational responses to violence; and
- Review and audit data with regard to patient's assaults on nursing staff in order to develop staff safety programmes.

The researcher suggests that a committee could be established, representing managers and senior mental health nursing staff from all the mental health hospitals in the Western Cape, in order to facilitate the above guidelines. Furthermore the researcher recommends that nursing staff who interacts with patients with a mental illness need to monitor themselves with regard to the following:

- ability to use anger constructively and not to take the anger of the clients as personal insults;
- capacity for clear, non-abusive verbal communication;
- ability for self-analysis;
- ability to listen;
- skills to establish and maintain empathic linkages with clients;
- ability to understand their own fears and anxieties about violence and to believe that violent mentally ill clients are treatable;
- to practice according the rules and regulations prescribed by the South African Nursing Council;
- To incorporate the principles of Batho–Pele in the care of all patients.

#### **5.4 PROBLEMS EXPERIENCED DURING THE STUDY.**

Interviews were mostly in English and Afrikaans; a few were translated by the interpretator from Xhosa to English. In theory, the use of an interpreter could have resulted in distortion of the originality of the perceptions of the respondents.

Although the selection criteria for recruiting study subjects were thoroughly discussed with the nursing staff, the researcher experienced difficulties with some nursing staff in that they wanted to choose “suitable” respondents. Some potential respondents refused to be interviewed because they felt intimidated by the nursing staff. The researcher then had to ask the next patient after that, according to the selection schedule. In two of the wards, nursing staff told some of the respondents “*not to talk nonsense or say too much*” during the interviews, which could have resulted that they did not share all their perceptions with the researcher – it is not possible to quantify the extent of such potentially negative influences. Indeed, the researcher was occasionally questioned by nursing staff “*whether she is there to spy on them*”.

Although some of the identified patients were willing to be interviewed, they were unable to wait for the scheduled interview time with the researcher due to the fact that they were discharged on that day and were waiting for their relatives to fetch them. The researcher accordingly had to ask other patients to participate. Others told the researcher they do not have a clear understanding what they have to do and preferred not to participate.

Transcribing the recorded interviews was difficult and exhausting, because the researcher had to do write down everything manually, while some of the respondents spoke inaudibly which slowed the transcribing process. Furthermore, there was considerable overlap between the external and situational factors in all the patterns which emerged from the responses.

## **5.5 CONCLUSION.**

A qualitative and explorative research study was conducted with patients who had been admitted for at least seven days in a pre-discharge ward in either Lentegeur or Valkenberg mental health facilities. Four questions were posed to the participants:

- How do you experience the atmosphere in the ward?
- Can you describe the attitudes of staff towards their patients?
- Describe your feelings, perceptions, thoughts, and views of the factors which may contribute towards aggression and violence in the ward.

- How do you think similar kinds of incidents can be avoided in future?

The researcher acknowledges that the study of patients' perceptions of the possible causes of aggression and violent behaviour could have been biased by such factors as fear of victimization and their underlying psychopathology. Therefore the researcher recommends that further studies, similar to this one, but on larger populations of patients in different settings, should be encouraged. It would be of considerable value in increasing the accuracy of the data and in further refining the conclusions and recommendations of this study. A better theoretical understanding of violence will assist nursing staff members to design and develop meaningful and effective management strategies.

Psychiatric nurses should ideally be fully aware which factors in the environment, and those relating to staff-patient interactions, contribute towards patients' aggressive and violent behaviour after admission to hospital, in order to ensure a therapeutic milieu for their patients wherein these patients will feel safe and in which their rights are respected (Mental Health Care Act 17 of 2002).

In conclusion, if health care providers aim to minimise the implications of aggressive and violent behaviour, then the old adage that "prevention is better than cure" should be an important focus of the management of patients in mental health facilities.

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## **APPENDIX A**

### **OUTLINE OF SEMI-STRUCTURED QUESTIONNAIRE: KEY QUESTIONS USED DURING ROUTINE PATIENT INTERVIEWS.**

1. How do you experience the atmosphere in the ward?
2. Can you describe the attitudes of staff towards their patients?
3. Describe your feelings, perceptions, thoughts, and views of the factors which may contribute towards aggression and violence in the ward.
4. How do you think similar kinds of incidents can be avoided in future?



## **APPENDIX B**

### **INFORMATION SHEET FOR PATIENTS.**

**Title:** “An investigation into patients’ perceptions of contributing factors towards their aggressive and violent behaviour after admission to a mental health facility”.

**Researcher:** Evalina van Wijk

MCur Nursing University of the Western Cape.

As a Master of Science (Nursing) student at the University of the Western Cape, I am conducting a research study as part of my degree. My research proposal was submitted to the University of the Western Cape’s Higher Degrees Committee.

I wish to explore the internal, situational and environmental factors that might possibly be contributing towards aggression and violent behaviour in mental health inpatient facilities.

I shall be audiotaping interviews with patients. These tapes will be transcribed and, on completion of the study, will be destroyed. Your name will not appear in the transcripts of the interviews, or in any reports relating to the research. Interviews will take place at a time that we both agree upon.

With your permission, I shall consult your clinical file in order to ascertain the reason for your admission.

Before participating, you will be asked to complete a form, which indicate your willingness to participate. You may withdraw from the study at any stage without any prejudice. You are free to speak with others before consenting to participate in this study.

**APPENDIX C**

**PARTICIPANT CONSENT**

**Title:** “An investigation into patients’ perceptions of contributing factors towards their aggressive and violent behaviour after admission to a mental health facility”.

**Researcher:** Evalina van Wijk.

I, (name) ..... have read the “Information sheet for patients” and agree to participate in this study.

The researcher has explained the nature and purpose of the study to me in my language of choice. I agree that the researcher may consult my clinical file in order to ascertain the reason for my admission. I understand that the confidentiality of the data, and the need to keep it anonymous, will be respected at all times. I may change my responses, or I may withdraw from the study at any time, without redress. I understand that I have the right to speak with others before consenting to participate.

-----  
SIGNATURE OF PARTICIPANT

-----  
SIGNATURE OF RESEARCHER

DATE:.....

DATE:.....

## **APPENDIX D**

### **ULWAZI OLULUNGISELWE ABANTU ABAZA KUTHABATHA INXAXHEBA KOLUPHANDO.**

**Isihloko:** "Uphando ngezinto ezenza izigulane zibe bukhali, zilwe emva kokulaliswa kwindawo zabagula ngengqondo."

**Umphandi:** Evalina Van Wijk

Imfundo enomsila kwezokonga kwidyunivesiti yasentshona koloni.

Njengomfundi kwiziqu ezinomsila kubongikazi kwidyunivesiti yasentshona koloni, ndenza uphando njengenxalenye yesifundo zam. Izicwangciso zophando ndizinikezele kubaphathiswa abaphambili abanyuliweyo kule dyunivesiti.

Ndinqwanela ukuhlola ndiphanole ngezinto ezibangqongileyo neemeko abazifumana bekuzo ezinokubangela umsindo kwimeko yesigulo sabo abakwindawo zabagula ngenqondo

Ndiza kusebenzisa itape xa nolibuza imibuzo kwizigulane. Yonke ingxelo yetape izakukhutshelwa ize itshatyalaliswe xa kugqityiwe. Igama alisayi kubhengezwa naphina kuluphando.

Siya kuvumelana ngexesha lokuthetha sobabine. Ngenvume yakho ndiza kujonga ifile ukuqonda isizathu sokulaliswa kwakho.

Umntu othabatha inxaxheba uyakusayina isivumelwario anokurhoxa nanini na kuso. Angalufuna uluvo lwabanye abantu phambi ko kwenza isigqibo.

## APPENDIX E

**Isihloko:** "Uphando ngezinto ezenza izugulane zibe bukhali, zilwe emva kokulaliswa kwindawo zabagula ngengqondo."

**Umphandi:** Evalina Van Wijk

Mna(igama) ..... ndiyifundile yonke ingcaciso malunga nomphathi nxaxheba, ndiyavuma ukuthatha inxaxheba koluphando.

Umphandi undicacisele injongo yoluphando ngolwimi endilwaziyo. Ndiyavuma ukuba umphandi angayijonga ifile yokugula kwam ukuze ayazi ukuba ndilaliselwentoni esibhedlela. Ndiyazi ukuba yonke into azakuyifumanisa izakuba yimfihlo negama lam liyakuhlonitshwa ngalo lonke ixesha. Ndingarhoxa nanini koluphando. Ndinelungelo lokuthetha nabanye abantu ngaphambi kokunika imvume ngophando.

-----  
UKUSAYINA UMPHANDI

UMHLA:.....

-----  
UKUSAYINA UMTHATHI

NXAXHEBA

UMHLA:.....

## APPENDIX F

### INFORMASIE BLAD VIR DEELNEMERS

**Titel:** “ ‘n Ondersoek betreffende pasiente se persepsies van die bydraende faktore tot hul aggressiewe en gewelddadige gedrag na toelating tot ‘n geestesgesondheid fasiliteit”

**Navorsers:** Evalina van Wijk  
M Cur Verpleging, Universiteit Wes-Kaap

As ‘n magister student in Verpleegwetenskap by die Universiteit Wes-Kaap doen ek ‘n navorsings studie as deel van my graad. My studie voorstel is voorgelê aan die Universiteit Wes-Kaap se Nagraadse Komitee.

My doel is om die interne, omstandigheds- en omgewingsfaktore te ondersoek wat moontlik kan bydra tot aggressiewe en gewelddadige gedrag in Geestesgesondheid binnepasient-fasiliteite.

Ek sal die onderhoude met pasiente op ‘n band opneem. Die bande sal, na dit op papier geskryf is, skoongevee word. U naam sal nie op die oorgeskrewe rekord verskyn nie, ook nie in die navorsingverslae nie. Onderhoude sal gereel word vir ‘n tyd wat u en myself pas.

Met u toestemming sal ek u kliniese rekord naslaan om die rede vir u toelating vas te stel.

Voor u deelneem, sal u gevra word om ‘n vorm te teken dat u toestem om deel te neem. U mag onttrek van die studie op enige stadium sonder enige benadeling. Dit staan u vry om met andere te praat voor u toestem om deel te neem aan die studie.

## APPENDIX G

### DEELNEMER SE TOESTEMMING

**Titel:** “ ‘n Ondersoek betreffende pasiente se persepsies van die bydraende faktore tot hul aggressiewe en geweldadige gedrag na toelating tot ‘n geestesgesondheid fasiliteit”

**Navorsers:** Evalina van Wijk

Ek, (naam).....stem hiermee saam om deel te neem aan die studie.

Die navorsers het die doel en metodes van die studie aan my verduidelik in die taal van my keuse. Ek gee toestemming dat die navorsers my kliniese rekord kan raadpleeg om die rede vir my toelating vas te stel. Ek stem saam om deel te neem en dat die onderhoud op band opgeneem kan word. Ek verstaan dat die vertroulikheid van die data, en die nodigheid om dit anoniem te hou, ten alle tye gerespekteer sal word. Ek mag my antwoorde verander, of ek mag my van die studie onttrek ter enige tyd, sonder enige nagevolge. Ek verstaan dat ek die reg het om met andere te praat voor ek toestem om deel te neem.

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HANDTEKENING VAN DEELNEMER.

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HANDTEKENING VAN NAVORSER.

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DATUM

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DATUM

## **APPENDIX H**

Attached:

1. Approval letter from UCT Research Ethics Committee to conduct study at Valkenberg Hospital.
2. Approval letter from medical superintendent, Valkenberg Hospital.
3. Approval letter from Lentegour Hospital Research Committee.



Research Ethics Committee  
Faculty of Health Science  
E46-26 Old Main Building, Grootte Schuur  
Hospital, Observatory, 7925  
Queries : Xolile Fula  
Tel:(021)406-6492 Fax:406-6411  
E-mail : Xfula@curie.uct.ac.za

14 May 2004

REC REF: 076/2004

Mrs E van Wijk  
14 Ullswater Street  
Pinelands  
7405

Dear Mrs van Wijk

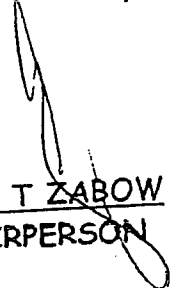
AN INVESTIGATION REGARDING CONTRIBUTING FACTORS WHICH MAY INFLUENCE  
PATIENTS' AGGRESSIVE AND VIOLENT BEHAVIOUR AFTER ADMISSION TO A MENTAL  
HEALTH FACILITY

Thank you for submitting your study to the Research Ethics Committee for  
reviewal.

It is a pleasure to inform you that the Research Ethics Committee has  
formally approved the above mentioned study.

Please quote the above Rec. reference number in all correspondence

Yours sincerely

  
PROF T ZABOW  
CHAIRPERSON



iries : M. Erasmus

rence :  
vysing :

ophone : 370-1403  
efoon :

te : 16 Feb 2004  
tum :

Provincial Administration : Western Cape  
Department of Health

Provinsiale Administrasie : Wes-Kaap  
Departement van Gesondheid

Uzawulo Lwephondo : Intshona Koloni  
Isebe Lezempilo

Geagte Mev Van wijk,

Navorsing: M Cur tesis

Baie dankie vir die aangepaste pasiente toestemmingsvorm sowel as die inligtingsvorm.

Ons het ook die deklarasie vanaf u promotor ontvang soos versoek.

Dit lyk asof alles nou in orde is en dat u met u navorsing kan begin.

Ons herinner u net aan die besluit by ons navorsings komitee vergadering dat u my sowel as die betrokke dokters en verpleegpersoneel moet inlig alvorens u begin.

Ons wens u alles van die beste toe en hoop die tyd wat u by Lenteguur Hospitaal spandeer sal baie vrugbaar wees.

*M. Erasmus*

M. ERASMUS.

Namens navorsings komitee

Lenteguur Hospitaal  
P.K. MITCHELLS PLAIN  
7785  
Tel. (021) 370 1111

Lenteguur Hospital  
P.O. MITCHELLS PLAIN  
7785  
Fax (021) 31 7359

Address all correspondence to the Senior Medical Superintendent.  
Rig alle korrespondensie aan die Senior Mediese Superintendent.

## APPENDIX I

“Patients’ perceptions of contributing factors towards their aggressive and violent behaviour after admission to a mental health facility”.

**Transcription of interview no. 4 to demonstrate the method followed in analyzing the data.**

**Key:-**

Researcher = Res

Patient = Pt

**Res:** Please explain to me how do you perceive the ward atmosphere in the ward?

**Pt:** I found the atmosphere in the ward not nice.

**Res:** Mmm...tell me what do you mean?

**Pt:** Since I came over to this ward, I feel a little bit more relaxed. In the other ward where we were locked in for the whole day was a nightmare. In that ward you must keep your mouth otherwise they (he starts mentioning names of nursing staff) the nurses are very angry and will punish you if you dare start complaining about anything in the ward.

**Res:** Mmm...What do you mean by punish?

**Pt:** They keep you longer there and sometimes some of the male nurses on night duty stinks of wine, but they can do what they want because they told us they are in charge of us. One night one of the patients tells him (the night nurse) he does not feel okay from the medication. The male nurse - not from this hospital told the patient “I am not from here, so I do not know what medicine you get and you will have to wait for the Dr to see you tomorrow. Luckily, one of the hospital nurses came to give him some medicine for the side effects which make him very sick.

**Res:** Mmm

**Pt:** Since I came here, I feel better. Although some of the nurses are a little bit friendlier, the rules in the ward are so strict. The nurses forced us to go to the climate meetings and when you told them you do not like it because it if you say something there are always fights afterwards. Then they told us “you must all go”. The nurses go from patient to patient asking us to say something, but they not really allow us to say our say or how we

really feel. When you said something they do not like, they will stop you and asked the next patient to start. Although they have an excuse that we must get finished because the group activity must start is not absolutely correct because they do not want to hear any negative things from us.

**Res:** Mmm

**Pt:** We are sometimes so afraid to open our mouths because we are scared for our safety.

**Res:** Why?

**Pt:** If you dare to say something that is negative about the ward and nurses, they make your life hell here.

**Res:** Mmm... What do you mean by saying that?

**Pt:** They deny you to visit your family for the weekend if you did do something wrong during the week-and you know we all look forward to a weekend out of this jail.

**Res:** Mmm... Is it all the nurses you refer too?

**Pt:** No, it is only the other shift that is like that. This shift is more flexible with visiting hours. The nurse on the other shift with the long hair will tell you straight "Your family must know by this time what the ward rules are. These make us very angry and confused because on certain shifts we are allowed to do things without being punished while the other shift treat us with an iron fist.

**Res:** Mmm

**Pt:** We, must always hear that the nurses do not get enough money for their hard work but why must they always come and go from the ward leaving us alone with a security guard that not do anything with us, she sits and sleep the whole day and if we dare to bother her with our concerns, she became very agitated. Although I said here are not enough nurses to look after us - some days here are enough but they are always busy -either in the kitchen eating or in the office busy on the computer.

**Res:** Mmm.

**Pt:** I can say in this ward the patients do not fight so much as in the locked ward, maybe is it because we are more free - some of us go to the OT (occupational therapy) during the week. But over weekends it is very quiet because we come from far and further here is very little to do. Another thing I notice is that those patients who stay in the ward during the week fight more about antjies (cigs) and eats after visiting times. Some of them hurt themselves out of frustration - they hit their fists against the walls.

**Res:** Mmm.

**Pt:** What me and of the others do not understand is why must we go so early to bed. We know there must be rules but to go so early to bed is the things that upset us. One evening I say to the nurse in a nice manner that I cannot go to bed so early because I am busy to watch an interesting program on TV. The nurses then put off the TV and grab my arm and pushed me into my room and throw me on my bed. I was very aggressive and kicked the door and throw my belongings very hard on the floor.- Please believe me, I was very upset.

**Res:** Mmm.

**Pt:** Every time we mentioned this on the climate meetings, but nothing happened. We are forced to stay in our rooms everyday from lunch till about 14.30 and if you dare coming out of there the nursing staff scream and swear at us and threaten us with "You must be careful you will go back to seclusion or do you want an injection - then you can see who the boss is here".

**Res:** Mmm...How let it feel you?

**Pt:** I am angry and very frustrated not only with the nurse, but if you can see the bathrooms.

**Res:** Mmm...What do you mean?

**Pt:** It is messy. Some of the patients - most of us smoke and yes we are ill and some of us are more ill than others but they use the basins and toilets as rubbish bins. Some of the patient's pass urine on the floor and the cleaning staff takes their time to clean it. We are very unhappy when we talk on the climate meetings about it - the nurses are very unsympathetic, they said we must remember this is a mental hospital and patients are sick. I know all of this, but don't care whether we fell on the slippery floors. I must say if nurse (he mentioned a name) is working we are so afraid, we are told by him and one of the others - I can't remember his name to shut our mouths.

**Res:** Mmm...What else do you think contribute to patient's aggressive and violent behaviour?

**Pt:** Here in this ward it is a little bit better because we are more free to walk to the OT or to the tuck shop where we hang around till lunch time. In the close ward it is hell. You feel like you are in jail. There is nothing going on - at least when here are students they invite us to their groups. I must say the people are calmer here as in those wards. Some of us are going to the occupational therapy - I personally do not like it here, but it is better than there.

**Res:** Mmm... Can you describe the attitudes of nursing staff towards their patients?

**Pt:** Some times you feel very sleepy from the tablets. One day I was so frustrated because all I told the nurse was that the tablet made me drowsy and I refuse to drink the blue tablet she gives me. The nurse then said: "You will drink it because the Dr said so. I raise my voice and the next moment she and two other nurses grab me and pushed me to the medicine room where they give me an injection.

**Res:** Mmm...Can you tell me who the she is you talk about?

**Pt:** She is the in charge here.

**Res:** Mmm...Okay you can go on.

**Pt:** I was then sent back to seclusion where I was left alone. It is terrible. There was no pee pot, the walls were filthy, and the blankets were dirty. It was covered with dry vomit-I feel sick and yes I am a poor person but my parents at least see that our home is clean. One night a male nurse, a Mr. (name was mentioned) was so angry with me because there were not enough blankets and pillows in the ward for all of us and when we asked for it he said: "Do you think the government have enough money to buy more? I then said to him I do not like this type of comments. He then said to us "if you people are not happy here why are you not rather go to private hospitals". I do not like the way he and others talk to us. He is arrogant and full of him self. What also made us angry here in this ward is the food. The portions are far too small and more than once the nurses sit nicely and eat our food especially in the afternoon and when we asked for more, they said: "You are already too fat – just look in the mirror. This is not nice to hear. It hurts.

**Res:** Mmm

**Pt:** We are treated like criminals. If you complain the nursing staff makes ugly comments. I do not want to mentioned names but because you said you will not mention our names - more than one time there are not enough face cloths and tooth brushes. We use each others' face cloth and use our clothes of the previous day to dry us. The other thing is when a person asking for toilet paper because most of the time there is not enough and we must ask our family's to bring for us from home. My family is very poor but they said they cannot stand it that I am so frustrated that they rather will ask their friends for toilet paper. My family said they are going to report this to the matron, but I asked them to rather keep quiet because I am too scared of what can happen to me.

**Res:** Mmm...What do you mean?

They argue with each other sometimes we hit each other but there are no nurses to see it and if they see it they are too weak to manage it. They swear at these patients and then the patients became more aggressive.

**Res:** What are the patients doing then?

**Pt:** They break things.

**Res:** Like what?

**Pt:** Once one patient grab one patient's watch and breaks it.

**Res:** What was the reaction of the other patients?

**Pt:** They all then start fighting that patient.

**Res:** Mmm...Do you want to tell me more?

**Pt:** It is not nice here at all - This is all I can say.

**Res:** Mmm...How do you think similar things like you mention can be prevent in future?

**The tape recorder stopped. Tape changed.**

**Res:** Sorry about that. Please can we go on?

**Pt:** I will like it if we can have better food and that the hospital matron can see that our ward is clean.

**Res:** Mmm...Anything you want more to say?

**Pt:** No nurse, nothing more.

**Res:** Thank you.

**Tape recorder switched off.**