PERCEIVED CAUSES OF PATIENT'S AGGRESSION AND VIOLENCE TOWARDS NURSES IN PSYCHIATRY DEPARTMENT OF MUHIMBILI NATIONAL HOSPITAL DAR ES SALAAM, TANZANIA

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By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Mental Health Nursing of Muhimbili University of Health and Allied Sciences

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1.0 Certification

The undersigned certifies that he has read and hereby recommends for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled: **"Perceived Causes of patient's Aggression and Violence towards Nurses in the Psychiatry Department of Muhimbili National Hospital"** in partial fulfillment of the requirements for the degree of Master of **Nursing (Mental Health)** of the Muhimbili University of Health and Allied Sciences.



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Dr. Deodatus C.V. Kakoko

(Supervisor)

Date 20/11/2010

2.0 Declaration and Copyright

I, **Vumilia Bettuel Mmari**, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature .....

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4.0 Dedication

This study is dedicated to my beloved family who tolerated as well as encouraged me to accomplish this study.

5.0 Abstract

Background: Aggression and violence pose a major problem for public health and health care systems. Aggression causes harm and injuries to self, others or the environment. The incidence of aggression in health care facilities is reportedly on the increase and concerns about management of this problem are growing. Nurses are exposed to aggression and violent behavior in their day to day work Health Service Advisory Committee (HSAC) 1987.

Objectives: The first objective was to assess the perceived causes of patient's aggression towards nurses in psychiatry department of Muhimbili National Hospital; the second was to explore how nurses assess and manage aggressive patients; and the last was to explore the perceptions/feelings of the patients on the management of aggression and violence.

Methods: Qualitative study design was adopted. Convenient and purposeful sampling approaches were utilized to obtain the sample. Two focus group discussions were conducted, one involving patients (n=5). Nurses (n=4) participated in interview and the key informant (n=1). All interviews were audio taped with the permission of participants and were later transcribed. Data were analyzed manually using descriptive content analysis method.

Results: Aggression is a frequent and problematic aspect of psychiatric in-patient treatment. This study has revealed that perceived causes of aggression and violence among patients at psychiatric department are: environment, long hospital stay, abusive language and poor relationship among nurses. The management approach is mainly chemical restrain.

Patients perceived environmental conditions and poor communication to be provocative of aggressive behavior. Nurses however, viewed the patients' mental illnesses to be the main reason for aggression, although the negative impact of the in-patient environment was recognized. From interview responses, it was evident that patients were dissatisfied with the care and management of aggression.

Conclusion: There are differences between the views of nurses and patients about causes of aggression and its management. 'Traditional approaches' (such as medication) seemed to be valued more by nursing staff. Training in the use of fundamental therapeutic communication skills was advocated by patients, whilst the need for greater attention to organizational deficits was advocated by nurses.

Recommendations: It is recommended that, Ministry of Health and Social Welfare should develop, implements, and monitors a national action plan for aggression and violence management. There is also a need to integrate aggression and violence prevention and management into educational policies.

The Department of Psychiatry should develop assessment form for aggression and violence and implement training in specific techniques that provide nurses with safe and effective ways of both preventing and dealing with aggression and violence such as therapeutic communication and de-escalation techniques on a regular basis.

6.0 List of Abbreviations and Definition of terms

CPN	Community Psychiatry Nurse
ENM	Enrolled Nurse Midwife
FGD	Focus Group Discussion
HAT	Health Attendant
HSAC	Health Service Advisory Committee
IDI	In depth interview
MNH	Muhimbili National Hospital
MOH&SW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health and Allied Sciences
NGO	Non-Governmental Organization
RN	Registered Nurse
TN	Trained Nurse
WHO	World Health Organization

Definition of terms

Aggression in this study aggression is defined as any verbal, non verbal or physical behavior that was threatening (to self, others or property) or physical behavior that actually did harm to self, others, or property (Morrison, 1998).

Delusion An irrational belief which has no basis in reality but which cannot be changed by logical persuasion and not in keeping with one's cultural or sub cultural group. (Uys and Middleton, 1997)

Hallucination A sensory perception that occurs in the absence of any appropriate external stimuli. (Kaplan & Saddock, 2003)

Mental health The Mental Health Foundation (MHF) (1999) stated that: 'Good mental health isn't just the absence of mental health problems.' A mentally healthy individual has: developed emotionally, creatively, intellectually and spiritually. Initiates, develops and sustain mutually satisfying personal relationships, face problems, resolves them and learn from them in ways appropriate for the child's age, develops a sense of right and wrong, is confident and assertive, is aware of others and empathizes with them, enjoys solitude, plays and learns.

Violence Use of bodily force to harm or hurt

Very great force in action or feeling (Wheeler, 2008)

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1.0 Chapter One: Introduction

1.1 Background

Currently aggression and violence pose a major problem for public health and criminal justice systems. Aggression usually causes harm and injuries to either self, others or the environment. (Whittington & Wykes 1994b).Despite the high prevalence and serious consequences, methodological problems and difficulties related to the innate nature of the mental illnesses hamper research on violence and aggression. Much has been learned about the complex and controversial relationship between violence and mental disorders and the assessing violence and aggression risk over the last 30 years (Whittington & Wykes 1994a).

Historically, psychiatry emerged to protect the public by confining people with mental illness who can pose a danger to the community (Turnbull, 1999). Privileged with considerable developments in the last century, most of the mentally ill are unconfined and psychiatry has seized its respectable place amongst other medical disciplines. Psychiatrists are no longer regarded as guardians of society against individuals that are "dangerous, bizarre, and immoral". Contrally to general public opinion, violence occurs in individuals with no psychiatry condition, as well as those with psychiatric conditions. In fact, violent crimes are predominantly committed by "mentally well people" and most mentally ill people never commit any act of violence throughout their illness.

Regardless of the existing statistics, mentally ill people are usually associated with violence and aggression in the minds of people, contributing to stigmatization. This stigmatization is mostly due to overblown accounts of individuals with psychiatric conditions committing violent acts. In a recent public survey of 1,444 citizens in the United State of America (USA), 95% of the public thought even when a mentally ill patient was not predicted to be violent to others, legal action was justified to prevent the anticipated harm (Pescosolido et al, 1999).

One of the methodologies used to assess violence and mental health is examining violence or aggression in psychiatric patients. A comprehensive study investigating the

rate of violence in patients with major mental illnesses including (schizophrenia, schizophreniform, dysthymia, mania, cyclothymia, delusional disorders, and brief reactive psychosis) estimated that 8.9% of whole patient population without co-morbidity, substance misuse commits violence. About twenty three percent among those who misuse substance commit violence (Phil and Hoaken, 1997).

A violence risk assessment study reported that 9% of patients with schizophrenia had carried out violent act, compared to 19% with depression, 15% with bipolar disorder, and 17.2% with other psychotic disorders. Epidemiological studies have also reported that those patients diagnosed with bipolar disorders, as well as psychosis are frequently involved in violent acts compared to those diagnosed with non-psychotic depression, anxiety disorders or without any psychiatric disorders (Swanson, 1990; Stueve, 1997).

A study done to examine psychiatric history and prior contacts with psychiatric services among offenders revealed that twenty five percent had prior psychiatry history. Most of those contacts were however related to personality disorder and substance miss-use. Although schizophrenia and affective disorders were over represented in this sample, the majority of these cases had also commitant substance misuse (Wallace, 1998)

It is impossible to predict which patient will be violent with certainty. The United Kingdom is vigorously developing systematized protocols for assessing the risk and management of violence, and find measures to prevent the violence before it occurs (Dolan and Doyle, 2000). Studies in recent years have focused on the accuracy of risk predictors for future violence.

Risk factors associated with aggression and violence can be grouped into three categories: Demographic, clinical and situational. Furthermore contextual cues available at the time of evaluation are helpful data in estimation of violence (Borum, 1996).

Past violent behavior alone appears to be the best demographic predictor (Davis, 1991).The predictive validity of past violent behavior increases with frequency and

seriousness of recent violent behaviors. The age at the first serious offense was also found to be a significant factor. Committing serious act of violent at an earlier age is inversely correlated with future risk; and the number of violent offences is positively correlated with future violent episodes (Borum, 1996).

Studies have reported that there is a causal connection between psychiatric diagnosis and violence (McNiel et al, 1988). Situational and structural variables within treatment and family settings can modulate the risk of violence. Social support networks, housing, and mental health care coverage are important factors in determining the risk of violence (Davis, 1991).

All of these facts indicate that violence is not necessarily characteristic of mental disorders but occurs, with a low degree of frequency, among mentally ill. However, people with certain mental disorders and who have some symptoms are at higher risk of engaging in violence. Nevertheless, risk assessment is crucial and could be life saving for the patient and people related to him/her. One has to also bear in mind that assessment of violence is an ongoing process and should be individualized. Some patients may require close monitoring whilst, for others the risk assessment may be reduced by taking appropriate measures within minutes (Uys and Middleton, 1997).

1.2 Statement of the problem

Studies of persons who are hospitalized in psychiatric facilities for long periods indicate high prevalence of aggression (Kaplan & Saddock, 2003 page 151). However (Whittington & Wykes, 1994b) revealed that the incidence of patient aggression is reportedly increasing yet approaches used to manage a patient with aggression and violence are under evaluated.

Aggression usually causes harm and injuries to either self, others or the environment. Much has been studied about the complex and controversial relationship between violence and mental disorders and the assessment of violence and aggression risk over

the last 30 years (Whittington & Wykes, 1994a). However, the perspective of nurses and patients on the causes of aggression and violence in mental health care facilities is a neglected area of investigation (Whittington & Wykes 1994b).

The need to explore the view of the 'aggressor' is paramount if health care professionals are to understand the cause of this problem and deal with it effectively. Therefore this study aims to explore the perceived causes of aggression and how it is managed. This will enhance the understanding of what is on the ground and suggest proper approach with which to manage aggression and violence.

1.3 Aim of the study

The main aim of this study was to explore perceived causes of patients' aggression and violence towards nurses in the department of psychiatry, how nurses assess and manage aggressive patient in the department of psychiatry; Muhimbili National Hospital as well as the patients' perceptions on the management of aggression and violence.

1.4 Specific objectives of the study

- To identify the perceived causes of patient's aggression and violence towards nurses in the department of psychiatry, Muhimbili National Hospital.
- To explore how nurses assess and manage aggressive patients to the department of psychiatry, Muhimbili National Hospital
- To explore patient's perceptions on the management of aggression and violence admitted at the department of psychiatry, Muhimbili National Hospital.

5 Justification of the study

ıe findings of the study are expected to:

- Add on knowledge of therapeutic communication skills, steps, approaches/strategies of managing aggression and violence for nurses working at the department of Psychiatry, MNH.

- Create awareness among stake holders on how nurses assess and manage aggression; how in-patients feel/perceive the care given during the aggression and violence, and change with manner in which nurses manage aggression and violence.

- Influence health policy makers to provide nurses with appropriate training on risk assessment and management of potential aggression and/or violence.

2.0 Chapter Two: Literature Review and Conceptual Framework

Many nurses are exposed to violent behavior in their day to day work (Health Service Advisory Committee (HSAC, 1987).

Being confronted by violence is a frightening experience. Nurses who are working in psychiatry department are usually in the frontline dealing with physical hostility and are entitled to have training in specific techniques that provide them with safe and effective ways of both preventing and dealing with aggression and violence (Dowson et al, 1999).

Most people are afraid of the mentally ill because they believe that such people are dangerous. In the era of deinstitutionalization, mental health workers have tried to disseminate information to allay that fear. Studies done during the first half of this century show that mentally ill patients are less likely to commit violent acts than the general population as measured by either arrest or conviction rates (Richardson, 1990).

In the second half of the century the picture has changed and the mentally ill show consistently higher arrest rates and higher rates for violent crimes (Richardson, 1990). One has to accept that violence forms part of mental health nursing, and one must therefore learn to cope with this aspect, both emotionally and physically. Ignoring is dangerous and under preparedness can endanger the patient, the helper and family. An evaluation of the literature on staff attitudes toward aggression in health care carried out in the Netherlands (Jansen, et al; 2005) found that, three quarters of the attention was placed on cognition rather than attitudes.

Aggression and violence go together. However, not all aggression leads to violence. Frustration is one of the most pervasive causes of aggression. When a person is moving towards a goal and that movement is blocked by interference, the result is frustration. One reaction to frustration is aggression. This pattern is often seen in children, who lash out at parents when not given what they want (McNiel et al, 1988).

Aggression may also be an automatic defense mechanism when anxiety rises, as in the case of perceived threat or attack. This kind of aggression can be called self-defense, but the threats may not always be real and the anxiety may be vastly exaggerated. Many psychiatric patients react with violence to threats that are part of their psychosis rather than an objective reality (Streiger, 2000).

People, who experience the world as hostile and negative as a result of deliberate action by negative forces, may be more inclined to aggression as a form of payback. Someone with a paranoid inclination may display this kind of payback aggression based mostly on the perception of the patient and with little basis in reality (Streiger, 2000).

Overcrowding of the ward and provocation by staff or other patients are the two main wards –related situational risk factors for violence in psychiatry inpatients. Anxiety, poor communication within staff and between staff and patients, conflict amongst staff members, inexperience and low tolerance of staff in managing violence and shortage of staff are significant staff-related predisposing factors (Davis, 1991).

It is not possible to predict violence in the long term, that is, to predict whether a particular patient will become violent in the future. However, it is quite possible to predict violent in short term. It is essential that nurses be aware of the risk of violence presented by a specific patient at a specific time (Streiger, 2000).

A detailed risk assessment allows the nurse to interpret early warning signs and to manage these before they escalate to the point of violent behavior. The types and range of risk factors are well documented within the literature (Steadman, et al, 1994). There is a range of assessment instruments available to assist nurses and clinical teams to identify the risk including risks of violence.

By understanding their individual risk factors the individual violent risk can be interpreted and expressed as a hierarchy of factors ranging from low or early warning signs to imminent risk of violence. If risk factors can be graded in this way nurses will be

able to plan appropriate intervention designed to interrupt the journey towards violence or de-escalate the risk of violence (Dowson, et al 1999).

The authors have observed a variety of approaches to managing physical aggression and the risk of aggression. Comprehensive risk assessment will provide nurses with an understanding of the context within which patient might express violence and of the associated factors. Risk factors may accumulate, if unchallenged, to create the context within which violent behavior is exhibited (Dowson, et al 1999).

Violence is not an isolated event, but is part of a process that involves both the patient and the staff. Some patients may be threatening, and the best predictor of violence has been found to be previous violent episodes (Hughes and Kleespies, 2003). Often intuition can tell you whether the patient may be violent, and it is better to err on the side of safety than to dismiss your feelings. Leaving your office door open and making sure that you are near the door may be warranted when working with hostile, unpredictable people or it may be prudent to interview the patient with a security guard nearby or with a colleague if you are working in a dangerous setting.

A number of techniques can be utilized in the managing the process of violence. During the first stage, the anxiety level, the patient may appear nervous and pace or move about restlessly. The proper technique at this stage is supportive staff demeanor that will promote verbalization of the feeling of anxiety. Empathetic responses and other interventions to reduce anxiety are appropriate. The second stage is the challenge level during which there are clear signs of aggression with verbal aggression evident. An appropriate technique is directive limit-setting, not in a threatening way but showing concern and empathy. A simple explanation of facts about how the verbal aggression may affect others usually suffices in calming the patient. However, if de-escalation does not occur, the third technique is initiate physical interventions (Katheelin W, 2008).

A supportive posture means that the posture should speak of support and not of assault. Do not approach the patient from the front or behind. Stay a little to the side, with arms

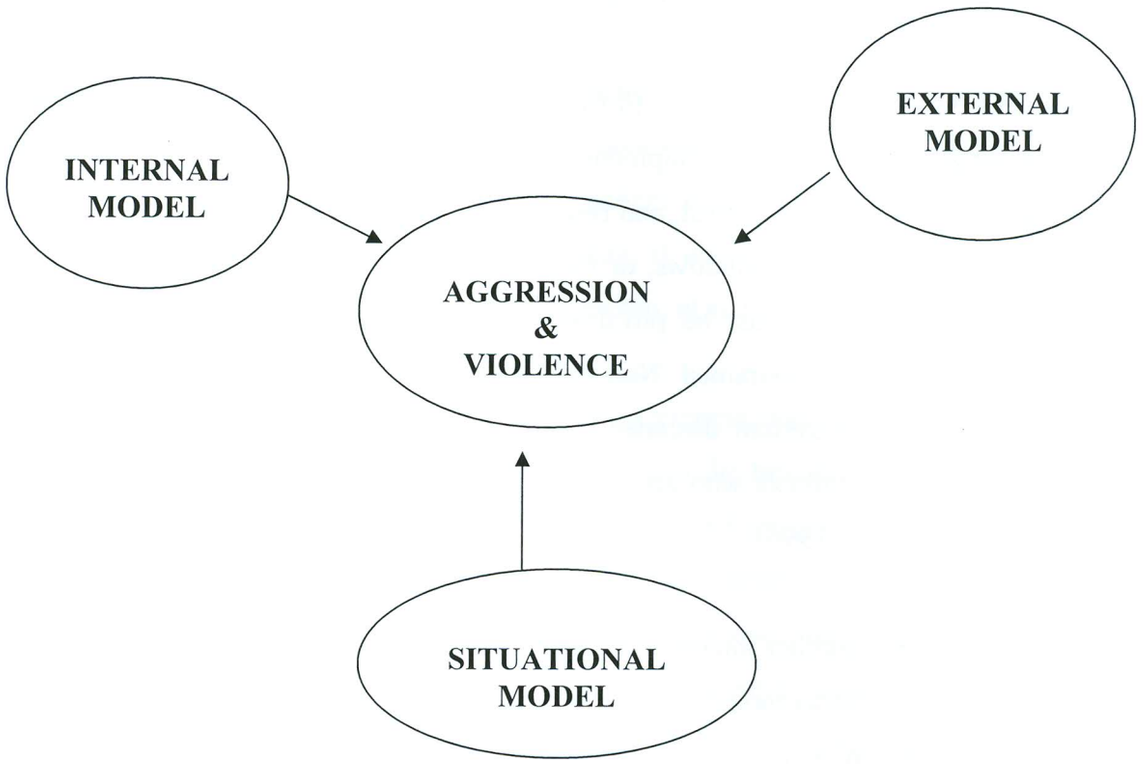
and hands relaxed and open. Do not crowd the patient, but do not stay too far away that a normal tone of voice is impossible. Do not touch the patient. The voice should be low and calm, but clear, do not shout. Do not challenge the patient. Avoid use of words such as okay? Use open ended questions which are more specific "Do you feel that people have been unfair to you? Rather than what is the matter" (Ewing, 1988).

Ensure that you have enough staff (4-6) as back up before approaching the patient. Remove dangerous furniture or equipment from the environment. The crisis level, during this phase there is a loss of control, and resultant physical violence on the part of patient. The patient may break the windows, or furniture, attacking staff or patients or injuring him/herself. The patient must be physically controlled by staff and either placed in seclusion or chemically restrained. Non-violent physical restrain is a safe, non-harmful behavior management system designed to aid staff members by maintaining the best possible care for individuals who are agitated or out of control, even during their most violent moment (Hoff, 1994).

Chemical restrain is another intervention, the most appropriate medication is diazepam 5-10mg given slowly intravenously over two minutes. It is important to administer slowly and carefully in order to prevent respiratory arrest. If intravenous medication is impossible, Haloperidol 5- 10 mg or chlorpromazine 25mg can be given intramuscularly (Hoff, 1994).

Tension reduction level is the aftermath of violence, there is a reduction of tension in the patient, both emotionally and physically. The patient is often drained emotionally and physically. He/She may be quiet, remorseful and apologetic. He/she may also not remember everything that happened before. He may be afraid, confused and/or ashamed. This is the start of gaining the control. The appropriate staff response is to establish therapeutic rapport and communication with the patient. The nurse can assist the patient with gaining control by assisting the patient with physical grooming. It is advisable also to discuss the events and the patient's feelings about them, opening the way for in-depth counseling at a later date (Morrice, 1976).

Theoretical conceptual framework



The reported rise of patient's aggression in mental health in patient's settings has been of interest to researchers for some time (Rippon, 2000), and a number of theories have been developed that endeavor to explain the cause. These can be narrowed down to three conceptual models (patterns/factors): the internal, external and situational/interaction models (Nijman, et al., 1999).

The internal model has been a strong one and numerous studies have explored an association between aggression and illness (Linaker & Busch-Iversen, 1995). Whilst some suggest that delusional violence is rare and factors such as agitation are more common precursors (Powell, et al., 1994), severe psychological is still thought to be a major source of patient's aggression. (Nijman, 2002; Stiernet, et al., 2000) found a strong association between thought disorders and violent behavior during inpatient treatment.

The external model asserts that environmental factors contribute to the incidence of aggression. Issues that have been explored include provision of poor privacy and space, location, type of regime and the impact of unit design (Nijman, et al., 1999). Carmel and Hunter (1993) suggest that the location of an incident was generally the result of associated organizational routines such as medication rounds, handover periods or mealtimes (Vanderslott, 1998). Reports that assault occurs most frequently on Mondays and Tuesdays may also be the result of an increase in nursing and medical activities after the weekend such as ward rounds and group therapy (Flannery, et al., 1994).

Situational/interaction model; as high lightened in a number of studies suggests that negative staff and patient relationships lead to patients' aggression (Nijman, et al., 1999., Duxbury, 2002). Sheriden, et al., (1990) found that patients commonly saw conflicts with staff as a contributory factor. (Whittington and Wykes, 1994a) suggested that certain staff are prone to being assaulted, indicating problematic rather than therapeutic relationships (Harris & Morrison, 1995). Limit-setting styles, coupled with a lack of opportunity for negotiation, are also reported to be problematic (Lancee and Gallop 1995), and some nurses have been accused of being in the wrong (Whittington & Wykes, 1994b). Professionals, it seems, are increasingly forced to act in controlling ways because of institutional pressure, despite controversy about the efficacy of these approaches (Gudjonson, et al., 2004).

The review of literature indicates that violence is not necessarily a characteristic of mental disorders but occurs with a low degree of frequency among mentally ill. However, people with certain mental disorders who have some symptoms are at a high risk of engaging in violence. Past violent acts and substance use disorders are apparently foremost risk factors associated with future violence.

Mental professionals have some limitation in predicting future violence. Risk assessment is crucial and could be life-saving for the patient and people related to him/her. It should be part of everyday psychiatric examination similar to enquiring about suicide and self-mutilation. Good clinical practice compels clinicians to familiarize themselves with risk factors and structure their assessment to guide their judgment in the management of violent patients. Some patients may require close monitoring whilst for some; the risk can be reduced by taking appropriate measures as soon as needed.

3.0 Chapter Three: Methodology

3.1 Study setting

The study was conducted in the psychiatry department of Muhimbili National Hospital. MNH is situated in Upanga west ward, Ilala district. Dar es Salaam. Its historical background is traced back to 1893, when an Arab merchant "Sewahaji" donated money to build a hospital for Africans, and it was named after him. In 1958, the British government built a hospital at the present premises start opened by Princes Margaret and it was initially named Princes Margaret Hospital. The Muhimbili National Hospital Act, 2000 repealed the 1976 Act and Muhimbili National Hospital was established.

Muhimbili National Hospital is the main consultative and teaching hospital in the country. The hospital is a self governing teaching hospital with its own board, which is answerable to the MOH&SW. The hospital has three main objectives: to provide medical services including treatment, care, and rehabilitation, to conduct scientific research and train a variety of health work force cadres.

Muhimbili National Hospital has various departments namely medical, surgical, Obstetrics/ gynecology, pediatric and psychiatric department. The Psychiatric Department has a capacity of 60 beds. It has four wards namely; acute, grade one, female, male wards and outpatient section.

The psychiatry Department provides a 24 hour services. However, is the only mental health facility that provide in patient care in Dar es Salaam. Currently the number of staff is: Grade "A" nurses are 20, ENM/TN-7, Community Psychiatry Nurses-none, Health Attendants- 32, Registrar-4, Psychologist-1, Consultants/specialists-7, Social workers-4. The 27 nurses (RN and ETN) are divided into three shifts per day. Morning duty is from 7am to 3pm, evening duty is from 2 to 8pm, and night duty is from 7.30pm to 8am. Other staffs do official hours starting at 8am to 5pm.

3.2 Study design

Qualitative study design was adopted. The main focus of this study was to comprehend the participants' experiences rather than achieving statistical power and generalisable or replicable findings (Creswell, 1998; Manen, 1990; Miles & Huberman, 1994; Patton, 1990).

A qualitative research approach has both advantages and disadvantages. Depending on a small number of respondents (Denscombe, 1998: Patton, 1990), the qualitative research approach generates criticism that it does not allow for generalizing to a larger population (Silverman, 2000). Miles and Huberman (1994) suggest that, "...words especially organized into incidents have concrete meaningful flavors that often prove far more convincing to a reader, another researcher, policy maker or a practitioner contrary to pages of summarized numbers..." This study will use the perception and experiences of both patients and mental health nurses to highlight important issues on aggression and violence perspectives.

3.3 Study population

According to Kothari (1992), all items in any field of inquiry constitute a population. Any researcher needs specification of the population to which the inquiry is addressed. The population affects decisions that researchers make about sampling and resources required for the study.

The population of this study consists of the following:

In patients

The researcher expected to get rich information, feelings, opinions, perceptions experiences from the patients and the whole process of management and care given in the ward during the aggression and violent situation.

Mental health nurses

The nurses are always in contact with patients, therefore, they are expected to give rich information about aggression and violence in the ward and how they assess and manage the situation.

Block manager

The manager was involved in this study as a key informant because he/she was responsible for providing guidance in violence and aggression risk assessment. The manager was also responsible for proposing or/and developing the staff violence and aggression assessment form. Furthermore, she/he was to recommend in service training on the management of violence and aggression for nurses

3.4 Sample

In this study the sample was drawn from in-patients and nurses working in Psychiatric department to get appropriate representation.

3.5 Sample size

Two focus group discussions for patient were conducted, one involving patients (n=5), one key informant (n=1) and nurses (n=4) working at the department of psychiatry were interviewed in this study.

3.6 Sampling procedure

Purposeful and convenient sampling strategies were utilized to obtain respondents in this study. Inclusion criteria: Nurses who are working in the Department of Psychiatric and in-patients were sampled. Patients with hallucinations, delusions, disorientation, inattention, or poor concentration were excluded from participating in the Focus group discussions. At least one nurse from each shift participated to enrich the information gathered. To maintain rigor of research the sample size included the full range of possible

cases or settings so that conceptual rather than the statistical generalization (Graneheim and Lundman, 2003).

3.7 Data collection methods

Data collection took place in the department of psychiatry from 13 July-03 August, 2009. In depth unstructured interview guides (Appendix B and D) that comprised a list of guiding questions were used. An interview guide is a list of questions that the interviewers were used to interact with participants. Focus Group Discussion guide (Appendix C) was also used. The focus discussion guiding questions were translated to Kiswahili for better understanding and easy participation of the patients.

3.8 Interview

In order to attain the required level of interactions between the researcher and participants, semi-structured interview guides prepared in English and translated in Kiswahili were used in this study to generate data. These methods were useful because individual respondents' experiences formed the basis for the study about their views on aggression and violence among in-patients.

The semi-structured interview, though favored in this study, is criticized for lack of standardization, reliability, and bias and for being time consuming (Pollio, Henley & Tompson, 1997). To dispel these fears, this study exercised thoroughness by ensuring that the researcher was well acquainted with interviewing techniques through a mentoring process of supervisor and careful field note taking. Tape recorder was utilized to capture the information each interview took average of 45 minutes.

3.9 Group Discussion

The focus group discussions were conducted in a quiet conference room at the department of psychiatric. Tape recorder was used to capture information. Each focus group discussion consisted of five group members; the aim of conducting a focus group discussion was to obtain views, feelings, perceptions, experiences from in-patients about

aggression and violence. The interview and focus group discussions guides based on the research study's themes. There were two focus group discussions for in patients. To facilitate free expression, focus group discussion for female patients was conducted separately from that of male patients.

In each interview and focus group discussion session, probes involved open-ended questions and occasionally close-ended questions to elicit information from the informants. Level three patients were involved in the study because they have stabilized. However, recruitment was done before enrolling the patient to the group discussion.

All interviews for individual participants and information obtained from focus group discussions were recorded through note taking and tape recording. The researcher wrote all important issues elaborated by participants in each theme. At the end of each session, the researcher spent some time to review the notes in order to make sure that all important matters that were raised during the interview and focused group discussions were noted. For the recorded information the researcher transcribed the information after discussion and interview. Each focus group discussion took average of 45 minutes

3.10 Non- participant observation

During data collection the researcher was also observing any crisis of aggression and violence in the wards, and how the staff handled the situation.

3.11 Validation of Instruments

Validity refers to the quality that an instrument used in research is accurate, correct, true, and meaningful (Enon, 1998). Instruments were proof read by the supervisor, other lecturers and fellow students. They were refined in terms of relevance, coverage, and consistency through various pieces of advice given by the panel of supervisors. All useful comments were incorporated. Inconsistencies and areas of ambiguities were spotted out. The instruments were then corrected and tested before data collection started.

3.12 Rigors of qualitative research

Credibility was established by ensuring strict participation of only patients who were admitted and nurses who are working at the department of Psychiatry. This was by strictly adhering to the selection criteria. Dependability was ensured by allowing for the process of data generation and analysis to be audited by use of audit trails. The data collection was done in the same area for all participants.

3.13 Data analysis

Data were analyzed manually. Content analysis approach was utilized. Data were put into meaning unit, condensation, categorized into themes, each of which was assigned an identification code. With a simple coding system, it was easy to arrange and rearrange the data in various themes (Creswell, 1998; Lacey and Luff, 2001).

The qualitative data analysis included transcription of all verbatim data sourced from the semi-structured interview and focus group discussion. Transcripts formed the data set that was analyzed. Data analysis involved reading and rereading the transcripts many times, both as a 'whole' to form initial impressions, and then as 'chunks' to analyze these pieces in relation to the whole script, as recommended by Burnard P. (1996). This process was repeated until no new interpretations were found in the data.

In the early stages of analysis, the transcripts were also read and notes were made by the researcher. 'Chunks' of meanings were then summarized by combining and collapsing the data into different themes. For example, all of the data that were discussed causes of violence and aggression were combined. This process was repeated for each transcript. Four themes emerged, namely perceived causes of aggression, assessing aggression and violence, management of aggressive patient and perception of patient on management of aggression. These categorized 'chunks of meaning' were then interpreted using processes of reflection, writing, rewriting, and discussing ideas with the research supervisor. Additionally, member-checking was used to enhance the creditability of data analysis,

and participants assented/agreed that they felt that their experiences had been truthfully represented.

3.14 Research assistants

One research assistant holder of Bachelor of Science in nursing was involved in the study, she was taking field note. Prior to the actual data collection, the research assistant received a one day orientation. The training content included the introduction of the tool, how to conduct interview and focus group discussion. Note taking in the field was also discussed on how to go about it. The research assistant also was introduced to ethical issues in research.

3.15 Ethical Considerations

The first step was to secure ethical clearance from the Research and Publications Directorate of MUHAS (Appendix E). The next step was to get the permission from the Director of Clinical Services Muhimbili National Hospital (Appendix F).

Despite the official permission to conduct the research, confidentiality and consent form were explained thoroughly in simple, understandable language, and participants were allowed to ask questions. Respondents signed the consent form. Permission was sought to tape and record of discussion, as it is difficult to capture everything during an interview and discussion. No names were used in this study, the interviewees and focus group discussion members were identified by numbers.

There were appropriate arrangements, such as having a scheduled interview and focus group discussion and ensuring privacy during the interview and focus group discussion sessions that enabled participants to respond freely. The instruments were administered with minimal interruption of daily activities in the department.

4.0 Chapter Four: Findings

4.1 Introduction

This chapter presents the results of the data on the perceived causes and management of aggression and violence among psychiatric in-patients at the Department of psychiatry Muhimbili National Hospital. The chapter is divided into four themes. The first theme, deals with the perceived causes of violence and aggression, the second theme presents the nurses assessment of patients before aggression and violence. The third theme focuses on care and management of aggressive and violent patients and the last theme is about the perception/feelings of the patients on the care and management of aggression and violence at the department of Psychiatry.

Aggression and violence have been identified as problems in department of psychiatry at MNH. According to the incidence report for the month of September, 2008, six (6) nurses were attacked and injured by patients due to aggression and violence. The causes for aggression varied among patients, some wanted to go home, some had no apparent reasons and one forcefully got out of the ward (Incidence report book at the department of Psychiatry, 2008)

4.2 Social demographic characteristic of respondents

A total of four interviews were conducted, the interview comprised 2 ENM/TN and 2 RN. Two focus group discussions were also conducted for inpatient both male and female patients were included in the study aged between 18 -45 year old. FGD comprised five members per group.

4.3 Perceived causes of aggression and violence

The task of this part was to explain what made the patients to be aggressive and violent in the ward.

Internal factor

From an internal perspective, nurses clearly reported that mental illnesses including substance and drug abuse are a strong precursor to aggression. In relation to this one nurse was quoted saying:

> *According to me for the time I have been working here majority of patients who are aggressive and violent are those who abuse substance like Marijuana (Bhangi) and cocaine most of the time are the ones who are aggressive than those with hereditary mental health illness* (Female registered nurse, married, female ward)

Another nurse had an opposing view that medication especially doses if it is not enough then the patient will be aggressive. In relation to this the following quote illustrates this point:

> *The first thing that makes the patient to be aggressive and violent in the ward is medication if did not get enough dose* (Female Enrolled nurse, grade one ward, married).

The other nurse had the same opinion, he responded that:

> *First and foremost a patient may be aggressive and violent in the ward because of drugs; If the dose patient did not receive adequate will be aggressive* (Male trained nurse, male ward married)

Whereas patients generally shared their view that mental illness causes the patient to be aggressive. In relation to this one patient reported:

> *Illness contributes to the aggression and violence and the way we live inside the ward it is tiresome. Sometime you may want to walk around, you become tired, but the first thing I can say is illness that contributes.* (Male patient, 25 years, male ward)

External factors

Environmental factors seemed to be problematic to both nurses and patients as demonstrated in the following quote from the patient:

> *Environment contributes to aggression, for example the room we are in, the room has grills we are like prisoner, the time to get out is only when we take porridge and sometimes we take our porridge while inside the room, we might not get out the whole day unless when your relative arrives you may get out, therefore this makes me annoyed and be aggressive. Why locking us behind the bars?* (Male patient, 21 years, male ward)

Another patient was saying that:

> *I want to contribute to this point, environment also contributes, it is true like in our place there is a fence like broilers house, and I wanted to add this from speaker number two* (Female patient, 22 years, female ward)

Another patient went further to explain the time for medication and doses, each nurse has his/her own time of giving medication and doses. One patient explained:

> *Enhee... It is concerning medication, one nurse can give you medication at 6 pm while the other at 6.30pm, another one at 7pm, so you find time differs. Why don't they plan time for medication if it is 6pm should be at that time to all nurses, to be frank this is very bad and it is disturbing, they can also disturb the medication in the stomach* (Male patient, 22 years, male ward)

Another patient from the same group this related to:

> *False promises from nurses, they tend to cheat us, an example is when you take us for discussion like this nurse tells you that you will be discharged on the following day for example on Tuesday, but when Tuesday comes they don't discharge you they tell you wait till another Tuesday. Lastly is about ward round, Drs have to see their patient at least every day and not once per week for example my round is Friday, so even if I feel better I won't be able to meet a Dr until Friday. This is wastage of time* (Male patient, 24 years, male ward).

Concerning time for meal one patient in FGD was quoted saying:

> *Meal time for example, most of the time lunch time and dinner are closely together, therefore we don't eat properly. For example you may have lunch at 2.00pm and supper at 5.00pm; it is too close only two hours, with this you cannot eat* (Male patient, 35 years, male ward).

Nurses recognized that the congested condition in the ward contributes to aggression, one nurse was saying:

> *The ward is full of patients; patients are congested, so this is one thing that makes the patients to be aggressive. They ask themselves why we should overcrowd ourselves in one place like this. Why don't we go home? So a patient is tempted to go home* (Female enrolled nurse, grade one, married).

The nature of building also was identified as the contributory factor, another nurse had this:

> *See the way the unit is built, there is no space to let the patient out, and there is no emergency exit door in case of fire or threatening patient (female* Registered nurse, female ward, married).

Interaction/situational factor

Contributory factors such as abusive language, poor communication were identified by patients as a precursor to aggression. Ineffective listening is also highlighted with the patient in their statements. One patient was complaining:

> *Sometimes you may have a problem while in the ward like thirsty you need drinking water or you want to talk to a doctor, then you call a doctor, when you call a doctor and tell him that I have problem does not respond, it pains, it makes people to be annoyed, and be angry You ask yourself why? Then you start to barge gates, sometimes you drag beds, this is due to nurses are not stable, they are not friendly (*Male patient 23, male ward, single)

On the aspect of bad language, another patient said:

> *Relationship is good, though some nurses have bad relationship you may need drinking water but they refuse by saying no water, nurses reply so harshly, there is no respect at all. Another nurse may tell you that don't disturb me I'm tired I want to sleep* (Female patient, 24 years, female ward, single)

In the same group another patient was supporting the point by explaining further:

> *When nurses want to give you injection do not communicate to you, they force us, using bad and abusive language, they call us mad, some nurses their names we know them and we have their names, we have reported them to their boss, but in here we don't disclose their names* (Female patient, 22 years, female ward, single)

4.4 Nurses assessment of patients for aggression and violent

Nurses were asked about the assessment of patients for aggression in their day to day work in order to explore factors that might contribute to preventing aggression and violence. Nurses were also asked if they have any observation form for potential aggressive patients. Through interview it was noted that there is no form to document observations, related to aggression what they do is just look at the patient during the morning and through experience they can determine potentially aggressive patients. One nurse was quoted saying:

> *I use to observe at the patient early in the morning when I arrive at work, and when I give medication I keep on observing. When giving medication one could take medication easily, but the other one will be troublesome. The one who took medication without coaxing the following day may refuse to take medication then I start suspecting that later will be aggressive* (Female registered nurse, female ward,).

One nurse reported that:

> *It is you as a nurse to determine that this patient might be aggressive and start to plan how to manage; otherwise I'm not sure if we have observation form for aggression*
> (Male enrolled TN, male ward).

The key informant was asked if there is an observation form for nurses to guide their observation and document in-patients aggression. The response was:

> *It is a general form for our patients not specifically for aggressive patient (*Male registered nurse, key informant).

In addition the key informant was also asked about the safety policy for nurses working in department of psychiatry with regard to aggression and violence, he said:

> *Recently we have developed the general policy to all cases, we have many and different cases not only aggression but aggressive being one of them (*Male registered nurse, key informant).

4.5 Management of aggression and violence

Nurses were asked if they had ever come across aggressive client, and how they managed those patients. During interview the use of medication was seen as the only method supported by almost all nurses. However seclusion was another approach to calm the patient. Nurse explained that:

> *I was supposed to inform others so that we could be in a group, because we were only two nurses. I went to male ward and female ward to inform other colleagues. We met there we were about six nurses, we used force to handle a patient, at the same time we had already prepared medication, we gave that medicine there after we informed a Doctor what happened and because we also gave medicine he had to document that drug*
> (Female Registered nurse, female ward).

Another nurse said:

> *Since I came here to the department of psychiatry there are a lot of patients I have attended them being aggressive and violent but we help them till they calm down. The first thing is*

> *team work, because with an aggressive patient you cannot manage alone, the team will be there, Dr. will be there and prescribe medication at the same time you give medication in team work. Team work first and then doctor comes for prescription, after prescription we give the patient the prescribed medicine* (Female enrolled nurse, male ward).

In the same way another nurse responded:

> *We lock them in a single room; sedate them continuously till when they cool down, nowadays in acute ward we have separate room for such patients (*Male enrolled TN, male ward).

4.6 Patient' perception/feeling on care and management of aggression and violence

Patients were also asked to express their feelings/perceptions on the care and management of aggressive patient in the ward, one patient from FGD remarked:

> *Is fairly well , for example this sister (no.1) when was brought in the ward, was put in the bed, injected, calmed down, when settled the first day, second day was transferred to female ward, because she was not aware* (Female patient, 22 years, female ward).

Another patient in the same group had a different opinion:

> *I'm not happy with the handling of violent patients, because there is a time when they tie a patient's neck with a bed sheet; this may hurt the patient or may cause death. For example, this patient, no.4 when she was aggressive she was tied to bed sheet around the neck. When the patient screamed the other nurse was told to continue tying the neck with sheet, if she continues crying then the tying also increases, therefore the other management is not right, and that is not good care* (Female patient, 20 years, female ward).

Another patient further expressed that:

> *I feel bad. At time they strangulate us, they tear your clothes, they force you, they strangulate your neck, they tie you with*

> *rope, and then they inject you without any discussion, without asking any question* (Female patient, 22 years, female ward).

Another patient narrated:

> *Myself I was beaten by one nurse, I wanted to get out and other staff in the ward also beat me as well* (Male patient 21 years, male ward).

Patients were also given chance to give suggestions and opinions in regard to care and management of aggressive and violent patients. Patients said they are human beings if the nurses want to do things for us they have to tell us very politely, we understand instead of forcing, everything forcing no humanity. In relation to this, a patient from one of the FGD expressed this:

> *Nurses should be considerate and thoughtful when caring us, not just like they treat cows, we are human beings, we have body like theirs, and we feel pain they think because we are mentally sick they can do what they want. If they want to treat us, give us injection or any care they have first to communicate with us. They have to tell us kindly* (Male patient, 24 years, male ward).

Another patient in the same group further explained:

> *My opinion is they should find an alternative way of handling an aggressive patient instead of tying a sheet around the neck, this may endanger life. Another thing is when a patient gets better and family members can be able to handle their patient, and then should be given medication to continue at home because you are well and there is disturbance in the ward sometimes you may request something from a nurse but you get bad reply; because you are better you may be more stubborn therefore it is better if patient feels ok should be discharged should not stay in the ward* (Female patient, 20 years, Female ward).

Another respondent in the same group had the following opinion:

> *My opinion is that a sheet should not be tied around the patient's neck because they can cause death, they may tie legs and arms until the patient calms down then they may inject, they have to observe until he awakes then should take care slowly till he gets better* (Female patient 22 years, Female ward).

Nurses were also given chance to explain whether they had any training in managing aggression and violence. One nurse described that;

> *I was requesting, for example "I" I'm enrolled nurse midwife, if there is chance I wish to study psychiatric issues, I like it* (Female enrolled nurse, male ward).

Other nurse was saying:

> *Since I completed my TN program, I have never attended any course regarding mental health I wish I could get chance to go for further training because things are changing* (Male enrolled TN, male ward).

The key informant was also asked if there was any plan to train nurses on the management of aggression and violence, he said currently no however, there is plan in place for continuing education not only for aggressive patient but for all cases. During the interview the key informant responded:

> *As I have told you in the beginning, we have guidelines, we have also what we call continuous education and we involve nursing officers, we have psychiatric nurses who have trained for four years some studied at Muhimbili, some at Mirembe, so they have techniques and whenever we call them for job we give them induction course and thereafter we conduct continuous education and we also guide them how to tackle these problems, they have special skills, they have special ways of approaching these patients and right now we have an arrangement, we have some continuous education, for example for this year we have a guideline for continuous education from January up to December, yesterday we talked about nursing management of a depressive patient and I think next if I'm not wrong, this month of March we are going to talk about, we are going to have nursing management of aggressive, and violent patients* (Male RN, the key informant).

5.0 Chapter Five:Discussion

This study contributes to the understanding of what makes the patient become aggressive and violent in the ward at the department of psychiatry MNH. Some of the reasons that were mentioned by patients and nurses are illnesses, abusive language, long hospital stay, and poor relationship among nurses.

5.1 Perceived causes of aggression

In this study, nurses and patients expressed reasons for aggression as problems with nurse relationship, illnesses and restrictive environment. Similar findings have been demonstrated in the previous work by Morrison (1998). Nursing staff perceived that it was internal factors that mostly led to patient aggression. As such there is evidence that pathology is associated with the incidence of violence (Link and Stueve, 1995).

Environmental factors, in contrast, were deemed to be problematic by both patients and nurses. Physical ward layout, restrictive practices and lack of free movement were attributed to aggression. For example, lack of free movement was highlighted as problematic by patients in the FGD. External model asserts that environment factors contribute to the incidence of aggression.

Existing research has examined the negative impact of environmental factors (Nijman, et al, 1999). The use of coercion, limit setting and an authoritarian nursing style has each been reported as a precursor to aggression (Lancee, et al; 1995). How the patient, staff and ward variables interact are not well understood (Nijman, 2002).

In relation to the effectiveness of interpersonal skills in managing aggression, patients clearly saw a number of deficits. The common perspective was that poor communication contributed to the development of patient's aggression a fact corroborated by comments that the use of negotiation was poor and de-escalation ineffective. Negative interaction in

particular, is increasingly identified as an antecedent to non-therapeutic relationships (Duxbury, 2002) and highlighted in this study.

The numbers of factors contributing to the communication problems include a lack of training, inadequate resources and the absence of clear policies (Wright, et al; 2000). Morrison (1998) also previously commented on the impact of non-therapeutic culture in psychiatric setting as a precursor to aggression. The promotion of therapeutic relationships is necessary if aggression is to be handled more effectively (Duxbury, 2002).

Davis, (1991) revealed that overcrowding of the ward and provocation by staff or other patients are the two main wards –related situational risk factors for violence in psychiatry inpatients. Anxiety, negative and demeaning authoritarian attitudes toward patients, poor communication within staff and between staff and patients, conflict amongst staff members, inexperience and low tolerance of staff in managing violence and shortage of staff are significant staff-related predisposing factors. This was also reported in this study from interview (Female Enrolled nurse, male ward).

5.2 Assessment of aggression and violence

A detailed risk assessment allows nurses to interpret early warning signs and to manage these before they escalate to potentially violent behavior (Cutcliffe, 2006). It was established during the FGD and IDI that nurses have no assessment form for potential aggression and violence. Kathleen, W. (2008) revealed that assessing the potential for aggression and violence is crucial, the following factors increase the risk of violence and, should they be present; the patient should be regarded as possessing a high risk for being violent. Medical history: confusion, drug abuse, alcohol abuse and brain injury. Childhood history: abused as a child, antisocial family, adult history: recent violent fight, financial difficulties and frequent change of abode.

5.3 Management of aggression and violence

Clearly patients were dissatisfied with the way aggression was managed. The research results suggested that approaches focused on control, using a number of methods such as restrain, seclusion and medication prevailed. The continuous use of traditional approaches of this kind has been recognized in literature (Turnbull & Patterson, 1999). The seclusion of psychiatric patients is viewed by others as a necessity and still by others as a therapeutic modality (Brown & Tooke, 1992).

With regarding to the process of aggression/violence management, this study revealed that during handling and managing an aggressive patient, there is no de-escalation nurses use force to give patients injections in order to calm them. Medication has been observed to be the first measure for managing aggressive patients followed by seclusion. The most appropriate medication is diazepam 5-10mg given slowly intravenously over two minutes. It is important to administer slowly and carefully in order to prevent respiratory arrest. If intravenous medication is impossible, Haloperidol 5- 10 mg or chlorpromazine 25mg can be given intramuscularly (Hoff, 1994).

The use of alternative strategies was suggested by patients in this study especially negotiation instead of using force and strangulation. The use of alternative strategies such as de-escalation was welcomed by Johnson (2001) and nurses believed that de-escalation was successful in preventing the development of violence.

5.4 Implication for nursing practice

Nurses who are working in the psychiatric department of MNH are usually confronted with physical hostility and are entitled to have training in specific techniques that provide them with safe and effective ways of both preventing and dealing with aggression and violence.

5.5 Implication for nursing research

More studies should be conducted to explore more about assessment for aggression and violence and new approaches to managing aggression and violence in all mental health facilities in Tanzania.

5.6 Limitations of the study

Whilst this is one of few studies exploring causes and approaches to manage patients' aggression and violence in Tanzania, some limitations are evident. First, the sample comprised only two focus group discussions and four interviews of nurses from mental health wards. Secondly, the limitations of relatively convenience sample threaten external validity. Thirdly, the validity of the patients' ideas and opinion were questioned.

6.0 Chapter Six: Recommendations

1. MOH & SW should create, implement, and monitor a national action plan for aggression and violence management.

2. There is a need to integrate aggression and violence prevention and management into educational policies

3. The department of Psychiatry should develop observation forms for aggression and violence to enhance proper care and management.

4. Implement training in specific techniques that provide them with safe and effective ways of both preventing and dealing with aggression and violence such as therapeutic communication and de-escalation techniques on regular basis.

5. There is a need to conduct further research to address the roots of aggression and violence and its consequences and management.

7.0 Chapter Seven: Conclusion

There are differences between the views of nurses and patients about the causes of aggression and its management. 'Traditional approaches' (e.g. medication) seemed to be valued more by the nursing staff. Training in the use of fundamental therapeutic communication skills was advocated by patients, whilst the need for greater attention to organizational deficits was advocated by nurses. From the interview responses, it was evident that respondents who were in-patient dissatisfied with the care and management during aggression.

This study has revealed that it is more common for psychiatric nurses to experience verbal and physical aggression (Whittington, 1994b). These important findings suggest that educative process such as in-service for nurses can assist in raising both the knowledge and the skills in the use of therapeutic tools such as de-escalation for aggression and violence.

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