LIVED EXPERIENCES OF NURSES WHO HAVE BEEN ASSAULTED BY PATIENTS AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE.

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ABSTRACT

Background: Nurses, because of their close contact with these patients, are frequently victims of assault. The aim of the study is to explore and describe the lived experiences of nurses, who have been assaulted by patients at a Western Cape psychiatric hospital. **Research Design:** A qualitative approach, using a phenomenological research design was used to achieve the aim of the study. The target population was nurses, who are employed at the hospital under study. A purposive sampling, consisting of six nurses, was selected to participate in this study. Data were collected by means of unstructured interviews with nurses who met the inclusion criteria. Data saturation was reached after the sixth individual interview. The interviews were audio taped and transcribed, verbatim, and field notes were taken, as well. Collaizi's method of data analysis was used to analyse the data and to identify themes and categories. The major themes that emerged were: Self-care incongruent to intrapersonal interest; Personal responses to trauma; Incongruence between patient behaviour and participant work experience; unprotected staff vulnerable to patient aggression; required and received supportive interventions. Ethical clearance was obtained from the Senate Ethics Committee at the University of the Western Cape. Permission to conduct the study was obtained from the Research Ethics Committee at a psychiatric hospital under study, as well as from the Department of Health, Western Cape. Participants were drawn from different units of the hospital. **Findings:** The findings revealed that nurses working at this psychiatric hospital frequently encounter assault and violence by patients, while providing care, to the extent that they view the workplace environment as unsafe and insecure. The way they experienced the assaults had some similarities; they all complained that they felt neglected by management after the assaults and that they experienced multiple bodily reactions to trauma. **Recommendations:** From the data gathered, it appeared that nurses were calling for support from those in authority, be it supervisors or hospital management. Some of the recommendations made by the researcher were: regular refresher courses on self-awareness training; counselling/debriefing; skills development workshops on management of aggression; and the feasibility of paying a special allowance to staff. **In conclusion:** The study revealed that lack of management support perpetuates the cycle of violence experienced, which, in most incidents, has a spill over effect in the personal lives of the nurses, who have been assaulted by patients. It is the researcher's belief that nurses should be supported in this stressful environment.

KEY WORDS

Assault

Experience

Nurse

Patient/s

Psychiatric hospital

LIST OF ABBREVIATIONS

APH: Associated Psychiatric Hospital

EN: Enrolled Nurse

ENA: Enrolled Nursing Assistant

ICAS: Independent Counselling Assistance Service

MHCU: Mental Health Care User

PTSD: Posttraumatic Stress Disorder

RN: Registered Nurse

SANC: South African Nursing Council

WHO: World Health Organisation

DECLARATION

I, Phikisile Thiery Yusi, do hereby declare that the study entitled *'Lived experiences of nurses who have been assaulted by patients at a psychiatric hospital in the Western Cape'* is my original work, that it has not been submitted for any degree or examination at any other University, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: Phikisile Thiery Yusi

Date: November 2015

Signed: ………………………………………..

DEDICATION

This thesis is dedicated to my late parents, Ntleki and Nomendile Yusi, who without any formal education encouraged me to study. They always believed that without education *'you are nothing'*.

ACKNOWLEDGEMENTS

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CHAPTER ONE   INTRODUCTION

1.1 .Introduction

s global concern (Moylan

& Cullinan, 2011). Rodriguez-Acosta, Myers, Richardson, Lipscomb, Chen and Dement (2010) assert that nurses are more at risk of becoming victims of violence than any other category of health care worker in a psychiatric hospital. Whittington (1996) and Nolan, Dallender, Soares, Thomsen & Arnetz (1999) revealed that violence in a psychiatric setting is very prevalent and nurses tend to be mostly subjected to violent acts, such as a slap, being hit by a weapon, threatened etc. International studies, such as those of Rodriguez-Acosta et al. (2008) concur with Whittington (1996) and Nolan et al. (1999) that the consequences of violence on nurses are psychological and physical trauma, powerlessness and the fear of being criticized by supervisors or managers. Contributing factors of patient violence against nurses in psychiatric hospitals include, but not limited to staff shortages, interpersonal conflict between patients and staff, restrictive policies and non-therapeutic approaches by staff (Fisher, 2003). Mental illness has also been identified by staff as a cause of patient aggression (Duxbury, 2002).
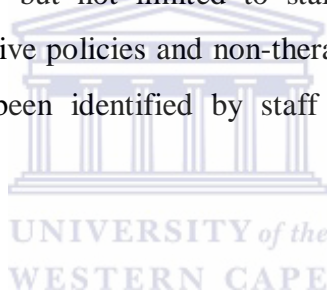
1.2. Background

Neuropsychiatric disorders are estimated to contribute up to 14% of the global burden of diseases, which is more than the burden of cardiovascular diseases or cancer (WHO, 2004). Furthermore, they account for a quarter of disability adjusted life-years (the sum of years lived with disability and years of life lost) in people (WHO, 2004). It is also estimated that 25% of the world's population will suffer from mental, behavioural, and neurological disorders, such as schizophrenia, mental retardation, alcohol and drug abuse, dementias, stress related disorders, and epilepsy, during their lifetime (WHO, 2004). Therefore, it is expected that some of these people would end up seeking psychological interventions at psychiatric hospitals for mental related disorders, care treatment and rehabilitation for conditions, such as schizophrenia, depression and substance abuse

The pressure on psychiatric carers is intensified, for them to deliver care to the different kinds of mental illness, namely substance induced psychotic disorders as more people seeking those

types of interventions. Often, patients, suffering from a mental illness related to substance abuse, have a tendency to be the perpetrators of violence. Violent attacks on health care staff by patients in psychiatric hospitals have been recognised globally as a matter of concern. According to Lawoko, Soares & Nolan (2004), although violence occurs in all occupational sectors, the area of psychiatric care is, however, associated with an increased risk of abuse and violence against healthcare workers. A study conducted by Moylan & Cullinan (2011) found that nurses were working under extremely high-risk conditions, and they were exposed to violence, such as strangulation and assaults that could lead to potentially fatal outcomes. These incidents of violence could have a negative impact on the emotional and physical well- being of nurses and the type of nursing care that they render. In addition, Bilgin (2009) asserts that nurses also have to contend with occupational stressors, such as low income and status, long working hours, as well as poor administrative and emotional support. In mental health settings, such variables are made worse by the prevalence and more dangerous stressor with a high level of violence directed to nurses by patients (Bilgin, 2009). Supporting the need for debriefing for employees, after incidents of violence, Flannery, Hanson & Penk (1994) emphasise that debriefed employees appear to recover quickly from patient assault.

Daffern, Howells & Ogloff (2007) confidently stated that research related to aggression indicate that 90% of assaults in psychiatric hospitals are directed towards nurses. Research finding have also shown that nurses are the main target of patients' assaults as they provide 24 hours care, are responsible for setting limits and administering the doctors' orders. These orders could be viewed, by the mentally disturbed person, as provocative, triggering the violence that increases nurses' vulnerability (Anderson & West, 2011). A survey about health and safety issues in the workplace by American Nurse Association on 4,826 nurses, as cited by Kindy, Petersen and Parkhurst (2005), found that 17% of the nurses had been physically assaulted, and 57% had been threatened verbally or verbally abused in the previous year. According to Kindy et al. (2005), 88% of the nurses also claimed that their health and safety concerns played a large part in their desire to leave the nursing profession.

There is various reasons alluded to about patients' violence. A study by Winstantley and Whittington (2004) showed that in 64% of aggressive incidents, the perpetrators (patients) of the aggression experienced some suffered i m p a i r m e n t in cognitive functioning at the time of the incidents. This is not only limited to acute and emergency units, but also to psychiatric settings, such as forensic wards, and child and adolescent wards, where

there is overcrowding, lack of personal space, restricted freedom and patients with a history of violence (Bilgin, 2009).

The researcher observed that nurses were assaulted by patients on a regular basis during his four-year work experience at a psychiatric hospital. These incidents were seldom reported, as the nurses involved feared the criticism, by their colleagues and managers, of being ineffective in managing psychiatric patients (Mckinnon & Gross, 2008; Lanza, 2011). Another reason cited was that the assaults would not be investigated, while some nurses were of the opinion that being assaulted by aggressive patients was an expectation, as it was 'part of the job'. The nurses reported feelings of frustration and hopelessness about the work situation. Various researchers (Lanza, Zeiss & Rierdan, 2006; Mckinon & Gross, 2008; Bock, 2011) concur that nurses are often at the receiving end of aggressive and violent behaviour, with some incidents being unreported; nurses even accept violent abuse by patients as a norm in psychiatry. These incidents, therefore, prompted the researcher to explore the lived experiences of the nurses, who care for psychiatric patients, not only nurses in acute and emergency units, but all psychiatric nurses with frequent contact with and close proximity with to patients, irrespective of their ranks.

There are four tertiary psychiatric hospitals, in the Western Cape Province, that provide treatment to, approximately, five million people (Statistics South Africa, 2012). Two of the hospitals offer mental health care services to people with mental illnesses, while one focuses on providing care, treatment and rehabilitation services to people with intellectual disabilities. The fourth psychiatric hospital offers services to both patients with mental illnesses and intellectual disabilities. Designated areas, known as catchment areas, are attached to these hospitals for patient referrals. The hospital selected for this study renders care to both patients with mental illnesses and intellectual disabilities.

1.3. Problem statement

The assault of nurses by patients in psychiatric hospitals is a global concern. While there may be various reasons for the underreporting of assault by patients, it has been established that violence has a negative effect on the physical and emotional well-being of the victim, who is the nurse. Perceptions have been alluded to by nurses, of being unsupported by fellow Colleagues, supervisors and managers. While violence against nurses has been explored

globally from different perspectives, namely, prevalence rates and interpersonal styles, there is a paucity of literature concerning how nurses experience the assault by patients, while working in psychiatric hospitals. This need has been recognised, and this study, therefore, seeks to explore the lived experience of nurses, who have been assaulted by patients in psychiatric hospitals.

1.4. Research question

What are the lived experiences of nurses, who have been assaulted by patients at a psychiatric hospital in the Western Cape?

1.5. Purpose

The purpose of the study is to explore the experiences of nurses, who have been assaulted by psychiatric patients at a psychiatric hospital in the Western Cape.

1.6. Objective

To describe the lived experiences of nurses, who have been assaulted by psychiatric patients at a psychiatric hospital in the Western Cape?

1.7. Significance of the study

It is envisaged that the results of this study will contribute to the body of knowledge about the abuse of nurses working in psychiatric hospitals. Understanding how nurses experience the Assault, may influence existing policies regarding the management of staff following the incidents of violent assault.

1.8. Definition of Concepts

For the purposes of this study, the following terms are used as defined below:

Assault – is a violent attack, which can be either physically and verbally, with an intention to cause harm to a person it is subjected to (Collins English Dictionary, 2011: 97). In this study, assault is physical assault by the patients on nurses, which includes pushing, strangulation, biting, hitting with fists, objects or being struck with an object.

Experience – is defined by Collins English Dictionary (2011) as a direct personal participation or observation, actual knowledge or contact. In this study, psychiatric nurses

have experienced assault, while providing care to mentally ill patients in a psychiatric hospital. Therefore, they possess actual knowledge of a series of events that they have participated in or lived through. The researcher, therefore, aimed to explore and describe the lived experiences of nurses, who have been assaulted by psychiatric patients at a psychiatric hospital, and to uncover what these lived experiences mean to nurses, who care for psychiatric patients.

Nurse – according to the Nursing Act, No 33 of 2005, a nurse is a person registered under section 31, sub-section 1, to practice nursing or midwifery (Nursing Act No. 33, 2005). In this study, a 'nurse' refers to all nurses working in the hospital.

Patient – according to the Mental Health Care Act, No. 17 of 2002, a Mental Health Care User (MHCU) is an individual with a mental illness that requires him/her to be detained, controlled and to receive treatment and rehabilitation (Mental Health Care Act, No. 17, 2002). In this study the term 'patient' was used, which refers to individuals, who are admitted to the selected hospital for care, treatment and rehabilitation due to mental illnesses.

Psychiatric hospital – according to the Mental Health Care Act, 17 of 2002, a psychiatric hospital is defined as a "health establishment that provides care, treatment and rehabilitation for patients with mental illnesses" (Mental Health Care Act, 17, 2002). In this study, a 'Psychiatric hospital' refers to the mental health institution in the Western Cape, where the study will be conducted.

1.9. Overview of the research methodology

In this study a qualitative paradigm and phenomenological design was adopted to describe the lived experiences of nurses, who had been assaulted by patients in a psychiatric hospital. The qualitative paradigm fits this study because it seeks an in-depth understanding of the participants' life experiences, and gives them meaning (Burns & Grove, 2011). The phenomenological approach was selected as the most suitable approach for this study because it provides the participants the opportunity to give a detailed account of their 'lived experiences' from their own perspective (Creswell, 2013: 76). The design and methodology of this study will be further discussed, in detail, in Chapter Three of this thesis.

1.10. Data analysis

The data obtained from the data collection process of this study was analysed using Colaizi's method of data analysis. A more detailed description of the data analysis process is outlined

in Chapter Four.

1.11. Ethics

Ethical clearance to conduct the study was obtained from the Senate Ethics Committee of the University of the Western Cape and the Ethics Committee of Lentegeur Psychiatric Hospital. All participants were above 18 years old and gave their informed consent to participate in the study. A more detailed description of the ethics will be given in Chapter Three.

1.12. Outline of the Chapters

Chapter 1 introduces the background and the rationale to the study, the problem statement, research question, the research objectives and significance of the study. Furthermore, the research design, methodology and ethics are also discussed briefly.

Chapter 2 discusses the literature review conducted on nurses' experience of assault by patients, while working in psychiatric hospitals.

Chapter 3 explores, in detail, the research design, methodology, recruitment of participants, sampling, data collection, data analysis, rigor in qualitative research and ethics.

Chapter 4 presents the findings of the study, as well as the discussion of the findings.

Chapter 5 concludes the study, briefly discussing the limitations and the researcher's Recommendations for practice

CHAPTER TWO   LITERATURE REVIEW

2.1. Introduction

In this chapter, a literature review of the empirical literature on the 'Lived experiences of nurses who have been assaulted by patients at a psychiatric hospital in the Western Cape' will be conducted. The literature review will inform on the current knowledge of this research study topic, in order to gain a better understanding of the experiences of nurses, who have been assaulted by patients in psychiatric hospitals.

The researcher conducted a search at the UWC library, which included the following databases: EbcoHost, CINAHL (Cumulative Index for Nursing and Allied Health Literature), Google Scholar and Psycho INFO. The following key words were used during the literature search, assault, experience, nurses, psychiatric hospital and patients. These key words were combined, for example, 'nurse's experience of assault', which yielded limited results of assault of nurses in South Africa, with most of the studies emanating from the United States of America and the United Kingdom. The literature reviewed focused on the prevalence of violence in the healthcare setting, factors relating to the incidents of assault, literature pertaining to the violence in the health care setting and its effects on nursing.

2.2. Prevalence of assault and violence in healthcare settings

The reviewed literature acknowledged the prevalence of violence in the health care sector as a global issue, and that nurses were always first to encounter the violence. A descriptive survey of verbal and physical abuse against nurses in Turkey. This survey consisted of 622 nurses who completed questionnaires on verbal and physical abuse found that 91.1% of nurses reported verbal abuse and 32% reported physical abuse. by Celik et al. (2007) According to Mckinnon and Gross (2008), a study conducted at Victorian Mental Health Service found that more 80% (n=63) of nurses had been victims of assault at least once, 56% had benn assaulted during the previous year and approximately 50% had been assaulted during their nursing career. A cross – sectional survey conducted by Kelly, Subica, Fulginiti, Brekke & Novaco (2015) aims at understanding factors related to inpatient assault of staff in a forensic psychiatric hospital found that nearly all staff reported verbal conflict with patients (99%) and 70% reported being assaulted during the previous 12 months. Farrell, Bobrowski

& Bobrowski (2006) assert that nearly 64% of nurses reported some form aggression, namely, verbal or physical abuse, over their previous four working weeks. Teymourzadeh, Rashidian, Arab, Akbari-Sari & Hakimzadeh (2014) they found that 69% of the participants reported at least one type of workplace violence within the previous year. Arnetz, Hamblin, Lessenmacher, Upfal, Ager & Luborsky (2014) pointed in their qualitative design study in that approximately 90% of 214v incidents concerned some form of physical violence directed to hospital employees and 34% of those incidence resulted in injuries that required an employee to stay out of work.

A quantitative study conducted by Lussier, Verdun-Jones, Deslauriers-Varin, Nicholls & Brink (2010) on nurses working in a forensic psychiatric hospital, in British Columbia, Canada, indicated that a small group of approximately 10% of the patients were responsible for more than 60% of all violent episodes recorded during a 1-year study period. A mixed method study by Moylan & Cullinan found that 80% of nurses were assaulted, 65% had been injured and 26 % had been seriously injured. Atan (2013) reported that 70% of the psychiatric nurses were subjected to verbal violence and physical violence, not only, from the patients, but also, their visitors (32.5% of all incidents of assault). According to Ukpong, Owoeye, Udofia, & Abasiubong (2011) there is plethora of literature from western countries that describe violence against mental health workers. The study found that 83.3 % of nurses were mostly frequently assaulted than other employees such as doctors with only 17.7 % of assaultive incidents directed to them. Studies conducted by (Duxbury, Bjorkdahl, & Johnson, 2006; Maquire & Ryan, 2007) suggest that nurses may be more exposed to violence or assault than other caregivers may. Incidents of aggression range from 60-90% in psychiatric hospitals, which is considered an extremely dangerous place of employment, as staff are constantly exposed to aggression and violence (Lau, Magarey & McCutcheon, 2004). Research studies by Kajee-Adams and Khalil, (2010) show an increasing trend of violence in general and psychiatric hospitals, as well as healthcare settings in Cape Town. Furthermore, the study revealed that 62 % of nurses employed in community health centres received threat of physical violence which constitutes psychological violence.

2.3. Types of Assault

Anderson and West (2011) conducted a study to ascertain the risk of violence to which mental healthcare staff is exposed. These authors concluded that nurses are exposed to various forms of violence, such as physical and psychological trauma, by psychiatric patients. In most cases, these incidents left nurses with their pride and self-esteem wounded, humiliated, violated, fearful, resentful, intimidated and hurt. Some of these incidents went unreported, due to the nurses' fear that their colleagues would criticise and blame them for the violence. The assaults on nurses include the following: verbal assault (swearing, cursing, racial abuse, demeaning remarks and threats) and physical assault (hitting, pushing, throwing objects, strangulations, grabbing and scratching).

A survey conducted by Ukpong et al. (2011) to investigate the physical assault against mental health staff of a Nigerian psychiatric hospital, found that pushing or shaking were the most common types of assault (36-44.4 % of cases). Whittington et al. (1996, cited in Nolan, 1999) suggest that the number of assaults and the nature of the injuries sustained by nurses, as the result of violence by psychiatric patients, are overwhelming, and that nurses are more likely to be physically assaulted, threatened and verbally abused, than any other health professional group.
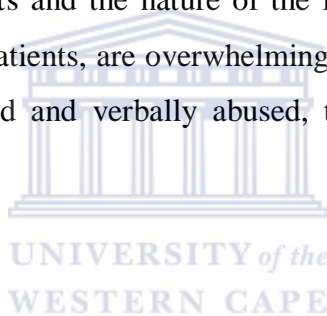
2.4 Gender and Risk of Assault

Apart from the physical assault of nurses by psychiatric patients, it appears the nature of violence female and male nurses encountered in the psychiatric setting somehow is different. Male tender to suffer from physical violence, while female nurses more likely to suffer from verbal abuse or sexual harassment. Flannery et al. (1994) assert that 70% of female nurses are more likely to be the victims of unprovoked assault, compared to their male counterparts (53%), who are would probably more often be victims of assault, during restraining and seclusion procedures of psychiatric patients. Whilst, Lawoko et al. (2004) conducted a descriptive cross-sectional design to compare a nature of violence encountered by female or male nurses in both Sweden and England and found that male nurses are more often subjected to violence than other personnel. James & Oud (2011) pointed out that male nurses were more likely to report experiencing episodes of physical violence compared to their female counterparts. Bimenyimana, Poggenpoel, Myburgh & Van Niekerk (2009) alluded to female staff voicing their dissatisfaction and embarrassment, when patients directed inappropriate sexual language at

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them and displayed inappropriate behaviours towards them. These behaviours may traumatise nurses and have long-term, adverse effects on their mental well-being.

2.5 Experiences of nurses who suffered an assault by patients

In a descriptive, cross-sectional study on nurse's experiences of violence at six University hospitals in Turkey, conducted by Atan, Baysanarabaci, Sirin, Isler, Donmez, Guler, Oflaz, Ozidemir & Yazartasbasi (2013), nurses expressed how violence impacted their lives. They claimed to have suffered different forms of assault that resulted in somatic symptoms, such as pain and palpitations. Some nurses also claimed to suffer psychological distress, emerging as feelings of anger, resentment, disappointment, fear and anxiety. The findings of the study revealed that job satisfaction was poorer among those subjected to assaults. Another study that focussed on the experiences of nurses, a New Zealand study conducted by Burns (2014), revealed that the nurses were afraid of patients, yet, despite their fears, they were expected to care for those patients. In the same study it was reported that nurses' families were also threatened, which resulted in them leaving the mental health sector permanently, because of concerns for their own safety and that of their families.

Kennedy and Julie (2012: 1) conducted a study in the Western Cape, South Africa, on nurses' experiences and understanding of workplace violence in a trauma and emergency department. They found that nurses in these departments were subjected to various kinds of abuse, such as physical threats, verbal abuse, psychological and imminent violence on a regular basis. In Nurses who had experience violence on continuous basis has accepted the violence as part of their job. The study also revealed the lack of policies and intervention procedures to deal with the victims of the abuse, after the violence or abuse by patients. A study conducted in West Africa, Nigeria by Ukpong et al. (2011: 48) also pointed out that the absence policies on reporting assaults as an issue. The lack of intervention procedures, such as post-assault debriefing, compelled nurses to use their colleagues for support when they had suffered an assault by patients, smoke breaks, friends and family as their sources of support, following the assault by patients. Some participants further expressed that most nurses were stressed out and carried that stress back home, often passing it onto their family members, children or husband.

Nurses described that the lack of supportive management actually led them not report assaultive incidents by patients. They further mentioned that they coping mechanism from assault is to pretend as if nothing has happened and move on with their lives. However Estryn-Behar (2008, cited in Kennedy & Julie, 2012) asserts that these kinds of maladaptive coping mechanisms may increase the likelihood of a reoccurrence of the effects of the violence, later in their lives. Kennedy and Julie (2012) highlight that nurses choose to have minimal contact with the perpetrators (patients) by either avoiding or ignoring them. With nurses ignoring or avoiding patients because of the verbal abuse, is tantamount to compromised care, for the same patients to whom they are expected to render efficient care (Kennedy& Julie 2012). Gerberich, Church, McGovern, Hansen, Nachreiner, Geisser, Ryan, Mongin & Watt (2004) warns that non-physical .violence, such as insults or swear words, have more severe effects than physical violence. An Italian, quantitative study on workplace violence against students and nurses, conducted by Magnavita and Heponiemi (2011), concur that suppressed negative feelings are known to cause psychological behavioural problems.

2.6. Factors associated with violent behavior

James, Isa and Oud (2011) argue that the resentment of patients, who are admitted against their will (involuntary admission), and the frustration of others, who have their freedom of movement curtailed, were possible factors that account for the high degree of intolerance and retribution directed toward nurses. Nurses' authoritarian and controlling communication styles are also perceived as precursors to aggression in the clinical setting (Bilgin, 2009). A study conducted over two decade by Flannery et al. (1994) contends that the abuse of substances, combined with a history of aggressive and violent behaviour, may lead to aggression and violent outbursts in patients. This is consistent with a study by Bock (2011), found 90% of the respondent agreed that there were 'types' that are more prone to aggression and vioelence,e.g male schizophrenic with with co-morbid substance abuse were identified as highly prone. The nurse's approach is also closely examined, concerning the violent behaviour of psychiatric patients. Nurses may be regarded as bullies, too confrontational at times, which could spark violence. Nurses are often the first psychiatric personnel that patients encounter and, therefore, the first to make contact with an aggressive or violent patient, given that nurses render 24 hour nursing care and have the most direct contact with patients (Macquire & Ryan, 2007).

Environmental factors (overcrowding, nurse/patient ratio), staff factors (experience and training in prevention and management of assault) and social factors (gender, age, history of violence) are regarded as reliable predictors of assault among psychiatric inpatients (Lawoko et al., 2004). A study conducted by Anderson & West (2011) found that people with serious illnesses, such as schizophrenia, major depression or bipolar mood disorder, were two to three times more likely to be assaultive. Moreover, other specific static risk factors include male gender, young adulthood, and lowered intelligence, history of head trauma, neurological impairment and dissociative states. Patients become bored or frustrated because there is a lack of activities in the wards to keep them occupied (Shattell, Andes & Thomas, 2008).

2.7. Impact of assault on nurses

Study conducted by Gates, Gillespie & Succop (2011) stated the negative impact violent incidents have on the victims. These include the following: physical injuries, disabilities and psychological problems, such as loss of sleep, nightmares, diminished confidence and flashbacks. Some victims have even considered resignation. A study conducted in Australia by McKinnon and Cross (2008) described the frequency and severity of injuries that psychiatric nurses sustained through assaults. These included the following: minor injuries, such as lacerations, cuts, abrasions, sprains; and major injuries, such as fractures and lacerations that required suturing.

Being exposed to any form of assaultive behaviour may lead to various responses by the nurses. Studies, such as that of Kindy et al. (2005), as well as Moylan & Cullinan (2011) were conducted in different countries, using different instruments to collect data; however, they identified some similarities in the types of responses from nurses regarding the abuse against them, namely, demoralisation, distrust and hyper-vigilance (Kindy et al., 2005); despair, helplessness, distress and fear (Moylan & Cullinan, 2011).

2.8. Under-reporting of assault

A study done in New Zealand revealed that the total number of reported assaults by patients on nurses for 2010-2012 was 4821; the incidents of assault doubling from a similar previous period to 2010- 2012 (Burns, 2014). The findings also show that mental health nurses were more frequently victims of assault, among all health professionals, and that the incidents of

assault were under-reported by nurses for a number of reasons. The reasons were identified as follows: desensitisation to violence; no time to do additional paper work; and the lack of active feedback in response to reporting. The flaws in the reporting process of assaultive incidents were also highlighted as reasons for under-reporting, participants felt discouraged because there was not much done about assaultive incidences or assaults were downgraded as minor offences by operational managers (Burns, 2014). Lack of support from authority, some incidents deemed not serious, figures were reported as one of the factors that surprised the number of incidents reported. The South African studies conducted in Cape Town by Bock (2011) and Kennedy & Julie (2012) found that consistent exposure to assault and this conditioned nurses into normalising the abuse as a norm in workplace environment. However, there are not many studies done on lived experiences of nurses (nurses of all categories, RN, EN and ENEs) who have been assaulted by patients in the psychiatric hospital of the Western Cape, and this research study aim to fill the gaps.

2.9. Conclusion

In this chapter, a literature review on the violent assault of nurses was conducted. The literature confirmed that assault on nursing personnel is common, and that nurses were adversely affected by these assaults. This chapter also highlighted a general reluctance to report these assaults and abusive behaviour, because of the impression that management structures often failed to respond appropriately to the reports. In addition to the failure of management to respond to these assaults, this chapter also presented information from studies that confirm the lack of reporting mechanisms or remedies to address this challenge, adequately. The factors that are predictors of assault were identified and described, as well as the impact of this violence on nursing staff. Various studies also confirmed that gender was a significant factor, and that particular types of assault were used in relation to the gender of nurses. The following chapter, chapter three discusses the research design and methodology that was used in this study.

CHAPTER THREE   RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

This chapter gives an account of the research design and methodology chosen for this study. The qualitative paradigm and phenomenological design was chosen to describe the lived experience of nurses, who have been assaulted by patients in a psychiatric hospital. The Husserlian phenomenological research design was selected as the most suitable design for this study because it provides the participants with an opportunity to provide a detailed account of 'lived experiences' from their perspective (Creswell, 2013: 76). The research methodology, which includes the research setting, population, sampling, data collection methods and Colaizzi's seven steps of data analysis, will be discussed in detail. \

3.2. Qualitative Research Approach

According to Streubert-Speziale & Carpenter (2007), a qualitative approach seeks an in-depth understanding, or an insider's view, with utmost respect for individual's perspective and his/her space. Furthermore, Woodgate (2000, cited in Streubert-Speziale & Carpenter (2007) asserts that all qualitative approaches 'share a similar goal in the understanding of a particular phenomenon, from the perspective of nurses experiencing the phenomenon. This requires that the researcher becomes intensely involved, when collecting data; in this case the researcher himself becomes the instrument (Polit & Beck, 2012) to get new information about the phenomenon under investigation. The qualitative paradigm fits this study well because it seeks an in-depth understanding to the participants' life experiences and gives them meaning (Burns & Grove, 2011).

Unstructured interviews were used to discover rich details about the experiences of the phenomenon under investigation. This provided the researcher with an opportunity for greater latitude for data collection. All people are unique and experience things differently; therefore, qualitative researchers believe that there are multiple perspectives to understanding their experiences (Streubert-Speziale & Carpenter, 2007). Given the nature of qualitative research, the researcher explored the insider's view with utmost respect for the participant's perspective and space.

3.2.1. Phenomenology

According to Creswell (2013), phenomenology describes the common meaning that several individuals give to their lived experiences of a concept or phenomenon. The phenomenological approach was selected as the most suitable approach for this study because it provides the participants with the opportunity to give a detailed account of the 'lived experiences' from their perspective (Creswell, 2013). Polit & Beck (2012) defined it as an approach that is rooted in a philosophical tradition, developed by Husserl (1859-1958). The aim of phenomenology is to examine the phenomenon as it is experienced by the participants, and to keep what is already known (researchers experience) about the phenomenon, separate from the participants' description. In addition, philosophical researchers ought to examine the essence of the phenomenon, as experienced by the participants, as well as the meaning they ascribed to it. Hayes (2001, cited in Streubert-Speziale & Carpenter, 2007) argue that, in qualitative research, the nurses are more concerned with values, beliefs and the meaning attached to health and illnesses, than to aggregates of the condition. The research question was best answered by adopting a phenomenological design approach, as the researcher was interested in exploring the lived experiences of the nurses; the purpose of the approach was to explore the lived experiences; and the approach provides researchers with a framework to discover what it is like to live such an experience.

Phenomenology starts with German mathematician, Edmund Husserl (1859-1938) (Creswell, 2007). Husserl believed that phenomenological researchers should focus on the underlying meaning of experience and emphasize the intentionality of consciousness, where experience contains both the outward appearance and the inward consciousness, based on memory and meaning (Creswell, 1998). Husserl was of the opinion that researchers need to set aside all prejudgements, he referred to as 'bracketing', described by Oiler (1982, cited in Burns & Grove, 2011) as the process whereby the researcher suspends or lays aside what s/he knows about the experience under study. De Vos, Strydom, Fouche & Delport (2011) agreed with Creswell (1998) that researchers must be able to distance themselves from their judgement and pre-conceptions about the nature and essence of the participants' experiences. For this reason, the researcher employed Husserl's philosophy.

The researcher observed that nurses were assaulted by patients on a regular basis during his three year tenure at a psychiatric hospital. Reporting of these incidences occurred randomly as

the affected nurses feared that they would be judged by others as being ineffective in managing psychiatric patients. Other reasons cited were that nothing would be done about the assaults whilst some nurses felt that being assaulted by aggressive patients was an expectation as it was "part of the job". Therefore, this prompted the researcher's interest to explore the lived experiences of the nurses who are caring for psychiatric patients not only in acute and emergency unit but to all psychiatric nurses irrespective of ranks with frequent contact and close proximity with patients. In spite of the fact that the researcher is an employee in the same psychiatric hospital in which the study is conducted, the researcher's preconceived ideas about 'the experiences of nurses who have been assaulted by patients at a psychiatric hospital' is to be put aside (Bracketing) in order not to interfere with data collection and analysis.

3.3. Research Design

Creswell (2009) defined research design as plans and procedures for research that span the decision from broad assumptions to detailed methods of data collection and analysis. Therefore, it is anticipated that the phenomenological research design, chosen for this study, will help to bring understanding to the lived experiences of the participants, who have been assaulted by patients in a psychiatric hospital.
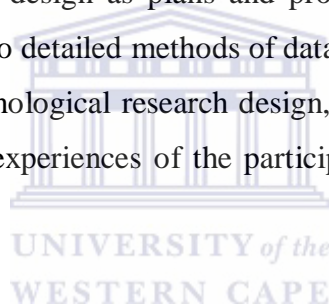
3.4. Research Methodology

Research methodology focuses on the research process, the kind of tools and procedures to be used, the individual steps in the research process and the most unbiased procedures to be employed (Mouton, 1996). In this section, the research process will be discussed, namely: the setting, population, sampling method, interviews, and data collection method and data analysis process.

3.4.1. Research setting

The study was conducted at a psychiatric hospital situated in the Mitchells Plain Health District. The hospital serves as the referral hub for mostly the urban and rural areas of the Western Cape Province. This institution also forms part of the Associated Psychiatric Hospital (APH) in the

Cape Town Metropole region and has a 740-bed capacity, which makes it the largest psychiatric institution in the Western Cape. Patients are admitted to the hospital from Mitchells Plain, Khayelitsha, Philippi and Delft. These areas have a high rate of unemployment, gangsterism, substance abuse and domestic violence. Patients have a propensity to violent behaviour, given that a large proportion of the patients admitted to the hospital, have a diagnosis of substance-induced psychosis and, therefore, admitted, involuntarily, according to the Mental Health Care Act 17 of 2002.

3.4.2. Population

Population is described by Burns and Grove (2005) as all the subjects/participants that meet the criteria of inclusion in a particular study. In this study, the target population was all the nursing staff, employed at the psychiatric hospital selected for this study. There is 414 nursing staff employed at the selected hospital.

Inclusion criteria: Participants should be male or female nurses of all categories, employed at the psychiatric hospital under study for at least twelve months, and must have experienced assaults by patients.

Exclusion criteria: Nurse Managers (as they are not directly involved with patients), agency nursing staff, and nurses with no history of being assaulted by patients, were excluded from participation.

3.4.3. Sampling and sample

A purposive sampling technique was used to recruit participants for this current research study. Purposive sampling indicates that the participants are selected because they possess some defining characteristics, which make them the holders of data needed for the study (Fouche & Delport, 2011). A sample size of eight nurses agreed to participate. Data saturation was reached after the 6th interview as no new themes emerged from the interviews. The participants were all nurses, who had been assaulted by patients at the psychiatric hospital in the Western Cape that was selected for this study.

3.4.4. Recruitment of participants

Ethics clearance was obtained from the Senate Ethics Committee at the University of the Western Cape (Appendix 4) to conduct the study. Written permission to conduct the study was sought (Appendix 5), and obtained (Appendix 6), from the Research Ethics Committee at the selected psychiatric hospital. The nurses were recruited by the researcher, who solicited an invitation to the Nurses' Forum meeting of the psychiatric hospital under study, where this research was introduced, by means of a presentation. The presentation provided information about the research study's background and significance. At the end of the presentation session, Participant information sheets (Appendix 1) with researcher's contact details were disseminated among those present. The nurses, who met the inclusion criteria, contacted the researcher and indicated their desire to participate in the research. A sample of eight nurses volunteered to be interviewed, and were selected from the population of nurses, who were assaulted, while on duty, by the psychiatric patients they cared for. After telephonic conversations between the researcher and the prospective participants, individual interviews were discreetly arranged at a time and venue of their convenience and choice. Each participant was given a consent form at the start of each interview (see Appendix 2) to sign. Information sheet contained of aim, objectives, risks and benefits involved in the study and the questions. It was explain on the information that participants were free to withdraw anytime they wish to do so. Eight nurses agreed to participate, however data saturation was reached after the 6th interview.

3.4.5. Data collection

Data collection included the recruitment of the participants, an explanation of the interview guide (see Appendix 3) and the data collection process.

3.4.5.1. Data collection instrument

As is the case with qualitative study, the researcher is perceived to be the data collection instrument. In this study, the researcher collected the data regarding the lived experiences of nurses, who had been assaulted by patients, through unstructured, in-depth interviews, which lasted between 30 to 60 minutes. Unstructured interviews provide the opportunity for greater latitude in the answers provided (Streubert-Speziale & Carpenter, 2003). An interview guide (Appendix 3) with open-ended questions, relating to nurses' experiences of being assaulted by

patients, was formulated, for example: 'Would you please tell me what type of assault you have experienced?' Probing questions were asked, whenever necessary, to obtain clarity, or to redirect, the interview. The interviews were audiotaped with the permission of the participants. The researcher also took field notes comprising of observations made during the interview.

3.4.5.2. Data collection process

The data collection was conducted by means of unstructured interviews to obtain data regarding the lived experiences of nurses, who had been assaulted by patients. The interviews were conducted by the researcher in a quiet, relaxed atmosphere, in a private room or office space, in the ward where the participants worked, in their preferred time, to be specific in the afternoon during their lunch or tea breaks. This was done to avoid any conflict or unnecessary risks to patients by leaving patients unsupervised during the interviews. The participants were required to sign an informed consent prior to the commencement of the interview.

An interview guide with open-ended questions, relating to nurses' experiences of being assaulted by patients, was used to guide the researcher. The participants were asked to share their experiences of being assaulted by patients and were allowed tell their story without interruption. Each participant were given time to speak exhaustively. Probing questions were asked, whenever necessary, to obtain clarity or redirect the interview. The interviews were audiotaped with the participants' permission. The researcher also took field notes of observations made during the interview, which included body language, as this could portray deeper expression of feeling by the participants. The audio tapes and filed notes were stored in a locked safe cabinet and key, with only the researcher and supervisors will have access to them. .The recordings will be destroyed 5 years after publication of the study.

3.4.6. Pilot study

A pilot study was conducted with two participants working at the selected hospital to determine whether the interview tool would produce any methodological challenges or test the interview guide (Appendix 3). Interviews were conducted in a private room or office space with a door that can close in order to protect privacy and maintain confidentiality. The two participants who participated in the pilot study were not included in the actual study.

3.4.7. Data Analysis

The audiotapes of one-on-one in-depth interviews between the participants and the researcher were transcribed verbatim. In this study, the data analysis process followed the seven (7) steps of Colaizzi's phenomenological method of data analysis, which included the following:

- Interviewing the participants, transcribing the data and reading the transcripts several times to gain an 'overall feel' from them.
- Extracting significant phrases, after reading the transcripts several times over again.
- Formulating meanings from the significant statements.
- Organising formulated meanings from significant statements into clusters.
- Integrating themes into exhaustive description.
- Approaching the participants to validate the findings.
- Lastly, writing a composite description that incorporates both the textual and structural descriptions to represent the 'essence' of the experience.

More detail description of above seven steps will be discussed below

Step 1: The researcher conducted all the interviews in a private room or office space at the psychiatric hospital, where the participants were employed. The researcher then listened to all the interviews and transcribed them verbatim. The researcher read and re-read each transcript several times over, line-by-line, to gain an 'overall feel' of the topic being researched. During this stage, any thoughts and feelings that arose in the researcher, due to personal experience of being assaulted by a patient, was written down in a bracketing diary. This helped the researcher to explore the phenomenon of assault, as experienced by the participants themselves.

Step 2: The researcher started to develop a list of significant statements. The statements on how the participants experienced assault were extracted from the transcripts. Repetitive statements or overlapping statements were ignored. After extracting the significant statements and phrases, the researcher and research supervisor compared the statements and reached consensus. Chapter Four gives an account of the significant statements.

Step 3: The researcher formulated meanings from the significant statements. Each underlying meaning was code in one category for they reflect an exhaustion description. Coliazi's (1978)

stated that the researchers must make every effort to formulate general statements or meanings on each significant statement extracted from participant's transcripts. The formulated meaning give light those meaning hidden in the six transcripts. Significant statements that were extracted transcripts of participants were used on chapter where the presentations and discussion of themes and sub-themes is done.

Step 4: The researcher organised the formulated meanings from the significant statements into categories or clusters. Then the researcher took all the categories that emerged examined and organised into themes that reflect the essence of what the participant's experiences. Emerged five themes were then discussed in details in chapter that follows chapter four.

Step 5. The researcher conducted or added all codes and segments to an exhaustive description of the experiences of nurses, who were assaulted by patients in the psychiatric hospital. Emerged themes and sub-themes were incorporated and formulated meaning that reflects the perceptions of nurses who experienced an assault by Patients in the psychiatric hospital.

Step 6: The researcher conducted the reduction process by integrating the results into the description of the phenomenon under investigation and the redundant, misused descriptions were gotten rid of. Five main themes emerged, which are explained, in more detail, in Chapter Four, along with their related sub-themes to generate clear relationship between clusters of theme and their extracted themes.

Step 7: A description of the assault as experienced by the participants was given, which included verbatim quotes. A description of how the assault happened was also alluded to, in which the researcher described the mental health context where the assault took place. Finally, a composite description of the assault, as experienced by the participants, and the mental health setting was presented, which represented the essence of assault of the participants, working in mental health care. The researcher returned findings back to the participants one by one in their preferred setting and discussed the results with them. And they were all satisfied that the results reflects their feelings and experiences.

3.5 Qualitative Rigor

3.5.1 Bracketing

It is the process whereby the researcher suspends or set aside his/her preconceived ideas about experience being studied (Burns and Grove, 2005). This is done to prevent any biasness with the data collected. The researcher 'Bracketed' his own feelings and experiences about the topic under investigation.

3.5.2. Trustworthiness

Trustworthiness in qualitative research is used to determine the accuracy of the data or findings. Burns & Grove (2005) state that in qualitative studies, the quality of the data collected is significant and can be determined by addressing the following terms, Credibility/authenticity, Conformability, Dependability and transferability.

3.5.2.1. Credibility/Authenticity

Credibility refers to the evidence that the inquiry was conducted in a manner, which ensured that the research subject was accurately identified, and described (De Vos, Strydom, Fouche & Delport, 2005). According to Shenton (2004:64), credibility measures or test what is actual intended. Futhermore, credibility is one of the most important factors in establishing trustworthiness. In this study the credibility was established by means of triangulation and member checking.

Triangulation

In order to ensure credibility of the study the researcher used more than one data collection techniques, such as interview, audio-record, observations of the during the interview and field notes. Data analysis was done with co-coder, the researcher and an experienced independent coder reached consensus regarding the research findings.

Member Checking

At the end of the data collection dialogue (Shenton, 2004), prior publication of the findings participants we asked to read transcripts of dialogue in which they have participated. The researcher met each of the participants one by one, this was done to confirm that their words match or verify what they actually intended on audio-tape.

3.5.2.2. Dependability

For this study, the researcher ensured dependability, by using various methods of data collection, namely, interviews, field notes and audiotaping. In addition, the researcher, also, conscientiously followed the seven steps of Colaizzi's phenomenological method of data analysis, as a guide to ensure the accuracy and dependability of the findings.

3.5.2.3. Conformability

The conformability of the study was ensured by providing a dense description of the research methodology. In addition, it was also established through triangulation, as well as through keeping an audit trail. Lincoln and Guba (1999, cited in De Vos et al., 2005) highlighted the need to inquire whether the findings of the study could be confirmed by another similar study.

3.5.2.4. Transferability

Transferability of this current study was ensured by the presentation of a dense description of the participant's research context and setting. Lincoln and Guba (1999, cited in De Vos et al., 2011) and Durrheim and Wassenaar (2002, cited in Maree, 2011) concur that transferability depends on the degree to which the generalisation about the data and context of the study can be transferred to a bigger or larger population.

3.6. Ethics

Ethics approval to conduct the study was obtained the study from the Senate Research Ethics Committee at UWC (Appendix 4). The researcher also wrote a letter requesting permission to conduct the study at the hospital, which was forwarded to the Research Ethics Committee of

Lentegeur Psychiatric Hospital (see appendix 5). Permission was obtained from the Research Ethics Committee of Lentegeur Psychiatric Hospital (Appendix 6). An application letter requesting permission was made to the Provincial Health Research Committee in the Western Cape (Appendix 7). Permission was granted by the Provincial Health Research Committee in the Western Cape: Health (Appendix 8).

3.6.1. Informed consent

Informed consent was obtained from the participants after they have been informed about research study, its purpose and outcomes. Helsinki Declaration (2013) emphasised that in medical research that involving human subjects capable of giving consent, each subject must be adequately informed of the aims, method, source of the funding, any possible conflict of interest, institutional affiliations of the researcher, anticipated benefit and potential risks of the study, the discomfort it may entail, post study provisions and relevant aspects of the study. Participants were provided with information regarding their participation in the study (Appendix 1), aims, benefit and risks involved with participants in the study .After ensuring that the participants has understand the information regarding the study, the were able to freely-give informed consent in writing, to say that they are willing to participate. This allowed the researcher to carry out interviews and audiotape recordings (see Appendix 2). Participants were fully informed about the nature of the study, that their participation in the study was voluntary, and that they could withdraw from the study at any time, without prejudice.

3.6.2. Privacy, Confidentiality and Anonymity

In the study, the researcher ensured that confidentiality was maintained in the study by concealing the names of the participants, as codes were assigned to each participant during the interviews and when the results were published. The participants were informed that the information recorded on audiotape and in field notes were locked in a safe cabinet to prevent unauthorised access to the information. They were also advised that, once the audiotapes were transcribed, they would be stored in a safe place and destroyed, three years following the completion of the study. Participants were informed that only codes would appear on the study, when it was published.

3.6.3. Avoidance of Harm and the Right to protection from discomfort

Assault is very traumatic experience and interviewing participants, who had experienced assault in the past, might still elicit an emotional response in the nurses. The researcher, therefore, guaranteed that participants would be referred for debriefing or counselling at the Western Cape Independent Counselling and Advisory Services (ICAS), should they become emotionally distressed during or after the interviews. To avoid any conflict between the employer and participants and unnecessary risks to the patients by leaving patients unsupervised during the interviews, interviews were held in the unit where participants working at the time suitable for them, to precise in the afternoon during their lunch breaks and tea time.

3.6.4. Autonomy and Responsibilities

The participants were informed that they had freedom of choice on what information to share, as well as how to share such information. They would not be coerced to participate in the study; it was their choice and decision to do so.

3.7. Conclusion

The chapter provided the research design and methodology most suited to this study. The research process and instruments were described and explained, as well as the research approach. The phenomenological approach was explained and a rationale provided regarding the suitability of this research approach. A detailed account was provided of sampling procedures, the data collection process and the data analysis procedures. The use of coding was explained, in relation to the study and the management of the data. This chapter further provided the ethics protocols and limitations of the study. Chapter Four provides the results and a discussion of the findings of the study.
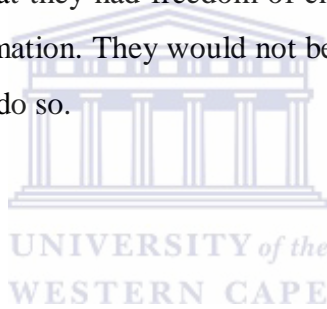
CHAPTER FOUR   RESULTS AND DISCUSSION OF THE FINDINGS

4.1. Introduction

In chapter three, the methodology that was utilised in the study was presented in a systematic manner in order to arrive at the findings. This chapter flows from chapter three; it presents the results of the analysed data, obtained from the participants of who took part in the study on the lived experiences of nurses who have been assaulted by patients in a psychiatric hospital in the Western Cape. Firstly, raw data is presented through themes that emerged and appropriate sub-themes and categories. Each theme is discussed in detail by unpacking the sub-themes and categories that emerged thus validating the findings. Direct quotes from participants are used to justify each finding presented under a certain theme. Moreover, the discussion of the results follows and relevant literature is used to support, validate or justify the findings of this study. Furthermore, in an attempt to provide structure to this important chapter, the demographic data of participants is presented and is followed by the presentation of themes in a tabulated format.

4.2. Demographic information of the participants

Initially, a total of eight nurses were invited to participate in the study, however, data saturation was reached after six nurses were interviewed. Thus a sample size of this study comprised of six nurses (N=6). There were two (2) male registered nurses and four (4) female Enrolled Nursing Assistants. The ages of the participants ranged between 30-64 years. The nursing experience for the participant group ranged from 9-39 years working in psychiatry.

4.3 Themes that emerged

Table 4.1 presents a summary of the five themes and the respective categories, which are the main findings of this study. These themes represent the overall experiences of nurses, who had been assaulted by patients. The responses are unique, and verbatim quotes are used to illustrate the participants' experience of being assaulted by patients, while working in a mental health care institution.

The results are presented as themes and their related categories, as they represent the

meanings the participants attached to their experiences. The participants' experiences ranged from how they neglected their self-care, to their experience of supportive interventions, as outlined in following table:

Table 4.1: Lived experiences of nurses who have been assaulted by patients

Themes	Sub-themes	Categories
1. Self-care incongruent to intrapersonal interest	Intrapersonal interest	Self-care of participants was neglected by professional demands of nursing.
		Nursing as a vocation was incongruent with the assault experienced.
		Retention of staff occurred due to the passion staff felt for working with mentally ill patients.
2. Personal responses to trauma	Physical effects of assault	Physical signs of trauma were reported in response to assault by patients and visitors.
		Severe pain in response to physical assault by patients was experienced
	Psychophysiological emotional responses	Self-protection through a 'fight and flight' reaction was expressed.
		Fears, being unsafe and insecure in the working area were reported.
		Annoyance at being violated by human excreta was experienced.
		Concern regarding long term effects of physical injuries on participant's future was expressed.
		Participants described feeling unappreciated and blamed by management for the assault.
		Anger, sadness and crying were experienced at being assaulted through no provocation.
		Presence of the perpetrator was perceived as threatening but relief was felt when patients were transferred to other wards.
		Flashbacks, hyper-vigilance, paranoia and distrust were experienced after the assault
		Vulnerability at the inability to protect them was counteracted by the desire to react to preserve dignity in the face of collegial humiliation.
		The act of physical violence was perceived as competition/rivalry between staff and patients which was influenced by background of staff
		Confusion, disorientation and inability to sleep were experienced as a result of the physical assault.
3. Incongruence between patient behaviour and participants' work	Managing aggressive patients	Patients were perceived to be unpredictable hence management became difficult
		Participants lacked work experience in managing aggressive patients behaviour

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		experience	
4. Unprotected staff vulnerable to patient aggression	Staff devoid of rights	Patient rights were protected by legislation hence no recourse for staff against assault
		The nature of the work made nurses more vulnerable to assault by patients
5. Required and received supportive interventions	Expressed need for support	Need for management support was verbalised.
		A need for a safe working environment was expressed.
		The need for psychological interventions to cope with the trauma of assault.
		Financial support to deal with the effects of physical trauma was expressed.
		Participants expressed the need for communication by the managers.
	Support received from peers and managers	Peer support was received in times of crisis
		Female participants enlisted the help of male nurses for protection against violent patients
		Free medical consultations were given to deal with the assault

4.3.1 Theme 1: Self-care incongruent to intrapersonal interest

Under this theme, there were somehow contradicting experiences from the participants. For example, participants described how their interest in nursing psychiatric patients took precedence over caring for themselves. Self-care, when dealing with the assault was secondary, as participants articulated their affection for their patients. It is only one sub-theme that came under this theme.

4.3.1.1 Intrapersonal interest

Participants in this study, despite the prevailing experiences of being assaulted, they continued to perform their duties, as they perceived themselves to be dedicated, despite being assaulted by patients and experiencing the effects of the assaults. Working with mentally ill patients was perceived to be desirable and a calling (vocation), rather than a profession, while patients were described, as being like a family away from home, as the following two participants articulated:

"We really got passion for these patients. I love my patients, really, irrespective what they do to me, and I really love my patients. I love working with

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people and I like helping people…" (P01).

*"… I'm loyal to my work …it is a calling, you must be there for clients, it's like
you*r *second family. Your family is at home and now it is your second family"*
(P04).

Other participants considered assaults by patients as part of the job. They also felt that they
had no choice when it came to caring for patients, who had assaulted them. This was
especially true, when they were on duty, as the following participants expressed:

"... You don't have a choice, if you are on duty that is our work'
(P02).
"...That but then afterwards, I learnt that ... this is part of the work"
(P03).

The mental health care environment was described as a difficult working environment.
Despite it being a high-risk area to work in, the participant's intrapersonal interest in nursing
maintained them in the mental health care environment.

''*We are nurses we really got passion we really got passion for our patients,
other people, other nurses from other hospital like private hospital or general
hospital or whatever ... i love my really irrespective what they do[assaulted] to
me , I really love my patients*'' *(P 01).*

4.3.2 Theme 2: Personal responses to trauma

Under this theme, participants described a variety of disturbing personal responses to the
assaults that they experienced at the hands of the patients. These included physical, and mostly
emotional and psycho physiological responses. The following are the sub-themes that emerged
under this theme.

4.3.2.1 Physical effects as a result of trauma

Physical signs and symptoms included severe pain, fractures, bruises and swelling. The

participants disclosed how their daily functioning, in many areas of their lives, was affected by the severity of the trauma. A participant describes having to make adjustments to cope, as indicated by following excerpts:

"When he throw [threw] *it* [trolley] *against* [my] *hand, I knew or feel that my hand was broken because* [of] *that sudden pain, it* [was a] *sharp pain. My thumb started getting blue and swollen, and painful. It happened suddenly, assault and I knew that it was a broken thumb. I couldn't write, I couldn't dry myself…, take a chair or sweep I had to do everything with my left arm , because I'm right handed but now I had to do everything with left hand"* (P04).

'…the *first time I was crying, because the patient broke my finger, then I didn't feel the pain immediately so then afterwards when I came home, discover that my finger was just dropping* [broken]" (P01).

4.3.2.2 Psycho physiological emotional responses

The physiological bodily responses reported, referred to the 'fight and flight' reaction in response to being assaulted. A participant felt that in an altercation with patients, running away from the situation was not an option, as preservation of life, *'fighting for my life',* became the primary aim of survival, as a participant described:

"…I go in for a fight, I don't stand back anymore. I fight to save my life. So when you are in the fight, its either fight or flight … most of the time you have to fight because you the staff member you cannot run" (P05).

Most of the participants described being physically assaulted by patients; however, one expressed how she was assaulted to a state of unconsciousness. Her recollection of the event was waking up with a swelling on her head, as the participant verbalised:

"The patient knocked me cold [unconscious] *and when I woke up I had a bump in [On] my head"* (P05).

Another participant described the daily abuse she had to face, being violated by a patient,

who threw excrement at her. She voiced her disbelief that a human being could act in such a manner, and further described the humiliation she faced, having to complete her shift in smelly clothes, as is expressed by the participant in the following quotation:

> *"Yes they spit in your face, they throw you urine with kaka [faeces] in your face and clothes everything that is the challenge every day you have to work with. ... it felt terrible because how can you, a human being, throw you with the kaka [faeces], the smell alone makes you vomit and you still to have [work for a]whole 12 hours with these clothes"(P01).*

In addition to being assaulted by patients, nurses were also subjected to assaults by the patients' family members. This participant describes the severity of the pain experienced due to the unexpected attack on the self by a patient's daughter, rather than the actual assault, as indicated by the following quotation:

> *"As I turn [end] my back then the daughter of our patient came behind, she hits me from behind.*
> *It was so sore because it was unexpected, and I was sitting with this pain"* (P01).
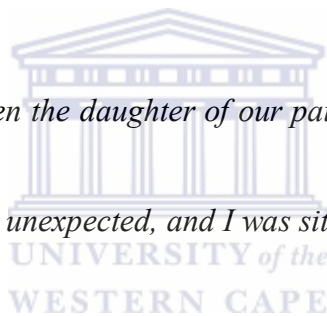
The participants also reported emotional and psychological responses to being assaulted by patients. They were assaulted while attempting to subdue patients, who were fighting. These responses included shock, anger, fear and sadness at being assaulted, unprovoked. A participant described the shock she experienced at being assaulted, which was perceived to be incomprehensible, as she alluded:

> *"... First of all, I was very shocked ''. And first of all for me to be assaulted it's never something I've in mind that I'll be assaulted"* (P02).

Yet another participant voiced the anger experienced at being assaulted, rationalising that working in the mental health environment was high risk, therefore, being assaulted was perceived to be part of the job, as quoted by the participant:

> *"I was very angry when I was assaulted but then afterwards, I learnt that ... this is part of the work but from the human point of view, you also become a little bit annoyed and*

angry" (P03).

The above participant verbalised that she initially felt intense anger, which somewhat dissipated into 'a little bit…' on learning that there was an expectation of being assaulted because of the nature of the work. The anger experienced was rationalised to 'a human point of view', indicating that nurses are also allowed to become angry at being violated, because they are human beings too.

In addition, the participants reported unprocessed anger, which affected their ability to care for the perpetrators of the assaults, expressed as 'you do not care or not interested', as reported by a participant:

"...you now come with this anger inside sometimes when patient come to you, just look at the patient like this as if you do not care or not interested" (P01).

Another participant verbalised that working in certain high risk wards brought along with it an expectation of assault, as is illustrated by the following participant's quotation:

"I was working in seclusion and seclusion is the most dangerous place to work in, but there you expect that the patients will assault you in 5A (acute admission unit)" (P05).

While some participants expected to be assaulted by patients, others struggled to come to terms with the fact that they were assaulted by the very patients to whom they provided care, which evoked intense feelings of sadness. This was especially true because the assault occurred, unprovoked and unexpected, as illustrated by the following quotation:

"We don't provoke the patient, it just come out of the blue that they assaulted us, for me I feel very heart sore and sad because if someone you render care to attack you..." (P01).

Cognitive reactions were also experienced because of the assaults. Some participants reported feeling confused and disorientated by the assault, while the presence of the perpetrator in the ward was perceived to be threatening. Relief was experienced when patients, who had assaulted staff, were transferred to other wards.

This meant that the participants did not have to see the perpetrator, and experience re-traumatisation, which sometimes happened following an assault, as the following participants expressed:

"I was so confused at the time that I did not know what was happening at the time" (P02).

"... Is much easier now that the patient is taken out of the ward, she is now in another ward" (P03).

The participants' reaction to the assault was sometimes delayed. Away from the threatening environment, the following participant reported experiencing bodily signs in reaction to the trauma experienced:

"Yes, it's only when I got home that I started shaking and feeling like… shivers and tremors" (P06).

In addition, some participants also alluded to post-traumatic stress signs and symptoms that they experienced, due to the assault. These included the inability to sleep, due to flashbacks; hyper-vigilance; and paranoia. A participant described her experience of being unable to sleep because:

"I keep on seeing this person, this patient coming to me and see her big hands striking me" (P02).

The same participant described her paranoia, which she related to feeling unsafe around the perpetrator, whom she did not trust, as well as being hyper-vigilant in the following quotation:

"Nurses have to watchful when she [patient] is in the ward. Of course I was very paranoid, as I said; I never have been assaulted by anybody. Because of that I don't trust and I don't feel safe around her, that's all I can tell you. That's it, and I am still like that honestly I do still feel like that" (P02).

The participants also described a sense of vulnerability that they felt at not being able to protect themselves, when patients assaulted them. The need to defend them against the assault was

evident, but some participants realised that retaliation was not an option, as the patients were mentally ill, as is illustrated by the participant who stated:

"..But unfortunately you cannot fight back to the patient because you must bear in mind it's [a]mentally ill patient, you cannot hit the patient back, if the patient hit [hits] you. But sometimes you really feel you must defend yourself and give the patient a smack or something but you cannot, you healthcare worker you cannot" (P01).

However, the desire to preserve their dignity, after the assault, meant that some staff retaliated. The rationale for fighting back emanated from the perception that victimisation would occur and that the injured staff member would be taunted by colleagues as a participant reported:

"...you have to fight because you the staff member you cannot run because most of the time if you run, the other staff members will make fun of you, the whole hospital will make fun of you and you will be victimised by management" (P05).

The same participant viewed physical fighting by patients as a competition between the staff and patients, in which there was only a win or lose situation. The following quotation refers:

"... and when the manager and the rest of the security came, it was too late. We were already beaten but we won the fight but the last time I got to be kicked against the stomach and punch against the head, that's one incidence' (P05).

Another participant disclosed the fear she felt at having to return to work and fulfil her duties, after being assaulted, as is expressed in the following excerpt:

"I was afraid to come to work, and I was afraid to walk down the passage" (P06).

This sense of vulnerability was further compounded by the lack of support they experienced from the managers, whom they felt, did not listen to their complaints about the patients as the following participant articulated:

"Even if we complain about these violent patients nobody listens" (P01).

Physical abuse by patients was perceived to have long-term effects on participants, which also had a spillover effect on their family life. The effects included re-traumatisation, because of injuries that did not heal, and of not being able to care for the family, when no longer in employment, as the following participants verbalised:

"So many years and all of a sudden if you should retire or resign, still not healed, you will be out but not healed from injury. You will sit for the rest of your life with that injury; it's like a knock that keeps on coming time and again". (P04)

"...as an older person , you don't want to be too badly hurt, by the time you finish working you are no good .You no help for your family…".(P02)

The blame was assigned to the nurses, when the patients assaulted them, as management felt that the nurses might have provoked the patients, who assaulted them. Participants felt unsupported and unappreciated as evidenced by the following quotation:

''They got nothing to do with the nurse, it's just, and did the nurse provoke the patient? What did the nurse do?" (P01).
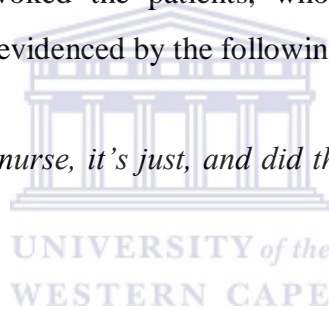
The participants endured assaults, while some tried to make sense of the experience.

4.3.3 Theme 3: Incongruence between patient behaviour and participants' work experience

This theme relates to the management of patients' negative behaviour and the way in which the participants experienced this behaviour. The participants had no frame of reference to deal with the assault, as it deviated from what they had previously experienced. This resulted in a sense of desolation, in the face of adversity. In order to understand their experience of assaults by patients, the participants described the different aggressive behaviour violence that the patients displayed. Two subthemes emerged that are a breakdown of the main themes.

4.3.3.1 Managing aggressive patients

The participants described a phenomena were they had to deal with aggressive patients who displayed unwarranted behaviours. These behaviours, which included unpredictability, rivalry amongst the patient population, rudeness and shrewdness, were unfamiliar to the participants, given their work experience of managing aggressive patients. Patient unpredictability was experienced, when the participants related that the attacks were unprovoked. The following quotation refers:

> *"...that patient is so unpredictable''*

Some participants identified some patients' behaviours as unrelated to mental illnesses, as they were simply, rude. They felt that some patients were not ill at all, but rather displayed antisocial behaviours, for which there was no medication, as the following participant related:

> *"No words [to describe them] because some of them are not sick, it's more of rudeness, some of them are very rude, for rudeness no medication" (P01).*

Another participant described how her work experience with aggressive patients did not contend with the current patient's type of behaviour, which was perceived to be cunning. There were no warning signs to indicate that the patient was going to attack the participant. The participant was usually familiar with aggressive patients' presentation, but the current patient's aggression did not conform to the usual presentation, as disclosed by the following participant's quotation:

> *"... I worked with lot of aggressive patients before but not as sly as this one... This one she does not come all to say I got you [I'm going to attack you], you know" (P02).*

4.3.4. Theme 4: Unprotected staff vulnerable to assault

In this theme, the participants experienced vulnerability, as they were unprotected by the mental health legislation, which focused on the care, treatment and rehabilitation of mental health care users.

4.3.4.1 Staff devoid of rights

. Nurses bemoaned that patients has rights and there is not much about nurse. Some respondents expressed that some patients were gang leaders who consistently disrupt the ward because they know that they are protected by patients' right charter. The managers at the workplace were also deemed unsupportive, which increased their vulnerability.   The participants alluded to the patient's rights of being protected by the Mental Health Care Act 17 of 2002. They experienced themselves as being disrespected by the patients, while doctors were respected. The participants further alluded to the fact that they had no recourse, when they were assaulted by patients as the following participants disclosed:

> *''You know some patients are murders and rapist and gang leaders'. ... patient has rights , you as the nurse you do not have rights ,the patient can assault , there is nothing to happen to that patient, patient will be discharged next week ''. P: 05 He can break your arm, break your leg, he can push out your eye, nothing will happen to that patient because the Mental Health Care Act protects that patient, it do not protect you" (P05).*

"...this mental health act protects the patient's rights, patients has [have] many rights, what about us?" (P04).

This perception was further enhanced by the participants' managers, whom they perceived to be unsupportive, as the managers defended the patients, when there was an incident of aggression in the ward. The participants also alluded to the respect that other professions received from patients, while nurses, being in the service forefront, did not receive the respect that they felt, they deserved.

> *"... it's like a white coat syndrome   everyone respects the doctor because he wears white but us nurses…we get taken for granted, we are like…uh…the mats or what do they say? A doormat, everyone can just step on you" (P03).*

Participants rationalised the assaults by patients as familiarity, as they spent twenty four hours a day with the patients, who were, therefore, familiar with them, giving credence to the quotation from a participant:

"Familiarity breeds contempt" (P03).

The management was perceived to be unsupportive after the participants were assaulted by patients. The participants shared disturbing experiences of not being granted permission to go home, or to the doctor, immediately after the incident. They felt that the managers were not keen to support injured nurses, as expressed by a participant as follows:

"You give them extra work now; you giving them work extra work, paper work. They don't want that paper work .So now you get beaten up by the patient and you got to be abused by the management because you give that person paper work now. WCA [Workman's Compensation Act] forms, and follow-ups , they have to arrange... maybe you off sick they have to arrange for overtime , someone to stand up for you now right ... And follow-up appointments for doctors , they have to check up if did you go to the appointments" (P04).

According to the participants, the reporting of patient assaults on nurses was perceived as extra work for the manager, who was inundated with completing the required forms to report the incident to the relevant authorities. Even when they were injured, participants reported that management often sought to place the blame on the nurses. Video footage, therefore, was viewed to ascertain whether the participants had provoked the patient, as is articulated in the following excerpt:

''So if the patient assaulted you, it's fine they do not use the cameras but if you assaulted the patient, they view the cameras''. They look; they review the cameras to see who started the fight" (P05).

The participants perceived themselves as not being offered any protection from their employers, in the event of assaults on their person, as the patients' rights superseded employee rights.

4.3.5 Theme 5: Required and received supportive interventions

This theme alludes to the support needs expressed by the participants and the supportive

interventions that were in place to support staff, which had been assaulted by patients.

4.3.5.1 Expressed need for support

The participants expressed the need to work in a safe environment. Safety became paramount as it had a spillover effect on the participant's families, who were indirectly affected by the assault, as the following participant expressed:

"... my husband was in shock, he was the one who was asking, what they are doing in your ward if you have patients like this" (P01).

The same participant alluded to the importance of a safe working environment for nurses, who had to care for mentally ill patients, as is indicated in the following quotation:

"... First of all make sure that we are safe because we are caregivers" (P01).

Psychological interventions were deemed important to help the participants deal with the trauma of being assaulted. The interventions focused on debriefing.

The participants expressed the need for financial support to deal with the effects of physical trauma. They mentioned that they needed an allowance, as compensation for working in an unsafe environment. The participant alluded to workers in other high-risk professions, who received an allowance, due to the nature of their work, as is stated in the following quotation:

"...and the other part that hurt me the most, we work in a psychiatric institution [participant raises her voice and becomes emotional], we don't get any danger allowances for many years back now, from 2005 until we... its papers in and out of the Unions. And we do not get any danger allowances where the Police, Correctional Services, air force and South African navy and all that, they get all that [those] allowances" (P04).

4.3.5.2. Support received from peers and managers

Participants also alluded to the support that they received from their colleagues and the management at the institution. The support received included, referral to psychological services, collegial support and financial assistance in the form of doctors' consultations. Psychological interventions refers to support received from psychologists, as well as referrals to ICAS (Independent Counselling and Supportive Services), which is affiliated to the mental health care institution, to assist participants in dealing with the trauma of patient assault, as expressed in the following quotations:

"Very good, yes I saw psychologists, even when I was back at work, I saw 6 psychologists. It worked for me because it helped with that thing of being scared of the patients" (P06).

Collegial support was provided by the security personnel and the professional nurses, employed at the institution. Regardless of the support received, the participant was still afraid of the patient, who had assaulted her, as indicated in the following quotation:

"...the security, they were quite supportive. Actually my peers were quite supportive and eh...
the PN [Professional nurse] was also quite supportive but I was afraid of the patient"
(P06).

Male colleagues were also considered supportive, as they took the brunt of the abuse. The female participants involved the males, when they had to manage aggressive patients in the wards, as disclosed by a participant in the following quotation:

"You always hear from the other staff members, other staff members say no don't worry,
let the male staff member stop them from fighting...um...the lady sisters must step to the
back, let the male subdue them" (P03).

Tangible support, such as free medical consultations, was arranged for staff, which had been assaulted.

4.4. Discussion of the Results

This study set out to describe the experiences of staff that had been assaulted by patients, while working in a psychiatric hospital.

4.4.1. Self-care incongruent to intrapersonal interest

Participants in this study, despite the prevailing experiences of being assaulted, they continued to perform their duties, as they perceived themselves to be dedicated, despite being assaulted by patients and experiencing the effects of the assaults. Working with mentally ill patients was perceived to be desirable and a calling (vocation), rather than a profession, while patients were described, as being like a family away from home, as the following two participants articulated:

4.4.2 Personal responses to trauma

Physical assault of nurses was significant in this study, as all the participants reported being physically assaulted by patients. Similar findings have been reported by Bilgin (2009), who found that 53% (n = 162) of the participants of the study were physically assaulted by patients, who had been diagnosed with severe mental disorders. However, a study conducted by Maguire and Ryan (2007) explored the experiences of aggression and violence among nursing staff in the mental health services in Ireland. They reported that 80% (n = 69) of participants of their study experienced non-threatening verbal aggression, with only 1% (n = 1) of the participants reporting severe physical violence. The sources of the assault included patients and their relatives. Violence from the visitors or relatives is well researched worldwide. A study by Hahn, Zeller, Needham, Kok, Dassen & Halfens (2008), concluded that the two sources of physically harm to nurses were patients and their relatives. Çelik, Çelik, Aırbah & Ugururluo (2007) reported that nurses, participating in the study, disclosed suffering from physical abuse by relatives (70,2 %) and patients (61,5%).

The participants of this current study recounted, in detail, the extent of the physical injuries they had suffered at the hands of the perpetrators, which occurred mostly because the abuse was unexpected. The injuries suffered by most of the participants were severe. These included fractures, swellings and, in one incident, the participant was rendered unconsciousness.

While physical injuries were visible, and may have elicited some support, the participants also

alluded to the psychological and emotional effects, the physical assault had on their personal lives. Daily functioning was affected, which is concerning, given that these nurses were expected to provide nursing care to the patients, who were responsible for impeding their ability to render this care. Bilgin (2009) asserts that violence and aggression displayed by patients may adversely affect the therapeutic environment. This also places the patient, as well as other patients, at risk, as the nursing care rendered may have been compromised, making the patient vulnerable in a non-therapeutic environment.

Anger was frequently expressed, as participants reported becoming extremely angry with the patients after the incident. Similar findings were reported by Çelik et al. (2007) in that anger, helplessness, humiliation and depression were the most common reactions to assault by patients. While these responses may be considered normal to an attack on the self, they may impair psychological functioning. Unprocessed emotions may have serious consequences for the display of caring in a mental health care environment. According to Lanza, Schmidt, McMillan, Demaio & Forester, (2010), staff who had been exposed to assault, may have suppressed reactions. They may experience these reactions as shameful and mismatched with their professional self-image. This would result in them keeping their reactions a secret, which, consequently, reinforces the belief that they alone are experiencing these feelings. Feelings of isolation and decreased self-esteem, therefore, may prevail.

In addition to the physical inability to render nursing care due to the severity of assault, this may affect caring on a deeper level, as participants felt the need to retaliate, interpreted as the need for retribution. However, on a surface level, assault was rationalised as 'being part of the job'. Similar findings were alluded to by Atkinson (2005), who found that violence against health care workers was viewed as a risk of the job, while patients were not held accountable for their behaviour. This author asserts that when this view is held, it creates an opportunity for bias, which increases the chances of health care workers being assaulted by patients, because patients are aware that they will not be held accountable for their behaviour. Literature allude that non-reporting and under-reporting of staff assault by patients occur for the following reasons: management responses to reporting incidents are negative, which discourages reporting of assault; blaming of nurses for the assault; and assault is perceived as being part of the job, given that the mental health care environment is considered a high risk area for assault (Moylan & Cullinan, 2011; Bilgin, 2009; Lanza, 2011).

While assault is a criminal offence, Kumar, Fischer, Ng, Clarke & Robinson (2006) found that staff do not report assaults to the police, and even when they do, a conviction of patients is rare. It is left to staff to decide whether patients, who assault staff, should be pursued. This may exacerbate the non-reporting of assault, as staff may feel that all the energy and time expended in reporting incidents, for which conviction is highly unlikely, may not be worth the effort.

4.4.3 Incongruence between patients behaviour and participants work

While the participants in this current study alluded to the attacks on themselves by patients as being unprovoked, Bilgin (2009) alluded to nurses' interpersonal styles, attitudes and experiences, which predisposes nurses to violence and aggression. This may well have been the case with the participants of this current study, who suggested an unawareness of how the allusions of Bilgin (2009) may have influenced their interactions with the patients. However, given that nurses working in psychiatric hospitals, have to make use of the self as a therapeutic instrument (Frisch & Frisch, 2011) when caring for mentally ill patients, this assertion may be unsupported. Additionally, in this current study, the findings suggested that the participants experienced patient characteristics that had changed, and that they had no working experience of dealing with the current aggressive patients. It may also be that staff members, genuinely, do not identify cues related to aggression, which puts them at risk of assault, as they are unaware.

A study by Myburgh (2007) is consistent with the participant's view about the right charter of the patients. Her study aimed at exploring how nurses understand their social and psychological worlds, specifically with regards to the phenomena of violence, abuse and neglect within health care. This study found that nurses the relationship between nurses and patients were affected by the introduction of the patients' rights charter that stipulates that patients had the right to be treated with dignity, respect, empathy, patience, tolerance and positive attitude. Some participants are of the view that some patient's acts are not caused by the impaired state of mind but they use them use mental health to 'cover up ' or commits criminal acts.

4.4.4 Unprotected staff vulnerable to patient aggression

The participants in this current study alluded to legislation that was established, which protected the rights of patients, while health care workers were not afforded protection against abuse. Similar findings have been cited by Bilgin (2009), who alluded to participants in their study being of the opinion that patients' rights were protected because of legislation, while nurses'

rights were ignored. This feeling of non-protection of nurses was further enhanced by the institutions' management of staff, who had been assaulted by patients.

However, in the areas that were considered 'high-risk', participants expected to be assaulted, given the patient behaviours they encountered. All the participants described feelings of being unsafe and insecure, while on duty. This experienced a spillover effect on their families, who were, therefore, concerned about their safety. Assault is a reality, when working with mentally ill patients, because of the nature of their illnesses. Similar findings were found by Poggenpoel, Myburg & Morare (2011), in which nurses perceived the mental health care environment to be a dangerous working environment. In another study by Arnetz, Hamblin, Essenmacher, Upfal, Ager & Luborsky (2014) on patient-to-worker violent incidents in a hospital, in the United States of America, approximately 90% of the 214 incidents, concerned some form of physical violence, directed towards hospital employees.

4.4.5 Required and received supportive interventions

In this study, management support was perceived to be lacking, as reporting incidents were perceived as increasing management's workload, due to the paper work that had to be completed. The participants also perceived the completion of documentation (incident report writing) as a futile exercise, as there was no recourse for them, other than being referred for medical assistance. The participants reported that they were often blamed for inciting the aggression in patients.

Blaming of the victim was reported by the participants, as it was perceived that they might have provoked the patients, resulting in the assault. However, all participants mentioned that the assaults were unexpected, as it occurred without provocation. Lanza (2011) asserts that the blaming of nurses for the assault has been reported in literature, since the 1980s, however, little has been done about it. This may be because nurses accepted that violence was part of the job. Lanza (2011) suggests that psychiatric nurses may not report the assault, which may reaffirm the public perception that mentally ill patients are dangerous. The stigma associated with mental illness may therefore be perpetuated. Given that mental health care workers work tirelessly to dispel people's fears about mental illness, reporting abuse may be perceived as a contradiction, as it would reaffirm the dangerousness of mentally ill patients. Patients are also not held accountable for their actions; therefore, the cycle of violence on nurses may be perpetuated.

Of concern in this study, is the institution management's perceived lack of support for injured workers. The participants reported that, in some cases, they had to remain on duty, despite being injured. Similar findings have been reported by Moylan & Cullinan (2011) in a study that examined assault and injury in relation to the nurse's decision to restrain. Their findings allude to their participants being threatened with dismissal, if they did not report for duty, despite their injuries, or have medical proof of the severity of their injuries.

The participants had to work in the units with the perpetrators, thereby increasing their risk of repeated assault. Within an unsupportive mental health care environment, the participants reported receiving support from colleagues. These included fellow nurses, security personnel, and even, other patients. This may be because they had also experienced assault by patients, as well as the lack of management support, which may have increased their empathetic responses to their colleagues. Bilgin (2009) avows that nursing staff need to be supported and cared for, so that they may feel safer, which would enable them to provide therapeutic care to patients. Some participants had never been subjected to violence in their homes and were, therefore, unable to comprehend the magnitude of violence displayed by the patients they cared for. They did not have prior experience to draw from, which exacerbated their distress.
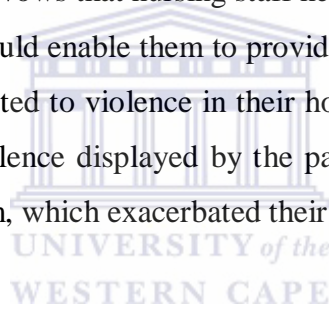
4.9. Summary

The mental health care environment is an unsafe nursing environment to work in. Physical assault of nurses is common, while nurses are vulnerable, as they have no recourse against the perpetrators. Assault is perceived to be part of the job, given the nature of the work. However, the participants experienced personal emotional trauma because of the assaults. The findings of this current study was compared with empirical literature in the discussion, which, in most incidences, supported the findings of this study, depicting violence against nurses as a global problem, rather than a contextual one.

Chapter Five presents the conclusions, limitations and recommendations for clinical practice, education and research.

CHAPTER FIVE   CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

The previous chapter presented the data analysis and the results of the analysed data. The objective of this study was reached, which was to explore and to describe the lived experiences of nurses, who had been assaulted by psychiatric patients at a psychiatric hospital. A descriptive phenomenological design was employed to achieve the objective. It has been disclosed that all the participants in this study were victims of physical assault, working in an unsafe environment. The participants neglected their self-care, in the interest of the patient they cared for. They experienced a range of physical, psychological and emotional reactions, in response to the assaults that they experienced. The management of patient violence was challenging, as they had no previous work experience to draw from. The participants had noticed that the patients' characteristics had changed from what they had previously experienced. Given the lack of staff policies and the nature of mental health work, they were vulnerable to patient assault. The participants also expressed various mechanisms of support that would alleviate and assist them to manage their distress. They lauded the support that they received from their peers and cited the free medical assistance as support from the institution management.

5.2. Summary of the findings and conclusion

The purpose of this study was to obtain information regarding the abuse of nurses by patients in a psychiatric hospital. The aim of the study was to:

•   Explore the lived experiences of nurses, who have been assaulted by patients at a psychiatric hospital in the Western Cape.

A descriptive phenomenological design was used to achieve the aim of study. A summary of the findings below will present a brief exposé of the five main themes that emerged during data analysis of the transcripts. The five themes and their related sub-themes are:

- Self-care incongruent to intrapersonal interest (intrapersonal interest);
- Personal emotional responses (physical effects of assault, psychophysiological emotional responses);
- Incongruence between patient behavior and participant work experience (managing

aggressive patients),

- Unprotected staff vulnerable to patient aggression (staff devoid of rights) and
- Required and received supportive interventions (expressed need for support, support received from peers and managers).

These themes, sub-themes, as well as categories are linked and represent the lived experiences of staff members, who had been assaulted by patients in a psychiatric hospital.

5.2.1. Self-care incongruent to intrapersonal interest (intrapersonal interest)

The participants neglected their self-care due to their interest in, and passion for, nursing. They reported affection for their patients, who were absolved from accountability for their actions, namely, assault of the participants (nurses), as the assaults were understood to be part of their job. The participants perceived the nursing profession as their vocation, which was paradoxical, considering their experience of patient assault. They also failed to comprehend the reasons for the assaults, which were unprovoked.

5.2.2. Personal responses (physical effects of assault, psychophysiological emotional responses)

The personal responses related to the physical, physiological, psychological and emotional reactions that the participants experienced in response to the assault. Physical responses were severe as the participants suffered from fractures, bruises and loss of consciousness.The participants related a range of psychological and emotional reactions, which included signs and symptoms of Post-Traumatic Stress Disorder. After the assaultive incidents, they were blamed by the institution management for provoking the patients to assault, although they reported that the incidents of assault were unprovoked. They experienced the urge for retribution in the face of collegial humiliation, when they failed to retaliate to the assault.

5.2.3. Incongruence between patient behaviour and participant work experience (managing aggressive patients)

The participants were unable to manage patient aggression as the behaviours displayed by the patients (cunning and unpredictable), were not previously experienced by them. The participants were, therefore, unable to draw from past experience of managing aggressive patients. This left the participants vulnerable to unprovoked assault.

5.2.4. Unprotected staff vulnerable to patient aggression (staff devoid of rights)

The participants reported that there was a lack of legislation to protect them against abuse by patients, while the patients were protected by formalised legislation. They attributed this to patient rights, and were of the opinion that their rights were being disregarded. The lack of management support from the institution exacerbated their vulnerability, as the assault was considered part of the job. The participants reported that the reporting of the incidents of violence was alleged to increase the manager's workload, given the amount of paperwork that had to be completed with each incident and, therefore, was not welcomed. In some incidences, the assault of staff was not considered serious and the participants were expected to continue their duties, despite being assaulted.

5.2.5. Required and received supportive interventions (expressed need for support, support received from peers and managers).

The participants expressed the need to work in a safe working environment. They were of the opinion that psychological interventions, such as debriefing and counselling needed to be introduced to support staff members, who had been assaulted. The possibility of remuneration for medical or psychological services to cope with the assaults was expressed. The participants asserted that management should consider paying them a 'danger allowance', depicting the mental health environment as a dangerous working environment to work in. However, they appreciated the support received from peers and, in some instances, the institution management. Support from management included free medical assistance, when the participants were physically assaulted. The female staff relied on the male staff to intervene, when patients were aggressive and fighting. This provided them with a sense of security, but exposed the male staff to physical assault by the patients.

In conclusion, work related violence, namely physical assault against nurses working in psychiatric hospitals, is a serious consequence of nursing work in a mental health care setting. The distress caused by the assault is manifested through a range of emotional reactions in nurses. Dealing with the assault in an unsupportive environment can exacerbate the trauma. However, given that violence against nurses is under-reported, the challenge that remains is, 'How can nurses be supported in this stressful environment, if the magnitude of the problem is unknown?'

5.3. Limitations of the study

The study population was purposively selected to fulfil particular inclusive criteria and, therefore, not all the nurses, employed at the participating hospital, could be selected to participate in the study, which resulted in a small number of participants. Given the time lapse after the assault, the participants may have had time to reflect and rationalise patients' behaviour and their reaction to the assaults, thereby minimising the effects thereof. The findings could also not be generalised, as the study was conducted at only one psychiatric hospital with a limited sample, which is not representative of all nurses at the participating hospital. However, the researcher purposively chose the sampling strategy, to gather information that met the aim of the study, and not to generalise or quantify the findings, looking for distinction based on quality. The participants' coping with physical assault by patients was not explored in this study, which may have elicited responses that could have enabled the staff to respond to staff distress as a matter of urgency.

5.4. Recommendations for nursing practice and education, and research

The recommendations below are based on the research findings and are made for nursing practice and education, as well as research.

5.4.1. Recommendations for nursing practice and education

Nurses have a need to work in a safe and secure environment; therefore, the assessment of risk factors that may potentiate violence should be done on a continuous basis. Specific policies relating to the processes of incident reporting should be formulated and implemented, so that staff can be assured that their well-being is important. Nurses should be involved in decision-making around patient care, which would lead to a sense of self-empowerment.

Staff should be encouraged to report incidents of violence in a supportive environment. Explore the feasibility of paying a special allowance to staff working in psychiatric hospitals, for payment of insurance against the long term effects of physical violence. Staff support structures should be identified within the psychiatric hospital for staff referrals. Regular refresher courses on self-awareness training should be conducted to ensure that staffs is skilled to read patient cues, and in response, implement strategies, such as de-escalation, immediately, in order to prevent incidents of violence against staff. Debriefing sessions must be formalised to increase

own awareness of interpersonal skills, thereby aiding staff in the awareness of cues that may be indicative of potential patient violence. Skills development workshops on the management of aggression to equip staff with skills to manage aggressive patients

5.4.2. Nursing research

A quantitative study on the emotional impact of physical assault on nurses should be conducted. A study should be conducted to ascertain the prevalence of assault on mental health nurses from a national perspective. Possible research topics include: Concept analysis of the term 'assault' in psychiatric hospitals.

5.5. Summary

This final chapter has provided an overview of the research process, which reflected on the purpose of the research and the objectives being achieved. Two limitations of the study were mentioned. Recommendations for the provision of psychological interventions in a safe mental health care environment were mentioned. Recommendations were made for potential research topics, which were considered suitable for research. In conclusion, the study has revealed that physical assault of staff working in psychiatric hospitals is a common occurrence. Given the belief that assault is part of the job, mental health care nurses struggle to comprehend the violence they experience, while caring for patients. Lack of management support perpetuates the cycle of violence experienced, which, in most incidents, has a spill over effect in the personal lives of the nurses, who have been assaulted by patients. It is the researcher's belief that nurses should be supported in this stressful environment.

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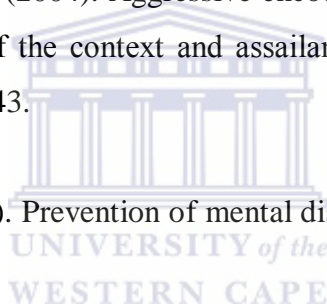
APPENDICES
Appendix 1: Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE
SCHOOL OF NURSING
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwc.ac.za

INFORMATION SHEET

Project Title: Lived experiences of nurses who have been assaulted by psychiatric patients in psychiatric hospital of the Western Cape

What is this study about?

This is a research project being conducted by Phikisile Thiery Yusi at the University of the Western Cape. We are inviting you to participate in this research project because you are a nurse and you work and care for psychiatric patients in a psychiatric hospital and you have experienced how it is like to be assaulted by psychiatric patient and therefore you are likely to share your experiences with the researcher. The purpose of the study is to explore and describe the lived experiences of nurses who have been assaulted by psychiatric at a psychiatric hospital in the Western Cape. Your contribution will be extremely appreciated and will make a difference in the lives of many other nurses who may learn from own experiences, provide insight into these experiences to the psychiatric community, make the voices of nurses with regard to violent attack heard, and affect nurse managers to respond proactively to challenges facing nurses in psychiatric hospital.

What will I be asked to do if I agree to participate?

You will be requested to share your experiences regarding of assault by psychiatric patient. The researcher will schedule an interview with you in a quiet and free from destruction room within the hospital. An unstructured interview will be conducted by the researcher and it will take about 30-60 minutes. The interviews will be tape recorded and transcribed verbatim. You will be asked open ended questions regarding your experiences of assault by psychiatric patient. E.g. I may ask you to describe how it is like to be assaulted by psychiatric patients? How would you describe your lived experiences of assault by psychiatric patient in the

hospital? And these questions will be followed by further questions depending on the answers that you give? There will be no right or wrong answer.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality all audio-taped interviews will be stored in a locked and safe cabinet, not permissible to everyone only the researcher to access to it and we will never mention your name in our records. If we write a report or article about this research study, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no potential risks in this study identified. However, if any psychological/emotional distress during the course of the interview experienced, I will make sure that you are referred to an appropriate empathetic specialist for counseling.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researcher to learn more about your experiences of assault by psychiatric patient. We hope that, in future, other nurses might benefit from this study through improved understanding of these experiences.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

You will be referred for counseling if you experience any psychological/emotional distress as a result of this study. Assault is very traumatic experience and interviewing participants who had assault experience in the past might still elicit an emotional response in the nurses. Therefore should a participant become emotionally distressed he/she will be referred for counseling at the Western Cape Independent Counseling and Advisory Services (ICAS?)

What if I have questions?

This research is being conducted by Phikisile Thiery Yusi with Dr S. Arunachallam (Supervisor) and Dr P Martin (co-supervisor) from the School of Nursing (SoN) at the University of the Western Cape. If you have any questions about the research study itself, please contact the following people:

Mr. PT Yusi (researcher) at 0834862566
 Address: 21 Woodlands Complex
Vrede Street
Durbanville
7550
Email: thiery.yusi@gmail.com
Dr P Martin (Co-supervisor) at: 021 959 9345; pmartin@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Head of Postgraduate Studies: Professor O Adejumo

Director of the School of Nursing: Professor K Jooste

Faculty of Community and Health Sciences,

University of the Western Cape.

P/Bag X17

Bellville

7535

021-959 2271

Supervisor: Dr. Arunachallam

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Appendix 2: Participants' Informed Consent Form

**UNIVERSITY OF THE WESTERN CAPE
SCHOOL OF NURSING**
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwc.ac.za

CONSENT FORM

Project Title: Lived experiences of nurses who have been assaulted by psychiatric patients in psychiatric hospital of the Western Cape.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name: …………………………

Participant's signature: …………………………………

Witness's name: ………………………..

Date: ………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher:

Study coordinator: Dr P Martin.

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959- 9345/2271

Cell: 0725742360

Fax: (021) 959- 2679

Email: pmartin@uwc.ac.za

Appendix 3: Participants' Interview Guide

**UNIVERSITY OF THE WESTERN CAPE
SCHOOL OF NURSING**

**Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9599345, Fax: 27 21-9592679
E-mail: pmartin@uwc.ac.za**

INTERVIEW GUIDE

These questions are the themes, but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.

Questions	Probes
1. Would you please describe what it is like to be assaulted by a psychiatric patient in the ward?	
1. How would you describe your lived experiences of assault by a psychiatric patient in the hospital?	
2. Please explain to me what this experience means to you.	
3. Would you please tell me what type of assault you have experienced?	

Appendix 4: Ethics clearance letter (UWC)

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

4 November 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mr PT Yusi (School of Nursing)

Research Project: Lived experiences of nurses who have been assaulted by psychiatric patients in psychiatric hospitals of the Western Cape.

Registration no: 14/9/28

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

A place of quality,
a place to grow, from hope
to action through knowledge

Appendix 5: Letter requesting permission to conduct study (Lentegeur Hospital)

<div align="right">
21 Woodlands

Vrede Street

Durbanville, 7550

23 January 2015

thiery.yusi@gmail.com

0834862566/ 071 3643798

LAU ext.: 1475
</div>

Director of Nursing

Lentegeur Psychiatric Hospital

Private Bag X 1

Highlands Drive, 7785

Dear Sir/Madam

REQUEST FOR PERMISSION TO COLLECT DATA/INFORMATION OF MY RESEARCH ON NURSES WITHIN THE JURISDICTION OF YOUR AREA/WARDS.

I Phikisile Thiery Yusi, persal 55155863, a postgraduate student studying towards a master's degree in advanced psychiatric nursing at the department of nursing at the University of the Western Cape. I am interested in conducting a study entitled 'Lived experiences of nurses who have been assaulted by patients at a psychiatric hospital in the Western Cape' as part of the master's program with School of Nursing UWC. I am professional nurse who currently works at Lentegeur Psychiatric hospital, LAU and I am interested in exploring and describing the lived experiences of nurses who have been assaulted by psychiatric patients at a psychiatric hospital in the Western Cape. In order for me to continue with the study I need your permission to interview at least 12 nurses who have minimum of at least 12 months working in psychiatric hospital and who have been assaulted by patients in psychiatric hospitals.

I hereby request authorization to conduct this research within the jurisdiction of your AREA. I will also request permission from those nurses who will be willing to participate in the

research study. I enclosed a copy of nurse's consent forms and the information sheet. The research proposal has been approved (see attached ethical clearance letter) by the ethics committee and the senate of the UWC, Lentegeur Research Committee and by the Department of Health Western Cape. Participation in this study is voluntary and participants have a choice to withdraw from the study at any given time. Anonymity and confidentiality of the participants and that of the institution will be ensured by using pseudonyms to protect the participants and institution identities. The results of the study will be made known to the participants and a copy will be made available to the nursing management of the institution before dissemination.

Thank you in advance for your cooperation and assistance.

Yours Sincerely
P.T. Yusi

UNIVERSITY *of the*
WESTERN CAPE

Appendix 6: Letter granting permission to conduct study (Lentegeur Hospital)

Co Highlands Drive & AZ Borman
Lentegeur
Mitchell's Plain
7785

Western Cape Government
Health

28 November 2014

Lentegeur Hospital Research Ethics Committee

Lentegeur Hospital
Highlands Drive
Mitchells Plain
7785

To whom it may concern

Re: Research Project – Nurses within the jurisdiction of your hospital.

Principal Investigators – P.I. Yusi

This serves to confirm that the above research project has been granted ethical approval by the hospital Research Ethics Committee 26/11/2014.

You would be required to submit progress and the final report to the hospital for our records of research conducted at the facility.

Yours Faithfully

Dr P. Smith
Chair – Research Ethics Committee
Lentegeur Hospital

1st Floor, Admin Building,
Tel (021) 370 – 1105 / 1409   fax(021) 371 7359   nadjccok@pgwc.gov.za

66

Appendix 7: Letter requesting permission from the Department of Health

Phikisile Thiery Yusi

<div align="right">

21 Woodlands

Verde Street

Durbanville, 7550

07 November 2014

Thiery.yusi@gmail.com

083 4862566

</div>

The Research Assistant

Attention: Ms Charlene Rodriquez

<u>APPLICATION FORPERMISSION TO CONDUCT MY RESEARCH IN THE FOUR PSYCHIATRIC HOSPITALS IN THE WESTERN CAPE METROPOLE</u>

I, PhikisileThiery Yusi, hereby formally apply for permission to conduct my research in one of the psychiatric hospitals in the Western Cape Metropole.

I am a registered nurse at Lentegeur hospital and I'm also a part time student at the University of the Western Cape and am enrolled in the MCur Masters programme in Advanced Psychiatry. I am a dedicated, sober mind, hardworking and committed registered nurse who always strife towards excellent quality conscious and cost effective nursing care. Hence the reason why I continually strive to enhance learning and improve my knowledge, competencies and skills to ensure that I make a positive contribution to enhance quality cost-effective health care.

The aforementioned proposed study will ensure that I obtain my Master's degree and will contribute to quality holistic and cost effective service delivery in the workplace and the community.
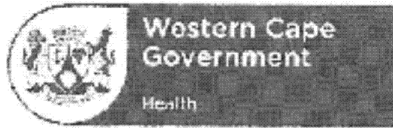
Please find enclosed a copy of proposal as well as the ethical approval letter from the research committee at UWC.

Thank You for considering my application. I eagerly await your favourable response.

Yours Sincerely

P. T. Yusi

Appendix 8: Letter granting permission to conduct study (Department of Health)

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za;
tel: 027 21 483 6867; fax: 027 21 483 9895
9th Floor Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP20_977
ENQUIRIES: Ms Charlene Roderick

Lentegeur Hospital
Highlands Drive
Mitchells Plain
7785

For attention: **PT Yusi**

Re: LIVED EXPERIENCES OF NURSES WHO HAVE BEEN ASSAULTED BY PATIENTS AT A PSYCHIATRIC HOSPITAL IN THE WESTERN CAPE

Thank you for submitting your proposal to undertake the above mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:
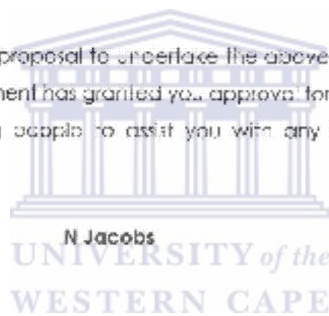
Lentegeur Hospital	N Jacobs	Contact No.: 021 370 1105

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 22/01/15
CC   F VAN DER WAT   CEO: LENTEGUER HOSPITAL

Appendix 9: Editorial Certificate

Idea Corporation t/a

AQUARIAN PUBLICATIONS

04 November 2015

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title
LIVED EXPERIENCES OF NURSES WHO HAVE BEEN ASSAULTED
BY PATIENTS AT A PSYCHIATRIC HOSPITAL
IN THE WESTERN CAPE

Author
Phikisile Thiery Yusi

The research content or the author's intentions were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax number, e-mail address or website.

Yours truly

E H Londt
Publisher/Proprietor

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PUBLISHER/PROPRIETOR
E H Londt