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A MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY PSYCHIATRIC NURSES WORKING IN A PSYCHIATRIC INSTITUTION

BY

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CO-SUPERVISOR       DR  A Temane

SEPTEMBER 2015
I dedicate this thesis to my entire family: parents, siblings and, in a special way, my two beautiful daughters Grace and Delphia and to their mom Deborah.

Thank you for your love and support that enabled me to go the extra mile while my strength seemed waning. At times when I felt discouraged, you were there to encourage me. You patiently put up with my long hours and some sleepless nights. You believed in me when I had doubts about myself, you prayed for me when I needed God’s strength the most.

Thank you for being who you are and above all thank you for letting me be me. I am most grateful to God to have you in my life.
Dear God of mercy and compassion, I thank you for immeasurable blessings you have bestowed on me, for guiding me to the completion of this work. May it change the lives of those it is intended to help.

Dear psychiatric nurse participants, thank you for opening my eyes to so many challenges you were going through. I could not have imagined that your dedication and commitment to psychiatric patients tell a story that even a deaf person can hear.

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Grace and Delphia, my beautiful daughters, I love you more than anything. Thank you for your presence, your smiles and noises at times that reminded me how blessed I am to be a father when I was totally absorbed by the books.

My Mom and Dad, Thank you for raising me in a loving environment, for teaching me how to be responsible. Dad you would have loved to see this work but the Good Lord had his plan. Rest In Peace beloved father.

To all of you, close and far, who touched my life during this research study in one way or another. Thank you so much and may the Good Lord be generous with you and all your loved ones.
SUMMARY

The researcher was working in a public psychiatric hospital when he noticed that aggression that psychiatric nurses experienced from the patients was spilling out of control. Psychiatric nurses were trying everything they could to manage this aggression but, with no positive results. He was moved by compassion and wanted to assist them as the ineffective management of aggression was leading to negative behaviours such as absenteeism, abusing drugs (mostly alcohol) and the development of an “I don’t care attitude”.

The overall purpose of the research study was to develop, describe, implement, and evaluate a model that could be used as a framework of reference to facilitate the effective management of aggression as an integral part of the mental health of psychiatric nurses experiencing aggression in a psychiatric institution.

A qualitative, exploratory, descriptive, contextual, and theory generative research design was utilised to accomplish the purpose of the research study. The model development comprised four steps.

Step one consisted of concept analysis that comprised identification, definition and classification of the central, essential and related concepts in the model. During concept analysis, the facilitation of the effective management of aggression was identified as the central concept for the model.

Step two consisted of the description of the relationship between the concepts of the model.

During step three, the model to facilitate the effective management of aggression experienced by psychiatric nurses working in a psychiatric institution was described. The model structure and process were discussed. The structure of the model was described based on its purpose, assumptions and the context. The central concept was defined, and the relationship statements were described. The process of the model was described in three phases: the relationship phase, the working phase and the termination phase. The evaluation of the model by an academic panel of experts in model development, and the description of the implementation of the model as well as the guidelines for implementation of the model were all achieved. The
evaluation of the model was based on the criteria of clarity, simplicity, accessibility and importance established by Chinn and Kramer (2008:238-248).

Step four consisted of implementation of the model through a relationship phase, a working and a termination phase. During the relationship phase, the advanced psychiatric nurse practitioner, together with psychiatric nurses, established a common understanding of what aggression consisted of in the context of how the psychiatric nurses experienced it and also their participating in this research study, its impact and how alternatives means to manage it could be sought and applied. This happened after rapport had been built and trust established. During working phase, the advanced psychiatric nurse facilitated the process enabling the psychiatric nurses to devise the alternatives and to commit to implementation of these alternatives. The termination phase consisted of the evaluation of the model based on the participants' experience during implementation and the withdrawal of the advanced psychiatric nurse practitioner, letting the psychiatric nurses take ownership of their gains and manage aggression effectively on their own.

Data was collected from 16 psychiatric nurses, representing ten wards, by means of naïve sketches and Tesch's method (Creswell, 2003:192) for open coding was used for data analysis. The interactions between the researcher and the participants lasted for six months through which several meetings were held. The process, frequency and the duration of these meetings are discussed in 5.2.2. Consensus was reached between the researcher and an independent coder. Guba's method of trustworthiness (Lincoln & Guba, 1985:301-331) criteria of credibility, transferability, dependability and confirmability were used. For ethical considerations, the recommendations of the South African Medical Research Council (MRC, 2003:2-6) concerning the autonomy of the person, beneficence, non-maleficence and justice were followed.

The psychiatric nurse participants expressed increased awareness of the work environment, and they rediscovered the joy of being psychiatric nurses and eagerness to share their experiences with fellow nurses. The rediscovered joy of being a psychiatric nurse enabled the psychiatric nurse participants in this research study to be more open and understanding to the psychiatric patients in resolving conflicts. This made patients more trusting and less aggressive as the patients
themselves became receptive to the psychiatric nurses’ endeavours. The goal of effective management of aggression was achieved.
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPER ONE: BACKGROUND, RATIONALE AND OVERVIEW</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Background and rationale</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Problem statement</td>
<td>13</td>
</tr>
<tr>
<td>1.4 Research purpose and objectives</td>
<td>14</td>
</tr>
<tr>
<td>1.4.1 Research Purpose</td>
<td>15</td>
</tr>
<tr>
<td>1.4.2 Research Objectives</td>
<td>15</td>
</tr>
<tr>
<td>1.5 Paradigmatic perspective</td>
<td>15</td>
</tr>
<tr>
<td>1.5.1 Meta-theoretical assumptions</td>
<td>16</td>
</tr>
<tr>
<td>1.5.2 Theoretical assumptions</td>
<td>18</td>
</tr>
<tr>
<td>1.5.2.1 Theory of Health Promotion in Nursing</td>
<td>18</td>
</tr>
<tr>
<td>1.5.2.2 Social Constructivism</td>
<td>18</td>
</tr>
<tr>
<td>1.5.2.3 Definition of key concepts</td>
<td>19</td>
</tr>
<tr>
<td>1.5.3 Methodological assumptions</td>
<td>22</td>
</tr>
<tr>
<td>1.6 Research design and method</td>
<td>22</td>
</tr>
<tr>
<td>1.6.1 Research design</td>
<td>23</td>
</tr>
<tr>
<td>1.6.2 Research method</td>
<td>23</td>
</tr>
<tr>
<td>1.6.2.1 Step one: Concept analysis</td>
<td>24</td>
</tr>
<tr>
<td>1.6.2.1 a) Phase One: Concept Identification</td>
<td>24</td>
</tr>
<tr>
<td>1.6.2.1 b) Phase Two: Definition and classification of concepts</td>
<td>25</td>
</tr>
<tr>
<td>1.6.2.2 Step two: Relationship statement</td>
<td>25</td>
</tr>
<tr>
<td>1.6.2.3 Step three: Description of the model</td>
<td>25</td>
</tr>
<tr>
<td>1.6.2.4 Step four: implementation and evaluation of the model</td>
<td>27</td>
</tr>
<tr>
<td>1.7 Measure to ensure trustworthiness</td>
<td>27</td>
</tr>
</tbody>
</table>
Chapter Two: Research Design and Method

2.1 Introduction

2.2 Research design
   2.2.1 Qualitative design
   2.2.3 Exploratory design
   2.2.4 Descriptive design
   2.2.4 Contextual design
   2.2.5 Theory generative approach

2.3 Reasoning strategies
   2.3.1 Inductive
   2.3.2 Deductive reasoning
   2.3.3 Analysis
   2.3.4 Synthesis
   2.3.5 Derivation

2.4 Research method
   2.4.1 Step One: Concepts Analysis
2.4.1.1 Identification of central concept 44
2.4.1.2 Definition of the central concept and classification 45
2.4.1.3 Step Two: Placing concepts into relationship 47
2.4.2 Step Three: Model Description 47
2.4.2.1 What is the purpose of the model? 47
2.4.2.2 What are the concepts of the model? 48
2.4.2.3 How are the concepts defined within the model? 48
2.4.2.4 What is the nature of the relationship? 48
2.4.2.5 What is the structure of the model? 48
2.4.2.6 On what assumptions is the model based? 49
2.4.3 Step Four: Model Implementation and evaluation 50
   a) Population and sampling 50
   b) Sampling criteria 51
   c) Sampling size 51
   d) The role of the researcher 52
   e) Data collection 53
   f) Data analysis 56
2.5 Measure to ensure trustworthiness 57
2.5.1 Criterion of true value: Credibility Strategies 66
2.5.2 Criterion of applicability: Transferability strategies 68
2.5.3 Criterion of Consistency: Dependability Strategies 68
2.5.4 Criterion of Neutrality: Confirmability Strategy 69
2.6 Ethical considerations 70
2.7 Summary 70

CHAPTER THREE: DEVELOPING A MODEL AS A FRAMEWORK
OF REFERENCE FOR THE FACILITATE EFFECTIVE MANAGEMENT
OF AGGRESSION EXPERIENCED BY PSYCHIATRIC NURSES WORK-
3.1 Introduction

3.2 Concept analysis

3.2.1 Phase 1: Identification of central concept

3.2.1.1 Aggression has Contributing factors

3.2.1.2 The experience of aggression leads to negative feelings ...

3.2.1.3 Psychiatric nurses are unable to manage aggression effectively

3.2.2 Phase 2: Definition of the of Central concept and essential attributes

3.2.3 Dictionary definitions of Facilitation

3.2.4 Dictionary Definitions for the concept effective

3.2.4.1 Subject Definitions of Effective

3.2.5 Dictionary Definitions of the concept ‘self-management’

3.2.5.1 Subject definitions of “Self-management”

3.3 Conceptual definition of the central concept

3.3.1 Definition of the main concept

3.3.2 Constructing a model case

3.4 Phase 3: The classification of the concepts

3.5 Relationship statements

3.6 Conclusion
CHAPTER FOUR: DESCRIPTION OF THE MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY THE PSYCHIATRIC NURSES WORKING IN A PSYCHIATRIC HOSPITAL

4.1 Introduction

4.2 Overview of the model

4.3 Structure of the model

4.3.1 Purpose of the model

4.3.2 Assumptions of the model

4.3.3 Context of the model

4.4 Theoretical definition of the concepts

4.4.1 Definition of the central concept: facilitation of effective management of aggression

4.4.2 Definition of related concepts

4.4.2.1 Facilitation

4.4.2.2 Effective

4.4.2.3 Self-management

4.5 Structure description
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5.1</td>
<td>Context of the model</td>
<td>110</td>
</tr>
<tr>
<td>4.5.2</td>
<td>Relationship Phase</td>
<td>112</td>
</tr>
<tr>
<td>4.5.3</td>
<td>Working phase</td>
<td>116</td>
</tr>
<tr>
<td>4.5.4</td>
<td>Termination phase</td>
<td>117</td>
</tr>
<tr>
<td>4.6</td>
<td>The model process description</td>
<td>119</td>
</tr>
<tr>
<td>4.6.1</td>
<td>Relationship Phase</td>
<td>119</td>
</tr>
<tr>
<td>4.6.1.1</td>
<td>Building trust</td>
<td>120</td>
</tr>
<tr>
<td>4.6.1.2</td>
<td>Understanding aggression according to the psychiatric Nurses’ perception</td>
<td>121</td>
</tr>
<tr>
<td>4.6.1.3</td>
<td>Imparting Hope and Belief</td>
<td>123</td>
</tr>
<tr>
<td>4.6.2</td>
<td>Working phase</td>
<td>133</td>
</tr>
<tr>
<td>4.6.2.1</td>
<td>Facilitation of self-awareness</td>
<td>125</td>
</tr>
<tr>
<td>4.6.2.2</td>
<td>Facilitation of Communication Skills</td>
<td>127</td>
</tr>
<tr>
<td>4.6.2.3</td>
<td>Facilitation of stress management</td>
<td>129</td>
</tr>
<tr>
<td>4.6.2.4</td>
<td>Facilitation of Conflict Management</td>
<td>131</td>
</tr>
<tr>
<td>4.6.3</td>
<td>Termination Phase</td>
<td>132</td>
</tr>
<tr>
<td>4.7</td>
<td>Guidelines for the operationalization of the model to facilitate effective management of aggression</td>
<td>133</td>
</tr>
<tr>
<td>4.7.1</td>
<td>Relationship phase</td>
<td>133</td>
</tr>
<tr>
<td>4.7.2</td>
<td>Working phase</td>
<td>137</td>
</tr>
</tbody>
</table>
4.7.3 Termination phase 144
4.8 Evaluation of the model 145
4.9 Conclusion 150

CHAPTER FIVE: THE IMPLEMENTATION, EVALUATION, AND GUIDELINES TO OPERATIONALISE THE MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY PSYCHIATRIC NURSES WORKING IN A PSYCHIATRIC HOSPITAL 151

5.1 Introduction 151
5.2 Implementation 152
5.2.1 Relationship phase 152
5.2.2 The Working Phase 153
5.2.2.1 Facilitation of self-awareness 155
5.2.2.2 Facilitation of communication skills 157
5.2.2.3 Facilitation of stress management 158
5.2.2.4 Facilitation of conflict management 159
5.2.3 Termination Phase 160
5.3 Description of the results 161
5.3.1 Research setting 162
5.3.1 5.3.2 Demographic profile of the participants 162
5.2.3 Researcher’s observation 162
5.4 Discussion of the results 164
5.4.1 Overview 165
5.4.2 The relevance of the model implementation met the psychiatric nurses’ expectations 169
5.4.2.1 The model answered to the psychiatric nurses’ workplace challenges 169

5.4.2.2 The suggested interventions were part of what psychiatric nurses are supposed to do 170

5.4.2.3 The model implementation increased awareness of the participants 171

5.4.2.4 The suggested interventions were part of what psychiatric nurses are supposed to do 170

5.4.3 The model implementation increased awareness of the participants 171

5.4.3.1 The increased awareness led to teamwork 173

5.4.3.2 The increased awareness led to improved quality patient care 174

5.4.4 The participants to the model implementation experienced mixed feelings ranging from empowerment to frustration 176

5.4.4.1 The participants who had a feeling of empowerment also felt urged to share their new experience 176

5.4.4.2 The participants who felt frustrated attributed it to either negative staff attitude, lack of consistency in dealing with aggressive patients or lack of confidentiality 182

5.4.5 The implementation of the model met with some challenges 185

5.4.5.1 Unpredictability of patients’ aggression 185

5.4.5.2 Mixing of all categories of patients 185

5.4.5.3 Lack of resources 186
5.4.5.4 Lack of support from nursing management 186

5.5 The psychiatric nurse participants’ experience of the model implementation 188

5.5.1 The model was understandable 189
5.5.2 The model was easy to implement 189
5.5.3 The model was relevant 190
5.5.4 Usefulness of the model 191
5.5.5 The overall impression of the model implementation 192

5.6 Summary 194

CHAPTER SIX: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS 195

6.1 Introduction 195
6.2 Conclusion of the research study 195
6.3 Limitations 200

6.3.1 Structural environment 200
6.3.2 Types of participants 201
6.3.3 The workplace environment for the researcher 201
6.3.4 The working environment of the participants 202
6.3.5 The use of English as medium of communication 202
6.3.6 The scarcity of information on aggression self-management in the South African context 202
6.3.7 The method of data collection 203
6.3.8 The researcher serving also as interventionist 203
6.4 Recommendations for nursing practice, education and research 203
6.4.1 Recommendations for Psychiatric Nursing Practice 203
6.4.2 Recommendations for nursing education 205
6.4.3. Recommendation for the nursing research 205
6.5 Summary 205
6.6 Original contribution 206
6.7 Conclusion 206

Bibliography 207

Indexes 230

Annexure I: Naïve sketches 250
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 2.1</td>
<td>Measures to ensure trustworthiness</td>
<td>57</td>
</tr>
<tr>
<td>Table 3.1</td>
<td>List of attributes to the concept “facilitation”</td>
<td>82</td>
</tr>
<tr>
<td>Table 3.2</td>
<td>List of the essential attributes of the concept “facilitation”</td>
<td>82</td>
</tr>
<tr>
<td>Table 3.3</td>
<td>List of attributes to the concept “effective”</td>
<td>85</td>
</tr>
<tr>
<td>Table 3.4</td>
<td>List of essential attributes for the concept “effective”</td>
<td>86</td>
</tr>
<tr>
<td>Table 3.5</td>
<td>List of attributes to the concept “self-management”</td>
<td>89</td>
</tr>
<tr>
<td>Table 3.6</td>
<td>Essential attributes of the concept “self-management”</td>
<td>90</td>
</tr>
<tr>
<td>Table 3.7</td>
<td>The essential and related criteria of the concept “Facilitation of effective self-management”</td>
<td>91</td>
</tr>
<tr>
<td>Table 5.1</td>
<td>The summary of the results of the model implementation</td>
<td>164</td>
</tr>
<tr>
<td></td>
<td>Grouped in central theme, categories and sub-categories</td>
<td></td>
</tr>
<tr>
<td>Figure 4.1</td>
<td>A model to facilitate effective management of aggression experienced by psychiatric nurses working in a psychiatric institution</td>
<td>100</td>
</tr>
<tr>
<td>Figure 4.2</td>
<td>The context of the Model</td>
<td>111</td>
</tr>
<tr>
<td>Figure 4.3</td>
<td>The relationship phase</td>
<td>113</td>
</tr>
<tr>
<td>Figure 4.4</td>
<td>The working phase</td>
<td>116</td>
</tr>
<tr>
<td>Figure 4.5</td>
<td>Termination phase</td>
<td>118</td>
</tr>
</tbody>
</table>
CHAPTER ONE: BACKGROUND, RATIONALE AND OVERVIEW

A weed is a flower whose virtues haven’t been discovered (Leeming, 2003:79).

1.1 INTRODUCTION

In this chapter, the background of the research study, the problem statement, the purpose and objectives of the research study, as well as the paradigmatic perspectives of the study are discussed. This chapter also covers the discussion on the measures to ensure trustworthiness and ethical considerations of the research study, the division of chapters and a conclusion.

Throughout this research study, the researcher will be referred to as “he” as this research has been conducted by a male researcher. For the purpose of clarity, the term “mental health care user”, as recommended by the Mental Health Care Act No 17 of 2002 (Government Gazette no. 24024), will be replaced by “patient”.

The Mental Health Care Act no 17 of 2002 (Government Gazette no. 24024) refers to the term “mental health care user” to designate any person who uses mental health care services, including patients, family members, and healthcare providers. Since this research study focuses on the aggressive incidents experienced by the psychiatric nurses from the patients, it is relevant that the concept “mental health care user” be replaced by the term “patient” to avoid confusion. Therefore, the word “patient” needs to be defined.

In the context of this research study, the concept “patient” will refer to any person, male or female, adults or adolescents, who use the mental health care institution services where this research study is being conducted. The person referred to as a patient, uses the mental health care institution for the sole purpose of receiving care, treatment and rehabilitation offered by the institution designated for such purpose as prescribed by the Mental Health Care Act no 17 of 2002 (Government Gazette no. 24024).
1.2 BACKGROUND AND RATIONALE

Psychiatric nurses, like other health care providers, work under challenging workplace conditions. These challenging conditions range from a shortage of staff to increasingly frequent aggressive incidents (Bimenyimana, 2008:37-57). The following extract from a medical doctor’s letter highlights the current situation.

“I write this in my room, after another sleepless night tending to the needs of others. I am tired to my core, yet I am unable to sleep because of the stress and anxiety I constantly feel. I have spent the last 24 hours saving the lives of my patients, and yet I have received nothing but abuse – from my colleagues, other healthcare providers and, mostly, the very people I am trying to help. I love my job. I love helping people…. Gone are the days when doctors, and other health-care providers, were treated with respect. And my biggest problem is that I do not know how much longer I, or my colleagues can cope” (Mkhize, 2013:n.p.)

The above excerpt describes the general conditions under which healthcare workers are operating in South African health care institutions. The challenges of aggression faced by psychiatric nurses in executing their duties will be further discussed.

Aggression has multiple forms and different definitions, depending on who defines or experiences it (Foster, Bowers & Nijman, 2007:141). In this research study, aggression is defined as any act or omission that results in physical, psychological, emotional, or spiritual discomfort. It entails verbal, non-verbal or physical expression such as swearing, hostile looks, threats, indecency, inappropriate touch, consciously withholding information regarding one’s health, intentional noncooperation, embarrassing someone and ultimately using physical force.

Despite its multifaceted forms and definitions, aggression affects every member of the human society directly or indirectly whether as a victim or a perpetrator. Aggression is not limited to any given space, time, or social strata. In the context of South Africa, aggression has become the central focus of the media and its magnitude is felt by everyone. Jolly (2010:1) and Ward, Van der Merwe and Dawes (2012:4-29) state that the country, its people and their history have consistently...
witnessed aggressive incidents since pre-colonial times up to today. These aggressive incidents that affect the members of the society affect also psychiatric nurses and patients alike, as these are also members of a community, members of the society. The aggression that affects the community affects psychiatric nurses and the patients as well and has an impact of how they interact and relate to one another. The aggression that patients and psychiatric nurses are exposed to in the community may be carried over in the psychiatric institution settings. Kelloway, Barling and Hurrel (2006:336) argue that members of organisations located in violent communities are more likely to be exposed to people who engage in violentbehaviours. Following this logic, and given the limited information on aggressive incidents experienced by psychiatric nurses in South Africa (Van Wittenburg, Long, Lu, Zhao, Corbiere, Henderson, Kidd, Saunders, & Yassi, 2004:1), I describe here below some aggressive incidents that took place in different components of the South African society, as this provides an overview of the aggressive incidents experienced by some psychiatric nurses in their living or workplace environments.

As long as ten years ago, comparing South Africa to the rest of the world, Matzopoulos (in Ward, Van der Merwe & Dawes, 2012:29) demonstrated that the South African homicide rate was more than five times higher than the global average; suicide among South African males exceeded world rates for all ages, except sixty plus years; and local road traffic deaths were roughly double the world rate. In recent years aggressive incidents have continued to be an everyday part of daily news in different media. The year 2008 was marked by xenophobic incidents that left tens of thousands of migrants displaced, amid mass looting and destruction of foreign-owned homes, properties and businesses across the country (Patel, 2013:n.p.). The same author reported the news from the Consortium for Refugees and Migrants in South Africa, stating that attacks on foreigners have continued, with national statistics showing that in 2011, on average, one person a week was killed while 100 were seriously injured and over 1,000 were displaced (Patel, 2013:n.p.).

When it comes to the perpetrators of aggressive incidents, even those entrusted with law and order enforcement are not exonerated. In April 2011, Andries Tatane, a community organiser and teacher, was filmed being beaten by police during a service delivery protest in Ficksburg. He later died from his injuries (Pithouse,
2011:n.p.). This was not the first time that the police were implicated in killing a civilian, and a few weeks after this incident, a police officer shot and killed a woman after she crashed her car into a stationary police vehicle (Mkhulisi, 2011:n.p.). The aggressive incidents on the part of the police culminated in the death of 34 miners in August 2012 when police used live ammunitions on unarmed striking miners. Dugard, Meyersfeld and Naylor (2012:n.p.), reaffirmed that Marikana was not the first instance of civilians who were striking being killed by the police.

Elsewhere, a minor contravention of the law such as unauthorized car parking could end up in death. Parker (2013:n.p.) reported that Mido Macia, a 27-year-old taxi driver, was handcuffed to the back of the vehicle and dragged along the road by the police about 400 metres while a large crowd was watching. He later died of his injuries. His crime was to have parked his taxi in a wrong place causing traffic obstruction.

In the health sector, the situation does not look different from the above mentioned incidents. The incidents described here are available on the Health Systems Trust website. In August 2007, an intern medical student was raped by two men at Chris Hani Baragwanath outside a blood bank in a secure area of the hospital, as reported in the “Mail & Guardian” newspaper. In March 2010, a Johannesburg paramedic was dragged into the bushes and raped by three armed men when she and a woman colleague were trying to rescue a toddler. In the same year (Mail & Guardian, 2010:n.p.), a 35-year-old doctor, who was specialising in paediatrics, was raped by three men in a ward at the Pelonomi state hospital, in Mangaung. The perpetrators were: a 16-year-old boy and two men aged 24 and 29. She lost consciousness. Medical staffs at public hospitals across the country have been subjected to armed robberies, murder and rape (McLea, 2010:n.p.).

Moselakgomo (2011:n.p.) reports that a doctor was killed at the Middleburg Hospital, in Mpumalanga, by a patient. The father of a 9-year-old daughter, Dr. Senzosenkosi Mkhize was stabbed to death by a patient in the chest. At the time Dr. Mkhize was working in the out-patient department, where the patient had gone for a consultation. In December 2011, the “Daily News” newspaper reported that at the state run hospital staff and patients feared for their safety after a suspected psychiatric patient murdered a fellow patient in an isolated male ward. In February 2012, the South
African Press Association-SAPA (2012:n.p.) reported the murder of a male nurse stabbed to death, allegedly by his girlfriend who was also a nurse, in the hospital nurses’ residence. The male nurse was stabbed in the chest around 8 pm and died on the scene. In May 2012 (Ntsoko, 2012:n.p.), five patients and a doctor were stabbed with scissors at the Chris Hani Baragwanath Hospital in Diepkloof, Soweto, at night, after a patient apparently went into a rage.

In their article, Kennedy and Julie (2013:1) state that aggression in South African society has reached epidemic levels and has permeated every part of the workplace. This research, done in a general hospital casualty, found that nurses experienced aggression from patients, their relatives and friends as well as from other health care professionals. Their findings also reinforced the research findings on the aggressive incidents psychiatric nurses are exposed to in psychiatric environment (Bimenyimana, 2008:38).

Aggressive incidents experienced by nurses come in all forms and at times originate from the nurses themselves. Kennedy and Julie (2013:1) found that nurses were experiencing physical threats, verbal abuse and psychological and imminent violence on a regular basis. Nurses tended to normalise abusive patients’ behaviour because of the perception that workplace abuse is part of their job risks. This resulted in the under-reporting of aggressive incidents. All categories of nurses in the study had resorted to one or more levels of aggression against other nurses during their nursing career. Professional nurses and senior nurse managers were identified as being the main category of nurses that frequently resorted to mistreating other nurses.

Psychiatry takes a back seat in the South African health sector (World Health Organisation- Assessment Instrument for Mental Health Systems-WHO-AIMS, 2007:8) as demonstrated by the fact that the percentage of government health department expenditure devoted to mental health is not known at a national level. This may explain why the aggressive incidents occurring in psychiatric institution are scarcely reported. Nevertheless, the above incidents show worrying examples of increased aggression towards healthcare workers, regardless of the perpetrators of these incidents. Whether these incidents are reported or not, their impact on nurses’
personal and professional development is not to be neglected especially, when it is known that aggression against psychiatric nurses interferes with their essential function and duties. Franz, Zeh, Schablon, Kuhnert and Niehaus (2010:1) state clearly that a high rate of aggression towards nurses directly contradicts the ideals of the nursing profession, which is to render quality patient care.

Up to now, all the means deployed to manage aggression worldwide have not yielded the expected outcome as psychiatric nurses still face aggressive incidents. One of the reasons may be because the ability to predict aggression in psychiatric patient populations remains one of the most challenging aspects of working with them (Krüger & Rosema, 2010:366). In the context of South Africa, there may be more reasons for persisting aggression, raging from the lack of coordinated activities and resources to the history of the country and its people. There is a gap between the rich and the poor and their respective residential environments. Ward et al. (2012:1), for instance, argue that the circumstances of having been a victim of aggression while growing up or growing up in dysfunctional families, poor performance schools and violent neighbourhoods, increase the likelihood of aggression.

Although it remains to be proven whether the patients who are aggressive may have been victims of aggression themselves, the stigma attached to mental illnesses and psychiatric institutions may still play a role. In a country where most of the unemployed are young people, it becomes difficult for someone who has been in a mental institution to be employed somewhere. There is also a problem of the scarcity of resources in psychiatric environments (WHO-AIMS, 2007:8) that does not enable psychiatric institutions to do a follow-up once a psychiatric patient has been discharged. Patients who are discharged are provided with one month treatment, a discharge summary and a referral letter to take to the nearest clinic for further treatment. However, neither the clinic where the patients are referred to nor the institution referring them has a way of following the process and checking the compliance of the patients. In this situation where patients are left on their own, they may feel rejected or abandoned by the system. Howes (2008:28) believes that rejection and abandonment by others cause feelings that are troubling, and these emotions are primitive in their power because they operate at a deep biological level,
a level that is inherently connected to the person’s very existence and survival. When life becomes a battle for survival, and appears to be meaningless, cheap, undervalued or valueless, the inexcusable aggressive acts become a way of life or death-in-life (Jolly, 2010:11).

On the psychiatric nurses’ side, there is a need to link theoretical knowledge with clinical reality when they move from student life to their professional career. This can be done through induction and mentorship, as a lack of these two can lead to negative consequences. The following quote from a participant (Bimenyimana, 2008:47) gives an insight into the newly employed psychiatric nurses’ experience with aggressive incidents encounters and how they are handled: “The time I was hit nobody helped me. They just said: ‘you do not have to worry, you are not bleeding, it is nothing’. In time you will see more”. This psychiatric nurse’s experience is not unique as many others had expressed the same sentiment in different words. Mohr (2003:17) argues that the innately humanitarian purpose of the nurses’ work is coupled with stressors that make them feel fearful, anxious, offended, helpless, repulsed, pitying, embarrassed, hopeless, angry, or all of these emotions.

Once a psychiatric nurse is acting on emotions instead of using reason, there is a reason to be concerned. The sentiment of the above participant clearly points to a situation that needs intervention. Judging the seriousness of an aggressive incident on physical injury narrows or even ignores the effect of the emotional, psychological, financial and even spiritual effects of other forms of aggression. One does not have to bleed to be hurt. The researcher’s concern is that this narrow understanding of limiting aggression to physical incidents also limits efforts in managing it. Aggression cannot be managed effectively if it is not understood comprehensively. Kool (2008:37) believes that aggression is best understood if it is dealt with comprehensively in its different types, which are physical or verbal, active or passive, direct or indirect. The unfortunate aspect is that research has found that psychiatric nurses cannot avoid aggressive incidents completely as their core of duties requires them to provide care, advice, or education to potentially or aggressive patients (Kelloway, Barling & Hurrel, 2006:262). This puts them at increased risk for assault, especially if the patients are experiencing frustration, insecurity, or stress.
Inoue, Mitsutaro, Kaneko and Okamura (2006:29) also confirm that the role of a psychiatric nurse could predispose the nurse to becoming the victim of aggression if that role is perceived to be one that should involve listening to and accepting everything. Van Wittenburgh et al. (2004:1) found that nurses experienced disproportionate levels of patient aggression when compared to other healthcare workers, and even when compared to high-risk occupations outside the healthcare system such as among police and prison officers. The main reason for this is that nursing staff do not feel able to defend themselves or even flee when assaulted because they have to protect other patients and must put the patients’ needs before their own (Lanza, 2011:548).

The consequences of aggression experienced by psychiatric nurses have been found to be detrimental internationally. Winstanley and Whittington (2002:302) reported that aggression toward healthcare staff, psychiatric nurses included, was becoming a common occurrence and of concern to staff and institutions alike. This aggression caused not only physical injuries, but also other less obvious but equally harmful implications for victims. For instance, when the psychiatric nurse’s self-esteem decreases the work also suffers. Janoff-Bulman (VandenBos & Bulatao, 1996:192) argued that after victimisation, the belief in personal invulnerability is severely damaged and the person is preoccupied with the fear of recurrence. The result of this preoccupation affects both the psychiatric nurse and the patient alike.

When nurses frequently experience aggression, the consequences for the patients and the entire organisation are severe (Franz et al., 2010:1). The fear that results from working in a climate of potential danger can have a damaging impact on patient care (Foster, Bowers & Nijman, 2007:140). If this fear is coupled with difficulties in understanding the causes of patients’ aggression, it may lead staff to managing aggressive incidents by means of physical methods (Foster et al., 2007:140) such as retaliation (Bimenyimana, 2008:47). Those psychiatric nurses who do not resort to retaliation may withdraw from patients and, as a result, this may have an equally damaging effect on the patient. There has to be a way of assisting psychiatric nurses in dealing with aggression effectively because, even after an assault, they must continue to relate to and care for the assailant, in spite of now being afraid of the patient (Lanza, 2011:548).
Despite the fact that experiences of aggression in healthcare facilities in general, and in psychiatric institutions in particular, have been researched worldwide, and that the negative consequences of this aggression have been established, the researcher met with enormous difficulties due to the fact that there are limited sources on the management of aggression in the South African psychiatric environment. There is a lack of formal baseline data on the management of aggression, leading to each psychiatric nurse managing it the best way he/she perceives it (Bock, 2011:21).

The researcher was also unable to establish the extent to which the psychiatric nurses are exposed to aggression nationwide and what remedial action is followed. This can mainly be because mental health is regarded as a priority. The report of the World Health Organisation on the Assessment Instrument for Mental Health System (WHO-AIMS, 2007) on South Africa shows that there is neither an official mental health policy present in the country nor a national mental health plan (WHO-AIMS, 2007:8). This is despite the high levels of mental illness in the population. The South African Federation for Mental Health’s publication (July, 2011:n.p.) for mental health awareness stated that about one in five South Africans suffer from a mental illness severe enough to affect their lives significantly. The organisation states further that thousands of South Africans would rather die than admit suffering from some sort of mental illness. There is still a stigma attached to mental illnesses and very little is done to alleviate it.

The WHO’s report (WHO-AIMS, 2007:24) shows also that there is a general lack of data regarding either professional training or continuing professional development after basic qualification in all provincial Departments of Health (WHO-AIMS, 2007:20). Yet the above findings do not limit the expectations of the government and the community from the psychiatric nurses to deliver mental health care to individuals, groups and families. Furthermore, the World Health Organisation’s report shows that the research in mental health has lagged behind and even those investigations conducted did not cover or address the problem of aggression in mental health institutions (WHO-AIMS, 2007:24). The lack of research on aggression and its management local based has prompted the researcher to use the findings of the research done elsewhere.
The management of aggression can be context bound, as what works in one area may not work in another. This has led to a lack of agreement on instruments used in measuring the effectiveness of the interventions. Franz et al. (2010:2) found that there are gaps in research regarding the prevention of aggression and after-care incidents against nurses. Morrison and Love (2003:148) argue that the lack of research based preventive standard measures from which to work has left thousands of nurses working in hazardous condition with few reliable sources at their disposal to prevent and effectively manage aggression toward themselves, their co-workers or patients in health care settings. An understanding of the factors which increase the likelihood that a patient will act in an aggressive way is needed in order to improve responses for managing aggression (Foster et al., 2007:141; Englander, 2007:7-11). The better way is to start by the understanding the possible causes of this aggression.

The context in which aggression takes place as well as the type of person aggressive incidents’ origin may play a decisive role. However, there is no single factor that can stand alone as the cause of aggression (Daffern, Howells, Ogloff & Lee, 2005:744); Daffern, Thomas, Ferguson, Podubinski, Hollander, Kulkhani, Decastella & Foley, 2010:369). This makes it difficult to devise a standard instrument for the management of aggression as the context and circumstances in which aggressive incidents occur must be taken into consideration. Every piece of information that allows one to gain an idea of instances of aggression and how to deal with these occurrences is then vital.

Using the Management of Aggression and Violence Attitude Scale (MAVAS) tool, Duxbury and Whittington (2005: 469) found that patients perceived environmental conditions and poor communication to be a significant precursor of aggressive behaviour. Nurses, on the other hand, viewed the patients’ mental illnesses as being the main reason for aggression, although the negative impact of the inpatient environment was recognised. In this complex and multifactorial causes of aggression, Martin and Daffern (2006:91), quoting the international labour office, state that workplace aggression must not be viewed as an individual problem but rather as a structural, strategic problem rooted in social, economic, organisational and cultural factors.
It is therefore important to mobilise all the human and material resources available in dealing with aggression and its occurrences. This also involves individual participation and organisational approach. Such an approach provides resources, policies and frameworks to support clinicians (Martin & Daffern, 2006:91). The first step would be securing the environment, because feeling safe and having confidence to manage aggression are perhaps prerequisites for all therapeutic interactions (Martin & Daffern, 2006:90-91).

The understanding of the factors and the context in which aggression is enhanced may improve responses for managing it (Foster et al., 2007:141). Kelloway, Barling and Hurrell (2006:151) state that a certain amount of assaultive behaviour is predictable in psychiatric settings and they believe that proper preparation and intervention could significantly reduce the frequency and seriousness of disruptive behaviour. However, anticipating the possible existence of aggressive incidents in psychiatric settings could immunise psychiatric nurses against aggressive incidents. VandenBos and Bulatao (1996:191) argue that knowledge of the existence of aggression in psychiatric institutions is not enough as psychiatric nurses are not socialised to expect to be victims of assault and most of them do not receive any academic education to prepare them for such a fate. The academic training required must be the one that helps psychiatric nurses to be ready to deal with aggressive incidents not just to expect them. Varcolis (2004:456) advises psychiatric nurses not to accept patients’ aggression as a fate, but rather deploy preventive measures for their own safety as well as that of their patients.

Preventing aggressive incidents or reducing their occurrences requires that psychiatric nurses be aware of the possible causes of such events as stated by different researchers. Daffern et al. (2005:743) believe that psychotic symptoms, prior aggression, poor anger control and dysfunctional impulsivity increase the likelihood of aggression. Involuntary admissions to psychiatric hospitals may also enhance the likelihood of aggression in patients (Daffern et al., 2005:743). However, in the research that followed, the same researchers found that there was no difference in perceived coercion between voluntary and involuntary admitted
psychiatric patients (Daffern, Thomas, Ferguson, Podubinski, Hollander, Kulkhani, de Castella & Foley, 2010: 373).

According to Winstanley and Whittington (2002: 314), some patients are predisposed to aggressive behaviour even before being sick (Winstanley & Whittington, 2002:314). Yet when this predisposition is coupled with the treatment that patients are not willing to take during the acute phase of mental illness (Daffern et al., 2010:369) the situation becomes even more challenging. Other factors that may trigger or enhance patient aggression vary, depending on the patient, the environment or the healthcare provider. For instance, Daffern et al., (2010:375) argue that the type of mental illnesses, specifically those characterised by thought disturbance and which incorporate delusions, unusual thoughts and hallucinations, may be a reason enough for the patients to be aggressive. The lack of basic skills and the person’s ineptness in performing such basic tasks as making requests, engaging in negotiations, and lodging complaints can also lead to patients’ aggression (Sadock & Sadock, 2003:156). The environment or background of the patient, such as being exposed to the prison environment where aggression is often the modus operandi for resolving conflict and where status can be afforded to those prisoners who are aggressive, can also contribute to patients’ aggression (Daffern et al., 2005:744).

Anger and the lack of impulse control may be an indicator of aggressive patients. Yet, there is no conclusive evidence for this because Daffern et al. (2005:744) found a lack of association between anger, impulsivity, and aggression. This renders anger management and impulsive-related interventions less relevant in the management of aggression (Daffern et al., 2005:744). Furthermore, research does not provide accurate prediction on which psychiatric patient will show aggressive behaviour (Duxbury, 2002:326), neither does it show linear relationships between any one risk factor and the occurrence of aggression (Modise, 2012:4).

The quest for effective management of aggression continues despite the lack of congruency among the researchers on how best to identify leading factors triggering aggressive incidents and how to prevent or deal with these triggering factors. Researchers are still convinced that providing staff with the necessary knowledge and skills by training them to anticipate and respond to aggression may give
employees the confidence to deal with potentially dangerous situations (Kelloway, Barling, & Hurrell, 2006:272). Martin and Daffern (2006:92) argue, however, that it is not clear whether the training programmes are effective at protecting employees exposed to aggressive patients, though training does help feel better about managing aggressive patients.

More research is needed in putting together all the factors that either lead to or decrease the likelihood of aggressive incidents because the prevention of severe aggression is an important clinical task, which requires empirically derived knowledge on risk factors (Ketelsen, Zechert, Driessen & Schulz, 2007: 92). The challenge of aggression experienced by psychiatric nurses continues to be a worldwide phenomenon existing in Europe, China, Japan, India, and Africa even if the types may vary (Kelloway, Barling & Hurrell, 2006:149) and it is the conviction of this researcher that this problem can only be dealt with effectively if its causal factors are well understood.

1.3 PROBLEM STATEMENT

The highest law in the country, the Constitution of South Africa (Act no. 108 of 1996:1247), in its Chapter Two also called the Bill of Rights states clearly that everyone has the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources. In this regard, psychiatric nurses have the right not to be assaulted or abused by the patients. They have the right to a safer workplace environment. How can they then manage this aggression while they are constantly in the presence of these potentially aggressive patients?

Although the State as employer is generally held responsible for the conduct of mental health practitioners in its service, no particular provision is currently made for the higher risks that state employed mental health care practitioners may be exposed to in the case of inadequate facilities and poor staffing (Van Rensberg, 2007:208). The research on the lived experience of aggression and violence experienced by nurses working in a Gauteng psychiatric institution (Bimenyimana, 2008:37-53) has shown that aggression is real, active, and extensive. As a result,
this aggression impacts on psychiatric nurses’ personal and professional development, and also compromises the patients’ quality of care.

Lanza (2011:547) found that nursing staff were not only being assaulted but also blamed for the assault and the fear that resulted from working in a climate of potential danger could have a damaging impact on patient care (Forster, Bowers & Nijman, 2007:140). The expectations from the employer, the patients, their family members, and friends exceed the means at the psychiatric nurses’ disposal to fulfil these expectations.

The researcher, in his quest to assist psychiatric nurses to manage aggression effectively, was motivated by the psychiatric nurses’ plight and by the fact that aggressive incidents have globally increased in psychiatric institutions during the second half of the 20th century (Bilgin & Buzlu, 2006:76). The psychiatric nurses in the institution face a challenge of securing the workplace environment with the means at their disposal and providing adequate care, treatment and rehabilitation to the patients despite their potential aggressive behaviour.

In summary, it appears that psychiatric nurses in the psychiatric institution clearly need assistance in creating a safe and secure workplace environment for themselves and for the patients. The researcher then asks:

a) What can be done to assist psychiatric nurses to manage aggression effectively in the psychiatric institution?

1.4 RESEARCH PURPOSE AND OBJECTIVES

Burns and Grove (2005:749) define the research purpose as a concise, clear statement of the specific goal or aim of the study that is generated from the problem. As for the research objectives, these should be clear, concise, declarative statements that are expressed to direct a study and should focus on the identification and description of variables or determination of the relationships among variables, or both (Burns & Grove, 2005:749).
1.4.1 Research Purpose

The overall purpose of the research study is to develop, describe, implement, and evaluate a model that can be used as framework of reference for the advanced psychiatric nurse practitioner to facilitate the effective management of aggression experienced by psychiatric nurses from the patients.

1.4.2 Research Objectives

These objectives are:

- to derive from my masters’ research central concepts to be utilized in the model, to define and classify them;
- to describe relationships between these concepts;
- to develop, describe and evaluate a model as a framework of reference for the advanced psychiatric nurse practitioner to facilitate effective management of aggression experienced by psychiatric nurses working in a psychiatric institution; and
- to implement and evaluate the model with psychiatric nurses.

1.5 PARADIGMATIC PERSPECTIVES

Chinn and Kramer (2008:184) define a paradigm as a worldview or ideology that implies standards or criteria for assigning value or worth to both the processes and the products of a discipline as well as for the methods of knowledge development within a discipline. Paradigm also implies a commitment to a collection of convictions which are meta-theoretical, theoretical and methodological by nature (University of Johannesburg, 2012:9). The research study takes as the point of departure the Theory for the Health Promotion in Nursing (University of Johannesburg, 2012:1-8) in its holistic approach to a psychiatric nurse who consists of body, mind and spirit, and functions in an integrated, interactive manner with the environment (University of Johannesburg, 2012:4).
1.5.1 Meta-theoretical assumptions

Assumptions are statements taken for granted or considered true, even though they have not been scientifically tested (Burns & Grove, 2005:728). They are a starting point or belief in a theory that is necessary in order to build a theoretical explanation (Neuman, 2009:61). The Theory for Health Promotion in Nursing (University of Johannesburg, 2012:1-8) and its assumptions is utilised as the baseline of the research study. In addition, as a researcher and being a Christian, I believe in God and in the human capacity to grow and develop. This Theory of Health Promotion in Nursing focuses on holistic aspects of a person who consists of body, mind and spirit and is interacting with his/her internal and external environment through the maximum utilisation of resources (University of Johannesburg, 2012:4-5). The person strives to ensure the respect for their rights and their place in the human society. Below are the main conceptual definitions of the Theory of the Health Promotion in Nursing:

1.5.1.1 Person: the whole person embodies the dimensions of body, mind and spirit (University of Johannesburg, 2012:4). In this research study, the person is any registered psychiatric nurse who is a sensitive therapeutic professional and functions in an integrated, interactive manner with other professionals, patients, patients’ relatives and friends in a specific environment, which is a psychiatric institution.

1.5.1.2 Psychiatric Nursing: this is an interactive process where the psychiatric nurse as a sensitive, therapeutic professional facilitates the promotion of mental health through the mobilisation of resources (University of Johannesburg, 2012:4). Cowman, Farrelly and Gilheany (2001:752) define psychiatric nursing as being related to managing patients and providing caring interactions. These activities appear to be fundamental to psychiatric nursing and central to mental health services. In this research study, psychiatric nursing is defined as a discipline that focuses on the prevention, promotion, restoration and maintenance of the mental health of the patients and their health providers.

1.5.1.3 Health: this is a dynamic interactive process in the psychiatric nurse’s environment (University of Johannesburg, 2012:5). These interactions in the
person’s environment reflect the relative health status of the psychiatric nurse. This interaction contributes to, or interferes with, the promotion of health.

1.5.1.4 Mental Health: this is a state of being in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stresses of everyday living (Uys & Middleton, 2004:753). In this research study, mental health refers to a psychiatric nurse’s mental ability to balance his/her personal and professional life leading to a physical, social, emotional, and spiritual equilibrium.

The promotion of mental health includes the promotion, maintenance and its restoration through the mobilisation of resources (University of Johannesburg, 2012:5). The mental health of psychiatric nurses is maintained and sustained by enabling them to use internal resources such as their faith, belief, skills and competence as well as their external resources comprised of colleagues, management and the advanced psychiatric nurse practitioner in managing aggression effectively.

1.5.1.5 Advanced psychiatric nurse practitioner: an advanced psychiatric nurse practitioner is a clinical nurse specialist who has advanced experience in psychiatric nursing specialty, is distinguished by a depth of knowledge of theory and practice validated by clinical practice and competence in advanced clinical nursing skills and has a Master’s degree in this field of specialisation (Stuart & Laraia, 2001:11). In this research study, the term advanced psychiatric nurse practitioner refers to a psychiatric nurse who, after registration as a professional nurse by the South African Nursing Council (SANC) has acquired a postgraduate degree, a Master’s in mental health nursing sciences and is registered by the South African Nursing Council as such.

1.5.1.6 Environment: the environment comprises an internal and external environment of the psychiatric nurse (University of Johannesburg, 2012:4-7). The internal environment of the psychiatric nurse consists of the dimensions of body, mind, and spirit. These three concepts have been defined above. The external environment of the psychiatric nurses consists of the physical, social and spiritual dimensions. The physical dimension refers to the physical structures of the specific psychiatric institution where the psychiatric nurse is employed. The social dimension
refers to human resources in the psychiatric nurse’s workplace such as colleague psychiatric nurses, the advanced psychiatric nurse practitioner, other members of the multidisciplinary team, the management and all other workers with whom they come in contact. The spiritual environment of the psychiatric nurse comprises values, beliefs and religious aspects that enable them to be who they are.

1.5.2 Theoretical assumptions

Theoretical assumptions include models and theories already existing in a related discipline (Mouton & Marais, 1992:20), which give form to the hypotheses or central theoretical statements of the research, and form the framework for the epistemic statements in the research (University of Johannesburg, 2012:12). To the knowledge of the researcher, this research study does not have a theory on which is based in the South African context. Therefore, the theoretical assumptions, in this research study, are based on those of the Theory for Health Promotion in Nursing (University of Johannesburg, 2012:4) and social constructivism (Creswell, 2013:24-25; Quale, 2008:59-61). These will be utilised to guide the process of research.

1.5.2.1 Theory of Health Promotion in Nursing

The Theory of Health Promotion in Nursing (University of Johannesburg, 2012:5) and its basic concepts: psychiatric nurse, environment and mental health have been defined (See 1.5.1.2 – 1.5.16).

1.5.2.2 Social Constructivism

Social constructivism is a worldview in which individuals seek an understanding of the world in which they live and work (Creswell, 2007:20). Social constructivism represents a particular way of constructing knowledge about science by studying the various actors and agents that are engaged in scientific activity (Quale, 2008:61). The social constructivist central aim or purpose of research is understanding (Robson, 2011:24) and relies as much as possible on the participants’ view of the situation (Creswell, 2013:24-25). Social constructivism indicates a focus on the individual rather than the group, and is concerned with how individuals construct and make sense of their world (Robson, 2011:24). Postmodernism challenges the idea of progress through reason. Modernism seeks general truth, postmodernism says there
is no basis for such claims to the truth. Social constructivism indicates a view that social properties are constructed through interactions between people rather than having a separate existence (Robson, 2011:24). Denzin and Lincoln (2008:258) state that constructivism aims at understanding a phenomenon and it is evaluated by the criteria of trustworthiness and authenticity.

The psychiatric nurse’s perception of reality is influenced and intertwined in his/her historical background, social upbringing and workplace experience. In the workplace setting, the psychiatric nurse’s reality is also influenced by his/her encounter with psychiatric patients’ aggression. When nurses can manage it effectively, they grow, become more confident and are ready to share the experiences. When the opposite happens, nothing seems to work and there is frustration. The psychiatric nurse’s understanding of aggression and possible causes thereof in the workplace is central to the way he/she deals with it.

1.5.2.3 Definition of key concepts

The conceptual definitions of the terms used in this research study are set out below.

- **Model**

A model is symbolic representation of an empirical experience in the form of words, pictorial or graphic diagrams, mathematical notations, or physical material (Chinn & Kramer, 2008:184). This is a general term referring to symbolic representation of perceptual phenomena but does not cover the full range of phenomena that are of concern within a discipline (Chinn and Kramer, 1995:216).

In this research study, a model is developed as a framework of reference and illustrates what the advanced psychiatric nurse practitioner does in facilitating the effective management of aggression experienced by psychiatric nurses working in a specific psychiatric institution.

- **Facilitation**

The concept of facilitation will be understood as a dynamic interactive process for the promotion of mental health through the creation of a positive environment and mobilisation of resources as well as the identification and bridging of obstacle in the promotion of mental health (University of Johannesburg, 2010:7). In this research
study, facilitation is defined as an interactive process through which the advanced psychiatric nurse practitioners assists and promotes the mental health of psychiatric nurses by enabling them to effectively manage aggression in their workplace environment.

**Effective**

According to Wehmeier, McIntosh and Turnbull (2005:469), effective means producing the result that is wanted or intended; producing a successful result. In this research study, effective represents the positive outcome, the end result of the model which is the constructive management of aggression. This means that all actions directed toward empowering psychiatric nurses in finding a positive and lasting solution to the management of aggression will be judged effective only if they have contributed to the achievement to the set goal.

**Management**

The Oxford Advanced Learner's Dictionary of Current English (Hornby, 2010:902) defines management as the act or skill of dealing with people or situations in a successful way.

In this research, management refers to the process of assessing the problem of persistent aggressive incidents, planning alternative means to counter these aggressive incidents, implementing and evaluating the means used, and finding the outcome to be positive. It means psychiatric nurses taking control of the workplace environment.

**Aggression**

Wehmeier, McIntosh and Turnbull (2005:28) define aggression as a feeling of anger or hatred that may result in threatening or violent behaviour; a violent attack or threats by one person against another person, or by one country against another.

In this research study, the researcher maintains the definition of aggression provided on page 5. Violence is defined as, except where the researcher refers to the previous
research study on the lived experience of aggression and violence, the use of physical force with intention to harm a person physically or to cause damage to properties. Therefore, violence is the extreme expression of aggression.

- **Experience**

According to Soanes and Hawker (2008:349), experience means an event which leaves an impression on a person. In this research study, experience means aggressive behaviour from the patients to which psychiatric nurses have been exposed either as victims or witnesses in the psychiatric institution where they work.

- **Psychiatric nurse**

A psychiatric nurse refers to a person registered as a professional nurse by the South African Nursing Council (Nursing Act 50 of 1978 as amended 2005:31) and who has been practising as such. In this study, a psychiatric nurse is a person registered with the South African Nursing Council as a professional nurse who has been working in the psychiatric institution at least for the last two years uninterruptedly; directing his/her efforts to managing aggression and promoting his/her mental health and the mental health of the patients under his/her care, treatment, and rehabilitation.

- **Psychiatric institution**

A psychiatric institution is defined as a mental healthcare facility where care, treatment and rehabilitation are provided in accordance with the rules and regulations of the Department of Health as stipulated in the Mental Health Care Act no. 17 of 2002. It is also called a health establishment (Government Gazette, 2002:10). In this research study, a psychiatric institution refers to a third level referral hospital where adults and adolescents, male or female, general or forensic are referred for being unmanageable in other health care facilities due to their disruptive or aggressive behaviour.
1.5.3 Methodological assumptions

The methodological assumptions reflect the researcher’s views of the nature and structure of the science in the discipline (University of Johannesburg, 2012:12). In this context, a model will be developed to facilitate the effective management of aggression experienced by psychiatric nurses in their workplace environment. A postmodern constructivist philosophy of Science will be followed in conducting this research. This will be discussed in depth in Chapter Two.

Qualitative, exploratory, descriptive, contextual and theory generating research designs are combined in this research study for the model development and implementation. The measures to ensure trustworthiness (Creswell, 2003:196) will be discussed in detail in Chapter Two of this research study so that the findings will be supported by the two principles of science, namely logic and justification. Logic is a science that involves valid ways of relating ideas to promote understanding (Burns & Grove, 2005:7). Logic is used in order to determine truth or to explain and predict phenomena. The researcher intends using inductive reasoning in acknowledging the uniqueness of every experience of the psychiatric nurse. The findings apply to the specific psychiatric nurses participating in this research, but can also be extended to all those individual psychiatric nurses working in psychiatric institutions and who have experienced similar instances of aggression from the patients (LoBiondo-Wood & Haber, 2010:131). The goal pursued in the research study is the development, the description, the implementation and the evaluation of a model that can be used as framework of reference for the advanced psychiatric nurse practitioner to facilitate the effective management of aggression experienced by psychiatric nurses from the patients.

1.6 Research Design and Method

Burns and Grove (2005:211) define a research design as blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings. The term research design also refers to the entire process of research from conceptualising a problem to writing research questions, and on to data collection, analysis, interpretation, and report writing (Creswell, 2013:5).
1.6.1 Research design

A qualitative, exploratory, descriptive, contextual, and theory generative research design is utilised in this research study. Walker and Avant (2011:7) define a theory as an internally consistent group of relational statements that present a systematic view of a phenomenon which is useful for description, explanation, prediction, and prescription or control.

According to LoBiondo-Wood and Haber (2010:86), qualitative study makes the world of an individual visible to the rest of other people. In this research study, the researcher will explore psychiatric nurses’ experiences, and will describe step by step how these experiences have been collected and what they mean to the authors in the natural workplace environment where they work (LoBiondo-Wood & Haber, 2010:86). The phenomenon of aggression as experienced by psychiatric nurses participating in this research study will be explored and described so that the researcher can assist them in finding the solution to their challenges (LoBiondo-Wood & Haber, 2010:89). The goal of this research study has been stated as the development, the description, the implementation and the evaluation of a model that can be used as framework of reference for the advanced psychiatric nurse practitioner to facilitate the effective management of aggression experienced by psychiatric nurses from the patients.

The process, in the facilitation of the effective management of aggression, will follow standard steps from the entry and building of rapport through the implementation of the model to the member checking of information obtained and its dissemination. More details on this will appear in Chapter Two.

1.6.2 Research method

The four steps of Chinn and Kramer (2008:223-237) for theory development are used. These four steps are: concept analysis, relationship statements, description of the model and the implementation and evaluation of the model.
During the concept analysis, the psychiatric nurses’ experience of aggressive incidents is explored through the identification and definition of the central concept. Based on the meaning that is attributed to their experiences, relationship statements are formulated. Then a model to facilitate the effective management of aggression experienced by psychiatric nurses working in this psychiatric institution is generated and described. The last step in this research methodology consists of implementing and evaluating the model. The implementation will be done by the advanced psychiatric nurse practitioner with the psychiatric nurses who have experienced aggressive incidents and have volunteered to participate in the research study. The evaluation will be done on two levels: first by the academic panel of experts in model evaluation, and secondly by the psychiatric nurses participating in the implementation of the model. The evaluation of the model by the psychiatric nurse participants will be enabled by the sharing of their experiences of the model implementation in dealing with aggressive incidents.

The sampling criteria, the data collection and analysis are discussed in Chapter Two. The four steps of theory development of Chinn and Kramer (2008:23-237) are briefly described below.

1.6.2.1 Step One: Concept analysis

This step consists of two phases comprising the concept identification and the definition and classification of concepts (Chinn & Kramer, 2008:223). The concept is derived from this researcher’s Masters’ dissertation as stated before.

- Phase One: Concept Identification

Concepts are identified by searching out words or groups of words that represent objects, properties, or events within a theory (Chinn & Kramer, 1995:109). During this phase, the concepts will be derived from this researcher’s Masters’ dissertation on the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution (Bimenyimana, 2008:36-56). In order to understand the real meaning of the psychiatric nurses’ experience of aggression, the researcher will revisit Tesch’s method (in Creswell, 2013:184; 1994:155) of open coding.


- **Phase Two: Definition and classification of concepts**

During this phase, concepts will be given meaning, or the meaning they represent will be expressed and linguistic representations of the concepts will be expressed in empiric reality (Chinn & Kramer, 1995:110). In order to achieve this, the researcher will use a range of sources including the hard copies and online dictionaries and subject specific literature. The survey list of Dickoff, James, and Wiedenbach (1968:434-450) will be utilised to classify the defined concepts. The process of coding will involve aggregating the text into small categories of information, seeking evidence for the code from different databases being used in a study, and then assigning a label to the code (Creswell, 2013:184).

**Step Two: Relationship statements**

Relationship statements describe, explain, or predict the nature of the interactions between the concepts of the theory (Chinn & Kramer, 2008:212-216). In this regard, the identified and defined concepts in step one will be expressed in the form of inter-related statements. As the central concept enfolds and is identified, its essential and related concepts will also be identified and a tentative definition for the model will be established.

1.6.2.2 **Step Three: Description of the model**

The description of the model will be based on the six components suggested by Chinn and Kramer (2008:235-248). These components are: purpose, concepts, definitions, relationships, structure, and assumptions (Chinn & Kramer, 1995:106-123). The model will be described in order to facilitate the effective management of aggression experienced by psychiatric nurses in a psychiatric institution on structural and process aspects. On the structural aspect, the purpose of the model will be stated, the concepts of the model, the central concepts and related concepts, will be defined as well as the assumptions on which the model is based and relationship statements will be described. The process will outline the purpose and objectives of each step of the model.
After the description of the model on structural and process aspects, the guidelines for the implementation of the model will be provided. Then the model will be evaluated by the panel of experts in model development. The evaluation of the model will use the Chinn and Kramer (2008:235-248) evaluation criteria of clarity, simplicity, generality, accessibility and importance of the model. A brief discussion of the evaluation criteria is provided below.

- **Clarity: how clear is the model?**

Concerning the clarity of the model, four areas will be assessed: semantic clarity, semantic consistency, structural clarity and structural consistency (Chinn & Kramer, 2008:238-241). In assessing the semantic clarity and consistency, the members of the panel will be asked whether the concepts are meaningful and helpful and whether the concepts are used consistently. In assessing structural clarity and consistency, the members of the panel will be asked whether the concepts provide a structural map and whether the structure of the model is comprehensible.

- **Simplicity: How simple is the model?**

In assessing the simplicity of the model, the members of the panel will be asked whether the number of concepts is limited to a minimum and whether provided concepts can be combined without losing the theoretical meaning.

- **Generality: How general is the model?**

Concerning the assessment of the generality of the model, the members of the panel will be asked to answer two questions. The first is: To whom and when the model can be applied? The second question is to answer to whether the purpose of the model applies only to a specific situation in nursing.
• **Accessibility: How accessible is the model?**

In order to answer to this question, the members of the panel will answer whether the concepts are within the realm of nursing and whether these concepts are grounded in empirically identified phenomena.

• **Importance: How important is this model?**

The model’s importance is evaluated based on whether the model has the potential to influence nursing actions or whether the model guides nursing practice. Concerning the evaluation of the participants, it is based on their experiences during the implementation of the model. The answers to all the above questions are found in Chapter Four, evaluation of the model by the academic panel (see 4.4) and in Chapter Five (see 5.4) where the experience of psychiatric nurse participants is discussed. The list of these questions is attached (see Appendix F).

1.6.2.3  **Step Four: Implementation and evaluation of the model**

After the description of the model, the model will be implemented by psychiatric nurses who voluntarily participate in this research study. The criteria for inclusion in the research study are stated in Chapter Two. The participants will have six months to implement the model and thereafter they will share their experience of implementation with the researcher either by one-on-one in depth interviews or by writing naïve sketches as their evaluation of the model. The sharing of participants’ experiences will be done simultaneously with the evaluation of the model as it is discussed later in Chapter Five.

1.7  **MEASURES TO ENSURE TRUSTWORTHINESS**

Guba’s model of trustworthiness criteria (Lincoln & Guba, 1985:301-331) will be used to ensure the research study’s trustworthiness. The criteria of credibility, transferability, dependability and confirmability will be followed.
1.7.1 *Credibility*: this is assessed based on whether the research’s findings are the true reflection of what the researcher intended to achieve in the context of where the research was done (Lincoln & Guba, 1985:290). According to De Vos, Strydom, Fouche and Delport (2011:419-420), the goal of credibility is to demonstrate that the research was conducted in such a manner that there is a match between research participants’ views and the researcher’s construction and representation of them. Various strategies for increasing the credibility of qualitative research include: prolonged engagement and persistent observation in the field; triangulation of different methods; peer debriefing; member checks; and formalised qualitative methods. In the context of this research study, the researcher will adhere to the above criteria so that the findings are the true reflection of the participants’ views.

1.7.2 *Transferability*: according to de Vos et al. (2011:420), transferability is used to ensure that the findings of the research can be transferred from one specific situation or case to another. O’Leary (2005:75) argues that transferability assesses whether findings or conclusions from a sample, setting or group lead to lessons learned that may be germane to a larger population, a different setting, or to another group. Given the fact that transferability may be a problem in qualitative research, De Vos et al. (2011:420) argue that the researcher can refer to the original theoretical framework to show how data collection and analysis will be guided by concepts and models. In this research study, the researcher will strive to use various methods in data collection so that transferability may be enhanced.

1.7.3 *Dependability*: this is assured when the researcher focuses on and answers the question whether the research process is logical, well-documented and audited (De Vos et al., 2011:420). In this research study, the researcher will use logic and justification as further criteria of the study and will describe and clarify every step taken during the research process. This will enhance the trustworthiness of the study where an inquiry auditor will follow the process and procedures used by the researcher (Brink, 2003:125). According to O’Leary (2005:74), dependability accepts that reliability in studies of the social sciences may not be possible, but attests that methods are systematic, well-documented and designed to account for subjectivities and bias.
1.7.4 Confirmability: can be compared to the concept of objectivity (De Vos, et al., 2011:421) whereby the researcher should provide evidence that corroborates the findings and interpretations by means of auditing. Brink (2006:119) argues that confirmability guarantees that findings, conclusions and recommendations are supported by data and that there is internal agreement between the investigator’s interpretation and the actual evidence. Trustworthiness will be discussed in depth in Chapter Two.

1.8 ETHICAL CONSIDERATION

Ethics is concerned with what is good or bad, right or wrong and the term generally refers to what one ought to do (Robson, 2011:198). De Vos et al. (2011:113) argue that the fact that human beings are the subjects of study in the social sciences creates unique ethical problems since data should never be obtained at the expense of human beings. The ethical principles guiding this research study are stipulated by the Medical Research Council of South Africa (MRC, 2003:2-6) as published on their website (www.mrc.co.za) and the United Nations Educational, Scientific and Cultural Organisation (UNESCO, 2006: 23-31). These principles are:

- autonomy or respect for persons;
- beneficence;
- non-maleficence; and
- justice

A detailed discussion on these principles of autonomy or respect for persons, beneficence, non-maleficence and justice follows below.

i. Autonomy or respect of the person

The principle of respect for the persons entails respecting the autonomy of the participants and their choices to participate or not to participate. According the Medical Research Council of South Africa (MRC, 2003:2-6), the autonomy of the participant, whether patient or volunteer, demands that the participant be treated as a unique human person within the context of his or her community system. Freedom of choice must be safeguarded.
Dhai and McQuoid-Mason (2011:14) argue that the respect for the person underlies the requirement that human participants decide and give their free, voluntary and informed consent to participate in research. This principle takes into consideration self-determination and is the basis of informed consent and respecting confidentiality in healthcare practice (Dhai & McQuoid-Mason, 2011:14). Burns and Grove (2009:188) argue further that the principle for respect for the person holds that persons have the right to self-determination. Self-determination is based on the recognition that humans are capable of controlling their own destiny and should be treated as autonomous agents (Burns & Grove, 2009:189). It is fundamental for the researcher to allow participants to use their right to decide because the personal information they share could potentially compromise their safety or the safety of the organisation if not managed properly (Gorman & Clayton, 2005:43).

The Medical Research Council of South Africa (2003:2-6) advises further that the social and cultural environment of the participants should be taken into consideration in all circumstances. People should be treated as human beings in the context of their social, political, economic and religious environments. For these reasons, an invitational letter will be sent to the participants setting out the research purpose, content and process. Furthermore, the participants will be asked to sign an informed consent (UNESCO, 2006:25) after the researcher has satisfactorily given them information.

Permissions from relevant authorities: the Ethics Committee of the University of Johannesburg (Annexure A, a & b) and the Ethics Committee of the University of Witwatersrand (Annexure A, c) and the permission from the hospital’s chief executive officer (Annexure B) to conduct the research in the psychiatric institution will be obtained before conducting this research. Anonymity and confidentiality are keys to safeguarding privileged information from the participants.

Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection (MRC, 2003:3-6). In this research study, psychiatric nurses who participate are considered to be independent persons.
All the participants are professionals who are able to consent and make a sound and informed decision.

Burns and Grove (2005:193) state that an informed consent consists of four elements which are: disclosure of essential information; comprehension; competency; and voluntarism.

- **Disclosure of essential information**: a letter will be sent to the prospective participants and it will detail the process involved in the research study. The purpose of the research will be explained as well as any risk foreseeable in participating if any.

- **Comprehension**: the letter will be written in plain English so that everyone who wants to participate would be able to read and understand the content. For further clarification, the researcher will provide telephone numbers and will make himself available for ample explanation and will answer all the questions that may not have been covered in the invitational letter until participants are satisfied.

- **Competency**: all the participants in the research study will be professional nurses who are able to differentiate right from wrong and can make a sound decision. Therefore they will all be competent to comprehend information and follow instructions. They will consent to participate knowing what they are doing and will sign the form which will be provided as an indication that they have understood the research process and are participating freely and voluntarily.

- **Voluntarism**: all the participants will freely volunteer after receiving all the information they need in order to participate in the research study. There will be no threat of punishment if they do not participate nor compensation to be given to the participants as a form of coercion (Polit & Beck, 2008:171-172). Rather there will be a paragraph in the invitational letter that will confirm the right of the prospective participants not only to refuse to participate, but also to withdraw at any time they may feel like doing so without any negative consequences from the researcher.
In summary, the invitational letter (Annexure D) that will be sent to the prospective participants contains the following information:

- the topic, the goal, and the objectives of the research study;
- the research method;
- the duration of the research;
- the right to participate or withdraw;
- the fact that there will be no monetary gain;
- the signing of a form giving a consent;
- the assurance that all the required permission will be obtained before starting the research;
- the assurance of anonymity and confidentiality; and
- the telephone numbers of the researcher and the supervisors in case a participant wants more information for clarification.

ii. Non-maleficence

Polit and Beck (2008:170) point out the obligation of the researcher to make sure that harm is avoided, prevented or minimised while conducting the research. Harm or discomfort may be in the form of physical, emotional, social or financial aspects. In this research study, no harm is foreseen.

The researcher does not anticipate any harm to the participants directly from their participation to the research study. However, all the precautionary measures have been taken to eradicate or at least minimise any adverse event emanating from this research study. No harm to the participants in this research is foreseen whether on physical, social or psychological levels. Talking about negative experiences of aggressive incidents and painful memories can be traumatic. A contingency plan has been put in place. In case of traumatic experience, the participants concerned will be referred to professionals for professional help.
iii. Beneficence

In order to determine the beneficence of the research study, one must first weigh the risk and benefit, or the amount of scientific good must outweigh the risk of harm (Tolich & Sieber, 2013:42). The Medical Research Council of South Africa (MRC, 2003:2-6) states that the term beneficence is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm; and (2) maximise possible benefits and minimise possible harms. A benefit is the opposite of harm, and refers to any favourable outcome of the research to society or to the individual (MRC, 2003:2-6). Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence.

iv. Justice

The principle of justice considers whether the individual is fairly treated (Dhai & McQuoid-Mason, 2011:15). The concept of justice includes both procedural justice and distributive justice. In procedural justice the researcher must make sure that the procedures are fair, reasonable, non-exploitative, and fairly administered (Tolich & Sieber, 2013:42). Distributive justice entails that those who bear the risks of research should be those who benefit from it (Tolich & Sieber, 2013:42). According to the Medical Research of South Africa (MRC, 2003:2-6) an injustice occurs when some benefit to which a person is entitled is denied without good reason, or when some burden is imposed unduly. Another way of conceiving the principle of justice is that equals ought to be treated equally.

In this research study, justice is served by treating all the participants equally, respecting them and acknowledging their right to decide what is good for them. Participants will be taken on the basis first in, first served. All the participants will have the same rights and privileges.
1.9 ORIGINAL CONTRIBUTION OF THE STUDY

The developed, implemented and evaluated model will be a significant contribution to the body of knowledge of psychiatric nursing and mental health. In developing a model to facilitate effective management of aggression experienced by psychiatric nurses working in a psychiatric institution, the researcher will be contributing not only to the mental health of the psychiatric nurses, but also to the improvement of the services rendered to the patients, the productivity of the institution and the well-being of the community and the nation at large. This research study will also inform policy-makers regarding the facilitation of mental health of mental health practitioners.

1.10 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

On completion of this research study, conclusions will be drawn with regard to the process of the research study. The limitations will also be stated, based on a number of challenges that the researcher will have met. Recommendations to relevant stakeholders such as the nursing practice, nursing education and nursing research will also be stated.

1.10 DIVISION OF CHAPTERS

The structure of this thesis is set out below

Chapter One: Background, rationale and overview

Chapter Two: Research design and method

Chapter Three: Developing a model for the facilitation of the effective management of aggression experienced by psychiatric nurses working in a psychiatric institution

Chapter Four: Description of the model to facilitate effective self-management of aggression experienced by the psychiatric nurses working in a psychiatric institution
Chapter Five: The implementation and evaluation of the model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution

Chapter Six: Conclusions, limitations, and recommendations.

1.12 SUMMARY

In this chapter, the background and the rationale of the study, as well as the problem statement, the purpose and objectives of the study have been explored and discussed at large. The measures to ensure trustworthiness as well as the ethical considerations have also been briefly discussed. The next chapter, Chapter Two, deals with the methodological aspects of the research.
CHAPTER TWO: RESEARCH DESIGN AND METHOD

"The lack of needed theory does not exclude us from the obligation to develop the knowledge that will lead to those theories" (Walker & Avant, 2011:41).

2.1 INTRODUCTION

In Chapter One the researcher discussed the overview of the research study stating the reasons why this research study was needed, and also the purpose and the objectives of the research study. In this chapter, the research design and method as well as the strategies used in reasoning will be discussed in detail. The logic of and justification for the choice of approaches followed will be provided. The trustworthiness and the ethical considerations pertaining to this research study will also be discussed in depth.

2.2 RESEARCH DESIGN

Burns and Grove (2005:211) define a research design as a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings. The purpose of a research design is to describe the overall plan for the description of the phenomenon, whereas the purpose of the research method is to specify the tools that will be utilised to describe the plan (Marshal & Rossman, 1995:40).

In this research study, a qualitative, exploratory, descriptive, contextual and theory generative, design is utilised in the model development (Chinn & Kramer, 2008:179-218; Burns & Grove, 2005:136-147).
A postmodern constructivist philosophy of science will be adhered to. This philosophical perspective relies on two concepts: postmodernism and social constructivism. According to Creswell (2007:25), postmodernism is a theory of which the basic concept is that knowledge claims must be set within the conditions of the world as it is today and in the multiple perspectives of class, race, gender, and other group affiliations. Postmodernism is an open set of approaches, attitudes to and styles of art and culture that started by questioning aspects of modernism (Hart, 2004:14). Denzin and Lincoln (2003:456) believe that reality is socially constructed.

Social constructivism represents a particular way of constructing knowledge about science by studying the various actors and agents that are engaged in scientific activity (Quale, 2008:61). Central to social constructivism is the attempt to understand scientific activity and scientific knowledge in social terms, as arising from interactions between various participating agents in the social domain (Quale, 2008:59). Such interpretations take place within the framework of a society, where the said interactions are constrained by various cultural, historical and political factors, which together form a background for the investigation (Quale, 2008:59). Creswell (2007:20) states that social constructivism is a worldview in which individuals seek understanding of the world in which they live and work. They then develop a subjective meaning of their experiences. These meanings are directed towards certain objects or things. The goal of the research is then to rely as much as possible on the participants' views of the situation. The social constructivist approach assumes that reality is socially constructed. This means that how one divides up the world in order to understand it is the result of historical, social and political processes (Green & Thorogood, 2011:15).

### 2.2.1 Qualitative design

Boeije (2010:11) indicates that the purpose of qualitative research is to describe and understand social phenomena in terms of the meaning people bring to them. The researcher choose qualitative research in order to study the phenomenon of aggression in its natural setting as this offers significant insight into the process of viewing situations and people holistically and answers questions that warrant detailed in-depth description (Mateo & Kirchhoff, 2009:131-132). The qualitative
research design allows an attempt to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2008:4).

Qualitative research enables one to learn from the participants in a setting the way they experience a phenomenon, the meaning they attribute to it and how they interpret what they experience (Morse & Richards, 2002:28). Although aggression may be common in psychiatric institutions (Winstanley & Whittington, 2002:302), the way in which psychiatric nurses experience it may differ from one person to the other. In the context of this research study, a qualitative approach is appropriate as it raises the awareness of some aspects of aggressive experiences, as lived and dealt with by psychiatric nurses, that have not been recognised previously (Mateo & Kirchhoff, 2009:132).

The choice for the qualitative approach was further motivated by the desire to obtain findings that reflect the participants’ perspective and that fit the substantive field. These findings will have relevance for the field and can be easily transformed into interventions for practitioners (Boeije, 2010:33). The findings will be obtained after data collection and data analysis. The collection of data follows the six months implementation of the model by psychiatric nurse participants and it is done through one-on-one interviews or naïve sketches. As the psychiatric nurses share their experiences of model implementation they also evaluate its process and effectiveness through their experiences in dealing with aggression. The qualitative design is also preferred in this research study because the knowledge gained from qualitative research will enable psychiatric nurses to manage aggression effectively by working on their psychological, social, and emotional aspects as well as the physiological components of their challenges in the workplace environment.

2.2.2. Exploratory design

According to Gray (2009:35), exploratory research seeks to explore what is happening and to ask questions about it. This research approach is particularly useful when not enough is known about a phenomenon. Exploratory research also aims at gathering new data in order to determine possible patterns and to establish relationships among them (Mouton, 1996:103). Following Creswell’s advice (2013:83; 2007:59-60), the researcher, as an employee in the psychiatric institution, will put aside his experience and understanding of the environment, as much as
possible, in order to take a fresh perspective towards aggression experienced by psychiatric nurses. The researcher, being aware of some incidents of aggression the psychiatric nurses had experienced, refrained from asking leading questions and puts aside his prior knowledge of the phenomenon but rather strived to remain objective interacting with participants and asking questions that do not influence the outcome of participants’ experiences. According to Fisher (2009:583), this process entails the researcher’s identification of vested interests, personal experience, cultural factors, assumptions, and hunches that could influence how he or she views the study’s data. The researcher will approach the nursing management and request that the names of the participants remain secret and their shared information confidential even if during data collection it may come out that some participants’ behaviours are judged unlawful or against the hospital policies. The exploratory approach starts, in this research study, when the researcher investigates how psychiatric nurses experience and deal with aggression in their workplace environment.

2.2.3 Descriptive design

Descriptive design refers to an empirically based assessment of what evaluation looks like, under different conditions, and what kinds of consequences result from various approaches to evaluation (Smith & Brandon, 2008:114). The purpose of a descriptive design is to provide a picture of a phenomenon or situations as they naturally happen and may be used for developing a theory, identifying problems with current practice, justifying making judgement, or determining what others in similar situations are doing (Burns & Grove, 2005:232; Gray, 2009:35-36). The researcher has engaged in this research study knowing that, in the current South African context, there is little known about the management of aggression experienced by psychiatric nurses. Furthermore, the experiences of psychiatric nurses faced with aggressive patients will be collected through interviews and will be described using verbatim quotes so that the meaning these psychiatric nurses give to their lived experiences may be faithfully transcribed and communicated.

2.2.4 Contextual design

The contextual dimension of the research refers to an analysis of social and historical processes, and the worth or validity of the project depends on how
The context of the research study is a psychiatric institution where psychiatric nurses experience aggressive behaviours from the patients. The psychiatric nurses working in the institution provide care, treatment and rehabilitation to patients who are referred from clinics and second-level hospitals mainly because these patients cannot be managed in the referring hospitals due to their uncontainable behaviour or attitudes. The model to facilitate effective management of aggression experienced by psychiatric nurses is contextually bound to this institution. LoBiondo-Wood and Haber (2010:131) argue that the outcomes of a research study are applicable to the participants in the research and to a specific environment as these emerge within the context of personal, historical, current relationships, and future plans as the individuals live daily life in a dynamic interaction with the environment. Good reports answer to the where, what, when, and who of the study (Locke, Silverman & Spirduso, 2010:12); what was done and how it was perceived (Smith & Brandon, 2008:230).

2.2.5 Theory generative approach

A theory is a set of interrelated concepts, definitions, and propositions that present a systematic view of phenomena for the purpose of explaining and making predictions about those phenomena (LoBiondo-Wood & Haber, 2010:587). Theory also refers to coherent frameworks that try to describe, understand and explain aspects of social life. The objective of theory development is usually to express a new idea or a new insight into the nature of the phenomenon (Walker & Avant, 2005:28). Although the phenomenon of aggression experienced by psychiatric nurses is not new, the way in which psychiatric nurses deal with this aggression in the context of this institution needs to be explored. Based on Walker and Avant (2011:4), the aim of theory development, in this research study, will be to help psychiatric nurses to understand practice in a more complete and insightful way. Theory development provides a way to identify and express key ideas about the essence of practice (Walker & Avant, 2011:3). In this research study, the process of theory generation or development starts with the conceptual framework (Chinn & Kramer, 1996:87) and aims at developing a model to facilitate effective management of that aggression.
experienced by psychiatric nurses working in a psychiatric institution. In developing the model, the three sources of experience related to the concept, which are the word, the thing itself, and the associated feelings, will be explored (Chinn & Kramer, 1999:54) and the three basic approaches of theory development, synthesis, derivation, and analysis; (Walker & Avant, 2005:30) will be utilised.

Walker and Avant (2011:18) state that the essence of practice theory is a desired goal and prescriptions for action to achieve the goal. In relation to the model to facilitate effective management of aggression experienced by psychiatric nurses working in a psychiatric institution, it is hoped that alternative means to deal effectively with aggression will enable psychiatric nurses to work in a safer and more secure environment.

2.3. REASONING STRATEGIES

Although reasoning is defined by different authors in different ways, they all converge on two ideas: that reasoning is a process and that reasoning follows a logical thought process. While Burns and Grove (2005:7) define reasoning as the processing and organising of ideas in order to reach conclusions, Wilson (1999:4) argues that reasoning is an attempt to answer a question by thinking about reasons – premises, evidence, warrant, justification, basis, grounds, rationale. Leighton and Sternberg (2004:3-4) define the concept reasoning further as a process of drawing conclusions which inform problem-solving and decision-making endeavours because human beings are goal driven, and the conclusions they draw are ultimately drawn to help them serve and meet their goals.

2.3.1. Inductive reasoning

According to Copi et al. (2009:482), induction provides the basis for one’s reasoning to establish truths in everyday life, to learn facts about the society and to understand the natural world. Inductive reasoning moves from the specific to the general whereby particular instances are observed and then combined in a larger whole, set of specific observations to the discovery of a pattern that represents some degree of order among all the given events (Babbie, 2005:22; Burns & Grove, 2005:8). This reasoning will be used during the analysis of the identified central concept.

2.3.2 Deductive reasoning

Deductive reasoning is formulating information taken to be true and expressing it, or part of it, in a conclusion (Leighton & Sternberg, 2004:133); deductive reasoning moves from the general to the specific, from a pattern that might be logically or theoretically expected to observations that test whether the expected pattern actually occurs (Babbie, 2005:23). This reasoning helps in understanding that a whole can be divided into pieces. It is therefore appropriate to get a whole before breaking it into pieces. Aggression must be understood in its entirety: how it affects the group of psychiatric nurses participating to this research study and the impact it has on the institution. Then its effect on personal and professional levels can be established. Girroto and Johnson-Laird (2005:36) argue that people will generally reason on the basis of prior belief if full deductive reasoning instructions are not given. Deductive reasoning will be utilised in describing guidelines to implement the model.

2.3.3 Analysis

Jorgensen (Boeije, 2010:76) states that analysis is the breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With facts broken down into manageable pieces, the researcher sorts and sifts them, searching for types, classes, processes, patterns or wholes. The aim of this process is to
assemble or reconstruct the data in a meaningful or comprehensive way. With this approach, the existing whole is broken down into parts; these parts, as well as the relationships between them, are then examined for better understanding (Walker & Avant, 2011:64; 1988:24).

The researcher intends to use analysis to clarify and define concepts related to psychiatric nurses’ experience of aggression and the way they deal with it. In analysis, one clarifies, refines, or sharpens concepts, statements, or theories (Walker & Avant, 2005:31). Furthermore, Walker and Avant (2011:63) state that analysis allows the theorist to examine and reexamine existing knowledge about a phenomenon, and this is a means to improve the accuracy and relevance of the knowledge.

This process is discussed in detail in Chapter Three where the central concept of the model to facilitate effective management of aggression is identified, defined and classified.

2.3.4 Synthesis

Synthesis is defined as a combination of parts to form a connected whole (Soanes & Hawker, 2008:1051); the construction of a whole out of parts (Mouton, 1996:161). It is the gathering of different elements of data into one logical and structural pattern or relationships not clearly seen before so as to form a new concept (Walker & Avant, 2011:63). Synthesis works well where there is a need to combine isolated pieces of information that are as yet theoretically unconnected, and it works well in collecting data or trying to interpret data without an explicit theoretical framework (Walker & Avant, 2005:30). In synthesis, information based on observation is used to construct a new concept, a new statement, or a new theory (Walker & Avant, 2011:63). Synthesis works well where a theorist is collecting data or trying to interpret data without an explicit theoretical framework (Walker & Avant, 2011:63). The process of concept synthesis is especially useful as a means of generating and naming potential nursing interventions and outcomes (Walker & Avant, 2011:113). Synthesis is used in this research study to place concepts into relationships with one another.
2.3.5 Derivation

According to Walker and Avant (2011:63), derivation allows the theorist to transpose and redefine a concept, statement, or theory from one context or field to another. Derivation provides a means of theory building through shifting the terminology or the structure from one field or context to another (Walker & Avant, 2011:63). This approach to theory building can be applied to areas in which no theory basis exists (Walker & Avant, 2005:31). The researcher will use derivation in describing guidelines to implement the developed mode. The process and procedure for theory development are discussed next.

2.4. RESEARCH METHOD

The four steps of Chinn and Kramer (2008:207-217) model development will be used in this study. These four steps are listed below and discussed in detail thereafter.

Step One: Concept analysis
Step Two: Placing concepts into relationship
Step Three: Model description and evaluation
Step Four: Model implementation and evaluation

2.4.1. Step One: Concepts Analysis

The term concept is defined as a complex mental formulation of experience (Chinn & Kramer, 2008:187). Concepts are constructs derived by mutual agreements from mental images (Babbie, 2005:124). Creating conceptual meaning produces a tentative definition of the concept and a set of tentative criteria for determining whether the concept exists in a particular situation (Chinn & Kramer, 1999:57). The process of concept analysis comprises identification, definition and clarification of the central concept. In order to analyse the concepts concretely, further steps are taken as discussed below.

2.4.1.1 Identification of central concept

According to De Vos et al. (2005:29) a concept expresses an abstraction formed by generalisation from particulars that are usually similarities. The labelling allows a person to think about these perceptions or experiences and to communicate them to
other people. Conceptualisation is then the thought process going on in the mind when one gathers impressions and perceptions, observes their similarities and puts them together to make up a new single thought which expresses the similarities, and then gives it a name (De Vos et al., 2011:30). Conceptual meaning conveys thoughts, feelings, and ideas that reflect the human experience to the fullest extent possible (Chinn & Kramer, 2008:186). The concepts can come from life experiences, clinical practice, basic or applied research, knowledge of the literature, and the formal processes of creating conceptual meaning (Chinn & Kramer, 1999:74). In this research study, the central concept will be derived from my previous research study: “The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution” (Bimenyimana, Poggenpoel, Chris & Van Niekerk, 2009:4-13). The identification of the central concept will consist of analysing the results and, with the available literature, finding the concept that represents the challenge that the psychiatric nurses are faced with in dealing with aggressive incidents and how the nurses will be assisted.

2.4.1.2 Definition of the central concept and classification

The process of concepts definition involves the use of dictionaries, websites and books - hard copies and online library - that relates to the concept to be defined. According to Chinn and Kramer (1999:64), dictionary definitions provide synonyms and antonyms and convey commonly accepted ways in which words are used, but these definitions are often circular and do not give a complete sense of meaning for the concepts. Essential criteria for describing a concept will be identified.

In defining the concepts, particular attention will be paid to the rules proposed by Copi and Cohen (2009:88-116; 1994:192-196). These rules focus on what is essential and should be the basis of a good definition such as clarity of the concept definition, the avoidance of negative or extremes in defining the concept, or vagueness and ambiguity.

The conceptual meaning will be contextualised by constructing a model case so that the understanding of the concept and the context in which it is to be understood can be clearer. Furthermore, the essential and related criteria, which are parts of the central concept of the model, are reflected in the model case. The dictionary
definitions together with subject definitions deepen the meaning and the understanding of the central concept.

During this process of defining the central concept and its essential and related criteria, the identified concepts are defined in the ways discussed below (Wandelt & Stewart, 1983:64-65; Wilson, 1987:23).

- **The definition of the concepts from the dictionaries**

  The definition of the concept from the dictionaries is not necessarily linked to the topic being studied, but rather a definition that may apply to various fields. The use of dictionaries will enable the researcher to retain those definitions that are relevant to the topic.

- **Subject definition**

  This process will be accomplished by extensively reading different sources related to the subject of interest, that is the facilitation of effective management of aggression. The collection of information from different sources on the subject will enable the researcher to have a broader view and understanding of the concept aggression which will result in its operational definition.

- **Formulation of a model case**

  A model case is the description of an experience that represents the concept in the best way of one’s present understanding (Chinn & Kramer, 2008:196). A model case will be developed in Chapter Three based on the psychiatric nurses’ experiences and this will be adding to the understanding of the purpose and objective of the research study.

- **Classification of concepts**

  The classification of the concepts is done by using the survey list of Dickoff et al. (1968:421) that include the agent, the recipient, the context, the procedure, the dynamics and the terminus. The agent refers to the person or group of persons, who performs the action and achieves the intended goal. The recipient is the person or
group of persons for whom or to whom the intervention is directed. The recipient is the beneficiary of the agent’s intervention. The context refers to the area or place where the intervention or action takes place. The procedure refers to the process or strategies that are utilised by the agent in order to achieve the expected or desired goal. The term dynamics entails the motivation, the driving force internal or external that enables both the agent and the recipient to do what it takes in order to achieve the expected or desired outcomes of the intervention or action. The terminus refers to the end result or expected outcome to be achieved after a successful intervention or action.

2.4.1.3 Step Two: Placing concepts into relationship

Relationship statements describe, explain, or predict the nature of the interactions between the concepts of the model (Chinn & Kramer, 2008:212-216). The process of designing the relationship statements requires specific attention to the substance, direction, strength, and quality of interactions between concepts. During this step, the research compared and contrasted different concepts, describing substantive interactions between the concepts (Chinn & Kramer, 1999:78).

2.4.2 Step Three: Model Description

The criteria of Chinn and Kramer (2008:246-248) in describing a model will be applied. These criteria are:

- the purpose of the model;
- the concepts of the model;
- the definition of the concepts within the model;
- the nature of the relationship;
- the structure of the model; and
- the assumptions of the model.

These six criteria are briefly discussed below.

2.4.2.1 What is the purpose of the model?

The purpose of the model is important because it answers the question “why” of the intervention or the reason why the model was developed. By answering the question one also specifies the context in which the model is developed and applied. In this
research study, the purpose is to develop and describe the model as a framework of reference in order to facilitate the effective management of aggression experienced by psychiatric nurses as an integral part of their mental health. The context is a psychiatric institution where psychiatric nurses meet with challenges in managing aggression effectively.

2.4.2.2 What are the concepts of the model?

Concepts are identified by searching out words or groups of words that represent objects, properties, or events within the model (Chinn & Kramer, 1999:88). One can begin to describe concepts by listing key ideas and tentatively identifying how these seem to interrelate (Chinn & Kramer, 1999:88). As mentioned before, the concepts of this model will derive from this researcher’s minor dissertation on the lived experience of aggression and violence by psychiatric nurses in a Gauteng Psychiatric Hospital (Bimenyimana, 2008:37-56).

2.4.2.3 How are the concepts defined within the model?

A definition is any explicit or implicit meaning that is conveyed relating to a concept (Chinn & Kramer, 1999:89). The researcher intends to describe definitions of the concepts by characterising the extent to which they are general or specific (Chinn & Kramer, 1999:90). Different sources will be used including dictionaries and books.

2.4.2.4 What is the nature of the relationship?

This question is answered by checking whether there is a link among and between concepts. The ways in which the relationships emerge provide clues to the theoretical purposes and the assumptions on which the theory is based (Chinn & Kramer, 1999:91).

2.4.2.5 What is the structure of the model?

According to Chinn and Kramer (2008:233), this question addresses the overall form of the conceptual interreleationship. It discerns whether the theory contains partial structures, or has one basic form. The nature of the model is determined by the meaning of the concept within the theory, and this answers how empirical experience is represented by the ideas within the model.
2.4.2.6 On what assumptions is the model based?

This question addresses the basic truths that underlie theoretical reasoning (Chinn & Kramer, 2008:233-247). The assumptions of the model are based on the Theory of Health Promotion in Nursing (University of Johannesburg, 2012:1-8).

The model is evaluated by answering the above question and further on, the adequacy of the model is based on the assessment of Chinn and Kramer (2008:238-248) following the criteria of clarity, simplicity, generality, accessibility and importance presented as questions which are set out below.

a) How clear is the model?

In order to determine how clear a model is, one has to consider the following points.

1. **Semantic clarity:** when concepts are clearly defined, empiric indicators can be more easily identified (Chinn & Kramer, 2008:238). The researcher will strive to use clear, concise, and complete definitions in order to avoid ambiguities in understanding the model.

2. **Semantic consistency:** semantic consistency means that the concepts of the theory are used in ways that are consistent with their definitions (Chinn & Kramer, 2008:240).

3. **Structural clarity:** structural clarity refers to how identifiable and apparent the connections and reasoning within theory are (Chinn & Kramer, 2008:241).

4. **Structural consistency:** refers to the consistent use of structural forms within a model (Chinn & Kramer, 2008:241; 1999:104).

b) How simple is the model?

This question addresses the number of structural components and relationships with theory (Chinn & Kramer, 1999:108). Simplicity means that the numbers of elements within each descriptive category, particularly concepts and their interrelationships, are minimal (Chinn & Kramer, 2008:242).
c) How general is the model?
The generality of the model refers to its breadth of scope and purpose (Chinn & Kramer, 2008:243). The above question addresses the scope of experiences covered by the model (Chinn & Kramer, 1999:109).

d) How accessible is the model?
Accessibility addresses the extent to which empirical indicators can be identified for concepts within the theory and how attainable the projected outcomes of the theory are (Chinn & Kramer, 2008:243; 1999:106).

• How important is the model?
In nursing the importance of a theory is closely tied to the idea of its clinical significance or practical value (Chinn & Kramer, 2008:245).

2.4.3 Step Four: Model Implementation and evaluation

The implementation and evaluation of the model to facilitate effective management of aggression experienced by psychiatric nurses working in a psychiatric institution are the last two steps in this model development. During the implementation of the model, the psychiatric nurses put into practice the alternative means, which have been devised in dealing with aggression effectively. The evaluation, by participants, consists of assessing and checking whether the interventions or actions taken yielded the desired results following the normal process of dealing with incidents of aggression effectively. This requires the psychiatric nurses who participate in this research study to take a step back and objectively look back to the road travelled while implementing the model. They share what their experiences have been on this road travelled through in-depth interviews or through naïve sketches.

The process starts with the selection of the participants or sampling that follows a certain set of inclusive criteria as discussed below.

a) Population and sampling

Population is defined as the entire aggregation of cases that meet a designated set of criteria (Mateo & Kirchhoff, 2009:156) and refers to all the individuals who meet the sampling criteria for inclusion in the study (Burns & Grove, 2009:343:344). Mateo and Kirchhoff (2009:156) differentiate between accessible population, which refers to
those available for selection because they meet the criteria for participation in the study, and target population which refers to the entire aggregation about which generalisations are to be made. In this study, target population refers to all psychiatric nurses working in the psychiatric institution.

Sample is defined as the portion of population selected in some manner to represent the entire group (Mateo & Kirchhoff, 2009:156). In this research study, the sample will consist of a portion of the psychiatric nurses working in the institution who meet the criteria for inclusion and have been selected to participate in the research study.

The sampling method used in this research study is purposive sampling. Mateo and Kirchhoff (2009:143) and Burns and Grove (2005:352) argue that purposive sampling is used to select those participants who meet certain criteria and who can provide the information required during on-going data collection and provide typical and divergent data (De Vos et al., 2011:392). The sampling criteria are discussed below.

b) Sampling criteria

The sampling criteria of inclusion will be a psychiatric nurse who:

- has worked uninterruptedly in this institution for at least the last two years;
- is able to write and speak English fluently as the researcher’s medium of communication is English;
- is willing to participate freely in this research study and to give a written consent for audio-recording of the interview or the use of written naïve sketches for the research study purposes;
- has sufficient knowledge on the environment where he/she is working and being able to give a fair account on what happens on daily basis with regard to aggressive incidents and their management thereof; and
- is able to critically examine his/her experiences and his/her responses to the situation.

c) Sampling size

There will be no limit to the exact number of the participants in the beginning of the research study. The number will, however, be limited during data collection where the researcher is to be guided by data saturation. Data saturation is defined as a
point at which the researcher cannot find anything new in the data (Mateo & Kirchhoff, 2009:143).

d) The role of the researcher

The researcher plays a role of a facilitator, a companion and a helper, depending on the situation at hand. Creswell (2013:45; 1994:145) and Marshall and Rossman (2011:112) argue that the researcher is the main instrument of data collection. The researcher will use communication skills and techniques in allowing psychiatric nurses to express themselves freely and this will allow him to receive accurately the message that is sent.

These are some of those techniques used:

   a. **Active listening**

Active listening technique will be used in letting the psychiatric nurses tell their stories in their own way while the researcher will be trying to understand the message communicated and the feelings attached to it. According to Thomas (2007:91), real listening requires demonstrating that the interest of the listener is not only in the content of what is being said, but also in the context of the discussion and the feelings expressed by the speaker. Wood (2007:124) adds that respecting what others say about what they feel and think is a cornerstone of effective interpersonal communication.

   b. **Exploring**

This technique will be used when the researcher needs to know more about what the participant is sharing or where the sender’s message is not clear enough. The advice of Wood (2007:125) is that, when one does not understand what others say, one should ask them to elaborate. His argument is that in asking, one shows that one is interested and respect the speaker’s expertise or experience.

   c. **Validating**

This technique will be used where there is an intensive emotion that the participant would be experiencing in relating his/her experiences of aggression. The researcher
will acknowledge the participant’s emotional expression by eye contact that will seem to say ‘I am here with you’. This will possibly give the participant an opportunity to recollect and continue telling the story. The researcher will also use active silence as a way of acknowledging the participant’s experience which may be painful or hard to re-live or express verbally. Wood (2007:151) states that in some cultures silence indicates respect and thoughtfulness.

e) Data collection

According to Burns and Grove (2009:695), data collection is an accurate, planned gathering of information that links to the research purpose or the specific objectives, questions, or hypothesis of the research. Data will be collected by the methods which are described below.

i. In-depth Interviews

The interview is a data-collection method that is mostly done in a face-to-face encounter (Rubin & Babbie, 2011:389). To get in-depth answers, besides redirecting the interviewee’s attention to the area more relevant to the enquiry, the interviewer needs to be able to listen, think, and talk almost at the same time (Rubin & Babbie, 2011:464).

A phenomenological approach will be utilised for data collection. Donaleck (2004:516) states that in nursing research phenomenology is used as method to explore the deepest meanings of some parts of the human experience. The task of phenomenology is to discover what life experiences are like for people (McKenna, 1997:33). The existential phenomenology of Heiddeger is the preferred choice as the researcher wants to understand the meaning participants attach to the phenomenon (Reiners, 2012:2). Mateo and Kirchhoff, 2009:133) state that phenomenological approach is an ideal approach when the researcher wants to understand the meaning participants give to their experiences. Data will be collected six months after the psychiatric nurse participants’ implementation of the model by psychiatric nurse participants. Maxwell (2013:100; 1996:74) argue that data collection is the means of answering the research questions and not a logical transformation of the latter. The researcher will structure the discussion for the purpose of obtaining
understanding, ideas, and thoughts about a specific topic (Kayrooz & Trevitt, 2005:9).

Participants will be given a choice between in-depth interview with the researcher and the writing of a naïve sketch about their experience with the model implementation. To all psychiatric nurse participants to the research study the following question will be asked: “What was your experience like when using this model implementation in dealing with aggression?” For the richness of data, the researcher will also use, besides in-depth interviews, field notes and naïve sketches.

ii. Field notes

LoBiondo-Wood and Haber (2010:272) state that field notes are a short summary of observations made during data collection. These notes are not restricted to any particular type of action or behaviour, but represent a narrative set of written notes intended to paint a picture of a social situation in a more general sense. During the whole process of data collection, the researcher will take notes on what is happening based on the interaction between the researcher and participants in the workplace environment and these will be incorporated in the data analysis as part of collected data. Below are the descriptions of the field notes.

- Observation notes

According to LoBindo-Wood and Haber (2010:271), observation is an important method for collecting data on how people behave under certain conditions. During observation, the researcher does not simply look at what is happening, but watches with keen interest for specific events that are in line with the study’s objectives (LoBindo-Wood & Haber, 2010:271). De Vos et al. (2011:335) argue that observation can be done in one or more forms such as regularity, duration, intensity. Before the observation takes place, the researcher has to decide on a number of forms of behaviour to be observed and whether outside observers, inside observers or the participants as observer will do the observation. The authors assert further that field notes should consist of everything the researcher sees and hears because the researcher is unlikely to know at the beginning of the study what might become important later on (De Vos et al. 2011:335). Field notes consist of a day-to-day report.
on the real observations done that follow two main rules: recording what the researcher sees or hears and expanding field notes beyond immediate observations. Ideally, field notes should contain a comprehensive account of the participants themselves, the events taking place, the actual discussions and communication, and the observer’s attitudes, perceptions and feelings.

In this research study, the researcher will write down the main ideas during the interactions with the research participants and in the evening a summary of the day’s experience will be written and kept as part of data collected. These will then be taken into consideration during data analysis process.

**Theoretical notes**

De Vos et al. (2011:410) state that theoretical notes, also called personal notes, are self-conscious, systematic attempts by the researcher to reflect critically on what took place, what he or she thought and experienced and also the reflections on the dimensions and deeper meanings of concepts. Theoretical notes also include the researcher’s critical reflection on his or her *feelings* about the research. Theoretical notes cover a variety of topics including reflections of the dimensions and deeper meanings of concepts, relationships among concepts and theoretical propositions (Rubin & Babbie, 2011:486).

In this research study, the researcher will keep these personal notes in a journal together with his critical reflections on what took place during the whole process of the research study, especially during implementation of the model. These notes will be part of the discussion of the result in Chapter Five.

**Naïve sketches**

Naïve sketches are described as documents written by participants to tell their stories and perspectives on their accounts of personal experiences with the phenomenon (Giorgi, 1985:1). The naïve sketches will be written by those participants who prefer to give a written experience instead of being interviewed and audio-recorded. These naïve sketches will be analysed and interpreted on the same level as the transcripts of the in-depth interviews.
f) Data analysis

According to De Vos et al. (2011:397), data analysis is the process of bringing order, structure and meaning to the mass of collected data. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal. The purpose of data analysis is to attempt to understand what a specific experience is like by describing it as it is found in concrete situation and as it appears to the people who are living it (Leedy, 1997:161). In this research study, the collected data will be independently analysed by both the researcher and the independent coder whose academic knowledge and competence in the field are recognised, and a consensus will be reached.

The following steps of Tesch’s method of open coding (Strauss & Corbin, 2015; Creswell, 2013:86) will be utilised:

- The researcher will read the transcribed in-depth interviews and naïve sketches a number of times, jotting down ideas as they come to his mind and will compare them to the field notes and personal notes.
- The researcher will pick up one transcribed in-depth interview or naïve sketch and tried to understand what the participant wanted to say. He will try to grasp the meaning by analysing the underlying message.
- The researcher will group the topics according to the themes and sub-themes in order to produce a whole out or parts.
- The topics listed above will be abbreviated and put into codes and compared and contrasted in order to ensure that no theme has been left behind.
- The central themes will be generated by listing similar topics together.
- The researcher will use appropriate vocabulary and the most descriptive wording in order to shorten and condense categories. Then a final decision will be made for each category and codes will be alphabetised.
- The data material belonging to the same theme will be assembled in one place, a preliminary analysis will be performed and, if necessary, existing data will be recorded.
- The researcher and the independent coder will meet to discuss the data analysis findings until a consensus is reached.
Open coding represents the operations by which data are broken down, conceptualised, and put back together in new ways (Strauss & Corbin, 2015:239). The independent coder, to be used in this research study as co-data analyst, has experience in qualitative research and is a holder of a PhD degree in Mental Health Sciences and works as a university lecturer and has written a number of articles in the field.

For the validation and contextualisation of the research findings, a literature control will be conducted. Marshal and Rossman (2011:77) claim that literature builds a logical framework for the research and locates it within a tradition of inquiry and a context of related studies.

2.5 MEASURES TO ENSURE TRUSTWORTHINESS

Babbie and Mouton (2001:277) define trustworthiness as an approach to clarify the notion of objectivity. The framework of Lincoln and Guba (in Polit & Beck, 2008:539) which is based on four criteria of credibility, transferability, dependability and confirmability and which will be used is set out below in table 2.1.

Table 2.1 Measures to ensure trustworthiness

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Application</th>
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<tbody>
<tr>
<td>Credibility</td>
<td>• Prolonged engagement with the field</td>
<td>The researcher will spend three months to gain entry in the field. He will work and support participants for six months while they implement the model. Rapport will be created in a context that enables trust and sharing during implementation of the model.</td>
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<tr>
<td></td>
<td>• Reflexivity Journal</td>
<td>A journal will be kept in</td>
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which experiences and observations are written reflecting always on the researcher’s involvement and how it may affect the data.

<table>
<thead>
<tr>
<th>Peer examination</th>
<th>There will be discussions with supervisors about the process and progress of methodology. Model evaluation will be conducted with experts in model evaluation. Consensus discussion with the independent coder will be reached. Doctoral seminars will be conducted.</th>
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<tbody>
<tr>
<td>Triangulation</td>
<td>In-depth interviews, naïve sketches, field notes and observation notes will be used. Triangulation of investigators: discussions with supervisors; data analysed by an independent coder with consensus discussion.</td>
</tr>
<tr>
<td>• Member checking</td>
<td>I will have formal and informal discussions with psychiatric nurses to verify the findings. Discussion with colleagues who are interested in the study will take place as a form of member checking.</td>
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<tr>
<td>• Authority of the researcher</td>
<td>I have experience in qualitative research being a holder of a Master's degree in mental health psychiatric nursing. I am a doctoral student in psychiatric nursing science with experience in research, interviewing and communication techniques. My supervisor and co-supervisors are professors and PhD holders in the field.</td>
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<tr>
<td>• Structural coherence</td>
<td>Focus throughout the thesis will be on facilitating effectiveness management of aggression experienced by psychiatric nurses working in a psychiatric</td>
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<td>Transferability</td>
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<td>• Sampling method</td>
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<td>• Dense description of results</td>
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<th>Dependability</th>
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<tr>
<td></td>
<td>• Dense description of research methodology</td>
<td>I will provide in-depth description of research design and methods that will be used.</td>
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<tr>
<td></td>
<td>• Triangulation</td>
<td>As discussed.</td>
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<td></td>
<td>• Code-recode procedure</td>
<td>An independent coder will be used for data analysis and discussions be held until a consensus will be reached.</td>
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<tr>
<td></td>
<td>• Dependability audit</td>
<td>Transcription of interviews, field notes,</td>
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Institution in order to present a holistic picture of the study.
<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer examination</td>
<td>journals, and naïve sketches will be kept for two years after the publication of the thesis.</td>
<td>There will be audit trial, collection and documentation of raw data, naïve sketches, field notes. As discussed.</td>
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<tr>
<td>Step-wise replication of research</td>
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<td>The same procedure followed in eliciting feedback from the psychiatric nurses regarding the implementation of the model.</td>
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<tr>
<td>Confirmability</td>
<td>Confirmability audit</td>
<td>There will be safe keeping of raw data: tapes and transcribed interviews, naïve sketches, journals, field notes for two years after publication of thesis as the chain of evidence of the research process.</td>
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<td></td>
<td>Triangulation</td>
<td>As discussed before</td>
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<td></td>
<td>Reflexivity</td>
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<td>Credibility</td>
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<td></td>
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<tr>
<td>• Reflexivity Journal</td>
<td>A journal will be kept in which experiences and observations are written reflecting always on the my involvement and how it may affect the data.</td>
<td></td>
</tr>
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<td>• Peer examination</td>
<td>There will be discussions with supervisors about the process and progress of methodology. Model evaluation will be conducted with experts in model evaluation. During discussion consensus discussion with the independent coder will be reached.</td>
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</table>
Docto**ral seminars will be conducted**

- **Triangulation**  
  - In-depth interviews, naïve sketches, field notes and observation notes will be used.
  
  Triangulation of investigators: discussions with supervisors; data analysed by an independent coder with consensus discussion.

- **Member checking**  
  - I had formal and informal discussions with psychiatric nurses to verify the findings.
  
  Discussion with colleagues who are interested in the study will take place as a form of member checking.

- **Authority of the researcher**  
  - I have experience in qualitative research being a holder of a masters’ degree in mental health psychiatric nursing.
  
  I am a doctoral student in psychiatric nursing science with experience in research, interviewing and
communication techniques.

My supervisor and co-supervisors are professors and PhD holder in the field.

| Transferability | | Focus throughout the thesis will be on facilitating effective management of aggression experienced by psychiatric nurses working in a psychiatric institution in order to present a holistic picture of the study. |
|-----------------|----------------|
| • Structural coherence | |
| • Nominated sampling | Purposive sampling will be used as the sampling method. |
| • Dense description of results | Complete description of demographic information will be provided. |
| | In-depth description of results with verbatim quotes will be provided. |
| | Literature control will be utilised to place the findings in the academic world. |

<p>| Dependability | |
| • Dense description of results | I will provide in-depth |</p>
<table>
<thead>
<tr>
<th>Research Methodology</th>
<th>Description of research design and methods that were used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Triangulation</td>
<td>As discussed.</td>
</tr>
<tr>
<td>- Code-recode procedure</td>
<td>Discussions with an independent coder will be held until consensus will be reached.</td>
</tr>
<tr>
<td>- Dependability audit</td>
<td>Transcription of interviews, field notes, journals, and naïve sketches will be kept for two years after the publication of thesis.</td>
</tr>
<tr>
<td>- Peer examination</td>
<td>There will be an audit trial, collection and documentation of raw data, naïve sketches, field notes.</td>
</tr>
<tr>
<td>- Step-wise replication of research</td>
<td>As discussed</td>
</tr>
</tbody>
</table>

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<tr>
<th>Confirmability</th>
<th>There will be a process of</th>
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</table>
2.5.1 Criterion of truth value: Credibility Strategies

The criterion of truth value addresses the concern about whether or not it is reasonable to believe or have faith in the results (Mateo & Kirchhoff, 2009:149-150). There needs to be confidence that the results are an accurate reflection of the view of the participants and the experiences that were studied (Mateo & Kirchhoff, 2009:149).

Credibility refers to the compatibility between the constructed realities that exist in the minds of the participants and those that are attributed to them (Babbie & Mouton, 2001:277). The researcher’s attention will focus on the following points.

2.5.1.1 Prolonged engagement with the field: the researcher will spend enough time with the participants on the site (Guba & Lincoln, 1985:302). All the steps regarding the implementation of the model will be explained. Psychiatric nurses will be given opportunities to voice all their doubts and concerns regarding their experiences in encountering and managing aggressive incidents. All their questions regarding the research study will be answered before they begin to participate. Even during the implementation, the researcher will continue to make himself available in order to support and learn from the participants’ experiences.
2.5.1.2 Reflexivity journal: Denzin and Lincoln (2003:283) define reflexivity as the process of reflecting on the self as a researcher, the human instrument. The reflexivity guides the researcher to come to terms not only with his choice of research problem and with those with whom he engages in the research process, but also with himself and with the multiple identities that represent the fluid self in the research setting. The researcher will keep a journal in which all his experiences and observations during the model process particularly during model implementation will be noted. All the objective and subjective information, the use of metaphors, non-verbal cues, postures and the feelings of the researcher will be jotted down as part of the data collection process.

2.5.1.3 Triangulation: this is the combined use of two or more theories, methods, data sources, investigations or analysis methods in the study of the same phenomenon and its purpose is to increase the overall validity of the study (Marshall & Rossman, 2011:252; Burns & Grove, 2005:224). In order to increase the credibility in this research study, the researcher will use various sources and methods (Corbin & Strauss, 2015:345; Guba & Lincoln, 1985:305). The process of data collection will involve in-depth interviews, a reflexive journal, field notes, naïve sketch writing, and observation of participants during the implementation process. The researcher and an independent coder will hold meetings and discuss data analysis in order to reach a consensus.

2.5.1.4 Member checking: in doing member checking, the researcher returns to the participants or to a subset of participants and shares the findings with them so that they can verify that the researcher has correctly understood their views and experiences presented in the interview (Mateo & Kirchhoff, 2009:150). At the end of data analysis, the researcher will meet with the participants and present to them the findings in order to check whether these reflect what they have meant in their interviews or naïve sketches. The input of the participants will be taken into consideration before the findings are finalised and published.

2.5.1.5 Structural coherence: this is the process that will be used in this research will be contrasted with the conventional method of research methodology so that the
findings may fit in the academic structure. This is where recontextualisation and the literature control will play their role.

2.5.2 Criterion of applicability: Transferability strategies

Applicability addresses an issue similar to generalisability (Mateo & Kirchhoff, 2009:150). Transferability refers to the instance where the findings can be applied in similar contexts or with similar other participants (Babbie & Mouton, 2001:277). In doing so, however, the researcher will have to bear in mind that the findings of this research study will be primarily applicable to the institution where the research is done and to the participants in a defined context. Mateo and Kirchhoff (2009:151) confirm that, in providing sufficient and detailed description of the research situation, the researcher enables the reader to determine whether the results are likely transferable to other settings. The transferability strategies are discussed below.

2.5.2.1 Sampling method: Babbie (2009:193) defines purposive sampling as a nonprobability sampling in which the researcher expects to get useful information. This purposive sampling will be the method of choice used to obtain relevant information from the participants.

2.5.2.2 Dense description of demographics of participants: the researcher intends to use the criteria mentioned (see 2.4.4.b). Other information about the participants will be provided in Chapter Five where the findings of the research study will be interpreted and discussed. The researcher will give detailed information on how data was collected and analysed. These details will be in Chapter Five where the findings will be discussed and supported by verbatim quotations.

2.5.3 Criterion of Consistency: Dependability Strategies

According to Hornby (2010:309), consistency is defined as the quality of always behaving in the same way. Dependability refers to the evidence that, if the study were to be repeated with the same or similar participants in the same or a similar context, its findings would be similar (Babbie & Mouton, 2001:278). Mateo and Kirchhoff (2009:151) indicate that what is important is that all aspects of data collection and analysis be employed and the insight generated be conducted in a way that is dependable. This is because, they continue to argue, things cannot be expected to be the same with repeated episodes of data collection, or with collection
of information from different groups. As people talk about their experiences, their perspective changes. Dependability strategies are discussed below.

2.5.3.1 Dense description of the research methodology: the dense description of the research method used is done throughout this research study. The researcher intends to describe the steps taken and supports them with literature review. Chapter Two, particularly, describes the steps that are to be taken in this research study and further steps will be explained in the next chapters where they feature.

2.5.3.2 Step-wise replication of the research method: all the steps taken in the research study will be supported by literature and references will be provided. The researcher intends to provide a clear understanding by describing every step before it is taken; the process is overseen by both the researcher and the research study supervisors.

2.5.3.3 Code – recoding of data: the data will be analysed by the researcher and an independent coder by means of code-decoding the data. This entails grouping or categorising ideas into themes and categories by codes during data analysis.

2.5.3.4 Dependability audit: it refers to the keeping of records of all the steps in the process of conducting the study, including procedure, methodological changes that are instituted, insight generated during data analysis and observational and field notes (Mateo & Kirchhoff, 2009:151). Every step taken in this research study will first be discussed between the researcher and the research supervisor and co-supervisors. At the end of the research study, the written thesis will be submitted to the scrutiny of the researcher’s supervisor, co-supervisors, and to the external examiners. The outcome of this study will be the original work of the researcher and all the sources used will be referred to in the text and in the index. All the field notes, memos, naïve sketches will be kept as a proof that indeed the original work belongs to the researcher and that this supports the findings, conclusions and recommendations.

2.5.4 Criterion of Neutrality: Confirmability Strategy

Neutrality refers to the degree to which the findings are a function solely of the informants and conditions of the research and not of other biases, motivations, and perspectives (Krefting, 1991:159). Confirmability refers to the degree to which the
findings are the product of the focus of the inquiry and not of the biases of the researcher (Babbie & Mouton, 2001:278). The researcher will endeavour by all means to be objective and to report the findings as the true reflection of data collection and analysis from both himself and the independent coder. Bracketing has been discussed as the means of ensuring neutrality though the researcher still believes that objectivity cannot be complete, given the fact that he works and interacts frequently with the environment and the participants. The confirmability strategies are discussed below.

2.5.4.1 Confirmability audit of whole research process: the chain of evidence. The researcher intends to remain faithful to the academic and ethical requirements in conducting any research study. Therefore, the outcome of this study will be the original work of the researcher and will be complying with the established standards for conducting a research study.

2.6 ETHICAL CONSIDERATIONS

Hammersley and Traianou (2012:16) define the concept ethics in two ways: first ethic means a field of study concerned with investigation of what is good or right and how this should be determined. Second, it is a set of principles that embody or exemplify what is good or right, or allow one to identify what is bad or wrong.

This research study is conducted according to the ethical guidelines of the Medical Research Council of South Africa (2003:2-6) as well as the guidelines of the United Nations Educational Science and Culture Organisation (UNESCO, 2006: 23-31). The principles of respect for the person, non-maleficence, beneficence and justice have been discussed extensively in Chapter One: see 1.8.

2.7 SUMMARY

This chapter dealt extensively with the research design and method that will guide the identification of the central concepts and the definitions thereof. The measures to ensure trustworthiness and ethical considerations were also discussed in detail. The next step is to develop and describe the model to facilitate the effective management of aggression. This is the objective of the next chapter, Chapter Three.
CHAPTER THREE: DEVELOPING A MODEL FOR THE FACILITATION OF THE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY PSYCHIATRIC NURSES WORKING IN A PSYCHIATRIC INSTITUTION

3.1 INTRODUCTION

The development of the model for the facilitation of effective management of aggression experienced by psychiatric nurses working in a psychiatric institution was done through the identification of the central concept, the definition of the central concept and other essential criteria, the classification of the central and related concepts as discussed below:

Walker and Avant (2011:60) define a concept as a mental image of a phenomenon, an idea or a construct in the mind about a thing or an action. Concepts are important as they are the building blocks of theory or model (Green & Thorogood, 2009:38). Chinn and Kramer (2008:187) define a concept as being a complex mental formulation of empirical experience. In this chapter, the researcher intends to analyse the central concept from which a model to facilitate effective management of aggression experienced by nurses working in a psychiatric institution will be developed. The process of the concept analysis comprises three phases and these are:

- the identification of central or main concepts;
- the definition of the central concepts and other essential concepts; and
- the classification of concepts.

“In order to properly understand the big picture, everyone should fear becoming mentally clouded and obsessed with one small section of the truth” Xunzi.
3.2. CONCEPT ANALYSIS

Walker and Avant (2011:157) go on to define a concept analysis as a formal linguistic exercise that determines the attributes of the defined concept. The process of concept analysis entails looking into mental complex formulations and empirical experiences. Walker and Avant (2005:64) further say that this exercise proceeds by examining the basic elements of a concept and allows one to distinguish the likeness and unlikeness between the concepts, resulting in a precise operational definition that by its very nature increases the validity of the construct, reflecting its theoretical base. The analysis of concept must be rigorous and precise, but the end product is always tentative because two people will see the same thing differently and also because of the fact that scientific and general knowledge changes so quickly; what is true today may not be true tomorrow (Walker & Avant, 2011:157). The three phases of concept analysis are discussed below.

3.2.1 Phase 1: Identification of central concept

In order to identify the central concept, I am now giving an overview of the findings from my Master’s research. I will end this by pointing out the central concept in paragraph 3.2.2 in view of these findings. My Master’s research study focused on “the lived experience of aggression and violence by nurses working in a Gauteng psychiatric institution” (Bimenyimana, 2008:36-56). The findings showed that psychiatric nurses working in this Mental Health Institution experience an overwhelming level of violence and aggression. This aggression is expressed verbally, physically, and emotionally. The factors identified to be contributing to this aggression are: admission of involuntary patients, staff shortage, lack of support from the management and among the members of the multidisciplinary team (MDT), and the lack of structured and comprehensive orientation. As a result, nurses experience negative feelings of fear, anger, frustration, despair, hopelessness, and helplessness. They then use ineffective coping mechanisms such as substance abuse, absenteeism, retaliation, a development of an ‘I don’t care attitude’, and apathy towards the work and towards what is happening around them.

The findings were grouped in three themes: 1) aggression has contributing factors; 2) the experience of aggression leads to negative feelings and causes physical, emotional and financial consequences; and 3) psychiatric nurses are unable manage
this aggression effectively but rather use ineffective mechanisms to cope with the situation (Bimenyimana, 2008:36:56). For further clarification, I find it necessary to elaborate more on the three themes so that the reader can understand how the central concept was derived.

3.2.1.1 Aggression has contributing factors

The psychiatric nurses working in the institution were faced with a number of challenges in dealing with aggression. This was expressed during the interviews where the psychiatric nurses described the challenges they were faced with. These challenges were: the types of patients admitted and the hospital environment, the shortage of nursing personnel, the lack of support from the nursing management, the multidisciplinary team (MDT) and the lack of comprehensive orientation. Although some of these challenges are even beyond the management or the multidisciplinary team, at times psychiatric nurses felt as if they are left to deal with aggressive incidents alone. The statements below are verbatim quotes from the participants as testimony of what they were experiencing (Bimenyimana, 2008: 44-47):

“Another cause of violence is... our patients are involuntarily admitted. You will find that this patient is very angry and bitter against his mother who called the police to bring him here due to committing violence at home after smoking dagga. When he gets here, he then shifts that anger toward you for keeping him here”.

“There was a time when a patient was kicking windows and then we had to put her in a side room and we were only two in the ward. So we couldn’t take her in a side room and she was fighting us, yeah and our clothes were torn”.

“As you can see today, I am working alone. I am one registered nurse to 35 patients. This shortage is de-motivating.”

“The nurses are expected to do everything, like when the psychologists come to here first of all they will depend on you for assistance, but at the end of the day, they will not respect you. A doctor will expect you to do everything: patients’ files and different forms, yet when you are alone nobody helps”.

“Usually the doctors will come and prescribe something, but they don’t help. You are just left alone there, you don’t get help”.

73
“When the staff is assaulted management is on the side of the patient”.

“When they come (meaning management), they talk to you but it’s like sort of highlighting your wrong doing most of the time. It’s all about the patient, the patient, which is ok, but what about you as someone who is working and then who is going through a situation?”

“It gets too frustrating when you work hard and you are not appreciated. The management should learn how to say thank you… I think the management fails to see that we need support just to build us up.”

“A patient was very rude and was an Afrikaner calling us kaffirs. I reported it and they told me…uh… that this patient is sick, he doesn’t know what he is doing so I must just not take it too hard, but it is too difficult for me to take that a patient calls me a kaffir, it’s not nice.”

“I was told by the sisters during orientation that there might be violence, but you don’t get full orientation”.

“The first time I experienced violence in this hospital I was very, very scared. It was a female and I didn’t expect that a female could be so violent… we were hiding for just I was scared, confused… nobody said anything to me.”

3.2.1.2 The experience of aggression leads to negative feelings and physical, emotional and financial consequences

According to Mohr (2003:17), the innately humanitarian nurse’s work purpose does not shield them from the stressors of feeling fearful, anxious, offended, helpless, repulsed, pitying, embarrassed, hopeless, angry, or all of these emotions. In the context of the participants’ experience there were also frustration, dissatisfaction, an ‘I don’t care attitude’, resentment, and other emotions shared by the participants as expressed through the following verbatim quotes (Bimenyimana, 2008:47-52).

“I would walk on my way to work, eish, just feeling this heavy load on my shoulders thinking I am going to that place, I’m gonna find so and so and I know they are like this, they are gonna do this”.
“If you go to the patients’ files and see that they have killed their parents. Then they threaten you. You end up having fear”.

“There is one patient even who went to the point of saying we will meet outside. He knows he is gonna get leave and he knows where I stay. So we will meet outside and he will get me.”

“… You think like… if a patient can injure me. If I am hit on the head and then I become a cabbage what is going to happen to my kids?”

“We are in the same boat: it happens to your colleague; next time it is going to happen to you”.

“You get frustrated, and sometimes you forget that you are a nurse and then you put your cards on the table. You retaliate because sometimes they attack you personally so you get angry and hit.”

“I just went in and took him out then I told him: no. Now it’s time to fight because I am a woman he is a man if he can klap me it means he can fight. So, yeah, I was ready to fight him. I was so angry I did fight and, you know, I gave him a bit of his own medicine”.

“At time, a patient purposely will tell you: yes, am sick and I can assault you and there is nothing you can do.”

“This doctor expected me… she was sitting down complaining and I was the only registered nurse there and then she asked me for a form, and then she asked me for a file and I just looked at her and felt angry”.

“Nothing good I can think of since I came here except maybe seeing them being well after seeing them coming to the hospital very sick and very psychotic and then seeing the change. You know it’s almost like two different people, but then they go home and come back!”

“I just say: God help me! Help me so that I can move away before I get carried away”,

“What change have I brought? What difference have I made? Because I remember there was a patient, he was depressed. The family wasn’t coming whatever; I took him Saturday with me, you know, one on one I encouraged
him: no don’t worry as long as you have your life you can at least still carry on and make something out of it. Yeah, then here comes a staff out of nowhere ‘Yeah, you are useless that’s why they don’t want you at home’. Then the patient takes a broom and breaks the windows. Then you start all over again”.

“We end up working for the sake of our families as there is nothing we can do to survive.”

“The only thing is like giving medication then we hope the patient will be fine because there are patients who came here and we gave them medication. They become better you send them home, but they go and do the same thing that they did before.”

“I am somehow de-motivated because there is no goal; I ask myself what skills am I taking from here?”

“Every day you come to work, you are de-motivated. You are just working because you have no choice”.

“I developed a ‘don’t care attitude’ because I felt that the management did little or nothing to address the issues.”

“You just work until you get used to violence and see it as normal”.

3.2.1.3 Psychiatric nurses are unable to manage aggression effectively, but rather use ineffective mechanisms to cope with the situation

Psychiatric nurses use knowledge and skills when confronted with aggressive incidents. At times it works, at others it doesn’t. There comes a time when everything they try does not work. They gradually go through the following process: first they ignore aggressive incident and do not want to get involved; then they realise that these incidents persist and try to intervene, sometimes getting physically hurt. Ultimately, they fight back and retaliate. As this is not an adequate way of dealing with aggression, they become more and more frustrated. Because psychiatric nurses still need to cope with the situation, they then abuse substances, absent themselves from work, even when they are not sick, or experience burnout. This is how the participants expressed it:
“Maybe that’s why in the nurses’ home there are so many bottles empty everywhere. They drink on almost daily basis because I know people who drink every day. No matter in or out, off or on duty, every day they must drink.”

“…On days like that, you would like to relax, but there is no entertainment in the hospital”.

“These things end up causing emotional stress to nursing staff and lead to alcohol abuse and a high rate of absenteeism.”

“I was not happy with the situation. I thought they don’t care, so started wondering why I should care about the hospital and that attitude. Why should I care because people don’t care about me”?

“…But the chair landed on my face and injured my nose. I thought of resigning from the institution and seeking employment somewhere else or whether I should let patients fight and not put my life at risk by separating them.”

From the above psychiatric nurses’ experiences, it is clear that

- Psychiatric nurses working in this psychiatric institution were faced with aggression on a daily basis.

- These psychiatric nurses tried to deal with the workplace aggression in all kinds of ways, but still the situation did not improve.

- Having used all the means possible at their disposal and realising that the results were still the unwanted ones, psychiatric nurses became more and more frustrated and filled with despair. The situation appeared beyond their control and the means they used to manage aggressive incidents proved to be ineffective. They needed assistance and alternative means in dealing with aggression effectively in their workplace environment.

In view of the aforementioned findings it is clear that psychiatric nurses need assistance in order to self-manage aggression effectively. Therefore, the central concept is the facilitation of the effective self-management of aggression
experienced by the psychiatric nurses in their daily encounters with aggressive psychiatric patients.

3.2.2 Phase 2: Definition of the central concept and essential attributes

Definitions are statements of meaning that provide a link between theoretic abstractions and empirical indicators (Chinn & Kramer, 2008:296). For each of the identified concepts, a dictionary definition, which provides synonyms and antonyms and convey commonly accepted ways in which words are used (Chinn & Kramer, 2008:197), and a subject definition, which conveys meanings that pertain to the domain of the discipline from which the concept comes (Chinn & Kramer, 2008:198) are offered.

Walker and Avant (2011:161) advise that while one uses dictionaries or thesauruses it is important to identify as many uses of the concept as possible because disregarding or ignoring some uses of a concept may result in an analysis that severely limits the usefulness of the outcome. It is for this reason that even the concept’s uses that are not part of operational definition were included in the definitions of the concepts identified and defined in this research study. Those definitions that come closer to the meaning of the concept to be defined are differentiated by being underlined.

The main concepts in this research study are commonly used in other disciplines, but seldom in the psychiatric nursing domain. In the following sections the central concept, namely the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution, is analysed.

3.2.3 Dictionary definitions of “Facilitation”

The use of the term facilitation has been found in a number of both hard copy and online dictionaries. From those multiple definitions of the concept facilitation, I record meanings that are pertaining to the concept in line with the goal and objectives of the development of the model to facilitate effective self-management of aggression. These are highlighted and will be put in a table later.

Soanes and Hawker (2008:356) define the word facilitation as making something easy or easier. Hiltz and Turoff (http://www.textweaver.org/facilitation.htm), define facilitation as the art of leadership in group communication. The free dictionary
The online definition dictionary (http://www.definitions.net) defines ‘facilitation’ as the act or process of facilitating. Princeton’s WordNet dictionary (http://wordnetweb.princeton.edu/perl/webwn) defines ‘facilitation’ as the condition of being made easy; the act of assisting or making easier the progress or improvement of something.

The verb from facilitation is to facilitate. Harper (2010:n.p.) defines the verb to facilitate as to render easy. The free dictionary (www.freedictionary.com) defines to facilitate as to make easy or easier and the American Heritage Dictionary of English Language (Houghton Mifflin Company, 2009) defines the verb to facilitate as to make easier, alleviate, ease, aid, assist, help, give help or assistance; be of service. To be of use, serve, contribute or conduce to, Increase the likelihood, cause, do, make, give rise to, to cause to happen or occur, make a stir. The ardictionary.com defines the verb to facilitate as to make easy or less difficult; to free from difficult or impediment; to lessen the labour of.

3.2.3. 1 Subject definition of “Facilitation”

According Barnhart (Hogan, 2002:10) facilitation comes from a French word ‘facile’ and Latin ‘facere’ to do or perform and means to make easy. Facilitation is a way of providing leadership without taking the reins. A person who makes the facilitation process happen is called a facilitator (Bens, 2005:7) and acts more like a referee, rather than being a player. The role of a facilitator is to get others to assume responsibilities and to take the lead. A facilitator helps members define and reach their goals (Bens, 2000:7). This is to avoid dependence that can have dire consequences once the facilitator withdraws from the process. Hogan (2002:10) states that facilitation is concerned with encouraging an open dialogue between individuals with different perspectives so that diverse assumptions and options may be explored. A good facilitator has the following qualities: self-reflectiveness; being a
process-person; who has a variety of human process technical skills; and knowledge together with a variety of experiences to assist individual or group of people to journey together to reach their goals. To these qualities, Bens (2005:8) adds the ability of being flexible and open-minded, believing that two heads are better than one. The following are the contributions that are made by a facilitator (Bens, 2000:7-8):

- helping the group define its overall goal, as well as its specific objectives;
- helping members assess their needs and create plans to meet them;
- providing processes that help members use their time efficiently to make high quality decisions;
- guiding group discussion to keep it on track;
- making accurate notes that reflect the ideas of members;
- helping the group understand its own processes in order to work more effectively;
- making sure that assumptions are surfaced and tested;
- supporting members in assessing their current skills, as well as building new skills;
- using consensus to help a group make decisions that take all members’ opinions into account;
- supporting members in managing their own interpersonal dynamics;
- providing feedback to the group so that they can assess their progress and make adjustments;
- managing conflict using a collaborative approach;
- helping the group communication effectively;
- helping the group access resources from inside and outside the group;
- creating an environment in which members have a positive, growing experience, while they work to attain group goal;
- fostering leadership in others by sharing the responsibility for leading the group; and
- teaching and empowering others to facilitate.
The theory of Health Promotion in Nursing defines facilitation as a **dynamic interactive process** for the promotion of health through the creation of a positive environment and the mobilisation of resources as well as the identification and the bridging of obstacles (University of Johannesburg, 2010:7).

Facilitation is also understood as helping people to understand how they think, interact, and feel about the role they play in situations happening in their lives and at work (Baxter in Hogan, 2002:55).

A facilitator needs effective management skills to help people and organisations in improving their own effectiveness and efficiency. These skills range from the ability to direct, supervise, encourage, inspire, and co-ordinate, through to facilitating action and guiding change. Facilitators also utilise planning, organisational and communications skills. These skills are supplemented by other qualities such as integrity, honesty, courage, commitment, sincerity, passion, determination, compassion and sensitivity.

Exforsys (http://www.exforsys.com) state that the facilitator guides the participants to a “learning journey” in discovering their own experiences and exploring those of others, identifying their strengths and weak points, and sharing what they already know with the rest. In some cases, the facilitator also shares his knowledge apart from just guiding them in the process. Good facilitation skills must be demonstrated. This would include the ability to communicate, the ability to manage and lead a group, the skill to listen actively and use effective questioning technique, and the capability to resolve easily the conflicts or misunderstanding.

**3.2.3.2 Summary of the definition of the concept facilitation**

From the above dictionary and subject definitions, the recurring words are: dynamic interactive process, making easier, guide and assistance. These concepts show that the concept of facilitation signifies and represents a process and dynamism in lessening difficulties, making things better or improving a situation.

The subject definition of the concept facilitation provides insight in understanding the behaviour and qualities that a facilitator must have in order to achieve the intended result of rendering assistance. Being self-reflective and person-centred allows and enables those requiring help to feel respected and free to be themselves in making a sound and informed decision to face difficulties with confidence and determination.
Below is Table 3.1 that indicates the list of identified attributes of the concept facilitation.

**Table 3.1 List of attributes to the concept “facilitation”**

<table>
<thead>
<tr>
<th>Making easier</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being of use</td>
<td>Aid</td>
</tr>
<tr>
<td>Contributing to</td>
<td>Serve</td>
</tr>
<tr>
<td>Conducive to</td>
<td>Art of leadership</td>
</tr>
<tr>
<td>Helping people to understand</td>
<td>Providing leadership</td>
</tr>
<tr>
<td><strong>Assistance</strong></td>
<td>Simplification</td>
</tr>
<tr>
<td><strong>Guidance</strong></td>
<td>Providing leadership</td>
</tr>
<tr>
<td>Help</td>
<td>Furtherance</td>
</tr>
<tr>
<td>Enabling</td>
<td>Boost</td>
</tr>
<tr>
<td>Reinforce</td>
<td>Support</td>
</tr>
<tr>
<td>Sustaining</td>
<td>Relief</td>
</tr>
<tr>
<td>Bridging of obstacles</td>
<td>Achieving a purpose</td>
</tr>
<tr>
<td><strong>Alleviate</strong></td>
<td><strong>Dynamic interactive process</strong></td>
</tr>
<tr>
<td>Mobilisation of resources</td>
<td>Creating a positive environment</td>
</tr>
</tbody>
</table>

**Guide**

**Table 3.2 List of the essential attributes of the concept “facilitation”**

<table>
<thead>
<tr>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dynamic Interactive Process</strong></td>
<td>Dialogue and exchange of ideas and experience</td>
</tr>
<tr>
<td></td>
<td>Promoting mental health</td>
</tr>
<tr>
<td><strong>To make easier</strong></td>
<td>Providing knowledge and skills</td>
</tr>
<tr>
<td></td>
<td>Lessen the difficult</td>
</tr>
<tr>
<td><strong>Assistance</strong></td>
<td>To help</td>
</tr>
<tr>
<td></td>
<td>Making resources available</td>
</tr>
<tr>
<td></td>
<td>To empower</td>
</tr>
<tr>
<td></td>
<td>Accompaniment</td>
</tr>
<tr>
<td></td>
<td>Lead</td>
</tr>
</tbody>
</table>
In this research study, facilitation is defined as a dynamic interactive process through which the advanced psychiatric nurse practitioner guides and provides assistance to the psychiatric nurses in making easier the effective self-management of aggression.

3.2.4 Dictionary Definitions of the concept “effective”

The Compact Oxford English Dictionary (Soanes & Hawker, 2008:317) defines “effective” as producing intended result or desired result. Fowler and Burchfield (2004:239) define effective as having a definite or desired effect. (http://www.kpilibrary.com) defines effective as being adequate to accomplish a purpose; producing the intended or expected result, actually in operation or in force, functioning, prepared and available for service, especially military service, works well. Other web definitions are: Princeton (http:\wordnetweb.princeton.edu/Perl/webwn) defines effective as producing or capable of producing an intended result or having a striking effect, able to accomplish a purpose; functioning effectively, works well as a remedy, having the power to produce an effect, producing a decided or decisive effect; efficient, serviceable, or operative; en.wiktionary.org/wiki/effective: producing the desired result. Business dictionary (http://www.business-words.com/dictionary) defines effective as producing a decided, decisive, or desired effect; impressive, striking; ready for service or action, actual, being in effect: operative, equal to the rate of simple interest that yields the same amount when the interest is paid once at the end of the interest period as a quoted rate of interest does when calculated at compound interest over the same period.

3.2.4.1 Subject Definitions of “effective”

According to Merriam-Webster Dictionary (2010), the word effective is sometimes used in a quantitative way, "being very or not much effective". However, it does not reveal in which direction (positive or negative) and the comparison to a standard of
the given effect. Efficacy, on the other hand, is the ability to produce a desired amount of the desired effect, or success in achieving a given goal. Contrary to efficiency, the focus of efficacy is the achievement as such, not the resources spent in achieving the desired effect. Therefore, what is effective is not necessarily efficacious, and what is efficacious is not necessarily efficient.

According to Gray (in Cowley, 2002:145), the effectiveness of a health care service or professional is the extent to which desired outcomes are achieved by it. The effectiveness of a service is its ability to achieve desired outcomes (Cowley, 2002:160). In this research study, the effectiveness of the model will be evaluated in relation to its ability to enable psychiatric nurses to self-manage aggression effectively. This in turn, will empower them to grow personally and professionally, and will also result in improved mental health.

According to Cowley (2002:160), individual empowerment combines:

1. a positive self-image or personal competence;
2. a sense of control over one’s life; and
3. individual participation and ability to influence decisions within institutions.

Zimmerman (in Cowley, 2002:175) believes that a process is empowering if it helps people to develop skills so that they can become independent problem-solvers and decision-makers. Once psychiatric nurses have overcome the challenge of managing aggressive incidents effectively, they will be more mature and will make sound decisions. Prosser (2005:8) argues that problems can either destroy individuals or they can make them wiser and more mature people whose judgment has improved immeasurably. The aim of this research study is to enable psychiatric nurses to deal with the challenges of aggression in a constructive way.

The model to facilitate effective self-management of aggression needs to be effective in order to enable psychiatric nurses to make a mature and responsible decision in dealing with aggressive patients. This is what Beyerlein, McGee, Klein, Nemiro and Broedling (2003:597) call psychological ownership. These authors define psychological ownership as a feeling of being tied to an object to the extent that the object becomes an important part of the individual’s identity (Beyerlein et al., 2003:597). The psychological ownership has three elements which appear below.
a) The first is a sense of efficacy or the belief in one’s ability to complete the task. This belief develops as the individual experiences a connection between controlling effort expended and achieving desired outcomes of the effect (Beyerlein et al., 2003:597).

b) The second is self-identity: work is an expression of identity, a way of defining individuality to others (Beyerlein et al., 2003:598).

c) Finally there is having a place or establishing a territory or home space: the fully developed person will have experienced achievement in two areas: how to collaborate with others and how to be comfortable facing the more individually focused issues of competence, identity, and moving from autonomy to interdependence (Beyerlein et al., 2003:601).

Table 3.3 List of attributes to the concept “effective”

<table>
<thead>
<tr>
<th>Capable</th>
<th>Adequate to accomplish a purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Producing intended result</strong></td>
<td>Efficient</td>
</tr>
<tr>
<td>Effectual</td>
<td>Produce an effect</td>
</tr>
<tr>
<td>Competent</td>
<td>Available</td>
</tr>
<tr>
<td>Having power to</td>
<td>Active</td>
</tr>
<tr>
<td>Impressive</td>
<td><strong>Operative</strong></td>
</tr>
<tr>
<td>Prepared</td>
<td>Functioning</td>
</tr>
<tr>
<td>Telling</td>
<td>Works well</td>
</tr>
</tbody>
</table>
Table 3.4 List of essential attributes for the concept “effective”

<table>
<thead>
<tr>
<th>Essential concepts</th>
<th>Related concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Producing intended result</td>
<td>Works well</td>
</tr>
<tr>
<td></td>
<td>Influencing</td>
</tr>
<tr>
<td></td>
<td>Has the ability to produce</td>
</tr>
<tr>
<td></td>
<td>Capable</td>
</tr>
<tr>
<td></td>
<td>Functioning</td>
</tr>
<tr>
<td>Operative</td>
<td>Impressive</td>
</tr>
<tr>
<td></td>
<td>Produces effect</td>
</tr>
<tr>
<td></td>
<td>Real</td>
</tr>
<tr>
<td></td>
<td>Efficient</td>
</tr>
</tbody>
</table>

In this research study, effective refers to the use of operative alternative means by psychiatric nurses aimed at producing the intended result which is their self-management of aggression.

3.2.5 Dictionary Definitions of the concept ‘self-management’

The Oxford online dictionary defines self-management as being the management of oneself by taking responsibility for one’s own behaviour and well-being.

Pearson (2010) defines self-management as the personal application of behaviour change tactics that produces a desired change in behavior.

Wikipedia (free encyclopedia, 2014) defines self-management as personal development, control of actions (to be in charge).

In health-care settings, Bramming, Gudmand-Høyer, Kärreman, Levay, Pedersen, Raffnsøe, Rennstam, Spicer and Spoelstra (2011: 214) define self-management as a
way of conceptualising the self-administration of therapy or the self-administration of drugs.

3. 2.5.1 Subject definitions of “Self-management”
According to Peacock, Ervin, Daly Ill and Merrell (2010:337) self-management refers to actions purposefully taken by individuals to change or maintain their own behaviour.
Self-management refers to the ability of an individual to regulate their emotions and resulting behaviours in ways that society considers acceptable. This includes the way in which individuals cope with unmet wants or needs, persevere when faced with obstacles, and set goals for themselves (http://www.performwell.org).

Self-management can also be defined as the decisions and behaviours that patients with chronic illness engage in that affect their health (http://www.improvingchroniccare.org).

Self-management is orientated to breaking down the processes of focusing, motivating, observing, and sustaining change efforts so that a people can, piece by piece, build their knowledge, insights, skills, comfort, and effectiveness (Cormier, Nurius & Osborn, 2013:559).

The definitions of self-management vary in part because of differing emphases regarding processes and strategies and the overlapping terms between self-management, self-control and self-regulation that are sometimes used interchangeably (Cormier, Nurius & Osborn, 2013:559).

Self-control entails the ability to withstand frustration, to assume responsibility for the self, to be self-directed, to control undesired behaviour by either self-reinforcing or self-punishing consequences, and to perceive the self as being in control rather than being a victim or external circumstances (Cormier, Nurius & Osborn, 2009:207).
Self-regulation is the ability to monitor and control our own behaviour, emotions, or thoughts, altering them in accordance with the demands of the situation (Cook & Cook, 2014:n.p.). It includes the abilities to inhibit first responses, to resist
interference from irrelevant stimulation, and to persist in continuing relevant tasks even when one does not enjoy them (Cook & Cook, 2014:n.p.). Self-regulation is mostly about **being able to control** one’s emotions and responses to situations and other people (Change-Management-Coach.com). Research consistently shows that self-regulation skill is necessary for reliable emotional well-being. Behaviorally, self-regulation is the ability to act in one’s long-term best interest, consistent with the person’s deepest values (Stosny, 2011:n.p.).

Self-assessment is the means by which self-awareness is achieved and both the process of self-assessment and the resulting increase in self-awareness are central to the theme of self-management (Rothstein & Burke, 2010:7).

According to Cottrell (2003:60), self-management encompasses a very broad range of skill, qualities, attitudes and experiences. Among these skills, qualities, attitudes and experience are:

- being able to analyse one’s situation, identifying strengths, weaknesses, opportunities and threats;
- identifying resources and sources of support;
- managing one’s time;
- adopting attitudes that support one’s aims;
- taking solution-focused approach to managing problems;
- managing one’s emotions;
- coping when in distress; and
- managing change, uncertainty and confusion.

Effective self-management relies on the following skills (City University London, 2015:n.p.):

- **Taking responsibility**: this means owning mistakes, talking about how you have learned from them and how they helped you develop professionally.
- **Initiative**: this involves taking ownership of responsibilities and responding to things without prompting from others.
- Resilience: this is the ability to adapt and bounce back when things do not go as planned.
- Assertiveness: in project meetings, this means listening but also ensuring that the best ideas are promoted in a sensitive and constructive manner.
- Time management: this demonstrates how you currently plan work.
- Flexibility: this includes stepping in at short notice to cover for someone who is ill.

Self-management can be used to live a more effective and efficient daily life, to break bad habits and acquire new ones, accomplish difficult tasks, and achieve personal goals (Pearson, 2010:n.p.). Self-management is important because it helps a people take control of their physical and mental health, reducing health cost and preventing greater issues in the future. Self-management is used in many fields from psychology to medical fields (www.ask.com). To function at thier highest level and master the art of living, people need to be able to access and express a deeper self. (Sheldon, Gunz & Schachtman, 2012:68).

**Table 3.5 List of attributes to the concept “self-management”**

<table>
<thead>
<tr>
<th>Taking responsibility</th>
<th>Sustaining change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of behaviour change</td>
<td>Building effectiveness</td>
</tr>
<tr>
<td><strong>Taking actions for change</strong></td>
<td>Ability to act</td>
</tr>
<tr>
<td>Self-administration therapy</td>
<td>Resilience</td>
</tr>
<tr>
<td>Flexibility</td>
<td><strong>Ability to regulate emotions</strong></td>
</tr>
<tr>
<td><strong>Ability to take control</strong></td>
<td>To cope with</td>
</tr>
<tr>
<td>Persevere</td>
<td>Setting goals</td>
</tr>
<tr>
<td>Essential criteria</td>
<td>Related criteria</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Ability to take control</td>
<td>Coping despite difficulties</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
</tr>
<tr>
<td>Taking actions for change</td>
<td>Sustain change</td>
</tr>
<tr>
<td></td>
<td>Persevere</td>
</tr>
<tr>
<td></td>
<td>Setting goals</td>
</tr>
<tr>
<td>Taking responsibility</td>
<td>Building effectiveness</td>
</tr>
<tr>
<td></td>
<td>Self-administration therapy</td>
</tr>
<tr>
<td></td>
<td>Application of behaviour change</td>
</tr>
<tr>
<td>Ability to regulate emotions</td>
<td>Flexibility</td>
</tr>
<tr>
<td></td>
<td>ability to act</td>
</tr>
</tbody>
</table>

The concept “self-management” is defined for the psychiatric nurses as the ability to regulate their emotions so that they can take responsibility for, and can implement actions for needed change resulting in taking control of their lives and self-managing aggression effectively.

**3.3 CONCEPTUAL DEFINITION OF THE CENTRAL CONCEPT**

The central concept of this research study has been identified as “the facilitation of effective self-management”. Definitions were provided for the concepts of facilitation, effective and self-management. Table 3.9 shows the list of the concepts retained for the purpose of this research study.
Table 3.7 The essential and related criteria of the concept “Facilitation of effective self-management”.

<table>
<thead>
<tr>
<th>Central concept</th>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilitation</strong></td>
<td><strong>Dynamic interactive process</strong></td>
<td>Dialogue and exchange of ideas and experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promoting mental health</td>
</tr>
<tr>
<td></td>
<td><strong>Make easier</strong></td>
<td>Providing knowledge and skill</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lessen the difficulties</td>
</tr>
<tr>
<td></td>
<td><strong>Assistance</strong></td>
<td>To help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accompaniment</td>
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<tr>
<td></td>
<td></td>
<td>Making the resources available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To empower</td>
</tr>
<tr>
<td></td>
<td><strong>Guide</strong></td>
<td>Showing the way</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providing direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lead</td>
</tr>
<tr>
<td><strong>Effective</strong></td>
<td><strong>Producing intended result</strong></td>
<td>Works well</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Functioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has the ability to produce</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influencing</td>
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<tr>
<td></td>
<td><strong>Operative</strong></td>
<td>Impressive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Produces effect</td>
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<tr>
<td></td>
<td></td>
<td>Efficient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Real</td>
</tr>
<tr>
<td></td>
<td><strong>Ability to take control</strong></td>
<td>Resilience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coping despite difficulties</td>
</tr>
</tbody>
</table>
3.3.1 DEFINITION OF THE MAIN CONCEPT

The facilitation of effective self-management of aggression is a dynamic interactive process through which the advanced psychiatric nurse practitioner guides and provides assistance to the psychiatric nurses in order to make it easier for them to take the actions required for the needed change. Psychiatric nurses are facilitated to utilise operative means and to take responsibility aiming at producing the intended result, that is, the self-management of aggression. Through the process, the psychiatric nurses are able to regulate their emotions and to take control of the workplace environment in effectively self-managing aggression from patients.

3.3.2 CONSTRUCTING A MODEL CASE

Walker and Avant (2011:163) define a model case as a concept that demonstrates all the defining attributes of the concept. The following model case is based on the essential attribute of the concept of facilitation of self-management.

Lerato (not her real name) is a 32 years old female professional nurse who has been working, in various units in this psychiatric institution, as a psychiatric nurse for the last ten years. She is married, with two children, and attends the Methodist church. Her children attend public school and she considers herself lucky because beside that she pays the school fees for her own children, she also pays for several nephews and nieces whose parents have died due to the AIDS pandemic. She lives 35 kilometres from the institution and uses public transport as she does not have her own transport. This is her story:
I have been working in this institution for the last ten years. About two years ago, I had lost the burning zeal I had when I started working here. Sometimes I used to wonder how long I would keep up with stress caused by aggressive incidents from the patients. Each day, when I woke up in the morning, I would kneel and pray so that the Lord could give me the strength to go through the day. Besides being a professional nurse, I am also a mother. I love my job and I care for the patients as if they were my own children. I used my professional skills and my motherly love, but I went back home crying most of the times, I was unable to cope. From the moment I entered the ward until handing over time, I would work like a slave. It was very difficult to draw up a programme that would be suitable to both psychotic patients and those who were recovering, but not yet ready to go home; to those who were higher functioning and those who had a mild retardation.

When I focused on those who were psychotic and needed extra attention, other patients would feel as if I did not care for them. Then they would start asking for attention by wanting to use the phone early in the morning, changing the channel of the radio or increasing the volume even when there was a ward-round or doing something else they knew would hit on my nerves. Whenever I made them aware of the wrongdoing, they would shout, scream, swear or even start breaking the ward’s windows. I did not know how to handle the situation and this triggered stress, causing me to go home crying.

Gone was the time we used to discuss issues in the climate meeting and come up with some doable solutions. Whenever we had meeting, it would end up in arguments as the patients brought in impossible demands such as requesting immediate discharge. I would tell them that the climate meeting does not cover the discharging of the patients, then they would start shouting. We decided to no longer have climate meetings to avoid unnecessary incidents. Rules and regulations were ignored by the patients who claimed jail was better than the hospital. It was at that time that one of the patients said that it would be better for him to go back to jail because there he would be able to do as he pleased. He added that the best way to get a chance to go back to jail would be by injuring one of the staff members. It made me scared to the point that I avoided him and I would not have individual psychotherapy with him because I had witnessed an injury that another patient caused to another staff member.
The patient was disruptive and the ward doctor decided to prescribe sedative injection to calm him down but the patient refused it. He started breaking the windows. To avoid further damage to him and other patients, the sister in charge had him restrained physically so that he could receive the injection. Two days later, the patient stabbed the same sister with a piece of glass that he had hidden in his locker in the dormitory. I started feeling afraid when I was alone with the patients, doubted my skills in handling aggressive patients and even wondered whether I was a good psychiatric nurse after so many years as a psychiatric nurse and yet not being able to manage aggressive patients.

I spoke to my pastor as I needed someone to talk to. My faith was being put to the test: I was fearful, short-tempered, I had difficulties in sleeping and I was becoming forgetful. I was asking myself whether God would consider me selfish if I resigned. The pastor listened attentively to what I had to say then told me that every gift had its own cross and that my nursing calling was not an exception. Because he did not condone what was happening, he advised to pray for guidance and to seek help from a professional. Despite my confusion, I was still convinced that psychiatric nursing was my calling. I wanted to work safely and feel happy once again.

I was very lucky. While I was still wondering how to seek professional help, struggling to find a way I could talk to another professional admitting my inability to manage my life and overcome patients’ aggression, Sue, the advanced psychiatric nurse, came along and offered to assist me.

She gently introduced herself and said that she was an advanced psychiatric nurse. At first I had mixed feelings of apprehension and relief. I was skeptical about whether she could really help me where I had failed but also relieved that at least we could talk confidentially nurse to nurse. With her skillful approach, she won my trust and confidence through a dynamic interactive process that enabled me to open up to her. In sharing with her my challenges in managing aggressive incidents, she made me aware of how sometimes I failed to take responsibility in what was happening around me. When a patient started a verbal attach, I would either withdraw from the place or ignore him completely. I was struggling emotionally and spiritually, unable to regulate my emotions.
Sue guided me and assisted me to be in touch with my feelings and to externalise things that I had been bottling inside for long. I started reflecting on what was happening to me in the workplace and how I was reacting to it. Through self-assessment, self-disclosure, and self-awareness, I came to realise that, at times, I had allowed my feelings and emotions to cloud my judgment in handling incidents of aggression. She encouraged me to take responsibility, that is, to accept myself for who I am, to examine my strengths and weaknesses objectively, to focus on the solution instead of focusing on the challenge, to utilise the suggested alternative means and to change what needed to be changed. This made it easier for me to assess the situation I was in objectively and to consider alternative operative means that would assist me in dealing with life challenges in general and workplace challenges in particular. I started taking actions that would lead to change and I made sure that I sustained these changes. Our dynamic interactive process was so rich that before I knew it, I was again smiling and getting up early for work without feeling tired or anxious about what the day would be. Things were falling into places (better mental health). These alternative means were so operative that I was able to regulate my emotions and deal with aggressive incident appropriately.

My passion for psychiatric nursing was re-ignited (feeling empowered) and I felt happy once again to be a professional nurse. Sue’s assistance (facilitation process) had produced the intended result. I was able to take control of my life and the workplace environment. I was answering to my calling, doing what I love in the way it was supposed to be done as the environment became less threatening. I succeeded in using my theoretical knowledge and clinical experience for the better. This has yielded a harvest: the quality of patients’ care has improved and I feel blessed. My faith in God has improved tremendously. I have come to understand that God held my hand even in the darkest moments when I thought he had abandoned me. My marriage has never been better than now and, I thank God, my children are doing very well in school. I still face aggressive patients, but my approach has changed. I was lucky to have a friend like Sue. There are colleagues who would benefit from such interventions if they had an opportunity. I still meet similar challenges to those I used to meet before, but my approach in dealing with them has changed. Aggressive incidents can be reduced to tolerable levels if psychiatric nurses get assistance and guidance on how to manage them. The need for training in effective self-
management is real. I am helping my fellows in a way I can. However, my help is like a drop in ocean. I believe that a more structured and professional approach toward self-management would enhance the psychiatric nurses’ ability to deal with incidents of aggression effectively.

3.4 Phase 3: THE CLASSIFICATION OF THE CONCEPTS

The classification of the concepts is done by using the survey list of Dickoff, James, and Wiedenbach (1968:421). The researcher has attempted to answer the following questions:

Who is the agent?
Who is the receiver?
What is the procedure?
What are the dynamics?
What is the context?
What is the terminus?

Concepts are classified here below based on the six questions asked above.

The agent is the person that makes the process happen. The agent is known by answering the following question: Who will be responsible for the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution? In this research study, the agent is the advanced psychiatric nurse practitioner who assists the psychiatric nurses to find an effective way of dealing with aggression.

The management also plays a role in the facilitation of effective self-management of aggression by allowing the advanced psychiatric nurse practitioner to use the facility and by providing the necessary resources, human and material, for the implementation of the model to take place.

The recipient is the person or persons who are the primary beneficiaries of the facilitation of effective self-management of aggression. In this model, the recipient is
the psychiatric nurse who works in this specific psychiatric institution and is experiencing challenges in the self-management of aggression so that he/she can deal effectively with aggressive patients.

**The context** is the situation or environment in which the facilitation for effective self-management of aggression takes place. The context in which the model takes place is a public psychiatric hospital. This psychiatric hospital is a provincial and academic hospital where psychiatric nursing students and medical students further their training in psychiatry. The main criterion for patients to be admitted is for the patient to be disruptive or unmanageable in the referring clinics and hospitals.

**The dynamics** in this model the facilitation of effective self-management of aggression consists of psychiatric nurses experiencing aggression by patients. The psychiatric nurses experience an overwhelming level of aggression from the patients. This aggression is real, active, and extensive as previously indicated on page 3 (3.2.1.1) and it is expressed verbally, physically, and emotionally. It has contributing factors and negative consequences. The contributing factors stated by the participants are, among others, the type of patients admitted here, staff shortage, lack of support from the management and among the members of the multidisciplinary team (MDT), and the lack of structured and comprehensive orientation. Nurses faced with this violence, experience negative feelings of fear, anger, frustration, despair, hopelessness, and helplessness. They then use ineffective coping mechanisms to deal with this violence. Among these ineffective coping mechanisms are substance abuse, absenteeism, retaliation, a development of an “I don’t care attitude”, and apathy towards the work and towards what is happening around them.

**The process** for the facilitation by the advanced psychiatric nurse practitioner of effective self-management of aggression by psychiatric nurses consists of three phases: the relationship phase; the working phase; and the termination phase. The process moves the psychiatric nurses from the feeling of being a victim to being in control of the workplace challenges.
The terminus is the effective self-management of aggression by psychiatric nurses.

3.5 RELATIONSHIP STATEMENTS

A psychiatric nurse who is experiencing aggression by patients and is unable to manage it effectively, needs assistance and guidance from the advanced psychiatric nurse practitioner in order to move from the position of victimhood to the position of taking control of the workplace aggression through a dynamic interactive process.

Operative refers to alternative strategies or means by which psychiatric nurses take that aim at self-managing aggression effectively by putting psychiatric nurses in charge of the workplace environment. These strategies must produce the intended result which is the effective self-management of aggression.

The advanced psychiatric nurse practitioner provides the needed assistance and guidance to the psychiatric nurses. This makes it easier for them to take actions for change in their workplace environment. Psychiatric nurses need to trust the facilitator and to believe in the process by taking responsibility for their actions or inactions in the workplace aggression.

The psychiatric nurse will succeed in dealing with aggressive incidents effectively by unleashing the power within and being able to regulate their emotions so that they can use their skills and knowledge soundly.

In embracing and implementing the alternative means, the psychiatric are empowered and grow both personally and professionally. They are able to take control not only of their lives and the workplace environment, but also of every decision they make and how they interact with fellow professionals.

3.6 CONCLUSION

This chapter dealt extensively with the identification of the central concepts and the definitions thereof. A classification of the concepts and the relationship statement was done. The next step is to develop and describe the model to facilitate the effective self-management of aggression and violence in the next chapter, Chapter Four.
CHAPTER FOUR: DESCRIPTION OF THE MODEL TO FACILITATE EFFECTIVE SELF-MANAGEMENT OF AGGRESSION EXPERIENCED BY THE PSYCHIATIC NURSES WORKING IN A PSYCHIATRIC INSTITUTION

Mary said: “We ask for strength, and God gives us difficulties, which make us strong. We pray for courage and God gives us danger, which makes us aware. We ask for favours, and God gives us challenges, which make us grow” (Caldweel & Stearn, 1977:132).

4.1 INTRODUCTION

In Chapter Three, the researcher discussed the identification, the definition, and the classification of the central concept and related concepts regarding the effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution. In Chapter Four, a description of the model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric hospital is presented.

4.2 OVERVIEW OF THE MODEL

The model to facilitate the effective self-management of aggression experienced by psychiatric nurses (see Figure 4.1) serves as a framework of reference for the advanced psychiatric nurse practitioner to assist the psychiatric nurses struggling to deal with aggression effectively in their work environment. The process of the model to facilitate effective self-management of aggression starts where the advanced psychiatric nurse practitioner, having noticed the ineffective self-management of aggression by psychiatric nurses, joins the psychiatric nurses in the search for some alternative means to enable psychiatric nurses to self-manage aggression effectively.
Figure 4.1 A model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution.
This process ends where the psychiatric nurses are empowered and able to take control of the workplace environment by achieving effective self-management of aggression.

In this research study, the central concept of the model was identified as the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution. The central concept was defined in Chapter Three as follows:

“The facilitation of effective self-management of aggression is a dynamic interactive process through which the advanced psychiatric nurse practitioner guides and provides assistance to the psychiatric nurses in order to make it easier for them to take actions for the needed change. Psychiatric nurses are facilitated to utilise operative means and take responsibility aiming at producing the intended result, that is, the self-management of aggression. Through the process, the psychiatric nurses are able to regulate their emotions and to take control of the workplace environment in effectively self-managing aggression from patients”.

The model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution is an interactive process that goes through three phases: the relationship phase, the working phase and the termination phase.

During the relationship phase, the advanced psychiatric nurse practitioner uses a dynamic interactive process to assist and guide psychiatric nurses towards the intended result, that is, the effective self-management of aggression.

During the working phase dialogue and the exchange of ideas between the advanced psychiatric nurse practitioner and the psychiatric nurses are generated in order for the psychiatric nurses to take action for change. This will assist them to regulate their emotions and to produce the intended results.

During the termination phase, the psychiatric nurses share and evaluate whether the outcome of self-management of aggression has taken place or has been achieved through their personal experiences during implementation. The advanced psychiatric nurse practitioner withdraws gradually from the process and the
psychiatric nurse participants are encouraged to take over the effective self-management of aggression and move forward.

4.3 STRUCTURE OF THE MODEL

The structure of the model is discussed following the sub-headings below:

- purpose of the model;
- assumptions of the model;
- theoretical definitions of concepts;
- relationship statements; and
- structure description;

4.3.1 Purpose of the model

The purpose of the model is to provide a frame of reference for the advanced psychiatric nurse practitioner for the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution. The outcome of the model is the effective self-management of aggression by psychiatric nurses.

4.3.2 Assumptions of the model

The assumptions of this model are embedded in the Theory for Health Promotion in Nursing (University of Johannesburg, 2012:4-14). Assumptions were also inspired by another source: the Cognitive Behaviour theory (Blenkiron, 2010: 1-276). These assumptions are set out below.

- Psychiatric nurses and the advanced psychiatric nurse practitioner are seen holistically, and embody dimensions of body, mind, and spirit and function in an integrated manner with the environment (University of Johannesburg, 2012:4).

- The environment includes an internal and external environment. The internal environment consists of dimensions of body, mind and spirit. The external
environment consists of physical, social, and spiritual dimensions (University of Johannesburg, 2010:5).

- Psychiatric nursing is an interactive process for the facilitation and the promotion of mental health (University of Johannesburg, 2012:5). This process is not a linear one. It requires patience, commitment, material and spiritual resources, and clear vision in a safer workplace environment.

- Psychiatric nurses mobilise resources by identifying and bridging the obstacles in the promotion of health (University of Johannesburg, 2012:7). The identification of obstacles entails assessing the environment (both internal and external) for what it really is and strategising on how to solve the identified problems in it with the available resources. The bridging of obstacles comprises self-assessment for the strengths and weaknesses, the resources (human and materiel) required for an effective and lasting solution (University of Johannesburg, 2010:7). The resources in the psychiatric nurse’s environment are centred on the use of the self as the main actor or the scene of effective self-management of aggression.

- Mental health is a dynamic interactive process in the psychiatric nurse’s environment (University of Johannesburg, 2010:5). For the psychiatric nurses to feel at ease while caring for the people with mental illnesses, they must perceive the environment as safe and welcoming allowing them to maximise their potentials in fulfilling their core of duty in caring for the mentally ill patients entrusted to them. The role of the advanced psychiatric nurse practitioner is to lead the way on the road which the psychiatric nurses have less travelled but need to take for growth and development. Psychiatric nurses are allowed to work on and modify their perception about the environment in order to modify it. Blenkiron (2011:1) argues that the problem is not so much the events in one’s life, but the way in which the person interprets and acts upon them.

- The facilitation of effective self-management of aggression experienced by psychiatric nurses promotes their mental health when they manage to take control of the workplace environment. This facilitation requires knowledge, skills,
goodwill, commitment, and time from both the psychiatric nurses and the advanced psychiatric nurse on one side, and the availability of resources and support from the nursing management on the other side.

- The advanced psychiatric nurse practitioner is a sensitive therapeutic professional (University of Johannesburg, 2010:4) who demonstrates knowledge, skills, attitude and values in facilitating the effective self-management of aggression experienced by psychiatric nurses from the patients. To achieve this, the advanced psychiatric nurse practitioner must be flexible and understanding, bearing in mind that some psychiatric nurses may be resistant or even hostile to change if they have come to believe that no change is possible or that the process for change may be painful compared to the situation they are in at present (McCormack & McCance, 2006:476).

- The workplace environment has a positive or negative impact on psychiatric nurses depending on how they perceive and interact with this environment. Working positively on how psychiatric nurses perceive workplace aggression, and instilling in them hope, will have a positive effect on how they self-manage this aggression effectively and will promote the mental health of the psychiatric nurses and improve the quality of care rendered to the patients. Clarke (2009:843) believes that hope is the foundation of recovery from mental health problems.

### 4.3.3 Context of the model

This model is implemented in a specific public psychiatric hospital in the Gauteng province, South Africa. This specific hospital is also an academic hospital where nursing, medical, psychologist, and occupational therapist students undergo training in psychiatry. This hospital in which the model to facilitate the effective self-management of aggression experienced by psychiatric nurses is operationalised is known for catering for general and forensic psychiatric patients. These patients cannot be managed in general hospitals and clinics due to their disruptive behaviour. It is for the same reason that the main criterion for a patient’s referral and admission
is based on being unmanageable somewhere else in the general hospitals and clinics; leading to the conclusion that a certain level of aggression from the patients is anticipated or expected to occur.

4.4 THEORETICAL DEFINITIONS OF CONCEPTS

Under the above sub-heading, the central and the essential as well as related concepts are defined.

4.4.1 Definition of the central concept: “facilitation of effective self-management of aggression”

The facilitation of effective self-management of aggression is a dynamic interactive process through which the advanced psychiatric nurse practitioner guides and provides assistance to the psychiatric nurses in order to make it easier for them to take actions for the needed change. Psychiatric nurses are facilitated to utilise operative means and to take responsibility aiming at producing the intended result, that is, the self-management of aggression. Through the process, the psychiatric nurses are able to regulate their emotions and to take control of the workplace environment in effectively self-managing aggression from patients.

4.4.2 Definition of related concepts

The related concepts are: facilitation, effective and self-management.

4.4.2.1 Facilitation

Facilitation is defined in this research study as a dynamic interactive process through which the advanced psychiatric nurse practitioner guides and provides assistance to the psychiatric nurses in order to make it easier for them to self-manage aggression effectively.

- A dynamic interactive process

The dynamic interactive process consists of dialogue and the exchange of ideas and experience that aims at the promotion of mental health. The open dialogue and
exchange of ideas and experience happens in a climate where learning and sharing are enhanced by openness and honest in sharing the challenges of experienced aggressive incidents, the means that are utilised in dealing with these challenges and strategising new means to meet the psychiatric nurses’ expectations realistically in effectively managing these incidents. The promotion of mental health is achieved when the exchange of ideas and knowledge leads to the effective self-management of aggression.

- **Guide/guidance**

The process of guidance entails leading, showing the way and providing direction. The advanced psychiatric nurse practitioner takes the leading role, not as an expert from out there but rather as a companion traveller. He/she inspires trust that prompts the psychiatric nurses to follow the road shown to them and that they have not really travelled. The advanced psychiatric nurse practitioner, encouraged by the determination of the psychiatric nurses to follow, shows the direction to the effective self-management of aggression should take. The shown way ends when the effective self-management of aggression has been achieved.

- **Assistance**

Assistance entails making resources available through the advanced psychiatric nurse practitioner’s help that enable the psychiatric nurses to look inward and discover that their positive attitude, courage and determination are all that they need in the effective self-management of aggression. The advanced psychiatric nurse practitioner accompanies psychiatric nurses on this journey of self-discovery by sharing his/her knowledge and experience in the field of psychiatric nursing. Once the psychiatric nurses replace fear by confidence and are willing to let go old ways of dealing with aggressive incidents and embracing the new ones, empowerment takes place. According to Rees (Dalrymple & Burke, 2006:108), the empowerment process is about replacing powerlessness with some sense of power so that confusion can give way to a feeling of coherence.
• Making easier

The process of making easier entails providing the knowledge and skills that lessen the difficult psychiatric nurses are faced with in self-managing aggressive incidents. The advanced psychiatric nurse practitioner has no illusions and grasps the fact that self-managing aggression effectively cannot be easy in the context where the main criterion for admission is being unmanageable. However, having knowledge of what to expect and how best to deal with aggression can make a difference. Therefore, the provision of knowledge can enhance the skills and lessen the difficulties in the self-management of aggression.

4.4.2.2 Effective

Effective is defined in this study as operative alternative means used by psychiatric nurses and aimed at producing intended result which is their self-management of aggression.

• Produce the intended result

Producing the intended result refers to assessing the means that were used in the self-management of aggression and realising that they are functioning and work well, and that they influence the psychiatric nurses’ ability to produce tangible results and are capable of sustaining the acquired results in the self-management of aggression.

• Operative

Operative refers to alternative strategies or means used in the self-management of aggression that are real, efficient, impressive and produce the effect that is intended. The effect to be produced is the effective self-management of aggression. The results of this self-management of aggression should be tangible, clearly visible and should have a continuous and lasting effect of the psychiatric nurses working in the institution. This can be seen in the decreased number and frequency of incidents of aggression, and also in the psychiatric nurses’ ability to act decisively and promptly.
4.4.2.3 Self-management

Self-management is understood in this study as being the psychiatric nurses’ ability to regulate their emotions so that they can take responsibility and actions for needed change, resulting in taking control of their lives and self-managing aggression effectively.

- **Ability to regulate emotions**

The ability to regulate emotions entails being flexible and having the ability to act in the required manner when new approaches are tried for a constructive solution. The psychiatric nurses show the ability to act by being proactive instead of being reactive. They do not wait for incidents to occur but rather anticipate the possibility of incidents of aggression that find them ready for action. Being flexible is vital, and especially in the beginning where trial and error is used in the effective self-management of aggression until the right combination is found.

- **Taking responsibility**

Taking responsibility entails building effectiveness, applying behaviour change and self-administered therapy. Building effectiveness requires psychiatric nurses’ to show objectivity in assessing the workplace challenges and their own contribution by action or omission in sustaining the status quo. Once their part in incidents of aggression has been established and there is a need for change, psychiatric nurses apply the behaviour change approach by modifying and adjusting what needs to be adjusted, because they understand the reason for change (Demetriou & Raftopoulos, 2004:186). Self-administered therapy, in the context of the psychiatric institution, means that the effective self-management of aggression depends mainly on the psychiatric nurses’ attitudes and determination. The advanced psychiatric nurse practitioner’s help cannot replace the psychiatric nurses’ effort, willingness and determination in the effective self-management of aggression.
• Taking actions for change

It entails setting goals and implementing actions in order to achieve the goals, and also persevering when faced with challenges and sustaining change once it has taken place. In setting goals, psychiatric nurses need to differentiate the ideal from the reality so that once their efforts are challenged by negative outcomes, they can persevere and push forward until the goals are achieved. Once the goals have been achieved, they must be sustained by constant efforts to overcome the challenge of complacency.

• Ability to take control

The ability to take control entails coping despite difficulties and being resilient. Coping despite difficulties requires a constant revision of one’s efforts and means in effectively self-managing aggression. This requires resilience: the resistance to the temptation to give in to discouragement and give up the fight. It also means building on what has already been achieved, enhancing one’s effort, becoming more skillful.

4.4.3 Relationship statements

A psychiatric nurse who is experiencing aggression by patients and is unable to manage it effectively, needs assistance and guidance from the advanced psychiatric nurse practitioner in order to move from the position of victimhood to the position of taking control of the workplace aggression through a dynamic interactive process.

Operative refers to the alternative strategies or means psychiatric nurses take that aim at managing aggression effectively by putting psychiatric nurses in charge of the workplace environment. These strategies must produce the intended result which is the effective self-management of aggression.

The advanced psychiatric nurse practitioner provided the needed assistance and guidance to the psychiatric nurses. This made easier the dynamic interactive process and the psychiatric nurses were able to take actions for change in their workplace environment. Psychiatric nurses need to trust the facilitator and believe in
the process by *taking responsibility* for their actions or inactions in the presence of workplace aggression.

The psychiatric nurses will succeed in dealing with aggressive incidents effectively by unleashing the power within and *being able to regulate their emotions* so that they can use their skills and knowledge soundly.

In embracing and implementing the alternative means, the psychiatric are empowered and grow both personally and professionally. They *are able to take control* of their lives and the workplace environment, but also of every decision they make and how they interact with fellow professionals.

### 4.5 STRUCTURE DESCRIPTION

The structure of the model as depicted in figure 4.1 will now be described under the following sub-headings:

- the context of the model;
- the process of the model;
  - relationship phase;
  - working phase; and
  - termination phase.

The model, as depicted in Figure 4.1, is framed in red colour and divided into different phases: relationship phase, working phase, and termination phase. The phases comprise those steps to be followed in the realisation of the facilitation of effective self-management. As displayed in the model structure, the process starts when the advanced psychiatric nurse practitioner takes the initiative of approaching psychiatric nurses and offers a helping hand, having observed the challenges they are faced with. The interactions between the advanced psychiatric nurse practitioner and the psychiatric nurses evolve around the therapeutic model phases.

#### 4.5.1 Context of the model

The model is implemented in a specific public psychiatric institution, as seen in figure 4.2 below. The institution in which the model to facilitate the effective self-
management of aggression experienced by psychiatric nurses from the patients is operationalised is a specialised psychiatric hospital.

Figure 4.2 The Context of the Model

Patients are referred for different reasons, ranging from observation to general patients (those who are psychotic and a danger to themselves, others and others’ properties, under section 34 of the Mental Health Care Act no 17 of 2002).

Psychiatric patients admitted under this section come in handcuffed by the police because of their levels of aggression and disruptive behaviour. When those who have been observed for mental health assessment are found to be unfit to stand trial, they are sent back to the institution by court order, either as state patients or involuntary patients. In all these instances a certain level of aggression from the patients is anticipated and expected to occur. In Figure 4.2, the red colour is used to illustrate the constant danger that psychiatric nurses are exposed to in rendering care to aggressive patients.

According to Chapman (2010:n.p.), the red colour is associated with, among other things, fire, violence, and warfare. Red also indicates danger, and for this reason stop lights and signs are red, and most warning labels are red. Red can actually
have a physical effect on people, raising blood pressure and respiration rates. Dark red indicates rage, anger and wrath. In the figure above (Figure 4.2) the dark red indicates mixed feelings of rage, anger, fear and frustrations that characterise the psychiatric nurses’ feelings in the workplace environment.

4.5.2 Relationship Phase

The relationship phase enables both the advanced psychiatric nurse practitioner and the psychiatric nurses to have a common understanding of the challenges at hand, the impacts of these challenges. It also offers some perspectives on how to move forward.

The relationship phase consists of footprints - in white colour-, a red circle, a drawing of the advanced psychiatric practitioner and a psychiatric nurse joined by a double-headed arrow and the word ‘facilitation, and three steps in a mixture of colours going from red to yellow.

4.5.2.1 Footprints: the beginning of a psychiatric nurse’s career

The footprints symbolise the beginning of a psychiatric nurse’ career. These nurses come into the workplace full of energy and enthusiasm to care for psychiatric patients.

In the beginning, the means applied by the psychiatric nurse in dealing with aggression seem to be working relatively well. As the situation remains the same, the psychiatric nurse starts realising that the usual means are no longer effective. The footprints are in white colour and the path travelled in blue.
The white colour symbolises light, goodness, innocence, and purity. White can represent a successful beginning (http://www.google.co.za/ meaning of colours). The blue colour that the psychiatric nurse treads on symbolises the efforts put in place to cope with and overcome aggression: integrity, knowledge, commitment, and strength. Chapman (2010:n.p.) says that the dark blues are an excellent representation where strength and reliability are important.

4.5.2.2 The red circle: Ineffective self-management of aggression

The red (in Figure 4.3) circle represents the ineffective management of aggression that hampers the psychiatric nurse’s effort to provide quality care to the patients.
Despite the energy, enthusiasm, commitment and integrity of the psychiatric nurse to provide the quality care, there comes a time where the psychiatric nurses become exhausted. They try to move forward but find themselves stuck in the circle of aggressive incidents. This is represented by one footprint stuck in the red circle. The situation that the psychiatric nurses find themselves in is pulling them down and they can no longer get out of the situation on their own. The circle represents the barriers that prevent the psychiatric nurses from getting where they want to be and prevent them from using all the means and resources that are available. The psychiatric nurse is afraid of confronting aggression and tries to bypass it but the foot is still caught in it, thus aggression cannot be ignored or bypassed.

4.5.2.3 The agent, recipient and ‘Facilitation’

The drawings depicting the human images represent the psychiatric nurse and the advanced psychiatric nurse practitioner. The psychiatric nurse’s face is expressed by a frown and has a blue top on. The frowning face expresses the frustration and despair experienced by the psychiatric nurse. The colour blue symbolises the seriousness of his/her intention but s/he is still conscious of the challenges. The advanced psychiatric nurse practitioner’s face shows a smile in orange t-shirt. The meaning is that the advanced psychiatric nurse is feeling hopeful that the solution to alleviate the psychiatric nurse’s sorrow may be at hand. The orange colour represents enthusiasm, creativity, determination, encouragement, and stimulation (Chapman, 2010:n.p).

The drawings showing the two professionals are joined by a double-headed arrow in purple colour and the word ‘facilitation’ in white. The double-headed arrow signifies the interdependence, mutual respect and exchange between the advanced psychiatric nurse practitioner and the psychiatric nurse; though the advanced psychiatric nurse practitioner initiates the facilitation process. The purple colour symbolises the richness of the exchange between the two professionals and it is associated with creativity and imagination (Chapman, 2010:n.p.), emanating from both the advanced psychiatric nurse practitioner and the psychiatric nurse. The white colour in which the word ‘facilitation’ is written symbolises the cleanliness of intentions and virtues of both the advanced psychiatric nurse practitioner and the psychiatric nurses to work hand in hand until a constructive solution is found. The
white colour is further associated with the healthcare industry to which both professionals belong (Chapman, 2010:n.p).

In the context of the relationship phase, facilitation means the joint journey in the search for a solution to the challenges of aggressive incidents. This joint journey is initiated by the advanced psychiatric nurse practitioner who felt compassion for the psychiatric nurse and was saddened by his/her inability to cope with the workplace aggression.

4.5.2.4 The three steps in the relationship phase

The focus of the relationship phase is to provide guidance to the psychiatric nurses in order to make it easier for them to deal with aggression effectively. The three steps (see Figure 4.3) represent the first pillar in finding operative alternative means to self-manage aggression effectively. Climbing steps requires focused attention and energy and if one is unable to climb alone, one needs support. That is the meaning behind the use of steps in structuring the model. Steps work in both directions: upward and downward. They are only safe if one step is taken at time and easy to walk one after the other. The process of each step will be described further in the chapter at process description. The colour used in the relationship phase moves from the red to yellow. The meaning is that once the help is available, the problem (red) becomes a challenge, hope replaces despair. The move from ineffective to effective self-management of aggression is a process on its own. This means that there is not instant solution and hence the red colour does not disappear immediately but gradually. Aggression is also managed gradually and progressively. The yellow colour is often considered the brightest and most energising of the warm colours; it is associated with happiness and sunshine and represents energy (Chapman, 2010:n.p.) that starts knocking at the door and brings with it hope and confidence. The psychiatric nurses start discovering that aggression in the workplace is not a life sentence, but a challenge that they are able to deal with.
4.5.3 Working phase

In the working phase, dialogue and exchange of ideas is generated between the advanced psychiatric nurse practitioner and psychiatric nurses in order to produce intended results of self-managing aggression.

![Image 4.4 The working phase](image)

The working phase is the platform where the opportunity is given to the psychiatric nurse to use the knowledge and skills acquired during the relationship phase. It is represented by four steps that detail different actions to be taken for the effective self-management of aggression to take place, as shown in Figure 4.4 above.

The working phase consists of four steps: the facilitation of self-awareness; the facilitation of communication skills; the facilitation of stress management; and the facilitation of conflict management. During this phase, theoretical and clinical knowledge are integrated in order to achieve the model’s objectives. The devised strategies are put to test and later on evaluated for their effectiveness. The colours move from the dark yellow to the dark green. The green colour is the opposite of red in road traffic and represents the free passage. It symbolises growth, harmony,
freshness, and fertility (Chapman, 2010:n.p.). In this model, the colours symbolise the move from hoping that aggression can be managed to believing and taking steps in managing it through decisive commitment. The ability to regulate emotions and to take responsibility is facilitated through the use of four steps as described in order for the psychiatric nurses to deal effectively with aggression.

4.5.4 Termination phase

During the termination phase, the advanced psychiatric nurse practitioner and psychiatric nurses evaluate whether the intended results, the effective self-management of aggression, has been achieved. The termination phase consists of one step which is taking control. It also has two footprints, a drawing of the psychiatric nurse, and a shining star in golden colour with inscription ‘effective self-management of aggression’ (see Figure 4.5).

4.5.4.1 The footprints and a golden shining star

The footprints have been described in the relationship phase. The difference between the description in the relationship phase and in the termination phase is that, contrary to the foot stuck in the circle, the footprints in the termination phase are free.

They actually head toward the star, meaning that once aggression is managed effectively, there are endless opportunities for creativity and innovation in caring for the psychiatric patients. The mental health of both the psychiatric nurses and patients will be enhanced.

The white colour has been described (see 4.5.2.1). The green colour represents new beginnings and growth. It also signifies renewal and abundance (Chapman, 2010:n.p.).
4.5.4.2 The drawing of the psychiatric nurse

The drawing of the psychiatric nurse shows her standing alone and with a happy face, unlike the one in the beginning of the facilitation process. This is because the psychiatric nurse who has now been empowered does not need assistance and guidance in the effective self-management of aggression. The acquired knowledge and skills have given the nurse courage that replaced fear and joy that replaced despair seen in the picture in relationship phase. The psychiatric nurse stares at the star with a smile knowing he/she has everything under control. The golden colour represents the feeling of prestige. The meaning of gold is illumination, wisdom, and wealth. Gold often symbolises high quality (Chapman, 2010:n.p.).

Having discussed the structure of the model in detail, it is now befitting for me to turn to the description of the model process.
4.6 THE MODEL PROCESS DESCRIPTION

The process of moving from ineffective management of aggression to effective self-management of aggression requires patience, understanding and compassion to self and others. It requires carrying a cross of uncertainty, ingratitude and despair at times. However, with faith and self-determination, the challenges are not only bearable but can be overcome.

The facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution is done in three phases: relationship phase, working phase, and termination phase. Although the phases are intertwined, it is safer to move gradually. The following is the discussion of the three phases.

4.6.1 Relationship Phase

The relationship phase revolves around the dynamic interactive process that enables the advanced psychiatric nurse practitioner to assist and to guide psychiatric nurses in their quest for improved workplace conditions, making it easier for them to manage aggression effectively.

The relationship phase consists of three steps: 1) building trust; 2) understanding aggression; and 3) imparting hope and belief (see Figure 4.3). During this phase, the advanced psychiatric nurse practitioner guides the process of facilitation from an ineffective self-management of aggression towards the terminus of the process, being its effective self-management. The advanced psychiatric nurse practitioner shows compassion and respect for the challenged psychiatric nurses and, most of all, s/he must know and understand what s/he is doing in order to inspire trust. The three steps are discussed below.
4.6.1.1 Building trust

“People don’t always feel comfortable asking for assistance with personal problems. Getting them to recognize the problem is often the first step” (Robbins & Hunsaker, 2012:155).

The advanced psychiatric nurse practitioner comes in with an open mind, a sensitive ear and a non-judgmental attitude in order to earn the psychiatric nurses’ trust. The building of trust needs to be carefully thought of regarding why the assistance is needed and how it will be achieved so that the proposed ideas can inspire confidence (Corey, Corey & Corey, 2010:140). The authors argue further that, once the members are inspired with confidence, they will see the researcher’s willingness to think about them as a sign that the researcher cares about them. Corey et al. (2010:140-141) state that, once the researcher listens non-defensively and respectfully, this conveys the message that the researcher values the subjective experience of members and they will see it. The research has to engage genuinely and appropriately in self-disclosure if they want to foster honesty and disclosure among members.

Furthermore, the advanced psychiatric nurse practitioner shows the willingness to engage in appropriate self-disclosure that will foster honesty and disclosure among the participants by putting aside what he/she already knows about the environment. The facilitator should refrain from critique that may hurt the psychiatric nurses’ feelings. This applies to all the participants, mostly those who are using ineffective coping mechanisms such as beating patients in retaliation or abusing substances (Bimenyimana, 2008:49-54). Being aware of the existing conflict between some psychiatric nurses and the nursing management (Bimenyimana, 2008: 63), the advanced psychiatric nurse practitioner treads carefully in order not to be seen as a management’s tool used in order to punish some psychiatric nurses. There is a lack of trust between nursing management and psychiatric nurses that makes the latter question every action of the former.
When the psychiatric nurses open up to the advanced psychiatric nurse practitioner, allows them to talk about their experiences, which at times may be unpleasant, and their inability to cope with the environment needs time and a non-threatening, non-judgmental approach, together with the assurance of confidentiality. Robbins and Hunsaker (2012:155) assert that when dealing with emotional and personal problems it is important to maintain confidentiality because people must feel that they can trust the facilitator and that there is no threat to their self-esteem or their reputation with others. Therefore, step one is not measured by a number of encounters or the time spent between the advanced psychiatric nurse practitioner and the psychiatric nurses, but rather by the readiness among the psychiatric nurses to feel safe and free to share their experiences, including their perceptions and attitude towards finding alternatives in dealing with aggression. It is essential for the advanced psychiatric nurse practitioner to hold the psychiatric nurse in unconditional positive regard for the relationship to be successful (Robbins & Hunsaker, 2012:153).

4.6.1.2 Understanding aggression according to the psychiatric nurse’s perception

Petersen, Bhana, Fisher, Swartz and Richter (2010:49) firmly believe that the first task in implementing any kind of change in health sector is to understand the logic of things as they are presently.

Psychiatric nurses react to aggression according to what they deem it to be or not to be. Sometimes what constitutes aggression for one psychiatric nurse may not constitute aggression for the other and this can hamper the teamwork and effective self-management of aggression in the process. It is then vital to encourage psychiatric nurses to understand and define aggression from an interactional and
situational context so that they can develop their interventions accordingly (Hahn, Needham, Abderhalden, Duxbury & Halfens, 2006:199).

The advanced psychiatric nurse practitioner encourages the psychiatric nurses to assess and define what they deem to be aggression and how this definition affects or impacts on the reaction to aggressive incidents. This is mainly because previous research shows a considerable variation in different individuals’ perceptions and definitions among psychiatric nurses despite the fact that this attitude of variance in the perception of aggression is considered to be one of its main causes (Abderhalden, Needham, Friedli, Poelmans & Dassen, 2002:110).

Psychiatric nurses are also encouraged during this step to be in touch with their inner self and consider what they deem aggression to be, perception, and how they react to it, attitude. Perception is defined by Newstrom and Davis (2002:10) as the unique way in which each person sees, organises, and interprets things and that having unique views is another way in which people insist on acting like human beings rather than rational machines. However, it is the researcher’s opinion that, if this unique way of seeing things or even doing things is not inspired by flexibility and accommodating others’ views, it can lead to drastic and destructive results.

In addition, Oskamp and Schultz (2005:9) define attitude as a predisposition to respond in a favourable or unfavourable manner with respect to a given object. Given the fact that the psychiatric nurses working in this institution have experienced aggression quite frequently, they come to expect that it will occur at any time and may even misinterpret the patients’ action in anticipating aggression.

A common understanding of what constitutes aggression or not is just the first step in the right direction, but it does not suffice on its own. This is because, even if everyone agrees that a practice is not helpful or even harmful, it is important to understand the ways in which the practice provides something for that community (Petersen et al. 2010:49). That is why the understanding of what aggression consists of must be followed by a certain undertaking of responsibility in what has been happening. Prosser (2005:93) believes that helping people to see that much of what they blame others for is actually within their control and is a fundamental step in
personal growth and development. The researcher does not intend to ask psychiatric nurses to define aggression nor to shoulder the responsibility for aggressive incidents. By sharing their experiences they will be telling a story on how they understand aggression and how they have been dealing with it. This narrative approach will give an indication of what to expect when aggression is contextualised.

4.6.1.3 Imparting Hope and Belief

“Your beliefs are yours only if you critically examine them for yourself to see if they are supported by good reason…your belief in large measure defines your life” (Vaughn, 2008:7).

While Snyder (2005:73) defines hope as the perceived capacity to: (1) develop workable goals; (2) find routes to those goals-pathways thinking; and (3) become motivated to use those pathways. Corey et al. (2010:252) define hope as the belief that change is possible. In the context of this research study, imparting hope entails encouraging psychiatric nurses to believe that change is possible, showing them that they have the capacity to change the status quo and assisting them to develop and implement strategies that enable them to self-manage aggression effectively.

Telling real life stories, by sharing life experiences, good and bad, and the lessons learnt from these experiences, psychiatric nurses can start seeing aggression with a different eye. This can make them believe that if others made it happen, they can also do it. This belief can ignite the fire of hope in their lives and yield positive results. Forsyth (2014:555-556) states that when suffering alone, individuals may not realise that their feelings and experiences are relatively common ones. It may even encourage those who are ashamed of sharing their negative experiences to share them, knowing that other group members will understand and assist them. Group-derived hope contributes to well-being, life satisfaction, and inspiration. Robbins and Hunsaker (2012:156) affirm that people need to know that problems have solutions and that they have the ability to improve. This is achieved by helping the psychiatric nurses to re-evaluate the way they deal with aggression, the pros and the cons of
the means they use and the possible reasons why these means may not be effective. The advanced psychiatric nurse practitioner must be aware of treading on a tight rope because it is not easy for everyone to expose their vulnerability. Robbins and Hansaker (2012:12) are of the opinion that people have fears, inadequacies, self-doubt, and insecurities that they do not want to reveal to others, or even to themselves. Psychiatric nurses may be afraid to tell their stories fearing the rejection of those who have lost hope and do not care anymore about what happens in the institution (Bimenyimana, 2008:37-57). This feeling can only be challenged by the psychiatric nurses themselves. Gitterman and Shulman (2005:18) are convinced that how people feel about themselves has a profound effect on day-to-day functioning. Assisting the psychiatric nurses to be in touch with their fears and to confront them may help them to rise above the difficulties and stand firmly in the face of adversity. This is what Gitterman and Shulman (2005:17) call rebound from adversity. The more emotionally significant, unique and life-changing the experience, the more it is likely to be remembered (Howe, 2008:104).

The process of rebounding from adversity does not suggest that one is incapable of being wounded or injured. Rather, a person may bend, lose some of his or her power and capability, recover and return to prior level of adaptation (Gitterman & Shulman, 2005:17). Encouraging them to be in touch with their real self, allowing themselves to be human, vulnerable, will help them not only to have hope but also to believe that they are not as powerless as they thing they are. Helping them to focus on what they are good at instead of dwelling on the past or even current failures will enable them to move forward confidently. It is also at this point that they must take responsibility for their own contribution to the status quo no matter how minimal this contribution may be. For the psychiatric nurses to benefit from this enabling process, they must recognise that at least some of their difficulties come from within themselves and that they have the power to improve their situation (Seligman, 2001:16). Psychiatric nurses are encouraged to trust one another and to share honestly their personal experiences regarding patients’ aggression. Once they trust one another enough to share their negative experiences, they may feel better as they will realise that fellow psychiatric nurses are facing the same challenges (Forsyth, 2014:555).
4.6.2 Working phase

The working phase offers the unique opportunity to match theoretical knowledge and clinical experience in a practical way. During the working phase, the psychiatric nurses put the acquired theory into practice in dealing with aggressive incidents. The working phase offers the place and time for implementation. It comprises activities of dialogue and exchange of ideas, taking responsibility for actions, taking actions for change and regulating one’s emotions. The working phase consists of the following four steps: 1) facilitation of self-awareness; 2) facilitation of communication skills; 3) facilitation of stress management; and 4) facilitation of conflict management (see Figure 4.4).

4.6.2.1 Facilitation of Self-Awareness

The greater our awareness, the more possibilities that are open to us and the more successfully we can address our fears and anxieties (Seligman, 2001:239)

Here I am going to discuss self with regard to awareness and how this self-awareness is important in finding solutions to challenges related to effective self-management of aggression. The facilitation of self-awareness enables the psychiatric nurses to be in touch with themselves, to assess the effect of their actions in the workplace environment and to take actions that are needed for the change to take place. The process of achieving self-awareness is discussed below.

The knowledge of self or self-awareness enhances personal development and may contribute to rendering a better service. According to Lynn (2005:169), self-awareness demands that people know intimately and accurately who they are.

However, sometimes this knowledge comes at a cost because it requires that a person admits to and exposes his/her vulnerability. Self-awareness on its own can be debilitating if it is not accompanied by the humility to accept oneself and the willingness to change what needs to be changed. Sturm, Taylor, Atwater and
Braddy (2014:659) argue that for self-awareness to successfully develop, individuals must have not only an understanding of themselves but also an understanding of and appreciation for others’ perceptions of them. Robbins and Hunsaker (2012:12) state that people avoid self-awareness because they want to protect, maintain, and enhance their self-concepts and the image others have of them.

The end result of self-awareness is to enable psychiatric nurses to know their abilities and short-comings, their reactions in the face of challenges, what makes them who they are and the decisions they take in certain situations, such as when experiencing aggression. By reassessing their own reactions when faced with aggressive patients, the psychiatric nurses can judge whether their reactions are appropriate or not. This can lead to enhanced self-control in cases where psychiatric nurses realise that some of the incidents could have been handled differently or even prevented.

Thus self-awareness can lead to self-control and self-control can enable a person to avoid aggressive incidents. Consequently, those actions that fuel or perpetrate aggressive incidents can be attended to differently. Psychiatric nurses learn how to remain calm decisively in finding a lasting solution to aggression based on individual capabilities. With self-awareness, psychiatric nurses will be able to be in touch with their inner being that will enable them to deal with factors that contribute to aggressive impulses such as provocation, anger, jealousy and envy, and keep aggression in control (Kool, 2008:73).

For the psychiatric nurses to move from the ineffective management of aggression to effective self-management of aggression, they need to understand who they are as this enables them to identify those emotional triggers that will cause reactions. The discovery of one’s strengths and weakness is not, however, enough in bringing about change. Only psychiatric nurses’ self-determination and commitment will turn the knowing into the doing. It is with this same idea that Lynn (2005:180) states that understanding one’s limitations is a gift that can collect dust in the closet of one’s mind if no action is taken.
Psychiatric nurses will have self-awareness if they step back and reflect consciously upon who they are and how they came to be in the current situation (Robinson & Harris, 2009:53). Psychiatric nurses, after becoming aware of themselves and the environment they are working in, will require resilience and flexibility in order to display favourable adjustments despite adversities (Marsh, Craven & McInerney, 2008:290). This is where the advanced psychiatric nurse practitioner assists and guides the psychiatric nurses to challenge their own beliefs and attitudes towards the self-management of aggression as well as their motivation to comply with social normative behaviour and the institution’s policies (Petersen, Bhana, Fisher, Swartz & Richter, 2010:33). Kool (2008:73) argues that, depending on what one does, the consequence in the form of action by the individual reflects one’s personality.

4.6.2.2 Facilitation of Communication Skills

"In the last analysis, what we are communicates far more eloquently than anything we say or do." (Covey, BrainyQuote.com)

The facilitation of communication skills takes place through dialogue and the exchange of ideas between the advanced psychiatric nurse practitioner and the psychiatric nurses. For this process to be effective, openness, active listening, a nonjudgmental attitude and honesty are keys for a successful facilitation of communication skills.

According to Tubbs and Moss (2003:45), communication is effective when the message from the sender reaches the receiver in the way it was intended. Because communication involves at least two people, one being the sender of the message and the other the receiver, it would be important to note, once more, that facilitating communication skills in a psychiatric hospital is a difficult task; given the fact that many a time the expectations of the message sender and of the receiver expectations differ (Tubbs & Moss, 2003:45).
During the facilitation of communication skills the advanced psychiatric nurse practitioner assists psychiatric nurses in teaching them or reviewing with them the key communication clues such as active listening, validating patients’ message, paraphrasing, identifying verbal and non-verbal clues of the patients’ message. For a better implementation of these skills, the advanced psychiatric nurse practitioner encourages role-play and simulation where one psychiatric nurse takes the role of a patient and another one a role of a psychiatric nurse. The role-play is followed by an active discussion and the advanced psychiatric nurse practitioner adds more information where needed. Some of these communication techniques are reproduced below from De Vos et al. (2011:345). They will also be used by the advanced psychiatric nurse practitioner during one-on-one interviews after the implementation of the model.

**Minimal verbal responses.** A verbal response that correlates with occasional nodding, for example “mm-mm”, yes, I see”, will show the participants that the researcher is listening.

**Paraphrasing.** This involves a verbal response in which the researcher will enhance meaning by stating the participant’s words in another form with the same meaning.

**Clarification.** This embraces a technique that will be used to achieve clarity on unclear statements, for example “Could you tell me more about…”

**Reflection.** Reflecting back on something important that the person has just said in order to persuade him or her to expand on that idea: ‘So, you believe that suicide is sinful?’

**Probing.** The purpose of probing is to deepen the response to a question, to increase the richness of the data being obtained, and to give cues to the participant about the level of response that is desired. It is a technique to persuade the participant to give more information about the issue under discussion. Methods to achieve this include contradicting, linking, challenging, faking puzzlement, and encouraging. Some non-verbal cue are also practised. According to Hargie and Dickson (2004:43) often non-verbal communication proves decisive in conveying information and making judgements about others. Psychiatric nurses are encouraged to interpret the non-
verbal behaviour that precedes patient’s aggression. Non-verbal refers to bodily activities that have a communicative function such as facial expression, gestures and movements (Hargie & Dickson, 2004:43).

Psychiatric nurses are also encouraged to send clear and unambiguous messages in order to avoid adding to the frustrations of patients who are unable to make sense of what is happening around them and may resort to aggression. Enabling psychiatric nurses to interpret verbal and non-verbal clues from the patient’s side will assist them to be able to understand what message the patients are trying to send and to respond appropriately. Psychiatric nurses need to sharpen and develop their observation and listening skills in order to correctly decode and accurately perceive what the patient’s message means (Goetsch, 2002:30).

4.6.2.3 Facilitation of stress management

The facilitation of effective self-management of aggression requires psychiatric nurses to take responsibility in assessing the sources of stressors. While Thompson (2009:22) defines stress as a person’s response to an inappropriate level of pressure, Hunsaker (2005:127) adds that this bodily response to any demand that is perceived as threatening to a person’s well-being can be psychological, emotional, and physiological. Chapter Three has already described, with verbatim quotes, some of these work related stresses deriving from my previous research (see 3.2.1.2). Weinberg, Sutherland and Cooper (2010:56) define a job stress as a situation wherein job-related factors interact with a worker to change his or her psychological or physiological condition such that the person is forced to deviate from normal functioning.

In assisting the psychiatric nurses and guiding them to how to deal with work stress, the emphasis is on being positive and using optimally the available resources...
Wishing to get more than what one has can, on its own, be a source of stress. Howe (2008:105) is of the opinion that stress is experienced when individuals feel that they are powerless to deal with the demands of a challenging situation. These demands can sometimes be self-made when a person ignores what his/her potentials are or refuses to acknowledge personal limitations.

Facilitating stress management for psychiatric nurses is a process involving alternatives to their mechanisms of coping with the work environment. Because stress depends on one’s response to pressure, stress is a very personal matter and will vary from person to person (Thompson, 2009:23). However, Weinberg, Sutherland and Cooper (2010:156) believe that there are three ways of managing stress in an organization and that these are:

- identifying and eliminating or minimising stressful situations;
- teaching the individual to cope with stress; and
- helping those individuals who have become victims of exposure to stress.

In identifying the stressful situations the advanced psychiatric nurse practitioner helps the psychiatric nurses to analyse the patterns that precede aggressive incidents, the actions or reactions of the psychiatric nurses to these incidents and the consequences on both sides after the incident has occurred. Ultimately the behaviours that reinforce aggressive incidents can be eliminated and stressors reduced.

In those instances where aggressive incidents cannot be eliminated or at least minimised, the advanced psychiatric nurse practitioner assists the psychiatric nurses to devise some positive coping mechanisms such as relaxation techniques, meditation and physical exercises. Hunsaker (2005:130) believes that stress management consists of three general skills: becoming aware of negative symptoms; determining the sources of stress; and doing something constructive to cope with stress. In addition to the advanced psychiatric nurse practitioner imparting knowledge to the psychiatric nurse, it is the psychiatric nurses’ responsibility to
identify which one of the three general skills above is appropriate to a given aggressive situation.

It is vital, however, to make sure that the psychiatric nurses understand the difference between managing stresses and eradicating stresses. The goal of this research study is not to eradicate stress but to deal with stress constructively. The goal is to help psychiatric nurses to reduce the stress to acceptable levels where they can still perform their duties and find joy in doing so. Hunsaker (2005:128) shares this opinion when he states that work stress will not go away, but it can be managed to lessen its negative consequences. In dealing with stress effectively, psychiatric nurses will be resilient to any workplace challenges or demands. Howe (2008:106) states that resilience is an individual’s ability to deal with stress, pressure and the demands made of him/her.

The level of stress control can be measured, to some extent, by the level of job satisfaction and productivity. Hunsaker (2005:128) believes that workers who experience high job stress typically have increased job dissatisfaction, reduced productivity, and more illness than those with low stress. Job satisfaction would enhance psychiatric nurses’ ability to cope with stress and it also depends on how well they can control the work environment. The control of work environment entails having a picture of what pressure one is encountering, the availability of coping resources and support (Thompson, 2009:24).

4.6.2.4 Facilitation of Conflict Management

“We who engage in nonviolent direct action are not the creators of tension. We merely bring to the surface hidden tension that is already alive” (Luther King Jr, www.brainyquote.com).

The facilitation of conflict management requires the facilitator to check the ability of those in conflict to regulate their emotions. It is this researcher’s conviction that
conflicts involve emotions and that while emotions are high it is difficult to listen to the voice of reason. Henceforth, the ability to regulate emotions may be the key to conflict prevention and resolution.

While De Dreu and Gelfland (2008:6) define conflict as a process that begins when an individual or group perceives differences and opposition between itself and another individual or group about interests and resources, beliefs, values, or practices that matter to them; Hunsaker (2005:247) sees it as a disagreement between two or more parties who perceive that they have incompatible concerns. Based on these two definitions, in solving a conflict, one of the goals is to try to change the positions or minds of those opponents by showing them where lies the real problem. In enabling the psychiatric nurses to deal with conflict effectively, the advanced psychiatric nurse practitioner assists them in defining what they term conflict and how they deal with it. This review helps them to differentiate between real and perceived conflicts. This includes changing the perception, opinions, and the behaviour psychiatric nurses have and show towards patients (Barbara & Budjac, 2007:47-48). It is easier for psychiatric nurses to identify the patients’ aggression than recognising their part in it. De Dreu and Gelfand (2008:16) argue that in conflict situations individuals tend to develop an inflated view of their own cooperativeness and their counterpart’s hostility. However, avoiding unnecessary conflict, reducing the effect of destructive conflict, finding a solution, and using any effective methods to control the direction of the conflict, are some of the examples of modern conflict resolutions (Zhang, Yi, Liu & Xia, 2014:370).

4.6.3 Termination Phase

Termination phase takes place once the intended results, the effective self-management of aggression, is produced or achieved. The termination phase allows the advanced psychiatric nurse practitioner, together with the psychiatric nurses, to
evaluate the effectiveness of the model to facilitate effective self-management of aggression experienced by psychiatric nurses from the patients. Having understood the challenges of aggression in the workplace environment in the relationship phase, and having gone through the implementation of alternative means in dealing with the said challenges, the termination phase allows both the advanced psychiatric nurse practitioner and psychiatric nurses to sum up the process and conclude whether these alternative means have been effective or not.

The psychiatric nurses take control of the workplace aggression while the advanced psychiatric nurse withdraws from the process to allow the psychiatric nurses to continue to grow and develop. For those psychiatric nurses who have embraced the new ways of dealing effectively with aggression and to whom the results are positive, they take control and move forward with growing strength and determination. For those whose experience has not been satisfying, they have two options: to go back to the drawing board and assess the possible reasons for not succeeding, or just to stop trying and fall back into the old ways.

For the advanced psychiatric nurse practitioner, the termination phase offers the opportunity firstly to assess the results, and secondly to withdraw from the process and allow psychiatric nurses to manage aggression independently from the facilitator’s assistance.

4.7 GUIDELINES FOR THE IMPLEMENTATION OF THE MODEL TO FACILITATE EFFECTIVE SELF-MANAGEMENT OF AGGRESSION

The process of the facilitation of effective self-management by the advanced psychiatric nurse practitioner for the psychiatric nurses experiencing aggression from patients encompasses three phases: the relationship phase, the working phase and the termination phase. The guidelines for implementing the facilitation of effective self-management of aggression are discussed below following the objective and actions taken for the goal to materialise.

4.7.1 Relationship phase

Given the type of patients admitted in this hospital - unmanageable and disruptive-, psychiatric nurses spent much time reacting to whatever is happening occurring and
have little time to think proactively about how better to prevent or self-manage aggression. Psychiatric nurses focus on physical injuries and damage to hospital property caused by the patients and ignore or forget about other forms of aggression that may cause the same or even greater damages than the physical ones.

The relationship phase then enables both the advanced psychiatric nurse practitioner and the psychiatric nurses, to define and understand together what aggression means in the context of the psychiatric hospital and to strategise for its self-management.

Through a dynamic interactive process the psychiatric nurses are given an opportunity to sit down and reflect on the workplace aggression in all its aspect: physical, psychological and emotional. This enables them to reflect on how aggression affects them, the way they react to it and the possible causes for its recurrence so that they can develop the means not only to deal with it but also to prevent it. The advanced psychiatric nurse practitioner assists them to assess themselves, their current experiences in the workplace environment and to think about their future (Thomas & Drake, 2012:7) and helps to guide them in developing alternative means to self-manage aggression effectively.

The psychiatric nurses are encouraged to focus and reflect mindfully on the negative thoughts and behaviour linked to their experiences and how these affect their lives (Dryden, 2012:26-27). Herbert and Forman (2011:8) argue that mindfulness includes heightened awareness of one’s subjective experience and nonjudgmental acceptance of that experience. The psychiatric nurses accept this guidance by participating actively in the discussions and by showing commitment to the effective self-management of aggression process.

4.7.1.1 Objective One

The objective is to enable psychiatric nurses to assess the workplace aggression objectively and to express their feelings freely regarding the experienced aggressive incidents. For the psychiatric nurses to express their feelings freely and honestly, there has to be the creation of rapport. The rules of engagement for the group members must be drawn and expectations clarified.
4.7.1.2 Actions

The advanced psychiatric nurse practitioner demonstrates genuineness, honesty and empathy to the psychiatric nurses in presenting the plan of action for self-management of aggression, and allows the psychiatric nurses to ask questions to clarify any doubt or skepticism they may have. The honest and genuine sharing of feelings and experiences encourages the psychiatric nurses to trust the advanced psychiatric nurse practitioner (Pervin & John, 2001:196). The advanced psychiatric nurse practitioner’s unconditional positive regard creates a climate that is not threatening in which psychiatric nurses can explore their inner selves (Pervin & John, 2001:196). The psychiatric nurses can then share their hopes and disappointment without fear of being judged or ridiculed. The empathetic understanding of the advanced psychiatric nurse practitioner involves the ability to perceive the psychiatric nurses’ experiences of aggressive incidents and what these experiences mean to them (Pervin & John, 2001:196).

Empathy creates a climate that is free of defensiveness (Barker, 2003:148). Sithole (2008:60) states that empathy is the ability to understand the emotional make-up of other people. The facilitator of effective self-management of aggression needs to place herself or himself in the psychiatric nurses’ shoes and understand the workplace aggression according to their perspective. This will inspire trust in the facilitator and belief in a possible change.

Once the psychiatric nurses have dropped their defensiveness, they take the risk of sharing their struggles with aggression openly. Johnson (2003:96) believes that without risk, there is no trust. Trust is established through a sequence of trusting and trustworthy actions and this includes taking a risk to rely on one another and each member making themselves vulnerable to each other (Johnson, 2014:98). This leads to openness, which is, the willingness to share one’s ideas, feelings and reactions to the current situation (Johnson, 2014:75). Once psychiatric nurses show openness, the advanced psychiatric nurse moved to the second objective which is self-assessment and commitment to change. Trust is increased when a person takes a risk and acts in a trusting way and the other person responds supportively in a trustworthy way (Johnson, 2014:358).
4.7.1.3 Objective Two

The second objective of the relationship phase is to help the psychiatric nurses decide to move forward and improve their workplace condition. The advanced psychiatric nurse practitioner helps the psychiatric nurses to be in touch with their feelings because feelings promote the urge to take action (Johnson, 2014:177).

4.7.1.4 Actions

The advanced psychiatric nurse practitioner encourages psychiatric nurses to conduct a self-assessment so that they can come to an understanding of who they are and why they react to the aggressive incidents in the way they do. The focus is on self-awareness. The process of self-awareness enabled by self-disclosure. According to Johnson (2014:48), self-disclosure is revealing to another person how one perceives and is reacting to the present situation and giving any information about oneself and their past that is relevant to understanding of one’s perceptions and reactions to the present. In sharing one’s strength and weakness, one increases the sense of who they are and the person they are actually talking to. This self-awareness obtained provides a basis for introspection, choice, priority setting, change and development (Rothstein & Burke, 2010:5). Self-awareness leads to self-understanding that enables one to solve personal problems (Johnson, 2014:55). Self-awareness takes place when the focus of one’s attention is on oneself and helps one to identify the actions that one needs to take to behave competently in different situations (Johnson, 2014:53). Self-awareness is the ability to reflect on one-self from different dimensions (Cormier, Nurius & Osborn, 2013:6). The advanced psychiatric nurse practitioner encourages psychiatric nurses to introspect and reflect on their selves through self-assessment.

Self-assessment involves the use of self-knowledge and introspection in a structured and guided format, the generation of information and data about oneself, and the use of this data to enrich the understanding of important personal issues in order to commit to developmental initiatives of one’s work (Rothstein & Burke, 2010:7). Further information on self-awareness is discussed later (see 4.7.2.1).
4.7.2 Working phase

The main objective of the working phase is to match theory and practice, helping psychiatric nurses to put into action the acquired information. Actions to be taken are based on areas of focus. These areas represent the main sources of the challenges where the difficulties arise between the psychiatric nurses and the patients. The four areas of focus are: self-awareness, communication skills, stress and conflict management. The order in which they are grouped is significant, as for example to be a good communicator or to manage stress effectively, one needs self-awareness.

4.7.2.1 Facilitation of self-awareness

a) Objective

The facilitation of self-awareness is the continuation of the relationship phase where psychiatric nurses are encouraged to be open and disclose information regarding the challenges they are faced with. The objective of the self-awareness is to enable psychiatric nurses to utilise the knowledge they have about themselves and to take sound decisions instead of being led by emotions. As the discrepancies are discovered between what is being done and what ought to be done, effective means are devised to fill the gap and overcome the aggression experienced from the patients.

b) Actions

The advanced psychiatric nurse practitioner helps the psychiatric nurses to review information regarding how to increase self-awareness through the following actions as recommended by Johnson (2014:57-59). These actions are:

- Introspection: this helps people become more aware of who they are and how they feel and react in different situations. The process entails looking inward and examining the inside information that a person alone has about his/her thoughts, feelings, and motives.
- Self-observation: a person can understand his/her attitude and emotions by inferring them from observation of his/her behaviour or the circumstances in which his/her behaviour occurs.
- Explaining one’s feelings, perceptions, reactions, and experiences to another person: this procedure can lead to new insights into oneself and one’s experiences. The argument is that oral explanation results in higher-level reasoning and deeper-level understanding.
- Comparing oneself to others: by comparison a person discovers his/her similarities, as well as his/her uniqueness, with others and forms an impression of what he/she is like.
- Interacting with a variety of diverse people: the more a person interacts with different people from different cultures, the more he/she becomes knowledgeable about him/herself and about others. As people get to know others, they get to know themselves as well.
- Requesting feedback from other people: the information received can confirm one’s view of self or reveal to the person the aspects of oneself and consequences of the behaviour one did not know.

Pervin and John (2001:20) argue that people are not always attentive to or aware of factors that influence their behaviour. Drawing the psychiatric nurses’ attention to self and how they have interacted with their environment could be the first step in finding a solution to aggressive incidents. Silvia and Phillips (2013:114-115) state that focusing attention on the self can lead to conscious awareness of the self and focusing attention on the self leads to a process of self-evaluation. With self-awareness, the psychiatric nurses use identified strength to plan for a better future in the workplace environment.

Clarkson (2004:39) argues that the awareness of a need is usually followed by excitement and mobilisation of self and resources. The mobilisation of self and resources would be in line with the effective self-management of aggression. The factors that defuse aggression are enhanced, while those that fuel it are discarded.

4.7.2.2 Facilitation of communication skills

a) Objective

According to Johnson (2014:127), to live is to communicate; because communication is the foundation for all interpersonal relationships. The facilitation of communication
skills aims at enabling psychiatric nurses to communicate in a proper manner that does not leave ambiguity or trigger negative feelings.

b) Actions

The advanced psychiatric nurse practitioner assists psychiatric nurses with information regarding the sending and receiving of messages, reading and interpreting non-verbal cues correctly and avoiding mixed messages that lead to misunderstanding or conflict. Communication enhances trust and allows openness. Johnson (2003:99) stresses that a high degree of trust allows for the open exchange of information and for problems to be disclosed and corrected before they are compounded. Both the advanced psychiatric nurse practitioner and psychiatric nurses work toward developing an atmosphere of mutual confidence and trust and practice communication skills. This atmosphere of mutual confidence enables both parties to drop defensive feelings and to build a constructive working relationship. Johnson (2014:102) believes that defensive feelings of fear and distrust are common blocks to the functioning of a person and to the development of constructive relationships. Acceptance is the key to reducing anxiety and fears about being vulnerable (Johnson, 2014:102).

Using simulations, the advanced psychiatric nurse practitioner and psychiatric nurses role-play how to send a message effectively based on Johnson’s criteria (2014:136-137) of sending message effectively. These include:

- clearly owning the message;
- describing other person’s behaviour;
- describing ways the relationship can be changed;
- making the message appropriate to the receiver's frame of reference;
- asking for feedback;
- describing your feelings;
- using nonverbal messages to communicate your feelings;
- making your verbal and nonverbal messages congruent with each other; and
- being redundant.
At the end of the exercise there is an open discussion on the effectiveness of the simulation and how to apply the exercise in a real situation. The listening skills of the participants are also discussed until every member in the group is satisfied about the way forward.

4.7.2.3 Facilitation of stress management

a) Objective

Stress is a nonspecific, general response of the body signaling a need to perform adaptive functions so that a balance can be restored (Johnson, 2014:288). There is a positive side to stress. According to Johnson (2014:288), stress alerts our bodies that action is needed to adapt to the external environment by changing our internal environment. The aim of the facilitation of stress management is to enable psychiatric nurses to manage effectively the stress related to the workplace environment. Information is exchanged and the best options for managing workplace stress are discussed.

b) Actions

The advanced psychiatric nurse assists the psychiatric nurses to define what stress means to them in the workplace context and to identify the stressors related to the workplace environment. Kinman and Jones (2005:102) argue that, despite the fact that stress has become part of the everyday language of the workplace, little is known about lay representations of the concept. Stress is then understood here as the adverse reaction psychiatric nurses have to the excessive pressures and to other types of demands placed on them at work (Burke, 2013:535).

Kinman and Jones (2005:112) state that work stress affects employees in four ways: psychological, behavioural, physical and cognitive. The experience of too high stress level for too long is detrimental to the psychiatric nurses as it can create physiological problems such as headaches, ulcers, and muscle pains (Johnson, 2014:288). Stress can also affect a person’s cognitive functioning, reduce performance, cause difficulties in concentrating, and also irrational and disordered thinking (Kinman & Jones, 2005:113).
Johnson (2003:288) advises that since stress cannot be avoided, people need to learn how to control its effect. The stressful aspects of work are categorised into individual factors and structural factors (Kinman & Jones, 2005:110). Psychiatric nurses are encouraged to identify and evaluate individual and structural factors that possibly need to be changed. How one manages stress has a great influence on the ability to reach out to other people and determines how much stress the person experiences (Johnson, 2003:300). Kinman and Jones (2005:118) also argue that the manner in which an individual conceptualises occupational stress may also influence his/her work-related actions, such as absenteeism, seeking promotion and turnover intentions.

The advanced psychiatric nurse practitioner discusses with psychiatric nurses Johnson’s way (2014:290) of achieving stress management that includes:

- using social support, talking to the people who care; and
- avoiding bottling one’s feelings in loneliness and isolation and accepting others’ support during periods of stress because failure to do that can create physiological damage and aggravate the effect of stress.

It is important for the advanced psychiatric nurse practitioner to stress that the management of stress is an on-going process that requires accepting its presence in one’s life and focusing on how to live with it constructively.

The approach that was taken in this research study was the acceptance that there will always be a certain level of stress and the commitment to doing what it takes to reduce its levels. This included changing the relationship the psychiatric nurses have with the internal experience of stress and promoting behaviour that is consistent with their values (Stafford-Brown & Pakenham, 2012: 594).

This is to be done through developing more effective organisational skills and self-examination (Kinman & Jones, 2005:114). The organisational skills can be acquired by attending workshops and reading enough of how to self-manage aggression effectively as this would considerably reduce stress levels. Self-examination refers to
an honest assessment of one’s actions and reactions enhanced by self-awareness. Kinman and Jones (2005:114) are convinced that self-examination through introspection is the most constructive method of managing stress.

Stafford-Brown and Pakenham (2012:594) also found that mindfulness and acceptance processes improved interpersonal functioning, including greater self-observation, self-awareness, emotional regulation, and less emotional reactivity in relationships. Psychiatric nurses were also encouraged to use available means in their respective wards such as team support. Van den Tooren and De Jonge (2008:76) believe that when nurses have to deal with impolite patients on a frequent basis, they may experience less emotional exhaustion if colleagues give them emotional support.

Other means that psychiatric nurses are encouraged to use are taking regular exercise, pursuing interests and hobbies. This may help the psychiatric nurses to avoid some mental disorders associated with stress such as substance abuse and depression (Bremner, 2005:10) and increase their psychological flexibility which is a prerequisite for meaningful living (Stafford-Brown & Pakenham, 2012:608).

4.7.2.3 Facilitation of conflict management

a) Objective

The objective of the facilitation of conflict management is to enable the psychiatric nurse to avoid unnecessary distractions that take away the focus and energy of dealing with the real problems related to workplace aggression.

The advanced psychiatric nurse practitioner encourages the psychiatric nurses to accept realistically that, like stress, conflict is a life companion. Whitworth (2008:921) argues that conflict is an inevitable part of life and that it is prevalent among registered nurses working in the healthcare environment.

b) Actions

There are five conflict management styles: competing, collaborating, compromising, avoiding, and accommodating with the underlying dimensions of cooperativeness and assertiveness (Whitworth, 2008:923). The advanced psychiatric nurse
practitioner assists psychiatric nurses to use conflict management styles in their day-to-day solving of conflicts. The psychiatric nurses are encouraged to utilise the skills so far developed in self-awareness and communication skills so that they choose the appropriate one from Johnson’s strategies for conflict resolution (Johnson, 2014:259). These strategies are:

- Withdrawing;
- Forcing;
- Smoothing;
- Compromising; and
- negotiating.

In withdrawing, a person gives up goals and relationship. Withdrawing from a conflict over an important issue with a friend is quite destructive (Johnson, 2014:259). In forcing, one achieves the goals no matter how it hurts the relationship (Johnson, 2014:259). In smoothing, one gives up the goals for the sake of maintaining the relationship (Johnson, 2014:259). In compromising, the goal is given up, the relationship is sacrificed partly in order to reach an agreement (Johnson, 2014:259). In negotiation, both goal and relationship are important. An agreement is sought that maximises joint benefits and resolve any tensions and negative feelings (Johnson, 2014:259). Each strategy is appropriate in certain circumstance, and the way people act in a conflict is determined by how important their personal goals and relationship are to them (Johnson, 2014:259).

Psychiatric nurses who want to grow personally and professionally will have to bear in mind how important it is for them to acquire the above skills. Whitworth (2008:921-922) suggests that it is impossible to operate at a maximum level of creativity, efficiency and productivity in the midst of turmoil. A mishandled conflict not only hampers the productivity, but also can release anger, anxiety, insecurity, and sadness that, if kept inside, make the person mentally and physically sick (Johnson, 2014:259). This can apply most specifically in an acute ward where conflict behaviours are ubiquitous in acute inpatients (Bowers, Simpson & Alexander, 2003:405). That is why Whitworth (2008:922) believes that increased understanding
of individual personality factors and how these relate to conflict management styles can facilitate positive outcomes for registered nurses in the healthcare environment.

### 4.7.3 Termination phase

#### a) Objective

The objective of the termination phase is for the advanced psychiatric nurse practitioner to facilitate the evaluation of the model implementation by psychiatric nurses and the maintenance of the previously gained knowledge and skills in effective self-management of aggression. The advanced psychiatric nurse practitioner allows the psychiatric nurses to take the achieved goal and objectives to a higher level and then terminates the process in order for the psychiatric nurses to continue with the effective self-management of aggression.

#### b) Actions

Maintenance can be understood as a time of perpetual adjustment so that one prevents a falling back into older habits, but rather integrates the new self and the new behaviour into one’s daily living (Cormier, Nurius & Osborn, 2013:280-281). The advanced psychiatric nurse practitioner helps the psychiatric nurses in assessing the effectiveness of the model implementation and in elucidating the benefits gained. He/she gradually withdraws from the process as the psychiatric nurses show signs of mastering the workplace aggression. The psychiatric nurses take charge of acquired benefits and take these to the next level.

Psychiatric nurses take control of the situation by sustaining the achieved results and by making sure that they move forward instead of backward because they are empowered. Wallace and Carter (2003:37) believe that the ability to produce and maintain new cognition and behaviour, as well as the overall expansion of consciousness results, in a state of empowerment.
4.8 EVALUATION OF THE MODEL

"It is not enough to take steps which may someday lead to a goal; each step must be itself a goal and step likewise" Von Goethe.

The evaluation of the model to facilitate the effective self-management of aggression experienced psychiatric nurses in a psychiatric institution is based on the criteria of clarity, simplicity, generality, accessibility, and importance of the model (Chinn & Kramer, 2008:238-248). The model was evaluated throughout by three experts: two professors and one PhD holder, who are the supervisor and co-supervisors.

The two professors are known, nationally and internationally, for their knowledge and expertise in the qualitative research, theory-generating and model development research methods. The two professors have longstanding experience, one in psychiatric nursing and the other in education. The PhD holder is a lecturer in psychiatric nursing science. Two formal seminars were presented. The first one was presented to a panel of experts in theory generation and model evaluation consisting of three professors and a PhD holder. The second seminar was presented during the annual research forum organised by the University of Johannesburg. On both occasions, the model was found to be complying with the criteria for model development as discussed below.

4.8.1 Clarity

Chinn and Kramer (2008:238) argue that in determining how clear a theory is, one should consider the following: semantic clarity, semantic consistency, structural clarity, and structural consistency. Further on both authors (Chinn & Kramer, 2008:238) define semantic clarity and consistency as the understanding of the intended theoretical meaning of the concepts; and the structural clarity and consistency as the understanding of the intended connections between concepts within the theory and the whole of the theory.
4.8.1.1 Semantic Clarity

In this research semantic clarity is assessed by how well the model can be understood and how consistently the ideas are conceptualised (Chinn & Kramer, 2008:238). The questions that were asked with regard to semantic clarity were based on whether the concepts of the modes were meaningful, helpful and consistent. The evaluation panel stated that the concepts were consistent, and meaningful and would be helpful in the self-management of aggression, as reproduced below:

- Are the concepts meaningful and helpful?

  *All the members of the panel answered “YES”.*

- Are concepts used consistently?

  *To this question also there was the unanimous answer “Yes”.*

4.8.1.2 Semantic Consistency

The evaluation of the model with regard to semantic consistency focused on whether the concepts of the model were used in ways that are consistent with their definition (Chinn & Kramer, 2008:240). The questions that were asked with regard to semantic consistency were based on whether the concepts of the model provided a structural map and whether the structure of the model could be comprehended. The evaluation panel answered that the concepts provided a structural map and the structure of the model could be comprehended. The questions and answers are reproduced below:

- Do the concepts provide a structural map?

  *The answer from all the members of the panel was: YES.*

- Can the structure of the model be comprehended?

  *Again, all the members of the panel answered with a “YES”.*
4.8.1.3 Structural Clarity

Structural clarity refers to how identifiable and apparent the connections and reasoning are within the model (Chinn & Kramer, 2008:241). The questions that were asked concerning structural clarity were based on the structure of the model, whether it was clear and easy to follow, and whether the connections within the model were easily identifiable and apparent. The evaluation panel stated that the model was clear and easy to follow; that there was a clear logic in the arguments and the consistency in the process was justifiable. Below some of the answers are reproduced following the questions:

Can the structure of the model be comprehended?

One of the members of the panel said:

“The model is clear and easy to follow”.

Another one added:

“There is a clear logic in arguments and the consistency in the process is justifiable”.

Others answered just with a “Yes”.

4.8.1.4 Structural Consistency

The questions that were asked concerning structural consistency were based on whether the structure was reflected in the linkages among elements in the model. The evaluation panel stated that there was structural consistency. Some suggestions were made, however, with regard to the order of the steps in the structure and the use of different colours. These suggestions were taken into consideration by the researcher. The modifications were made as suggested until both the researcher and the research supervisors were satisfied.
4.8.2 Simplicity of the model

While evaluating the model for its simplicity, the focus was on the number of elements within each descriptive category, particularly the concepts and their interrelationships (Chinn & Kramer, 2008:242). The questions that were asked with regard to the simplicity of the model were based on whether the number of concepts was limited to a minimum and whether concepts could be combined without losing theoretical meaning. The evaluation panel stated that the concepts were limited to the minimum; the concepts could be combined without losing the meaning.

The following are the two questions asked on the above subtitle and the answers given by the panel.

- Is the number of concepts limited to a minimum?
  To this question there was a unanimous “yes” from the panel members.

- Can concepts be combined without losing theoretical meaning?
  To this question also there was a unanimous “yes”. As it can be seen, to the above questions and the previous ones, the answers were short because the researcher used close-ended questions on the evaluation sheet.

4.8.3.3 Generality of the model

The generality of a model refers to its breadth of scope and purpose (Chinn & Kramer, 2008:243). The questions that were asked with regard to the generality of the model were based on to whom this model applied and when it was applicable; whether the purpose of the model applied to specific situations. The evaluation panel answered that the model was general and that it could be applied to the psychiatric nurses experiencing patients’ aggression or to all nurses working with patients. The panel also stated that beside that the model was applicable to psychiatric hospital context it was also transferable to other areas where healthcare staffs were exposed to patients’ aggression or anywhere in any nursing situation.
4.8.3.4 Accessibility of the model

Accessibility addresses the extent to which empirical indicators for the concepts can be identified and to what extent the purposes of the model can be attained (Chinn & Kramer, 2008:243). The questions put to the panel were:

- Are the concepts within the realm of nursing?
- To which degree are the concepts grounded in empirically identified phenomena?

These were some of the answers:
- Yes, the concepts are accessible.
- Yes, the concepts are grounded.
- Yes, mental health nursing.

All the concepts are empirically grounded.

4.8.3.5 Importance of the model

In nursing, the importance of the theory is closely tied to the idea of its clinical significance or practical value (Chinn & Kramer, 2008:145). The questions that were asked with regard to the importance of the model were based on whether the model had a potential to influence nursing actions, whether the members of the panel liked the model and whether the model guided nursing practice. The evaluation panel stated that the model had the potential to influence nursing actions; and that it could be an avenue to address a really serious challenge in interacting with challenged patients. The members of the evaluation panel also stated that they liked the model because it is simple and clear and it will assist in facilitation of mental health of nurses. Further on, the evaluation model stated that the model could guide nursing practice for nurses to have structured debriefing sessions to prevent secondary trauma, or as a frame of reference.

Below are the questions posed to the panel members and their answers:

- Does the model have the potential to influence nursing actions?
“Yes the model has the potential to influence nursing actions”.

“This can be an avenue to address a really serious challenge in interacting with challenged patients”.

- Do I like this model?
  
  “Yes. I like the model”.
  
  “Yes”.

- Why?
  
  “The model is simple and clear”.
  
  “It will assist in facilitation of mental health of nurses”.

- Does the model guide nursing practice?
  
  “Yes. For nurses to have structured debriefing sessions to prevent secondary traumatism”.
  
  “As a frame of reference”.

4.9 CONCLUSION

In this chapter, the description of the structure and the process of the model for effective self-management of aggression experienced by the psychiatric nurses in psychiatric hospital have been presented. Guidelines to operationalise the model were also provided. The evaluation of the model by a doctoral seminar has also been discussed based on the answers received from the panel members. The next chapter contains a detailed description and findings of the implementation of the model by the psychiatric nurses.
5.1 INTRODUCTION

Chapter Four dealt with the description of the model for the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution. The structure and the process of the model were also discussed as well as the guidelines for the implementation of the model. In this chapter, the implementation of the model, the results and the participants’ evaluation of the model are discussed.

The implementation is understood here as putting into action the alternative means or strategies that were developed for the effective self-management of aggression. The implementation process started with the researcher's idea to conduct a research study on the effective self-management of aggression and will actually end after the communication and dissemination of the findings. The three main phases: the relationship phase, the working phase, and the termination phase continued to be applied throughout the model implementation.

The researcher’s motivation to develop a model for the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution originated from the results of his Masters’ research findings that showed ineffective self-management of aggression in the institution (Bimenyimana, 2008: 37-57).
5.2 IMPLEMENTATION

The implementation of the model took place after the psychiatric nurses who agreed to participate were ready to try alternative means in order to self-manage aggression effectively. The researcher and participants had already discussed the possible factors that either trigger aggressive incidents or sustained these incidents. The whole process of implementation from the beginning to the end is discussed in the following paragraphs.

5.2.1 The relationship phase

The relationship phase was groundbreaking in this study and it was full of surprises with an unexpected number of psychiatric nurses participating. The aim of this phase was to place the psychiatric nurses' mind and heart at ease so that they could realise that aggression is not a fate but rather a challenge that can be overcome. In order to achieve this, the researcher had first to gain their trust through personal and group contacts. This process entailed getting to know the prospective participants and letting them know the researcher and the researcher’s intentions. The researcher had worked with psychiatric nurses in different wards, but did not know much about how they handled aggressive incidents individually. What follows is a personal account of personal his experiences.

The visit to the different wards happened after I had obtained all the required ethical and academic clearances and after having sent an invitational letter to the wards for the prospective participants. I visited the psychiatric units in order to meet with psychiatric nurses and brief them on what I intended to do though the invitational letter had most of the required information. Initially, I had planned to have one or two meetings with the prospective psychiatric nurses. These two meetings would have enabled me to explain to the psychiatric nurses interested in participating to the research study what the model to facilitate effective management of aggression they experienced entailed and what their involvement would consist of.

At the first meeting, four psychiatric nurses were present. I got there early and prepared the room that the management had put aside for the meeting. I waited and when it was time for the meeting, there were only two psychiatric nurses. We waited and half an hour later, there were four psychiatric nurses in total. We started the meeting and discussed the topic, the issues around voluntary participation,
autonomy, confidentiality and anonymity and the duration of the implementation of the model. As the attendance was low, we agreed to convene another meeting in a week’s time. In the meantime, those who had attended the meeting were asked to spread the word for a higher attendance next time. I sent with them new invitational letters to the wards letting the psychiatric nurses know the date of the postponed meeting. At the second meeting, three psychiatric nurses were present, but none of those who attended the first meeting was present. We discussed the topic then they told me that it was going to be difficult for me to get more than five psychiatric nurses at one time given the staff shortage in the wards and off-duty changes on a weekly basis.

I then decided to go to the units and meet with those who might wish to participate but could not attend the two first meetings. That is how I moved from ward to ward, meeting with psychiatric nurses individually or in a group explaining the goal and objectives of the research study, the process of the research study, the requirement of participation and ethical consideration pertaining to their involvement. In the meantime those who wanted to participate were also recruiting their colleagues and friends, and the number of participants became even greater than I had anticipated. I had formal and informal meetings in the units and the decision to meet them individually or in group depended on the participants' availability. The relationship steps as described in Figure 4.1, the building of trust, the understanding of aggression and the imparting of hope and belief, were followed. When the psychiatric nurse participants showed that they had understood the dynamics of the workplace aggression and believed that they could deal with it differently through their commitment to seeking alternatives, we moved to the next phase, the working phase that consisted of implementing agreed upon strategies.

5.2.2 The working phase

The working phase is characterised by the commitment of members to explore significant challenges (Corey, et al., 2010: 228). During the working phase, the psychiatric nurses put into practice the agreed upon alternatives and these were based on specific identified challenges. I stressed the move from the theory to the practice because, during our discussion, it became clear that most of psychiatric nurses knew what they were supposed to do, but due to some reasons not even
known to them they were still unable to put their knowledge into action and self-
manage aggression effectively.

The choice of the participants, as well as, the criteria for inclusion have been
discussed in detail in Chapter Two (see 2.4.4, a & b). The process of implementing
the model took six months. The psychiatric nurses who agreed to participate were
informed from the beginning that they had six months to implement the model after
which they would share with me their experience during implementation through one-
on-one interview, focus group, or naïve sketches. The number of psychiatric nurses
who participated is sixteen (n=16) from ten wards. The interactions between the
researcher and the participants lasted for six months through which several meetings
were held. The two first meetings entailed the provision of information on the
research purpose, objectives, and process in addition to information contained in the
invitation letter. The attendance was below the expectation. The researcher then met
with individual participants in their respective wards repeating the above information.
These meetings lasted between 45 minutes and an hour depending on the
participants’ ability to process information. When everyone had understood what was
required, the implementation took place. During the first month of implementation, I
met the participants once two weekly. The next four months, participants were
encouraged to work independently and I only met those who needed either
clarification or assistance. The meetings were informal. In the last month, the six, we
met twice: first for data collection, second for member checking after data had been
analysed by the researcher and the independent qualitative data analyst.

The model implementation focused on four main areas:

g) facilitation of self-awareness;
h) facilitation of communication skills;
i) facilitation of stress management; and
j) facilitation of conflict management.

These four areas were identified as representing the pitfalls where shortcomings that
hamper the effective self-management of aggression come from. It is important to
clarify how the process of identifying these areas took place. The psychiatric nurses,
through awareness of self and environment, in the relationship phase came to
identify the factors and circumstances in which incidents of aggression were most likely to happen. In doing so, they not only pointed to the shortcomings but also proposed possible solutions in dealing with the challenges. These possible solutions called strategies or alternative means were then implemented.

5.2.2.1 Facilitation of self-awareness

The process of self-awareness entails the ability to imagine a future that is better than the past, evaluate alternatives, identify problems, and a yearning to progress toward an ideal (Ashley & Reiter-Palmon, 2012:1).

During our mutual discussion, the advanced psychiatric nurse practitioner and psychiatric nurses came to realise that at times the psychiatric nurses focused more on the task to be accomplished without considering how the task was performed and the impact this had on the patients who were the recipients of these performed tasks. Patients felt disrespected and ignored, while the psychiatric nurses would feel frustrated and call the patients ungrateful. This conflict time and again ended up in confrontation and aggressive incidents resulted. The following two examples were brought forward by the psychiatric nurses who argued that patients might feel disrespected if the following incidents happened. As in the following paragraphs, every discussion was based on two points: firstly, analysing the actual challenge and secondly, devising possible remedial action to the challenge.

In acute wards, patients are restricted to smoking their own cigarettes after breakfast, lunch, and supper. The cigarettes are kept in a locker for safekeeping. It becomes a problem when the meals are late from the kitchen because nurses will not issue the cigarettes in due time. When patients fail to understand what is happening or to cope with the craving, they demand their cigarettes. The psychiatric nurses tell them that they know the rules, they smoke after meals. Patients become agitated and frustrated and they then start acting out either by swearing at the nursing staffs, or by breaking windows.

During the discussion, it became clear that in instances like this one, the psychiatric nurses failed to acknowledge the patients’ need to smoke and the craving. No
explanation was provided about why the meals were delayed. Patients then felt then ignored and disrespected. The psychiatric nurses stated that there are rules yet failed to check whether these rules enhanced patients’ cooperation and nurses’ good practice. The remedial action would have been communication and negotiation of an amicable solution. The participants were encouraged to be flexible and to communicate with the patients and to act in the best interest of the patients. The process of keeping patients informed on what is happening and getting them involved in finding a solution to the challenge will enable them to feel considered and respected.

The following challenge is related to the ambiguities surrounding the handling of aggressive patients after admission in the ward.

The Mental Health Care Act no 17 of 2002 obliges psychiatric nurses to administer treatment to a disruptive psychotic patient even if he/she refuses it (Government Gazette no. 24024). As there is no guideline on how to do it, some psychiatric nurses use this as an excuse and give the psychotic patients and injection without explaining to them why. When a patient starts pacing up and down in the ward, one of the best options to limit the damages to the patient him/herself, to other patients or the institution’s properties is to sedate him/her. While preparing the injection, the nursing staff will not consider explaining to the patient what the injection is for and why he/she must get it assuming that the patient will refuse anyway because of psychosis. They call the patient for injection without further explanation. If the patient refuses, they pin him/her down and give the injection. If this patient is paranoiac and thinks that everyone is out there to get him/her and is pinned down and given injection without discussion or information, then his/her delusion is enhanced. He/she will strike the first nurse to approach him in what he believes to be self-defence.

The remedial action to this challenge would be to incorporate in the ward rules and regulations a standard operating procedure (SOP) that, based on Mental Health Care Act no 17 of 2002, states what to do in a situation where there is a psychotic patient who is disruptive and needs to be sedated. In the meantime the participants were encouraged to explain to the patient, step by step, what they were doing, even
when they were convinced that the patient was psychotic and unable to comprehend. If the patient seems to target one professional nurse, other nurses should take over; it is what teamwork is all about.

Participants agreed that at times they never thought the patient would perceive their action as an attack or disrespectful. They had come to acknowledge their part of responsibility in what was happening and pledged to change the approach. Showry and Manasa (2014:16) state that self-awareness at work is understood as being the practice of reflecting on experiences and precisely assessing one’s own behaviors and skills as they are manifested in the workplace.

5.2.2.2 Facilitation of communication skills

The work of psychiatric nurses in the ward puts them at the heart of everything that happens in it as they are with the patients consistently. They work in a multidisciplinary team that is diversified. There are other workers who are not members of the multidisciplinary team but they are in constant contact with the patients. These workers hardly know something about psychiatric illness and how to deal with mentally ill patients, for example the cleaners, but their behaviour affect the whole team. Patients address everyone in the unit either as a doctor or as a nurse putting everyone in the same group. They do not recognise those different categories. When they feel they have been wronged they attribute it to the nurse or the doctor. It was therefore identified that the way some members of the multidisciplinary team communicated with the patients is a challenge that need to be attended to in order to self-manage aggression effectively.

Several verbal aggressive incidents based on poor communication skills were identified. A member of the multidisciplinary team frustrated or overwhelmed by the demands of the workplace environment would discharge their frustration on to the patients and say something that really hurt the patient’s feeling and fuel aggression. This is one of those incidents from the staff members directing provocative language to the patients:

“You brought this illness upon yourself by smoking marijuana and drinking alcohol. This is why you are in the hospital and that is why your family members have abandoned you”… "You are a failure"; "You will never go back
home”; “That is why your family / mother does not want you”; “You are crazy, (wahlanya)”.

Although in the discussion it was said that the above utterances were revolting, humiliating and unprofessional, it was also said that those who utter them do it out of ignorance and frustration. It was said that this kind of behaviour could be found with cleaners who do not know how to handle patients.

To find a solution to a challenge like this one, there is a need to include cleaners in ward’s in-service training and organise workshops on institutional level. These members of the team who do have background training in psychiatric illnesses may be given basic information on what to expect from the patients. It was also suggested that once the patients are stable and can follow ward routine, they should be informed about the different components of the multi-disciplinary team and the role of each one so that they do not confuse a cleaner with a nurse.

5.2.2.3 Facilitation of stress management

Working with people whose mental capacity to decide and differentiate right from wrong is a challenge. When these patients are then aggressive the challenge becomes even greater. When psychiatric nurses portray an “I don’t care attitude”, the environment becomes even more stressful for those who are still committed to giving their all in caring for the patients. A caring attitude is needed for the psychiatric nurses and other members of the team. The following example does not justify the uncaring attitude of some professionals, but may explain why they end up like that: this is based on true experiences shared by some psychiatric nurse participants

Imagine a psychiatric nurse being on duty and a psychotic patient fighting a fellow patient and banging his head on a wall. The psychiatric nurse intervenes, but finds the victim bleeding, the brain coming from the nose. The psychiatric nurse experiences and witnesses this incident powerlessly. The following day, s/he is expected to report on duty as if nothing has happened. No debriefing, no counselling.

It was suggested then that psychiatric nurses and nursing management work on achieving a constructive working relationship. Psychiatric nurses need to use
assertiveness to express their feelings instead of bottling them or sometimes using passive means such as absenteeism. As a remedial action, proper debriefing after an aggressive incident, no matter how small it may look, is very much needed. It will allow the victim to ventilate his or her fear and frustrations and look back to the incident and evaluate whether things could have been done differently. There has to be a structure that enables psychiatric nurses to get adequate help both physically and emotionally when they need it. The morale of the staff needs to be uplifted by making them feel that they belong and that they are psychologically and emotionally supported.

5.2.2.4 Facilitation of conflict management

The conflicts evoked here arise from the lack of team-spirit or teamwork and from inconsistency in dealing with aggressive patients, especially when the latter act deliberately and consciously. The two following examples illustrate what transpired:

In some instances an intern psychologist will have a one-on-one session with a patient. The patient says that nurses dislike him and other patients are abusing him. Without verifying the information for its reliability, the intern lashes out at the psychiatric nurses and starts lecturing them on the patients’ rights charter. Furthermore, psychiatric nurses verbalised that they feel their input and contribution during ward-round meetings are not taken seriously. Yet they are the ones with the patients most part of the time. This makes some of them refuse to attend ward-round meetings, or they attend and say nothing.

This challenge can be dealt with by encouraging open communication among the team members. There can be no teamwork where communication and role determination in the team are not clarified. Participants are encouraged to develop team spirit by regular meetings in which all the members could speak freely and express their hopes and dreams, and also the sharing of a cup of tea after at tea-break on ward-round days, or having a meal together once in two months. During this time all ward staff would participate and share not only the meal, but also talk about themselves in order to get to know one another, focusing on what makes the
team move forward and finding solutions to the workplace challenges in a win-win approach. This would mean putting common interest before personal interest.

The other source of conflict is the handling of patients who act aggressively knowing what they are doing.

_The incident described here happened in a forensic ward where a patient wanted to phone at his own time while there was no reason for that. A psychiatric nurse tried to set limits and the patient decided to break the TV screen to punish the psychiatric nurse. The ward doctor was called in and the patient lied that a voice told him to do it. The doctor discovered that it was a lie, the patient was not hallucinating, but there was nothing she could do. The patient came to the psychiatric nurse and then said: “I told you so. Next time it will not be the TV but you”._

There should be clear indication showing which measures should be taken not to punish the patient, but to correct them and to prevent incidents from recurring. To achieve this, at least the multidisciplinary team members should meet and decide on the rules and regulations stable patients are to follow in the ward. Those who hide behind their mental illnesses, should be told what the consequences of their actions will be.

After enough discussion and exchanges, it was agreed by the advanced psychiatric nurse practitioner and the psychiatric nurses - that the time for implementation was six months. The participants were encouraged to use innovative and creative ways based on the four areas discussed and to write in their journals their personal experiences and the outcomes of interventions. During this whole time, the researcher made himself available himself and assisted where necessary.

**5.2.3 Termination Phase**

The termination phase consisted of two activities that ran simultaneously: the evaluation of the model process and outcomes and the withdrawal of the advanced psychiatric nurse practitioner as the process terminated.
After six months of implementation of the model, the researcher asked the participants to share their experiences concerning the model implementation. To all who had participated, this question was put: “What was your experience like when using this model implementation in dealing with aggression?” In order to help the participants to elaborate on their answers, four sub-questions were posed to them. These are:

- Was the model understandable?
- Was the model useful?
- Were you able to adjust it to your unit?
- What is your overall impression of the model?

The data was collected by means of field notes and naïve sketches. Initially, the researcher had planned to have one-on-one interviews or a focus group. At the end of the implementation, participants started postponing the time for the meeting. After consultation, the participants opted for a written summary from the ward’s participants. All the participants in the same ward would sit together, share their individual experiences. One of them was to play the role of group leader, while another one would be a scribe. A written report from the ward was then handed over to me.

Some of these naïve sketches were handwritten others were typed. I typed those that were handwritten and sent the copy of all the collected naïve sketches to the independent coder. Both the independent coder and I analysed the naïve sketches separately and independently. We met for discussion and a consensus was reached. The independent coder has experience and academic recognition in qualitative research and is a lecturer at the University level. The data was analysed following Tesch’s steps of open coding (Creswell, 2003:192). The following is the description of the results.

5.3 DESCRIPTION OF THE RESULTS

Initially, the psychiatric nurse participants were skeptical, wondering whether anything could really change the manifestations of aggression in this institution. This was despite a long process we had gone through regarding the self-management of
aggression. Information and knowledge had been exchanged and we had come to an agreement that aggression could be brought to an acceptable levels. During the process of model implementation, some of the participants expressed feeling frustrated. This frustration was caused by their awareness: first they noticed that the usual methods of self-managing aggression used by colleagues were not adequate; second they became aware that they were working harder than their colleagues to do damage control. In the end all of them were positive about having participated in this research study. Below is a description of the research setting and profile of the participants before the discussion of the outcomes of the model implementation.

5.3.2 Research setting

The implementation of the model took place in both general and forensic psychiatric units. Ten wards participated in the model implementation and the number of psychiatric nurse participants was sixteen: eight males and eight females. The results discussed in this chapter are from seven wards because other three wards did not participate in the final evaluation of the model. Of these seven wards, four forensic wards and three others are general psychiatric wards. Each ward was represented by one psychiatric nurse.

5.3.3 Demographic profile of the participants

The sixteen psychiatric nurses who participated to the model implementation were all permanent employees of the institution. The participants’ age ranged between 27 and 55 years. They had all worked in the institution at least for the previous three years. The youngest had been employed in the institution for the previous five years and the eldest for 25 years. All the participants had worked both in acute and forensic units. The psychiatric nurses worked independently, though at the end of the implementation they chose to submit one report per ward. All the reports were written in English.

5.3.3 Researcher’s observation

The psychiatric nurses participated actively, from the beginning until the end, showed commitment and determination throughout the process. They stated that at times colleagues who were not participating were teasing them, calling them ‘expert’ aggressive managers. However, when there was an incident, these ones who were
not participating would want the ones who were participating in the research study to be the ones to intervene. Others were frustrated by this behaviour and wanted to quit but after discussion they continued and went on to benefit from the implementation of the model. In addition, those who did not recover from this frustration revealed it during the writing of naïve sketches. For those who were positive about the implementation of the model, their challenges and resilience are recommendable and reported in the discussion of the results.

What was of concern for me was that a number of psychiatric nurses, among those who had participated actively, used the opportunity during the evaluation to vent their anger and frustration about how dissatisfied they were with their managers’ leadership style. After member checking, it became clear that these psychiatric nurses are not assertive enough to discuss their concern with the management. They then take every opportunity they get to voice their discontentment, even if the context is not appropriate for their concerns. Other psychiatric nurses believe that they do not have enough opportunity to express their feelings, or seem to think that their grievances are not taken seriously. They then use every opportunity and venue that they can get to express those bottled feelings especially if the person they are talking to is not part of the management.

The outstanding example of this behaviour is for instance when a participant was asked what was their experience with the implementation of the model. In reply, one participant brought in the lack of support from the management. The participant went on to voice their frustrations against an Operational Manager who, it is claimed, sits the whole day doing nothing. The other issue that was raised is the inequality of salaries among psychiatric nurses. From afar this statement may appear irrelevant to the experience of aggression they were asked to share. However, analysed closely, these incidents show how some psychiatric nurses are dissatisfied with the environment in which they are working. This dissatisfaction can play a key role in the way psychiatric nurses perceive and deal with the workplace aggression. The inequality in wages for the psychiatric nurses who have the same job description is demotivating. It may have a negative effect on the collective effort in the management of aggressive incidents. I also noticed that the lack of harmonious working relations among psychiatric nurses. This was shown by the frustration experienced by psychiatric nurses participating to this research study who were left
to deal with aggressive patients because ‘they were judged to be experts in dealing with aggression’ while the opportunity had been offered to everyone. This will also be reported in the discussion of the results and will be supported by verbatim quote.

5.4 DISCUSSION OF THE RESULTS

The model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution sought a positive and lasting answer to this prevailing aggression in the work place. The implementation of the model was based on critical and persisting challenges that psychiatric nurses met in their day to day rendering of quality of care to the patients. At the end of the model implementation, the participants were asked to assess and evaluate whether the answers to their challenges had been found. Therefore, their experiences were influenced by whether the implementation of the model assisted them in dealing with aggression in self-managing it effectively or not. The results are presented in central theme, themes and categories in Table 5.1. Below is the summary of the table of the results.

Table 5.1 The summary of the results of the model implementation grouped in central theme, categories and sub-categories.

**Central theme:** The implementation of the model to facilitate effective self-management of aggression was perceived as a success. This success was mainly attributed to the fact that the model was relevant to the needs of the participants and their core of duty. It offered a structured approach in dealing with aggression through the raised awareness of the participants. Tangible results were improved teamwork that led to improved patient care and respect from each other- patients and staff, aggressive incidents decreased and patients recovered quicker than before. The participants in the implementation of the model felt either empowered or frustrated and reacted according to the feelings experienced. Those who felt empowered were eager to share with others their experience with other nurses, while those who felt frustrated were looking for the reasons of not succeeding.
### Themes

<table>
<thead>
<tr>
<th>Categories</th>
<th>5.4.1 The relevance of the model implementation met the psychiatric nurses’ expectations.</th>
<th>5.4.2 The model implementation increased awareness of the participants.</th>
<th>5.4.3 The participants in the implementation of the model experienced mixed feelings ranging from empowerment to frustration.</th>
<th>5.4.4 The implementation of the model met with some challenges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1.1 The model answered to the psychiatric nurses’ workplace challenges.</td>
<td>5.4.2.1 The increased awareness led to teamwork.</td>
<td>5.4.3.1 The participants who had a feeling of empowerment also felt urged to share their new experience.</td>
<td>5.4.4.1 Unpredictability of patients’ aggression</td>
<td>5.4.4.2 Mixing of all categories of patients</td>
</tr>
</tbody>
</table>
| 5.4.1.2 The suggested interventions were part of what psychiatric nurses are supposed to do. | 5.4.2.2 The increased awareness led to improved quality patient care. | 5.4.3.2 The participants who felt frustrated attribute it to: 
- Negative staff attitude 
- Lack of consistency in dealing with aggressive patients 
- Lack of confidentiality | 5.4.4.3 Lack of resources | 5.4.4.4 Lack of support from nursing management |

### 5.4.1 Overview

“The implementation of the model to facilitate effective self-management of aggression was perceived as a success. This success was mainly attributed to the fact that the model was relevant to the needs of the participants and their core of duty. It offered a structured approach in dealing with aggression through the raised
awareness of the participants. Tangible results were improved teamwork that led to improved patients’ care and respect from each other—patients and staff, aggressive incidents decreased and patients recovered more quickly than before. The participants in the implementation of the model felt either empowered or frustrated and reacted according to the experienced feelings. Those who felt empowered were eager to share with others their experience with other nurses, while those who felt frustrated were looking for the reasons of not succeeding. The model implementation also met with some challenges linked to the environment where it was implemented. These are lack of unpredictability of the patients, mixing of all categories of patients, lack of resources and the lack of support from the nursing management”.

The model implementation has succeeded in achieving its intended result of effective management of aggression. As in any other real life situation, the success was also coupled with a number of challenges. The participants who focused of the goal instead of focusing on the challenges were rewarded and became empowered by the results. Those who focused more on the challenges were discouraged and felt frustrated. The environmental factors that could contribute to the success or lack of success of participants are also linked to the culture of the institution that needs to be challenged for anyone who works there to move forward.

Psychiatric nurses participating to this research study shared their experiences in different words, yet conveyed to the same message: that they felt comfortable implementing the model. They said that the model was an eye opener and that they had gained from the model implementation. They also said that they had all they needed to self-manage aggression effectively except coordination. These were some of the verbatim quotes of the participants:

“I feel that a whole lot has changed in my working experience. Before this model, we were working as we saw fit but not doing the right thing. But now we can communicate better amongst ourselves and with the patients.”

This participant stated how the model touched on the problem they face regularly in their work environment:
“We all come across all the problems that the model mentioned on a daily basis.”

Referring to the utility of the model implementation, this participant said:

“This model is very useful in a sense that patients are more relaxed, they are able to report if there is something wrong.”

Another one remembered how it all started:

“We learnt to work together as a team, reminding each other to follow the model interventions when we felt we were not doing what the interventions required before we got used to them.”

This participant shows where they are now after implementing the model:

“We are able to respect and care for the patients better and we improve ourselves through ward in-service training.”

Another participant added:

“Even as staff members we are more open, we work as a team and we are able to communicate more”.

In reducing their defense mechanisms, the psychiatric nurses allow the patients to also evaluate whether their behaviours are appropriate. The result is that everyone works on their strength and weakness in making the environment less hostile. Forsyth (2014:324) argues that in some situations, individuals perform more effectively when working in the presence of others, striving to give a good impression. This is either because they want to be affirmed or to affirm themselves. Sherman (2014:834) states that self-affirmations reduce defensiveness in response to threats to individuals’ health, attenuate physiological stress responses to laboratory and naturalistic stressors, and improve academic performance among
individuals experiencing identity threat. Self-affirmations boost self-resources, broaden the perspective with which people view information and events in their lives, and lead to an uncoupling of the self and the threat, reducing the threat's impact in affecting the self (Sherman, 2014:834).

The next participant went as far as wishing the model implementation to be recommended by the management for more outcomes saying:

“If only our managers could really have a look at the model and do an introspection into their leadership styles and change where possible”.

The above participant meant that managers should know not only themselves but also those they are managing or leading. According to Showry and Manasa (2014:17), introspection is the road to self-awareness. It is the internal ability to get in touch with the self and learn about the self by examining the most essential resources such as characters, traits, beliefs, values, strengths, abilities, motivations and desires that form the leader’s identity and make him/her assessment accurate.

The psychiatric nurses who participated in this research study assessed the situation objectively and worked on those aspects that they were able to modify. However, they found that some aspects needed management’s intervention. In my previous research (Bimenyimana, 2008:60) I had recommended that management become more visible and supportive especially after an injury has occurred in the unit, either to the psychiatric nurse or the patient. Management cannot be blamed for psychiatric nurses’ inability to self-manage aggression effectively. However, the role of the management in doing little or nothing to show support to the psychiatric nurses who are battling with aggression cannot be ignored. They need to be aware of what is happening on the ground by questioning their own role. The introspection that the above participant is suggesting the management should have could enable them to understand their thoughts, feelings, and reactions in different situations about different aspects of themselves (Showry & Manasa, 2014:17).
5.4.2 The relevance of the model implementation met the psychiatric nurses’ expectations

Participants in the implementation of the model believed that part of the reasons why the implementation of the model was easy was because it met their expectations. They needed something to work with and when the opportunity was presented they made good use of it. This does not mean, however, that everything was rosy. As it will be seen later in these paragraphs some participants encountered challenges. For those who used the model positively, this is what they said:

This participant said:

“It was easy to implement the model as it advocates the therapeutic skills that are applied daily in the nursing care and are part of our scope of practice.”

Another participant added:

“The model interventions were accepted by all the staff in the ward and it helped where we tried the method of changing how we deal with choosy patients.”

The implementation of the strategies helped the participants put things in perspective. They already knew what needed to be done, but needed to hear it from a different source.

This participant said:

“It does not mean that we didn’t know a thing, but hearing it again from a different source and not from the management, gave us a challenge that had to be dealt with positively”.

5.4.2.1 The model answered to the psychiatric nurses’ workplace challenges

The challenges of psychiatric nurses in dealing with aggression differ as the psychiatric nurses themselves differ individually. Thus it goes without saying that even their experiences with the model implementation were different.

This participant said:
“*The implementation of the model helped us to understand better the situation we are in and what to do when dealing with aggression.*”

Another participant said:

*“We all come across all the problems that the model mentioned on a daily basis”.*

Another participant stated that the implementation of the model was bearing fruit:

*“The implementation of the model was worthwhile because more patients are getting better faster and granted leave of absence (LOA) and the statistics of those doing well outside increasing”.*

Although this statement could not be verified, as it was mentioned by one ward, the importance of health education regarding compliance with treatment and side effect of treatment and what the patient should do can make a big difference in enabling patients to comply with treatment at home.

This participant suggested that the model be supported and endorsed by the nursing management in the following statement:

*“This is the right direction, we are moving in, provided management show commitment and dedication to the wellbeing of the hospital and its personnel”.*

Another one said:

*“We felt that this tool (the model) is very useful, that if it can work as a hospital ‘thing’ and will definitely change for better”.*

5.4.2.2 The suggested interventions were part of what psychiatric nurses are supposed to do

The participants in the implementation of the model made the above observation based on the fact that the implementation of the model required nothing that was outside their daily task. They just needed to be reminded to assess their effort in connection with the outcomes.
One participant said:

“When they displayed aggressive behaviour, we tried to understand what triggered the behaviour and how best we could solve that problem.”

To achieve the expected outcomes something had to be done. This participant said:

“We also planned in-service training list for presenting these topics on the ward level.”

Another one added:

“We have started with monthly meetings after the ward round where we share ideas, raise concerns and try to iron-out problems.”

5.4.3 The model implementation increased awareness of the participants

The increase of self-awareness by the implementation of the model enabled the participants to read the situation correctly and to respond to it appropriately. To be able to do this, psychiatric nurses needed to know first what is happening internally, what is happening in their workplace environment and how they are responding to it. This propelled them to develop a sense of self and directed them to convert weaknesses into strengths by working on their ‘selves’ (Showry & Manasa, 2014:17).

This is how it was expressed by one of the participants:

“It does not mean that we didn’t know a thing, but hearing it again from a different source and not from the management, gave us a challenge that had to be dealt with positively”.

Psychiatric nurses were able to assess the situation objectively and to act swiftly when necessary. This participant said:
When the aggression was completely caused by being totally out of touch with reality, the best thing was acting decisively: giving sedation and secluding as per prescription. This was done in time before damage to property or injury to staff and other patients occurred.”

Another participant added:

“People became aware of how to handle day to day problems in the ward rather than becoming tired and developing an ‘uncaring’ attitude”.

Showry and Manasa (2014:18) are convinced that self-awareness of one’s goals, values, beliefs, traits, competencies, time horizons, and ways of acting, thinking, and feeling are the self-resources that guide effective leaders.

The implementation of the model was a dynamic process: it went through the stages that can only be identified by the participants as they look back.

This participant said:

“The first thing I did was to observe what was happening around me then I really saw that maybe we were not treating the patients as they should be treated”.

This participant observed that:

“Before I used this model, I was not aware how different our way of rendering care was. Then the model opened my eyes and made me see the things I was not seeing before, such as how difficult it is to have consistency in the team”.

One participant remarked that the awareness brought by the implementation of the model also brought some challenges that at times caused frustration before one realised what had to be done:

“When I saw something that was supposed to be done not done, I would do it but then it made me feel bad, something that did not happen before. Maybe it is because I was now aware that my fellow psychiatric nurses were not working as hard as they should”.
5.4.4.2 The increased awareness led to teamwork

The main contribution of the model implementation to the psychiatric nurses was to make them aware of the situation. Once this was done, psychiatric nurses who participated to this model implementation were able to devise means to deal positively with the situation through teamwork.

Five out of seven wards' received reports stated an improvement in teamwork while one team mentioned that they were still at a trial stage. One report stated that teamwork was non-existent. For those who believed that the increased awareness had led to teamwork, this is what they said:

"Team building activities, like having tea together with all the Multi-Disciplinary Team (MDT) members during ward rounds breaks were advocated and were successfully implemented".

The team members communicated often and this allowed them to discuss freely issues and to come up with an agreed upon strategy. Ma (2007:10-16) argues that poor communication skills and an unstable nurse-patient relationship can have a detrimental effect on patients’ physical and psychological health during the hospital stay. Bond (2012:129) believes that team building activities promote teamwork and collaboration and provide opportunities for team members to work as a cohesive unit to achieve a common goal.

This participant stated:

“In ward rounds, other multidisciplinary team members were asked to allow nursing personnel to be given chance to interview patients.”

In the team, everyone had a say and responsibility. This participant stated:

“In the ward, in-service training is provided monthly on a rotation basis by nursing staffs, so that every staff member has a chance to teach others.”
This participant is convinced that the implementation of the model has brought respect and cohesion:

“In the ward, we do not have a problem with teamwork now as everyone is involved and the doctors appreciate the input of any nurse.”

This participant added:

“To adapt the model implementation to the ward environment, we sat down as a team and agreed on what to do.”

This participant said:

“We used the model interventions on a daily basis by working together as a team and reminding each other to follow them when we felt we were not doing what these interventions say before we got used to them.”

From the above statements, one can deduce that teamwork was effective. According to Brennan, Bosch, Buchan and Green (2013:3) factors that are thought to influence team function are contextual, organisational, team, and individual. When individuals are referred to, an element of subjectivity also emerges. This may explain why where some participants are satisfied with teamwork while others do not even believe teamwork exists in their ward. Brennan et al. (2013:13) argue further that a team building is an important outcome of continuous quality improvement that may enhance the effectiveness of care. Teamwork is recommended as a core component for increasing the value of care (Frykman, Hasson, Athlin & Schwarz, 2014:3).

**5.4.3.2 The increased awareness led to improved quality patient care**

Psychiatric nurses being aware of what they ought to have done and how they should do it, they put to good use their knowledge and skills. Patients benefited from this new approach.

This participant said:

“We taught ourselves to talk and address the patients with respect, even when they displayed aggressive behaviour.”
One participant affirmed:

“At the end of the model implementation, nurse-patient relationships were improved. Aggression was reduced as there was more communication and respect between the two parties.”

Ma (2007:10) argues that psychiatric staff play an important role in providing both a secure base for patients whose attachment needs are activated during periods of distress and corrective experiences that disconfirm patients’ insecure ‘internal working models’ of attachment relationships thus enabling more secure ways of interacting with others.

The result of psychiatric nurses’ change in attitude and behaviour is fruitful. This participant stated:

“Patients began to develop trust towards nursing professionals, and became co-operative and less aggressive”.

Ma (2007:10-16) believes that part of the clinician’s task is to help clients to modify their strategies for approaching interpersonal relationships and regulating emotions, thus promoting more adaptive functioning. Using alternative means or strategies in order to prevent or reduce aggressive incidents is what Nice (in Price & Baker, 2012:310-319) calls de-escalation techniques. These techniques consist of a variety of psychosocial techniques aimed at reducing aggression and disruptive behaviour. Although research continues to identify staff–patient interactions as a frequent antecedent to assaults on psychiatric wards, Duxbury (in Price & Baker, 2012:310-319), it has also been found that staff skills, including, characteristics of effective de-escalators, maintaining personal control, and verbal and non-verbal skills help to gain the patient’s trust, making appeals for self-control more likely to be accepted (Duperouzel in Price & Baker, 2012:312).
5.4.5 The participants to the model implementation experienced mixed feelings ranging from empowerment to frustration

As mentioned above, some of the psychiatric nurse participants in this research study benefited more than others. It remains a question to be explored why some benefited, while others were frustrated by their colleagues who were not doing things right, according to them. The focus of this research, however, is on how the model was implemented and not on why some participants experienced frustrations.

5.4.4.1 The participants who had a feeling of empowerment also felt urged to share their new experience

Those whose experience of model implementation was positive acknowledged having worked on two aspects: respect and human dignity. Once the patients felt that they were respected and regarded as human beings with dignity, some of the behaviours that were defense mechanisms fell away and there was an improved relationship, trust and other mutual benefits. Psychiatric nurses were encouraged by the behaviour changes of the patients and were motivated to do more either for the patients or for their colleagues which improved the trusting work relationship. In the following paragraphs, I will discuss what benefits were gathered from the participants, starting with respect and dignity followed by an improved trusting work relationship.

- Respect and dignity

This participant said:

“Patients are treated with respect, ward rules and expectations are clearly explained on admission and constantly restated during breakfast; things like when to smoke and how to address problems without being aggressive.”
Another one added:

“When it comes to administering medicines, we did not encounter any problems because we have made it a point that we don’t argue with patients. We give the patient an option: if he refuses oral medication he gets an injection so at least they know what is at stake and it has been working so far.”

Respect and dignity can only be evaluated by knowing what these terms mean to the patient. Caspari, Aasgaard, Lohne, Slettebø and Naden (2013:2319) found that respect was an important part of being considered and it gave meaning to how the patients regarded themselves and their situation.

This other one said:

“Where respect is concerned, we are able to work on it in the ward by updating our patients and treating them with dignity.”

Edlund (in Caspari et al., 2012:2319), explored the concept of dignity empirically and found that it may be seen on three levels: (1) the concrete reality with an external relative dignity, that is, to be autonomous; (2) the experienced reality with an internal relative dignity, that is, to experience dignity through social relations; and (3) the ontological reality or absolute dignity, which may be found in responsibility, freedom, duty and service for others. Haddock (in Caspari et al., 2012:2319) found that dignity entailed a mutual understanding of one another’s humanity, along with an acceptance of each other’s unique personality. According to Caspari et al. (2012:2321), dignity is promoted and preserved under the following conditions:

1. when the patient becomes an active agent in the process of rehabilitation;
2. when the patient’s feelings and thoughts are respected;
3. when the family of the patient is included and listened to;
4. when the patients are free to make critical comments, to be themselves and to be autonomous;
5. when members of staff are able to cope with the patient’s disabilities and bring out the best resources the patient has; and
6. when the aesthetic environment is attended to and enhanced.

Part of showing patients that they are respected was for the psychiatric nurses to call them by their names contrary to what was happening before. This participant said:

“Patients were always addressed relevantly (by name) not according to their diagnoses or labelled as mentally ill patients”.

The shift from just doing the job but rather focusing on the patient and what they need is called patient-centred care and it is vital in defusing aggression. The person-centred care is beneficial to the patients as the outcomes include their satisfaction with care, improved health and their involvement in decisions relating to their care (Ma, 2007:10-16).

The participants, who engaged the patients and involved them in decision-making, reaped positive results. This participant said:

“By sitting with the patients and explaining to them what was happening, it made a huge change”.

The change in approach made patients feel valued and appreciated as human beings. This opportunity also allowed them to express themselves and take some of the decisions regarding their health. Pope (2012:35) has no doubt that when the patient is at the centre of care, the outcomes are beneficial to both patient and nurse. These outcomes include patient satisfaction with care, improved health and involvement of patients in decisions relating to their care. This requires that nurses who provide patient-centred care engage with individuals, work impartially with their beliefs and values and collaborate with other staff in the multidisciplinary team (Ma, 2007:10-16). At the end, the psychiatric nurse is also developed and satisfied to make a difference. Pope (2012:34) states that job satisfaction is achieved when nurses provide care because of personal motivation rather than doing what is
expected of them. Other benefits of person-centred care are increased patient satisfaction with the level of care, a reduction in anxiety levels among nurses in the long term, and promotion of teamwork among staff (McCormack & McCance, 2006:473). When patients' anxiety is reduced and the level of satisfaction is increased, the level of patients' aggression will also decrease as there is no reason for them to threaten staff members. The less the psychiatric nurses are worried about their own safety, the more they focus on the patients. After having involved the patients and having some assurance that they were safe in working in this environment, psychiatric nurses dedicated more time to caring for the patients.

Another participant said:

"More time is now spent with the patients in group activities”.

The allocation of time to the patients and listening to them is called the process of care (McCormack & McCance, 2006:474). These authors argue that the processes of care cover a wide range of nursing activities that constitute caring as perceived by patients and include providing for patients’ physical and psychological needs, being attentive, getting to know the patient, taking time, being firm, and showing respect (McCormack & McCance, 2006:474).

Price and Baker (2012:315) confirmed that aggressive incidents could be reduced by listening to patients, using empathy, and interpreting non-verbal cues; as these are considered to be useful in terms of accurate assessment of the individual’s emotional state and the formulation of appropriate interventions. An accurate assessment will also allow psychiatric nurses to involve patients in the decision-making concerning their health and beliefs as a continuation of person-centred care.

Another aspect psychiatric nurses worked on, and which seemed to bear fruit, was improving their working relationship with the patients as discussed below.
• Improved trusting work relationship

Psychiatric nurses who were encouraged by positive responses of the patients made an effort on their side so that the benefits gained could be sustained. Patients also did the same on their side and the outcomes were encouraging on both sides.

This participant said:

“I started being polite to the patients and found that actually it was not hard. Patients started reporting incidents to me whether related to fellow patients or staff. I gained their trust”.

Another one said:

“Mindset and attitude changing occurred when staff was satisfied. Often people are reluctant to work or cooperate because of being inadequately judged”.

Pope (2012: 35-36) believes that the nurse-patient relationship should focus on connection, trust, and understanding between two individuals, rather than on like and dislike. Nurses should know that they are caring for a person and that patients are at the heart of nursing culture. This is fundamental to the improvement of attitudes because the most powerful figure in the group decides what practice is acceptable, what it is not and when change needs to happen. When change did happen, patients' aggressive outbursts decreased. This is how one of the participants described it:

“Patients have begun to develop trust towards nursing professionals, and become co-operative and less aggressive.”

This other one said:

“Patients gained self-worth and became less frustrated, and displayed less aggression.”

By reassuring the patients, the psychiatric nurses enabled the patients to feel secure and less frustrated. Ma (in Berry & Drake, 2010:308) states that the role of mental
health professionals in facilitating the development of secure attachments has been acknowledged. The therapeutic relationship has been conceptualised as an attachment relationship that can provide a secure base for self-exploration and the modification of insecure attachment styles. Incidents of aggression were also reduced. This is the statement of one of the participants:

“Incidents were reduced: physical fights among the patients. In the previous months, the stitch pack was used every week in suturing injuries. Now it stays unused for close to two months.”

In this instance the reduction of aggression may be attributed to paying attention to what patients really needed. Secker, Benson, Balfe, Lipsedge, Robinson and Walker, (2004:175) have found that the apparent inability of staff to look at what is happening from the patient’s perspective can be the source of aggressive incidents.

In their research, Pulsford, Wright, Duxbury, Crumpton, Baker and Wilkins (2013:296) found that the attitudes and beliefs of staff regarding patient aggression will influence the management strategies they adopt. When staff and patients’ attitudes towards one another change, the dynamism of aggression also changes. The feelings that psychiatric nurses experienced were contagious. From the patients, they went to other members of the multidisciplinary team. This is what one participant said:

“Teamwork spirit is in the process, but we started with monthly meetings after the ward round where we now share ideas and raise concerns and try to iron-out problems.”

This participant said:

“Improved patients were identified and reported to MDT and advocated to be transferred to rehabilitation wards with less noise or to be granted LOA”.

The insight of the patients also improved gradually. In a sense the insight may not have been improved as perceived by the participants, but rather because of health
education that was regularly provided, patients came to understand their mental health condition and participated more actively in their recovery.

This participant said:

“Monthly health educations to improve patient's insight was given and recorded”.

5.4.5.2 The participants who felt frustrated attributed it to either negative staff attitude, lack of consistency in dealing with aggressive patients or lack of confidentiality

Individual people react differently to the same situation. The challenges that the participants who did not benefit from the model implementation met were met by those who benefited from the model implementation. What might have been the difference is the way they reacted to these challenges of the negative attitudes of their colleagues, the lack of consistency in dealing with aggressive patients and the lack of confidentiality. As Churchill said (Blinkiron, 2010:6): “The optimist sees opportunity in every danger; the pessimist sees danger in every opportunity”. Their experiences with the challenges are discussed below.

• Negative staff attitude

This challenge could possibly be attributed to the lack of communication or misunderstanding between staff members. The participants who complained about being called to ‘demonstrate their skills’ in handling aggressive patients might have been oversensitive in thinking that they were being put to the test by their colleagues who genuinely needed assistance. The colleague called them after realising that they were unable to deal with an aggressive patient and hoping that these colleagues would help. The psychiatric nurse might have interpreted it as being put to the test and then experienced frustration.
This is what one participant said:

“I became frustrated as I realised that all along I had been doing the work alone.”

This incident was expressed by the ward that was also struggling with teamwork building. This is what another participant said:

“There were those nurses who were negatively uttering statements like, ‘it will never work’”.

According to Price and Barker (2012:317), staff may feel vulnerable to criticism from their peers if they adopt a creative, autonomy-confirming approach that fails, whereas the negative consequences of adopting more restrictive measures might not be as immediately apparent.

- Lack of consistency in dealing with aggressive patients

The lack of consistency in dealing with aggressive patients was also mentioned as a stumbling block in the implementation of the model. When one psychiatric nurse initiates the change, another one will come and start over instead of continuing where the other left off. This participant mentioned that:

“The only problem is consistency amongst the nurses towards patients. Because of this problem of consistency among staff members, change is difficult and patients are divided.”

This participant added:

“Staff needs to be educated on consistency as it is still a challenge”.

One of the participants clarified what inconsistency meant in this way:

“Nurses seemed to overdo measures when enforcing order, then patients felt threatened and that made them more aggressive.”
The illustrative example mentioned is where a patient spent eight hours in seclusion while it was prescribed for two hours. Another participant equated the inconsistency to a sickness that the hospital is suffering from in these words:

“The sickness of X hospital (the name omitted for confidentiality reasons) is just inconsistency and negativity that are orchestrated by laissez-faire management”.

• Lack of confidentiality

Lack of confidentiality in this context is related to the lack of trust among the staff and the nursing management. The lack of trust between employees and the wellness committee is a challenge at the psychiatric institution. Working in an environment where aggression is experienced on a daily basis, whether personally or as a witness, and not being able to debrief anyone can only yield negative results.

This participant said:

“Staff experience traumatic events when in the hospital, working or residing in hospital premises but nobody cares. Instead gossip comes from the management offices.”

Another one said:

“People have grown professionally and the hospital made sure they appoint someone for wellness, but most people don’t use the resources because they feel there is still a lack of confidentiality. So they deal with their issues their own way”.

The lack of trust in the institution’s services could explain the use of ineffective coping mechanisms such as abusing alcohol (Bimenyimana, 2008:47). It also allows a blaming game and triggers feelings of incompetency. Some psychiatric nurses start wondering why they are unable to self-manage aggression while others can do this.
According to Vander Elst, Van den Broeckb, De Witte and De Cuyper (2012: 252-571), the above-mentioned psychiatric nurses may be suffering from competence frustration that occurs when employees feel as if they are ineffective and cannot achieve the desirable goals in their work.

5.4.6 The implementation of the model met with some challenges

The challenges mentioned here are different from the frustration that some of the participants experienced while implementing the model. These challenges originated from factors over which the psychiatric nurses did not have control. These factors are: the unpredictability of patients’ aggression, the lack of proper facilities and a shortage of staff that leads to mixing all types of patients, the lack of resources, and the lack of support from the nursing management.

5.4.5.1 Unpredictability of patients’ aggression

The unpredictability of patients’ outbursts and aggression will always be an occurrence in a hospital that admits patients based on the levels of disruption. However, psychiatric nurses cannot ascertain who will be more or less disruptive among the psychotic patients whose mental status can change from minute to minute.

This participant said:

“The handling of aggressive patients is not easy, for instance a patient may start to break windows without prior signs... there is no time to explain to them, but to try and stop them... you ask them to stop, they don’t even look at you”.

In their research, Ketelsen, Zechert, Driessen and Schulz (2007: 94) found that there were also incidents of aggression whose exact cause could not be established or identified either by the nurses as victims or by the patients as perpetrators.

5.4.5.2 Mixing of all categories of patients

Mixing all categories of patients in one ward: psychotic and a-psychotic patients does not make the effective management of aggression easy. In some instances,
this mixing of patients is a source of aggressive incidents. When patients are overcrowded and personal space is invaded the environment can be conducive to aggression.

As this participant stated:

“To accommodate both stable and unstable patients is still a challenge. We have few activities in the ward and rehabilitation wards are full”.

5.4.5.3 Lack of resources

The resources needed or indicated by the participants during the implementation of the model were multiform: structural, financial and human. In the statement below, the participant laments that a patient escaped from the unit by jumping over the wall and blamed the staff for the escape. However, if the infrastructure had not tempted the patient to jump, if there had been enough staff on duty, the chances of patient jumping would have been minimal.

This is what the participant said:

“For instance one observation patient decided to jump over the wall while everyone was watching helplessly but at the end we got warnings (from the nursing management). We ended up not knowing whether we were trained to jump or to nurse and that frustrates us.”

According to Frykman, Hasson, Athlin and Schwarz (2014:15) the allocation of resources for ongoing problem-solving and adaptation is an important factor in an effective solution to the problem.

5.4.5.4 Lack of support from nursing management

The following statements show that psychiatric nurses do not have trust in their nursing management and actually consider it as part of the problem in self-managing aggression. Whether these perceptions are founded or not, the fact remains: management must try to reassure psychiatric nurses of their support. Otherwise no intervention will last in a climate of defiance between the psychiatric nurses and their
nursing management. These are the statements made by psychiatric nurses with regard to their perceived lack of support from the nursing management:

This participant said:

“**You cannot expect management to take you for debriefing or listen to your side of story when there is an incident because all they know is that you must work and not complain.**”

And this one said:

“**Also we do have meetings with management but most of the time they make decisions.**”

Another one added:

“**There is a lot of favouritism in the hospital and other peoples’ opinions are not taken into consideration.**”

This one adds:

“**Nobody cares, instead gossip comes from the management offices, and criticism which lowers their morale.**”

This participant stated:

“**Managers gossip about us and they favour their friends and relatives.**”

For the psychiatric nurse to continue the fight against aggression, the management needs at least to acknowledge their efforts. Gutierrez, Candel and Carver (2012:1603) argue that the organisation’s positive appraisal of its employees has been linked to positive affect, job satisfaction, reduced stress, and greater job involvement.
5.5 THE PSYCHIATRIC NURSE PARTICIPANTS’ EXPERIENCE OF THE MODEL IMPLEMENTATION

“The process that took place to record the experience of the participants to be collected as data has been discussed in this chapter (see section 5.2.3).

From the main question “What was your experience like when using this model implementation in dealing with aggression?”, the researcher guided the participants to elaborate on the main question based on the following five sub-questions:

1) Was the model understandable?
2) Was the model easy to implement?
3) Was the model relevant?
4) Was the model useful?
5) What is your overall impression of the model?

There was no limitation imposed concerning how long participants could express themselves. The purpose was to collect firsthand the individuals’ experiences with regard to model implementation and whether there had been any improvement in their way of dealing with aggression. All the participants responded that the model was understandable, easy to implement, relevant and useful. There were, however, participants who found the model difficult to implement due to their colleagues’ attitude that discouraged them, they said. In the end, they all agreed that the model would be a helpful tool to deal with aggression if it was supported and endorsed by the nursing management. I now return to a brief discussion of the five elements on
which the participants shared their experiences before giving their overall impression.

5.5.1 The model was understandable

When the researcher asked the question whether the model was understandable, his intention was to know whether the way in which the model was structured, its process and content both theoretical and clinical were coherent and that participants were able to comprehend them easily.

The participants stated that the model was understandable as they were able to follow its process and implement what it required with minimal or no difficulties. Where the difficulties arose, it was mainly because of the unit culture and work style adopted by the team and not because the participants did not understand what was supposed to be done. Individual characteristics also played a role where at a first challenge or discouragement they decided to give up, while others shared the challenging experience with the advanced psychiatric nurse practitioner. For these participants who were open and were not discouraged by colleagues’ attitudes, they grew stronger and benefited fully from the model. For those who gave up, it was easier for them to attribute it to the ward environment and to play what appeared to be a blaming game.

This participant said:

“The model’s strategies were understandable and we used them on a daily basis”.

Another participant stated:

“This model equipped us with skills and knowledge on how to work with psychotic patients”.

5.5.2 The model was easy to implement

The application of the model was enhanced by its relevance to the participants. By ‘easy to apply’ the researcher wanted to know whether the alternative means to self-manage aggression effectively could be easily applied or adjusted to the ward context and bring about the expected outcomes. The participants responded that, depending on the circumstances some, of these alternative means were easily
applicable while others were not. The researcher noted, however, that those alternative means judged to be not applicable were those that needed more time to be implemented. The participants focused on the short-term goal and immediate response such as in-service training in communication skill whereas those for long-term goals such as building teamwork took longer and were judged difficult to apply.

This participant said:

“Some areas of the model worked more than others such as in-service training.”

As for the relevance, this participant said:

“It was easy to implement the model strategies as they are the therapeutic skills that are applied daily in the nursing care and are part of scope of the practice.”

5.5.3 The model was relevant

The relevance of the model is also linked to the usefulness aspect of the model. Psychiatric nurse were motivated by the expected outcome: they had been struggling to self-manage aggression effectively. The promise of finding a solution to the challenge of aggression was enough to ignite the desire and the commitment to change. Beyerlein, Beyerlein and Kennedy (2006:116) believe that useful and meaningful information is the lifeblood of the organisation. Once the participants believed that the information provided on the effective self-management of aggression was relevant and meaningful, their attitude changed and what had been a challenge became a possibility. They decided to commit knowing that things would not turn around immediately, but they were ready to face the challenge. When the participants’ attitude changed, the environment also changed. When the participants changed their perceptions toward aggressive patients, their way of handling them also changed and so did everything around them. Prilleltensky and Prilleltensky (2006:106) argue that well-being is not about achieving perfection in relationships, resourcefulness, or working environment. It does not require being joyous and optimistic at all times; it is more about thriving and flourishing rather than simply avoiding difficulties.
This participant said:

“We all come across all the problems that the model mentioned on a daily basis.”

Another participant added:

“This model equipped us with skills and knowledge on how to work with psychotic patients.”

5.5.4 Usefulness of the model

Usefulness was linked by the participants to how the model implementation answered to their aspirations. In their own words, the participants said that the model was useful and pointed in the right direction.

Ben-Shahar (2011:205) argue that what people focus on determines whether they lead an active or a passive life. When the psychiatric nurses started implementing the model they shifted the focus from the problem to the solution and all their effort centred on getting something positive out of the model. For those who had a positive attitude, they started being creative as they changed their perspectives by seeing the situation from another point of view. This allowed them to develop an understanding of the situation by appreciating the different elements (Thompson, 2009:66).

This participant stated:

“This model is very useful in a sense that patients are more relaxed and they are able to report if there is something wrong, either with fellow patients or they feel ill-treated by staff members.”

Another participant added:

“I am happy about it as I do not anymore wake up in the morning wondering whether I should go to work or not.”
5.5.5 The overall impression of the model implementation

The model was implemented in the context where the psychiatric nurses were working and focused on the real challenges that they were faced with. It is for this reason that the participants identified the practical relevance of it and were able to also notice the influence the model implementation created. All the participants wished to see the model being endorsed by the management as part of policy on the management of aggression.

The model was devised and implemented in accordance with the agreed upon process between the researcher and the participants. The change took place as the psychiatric nurses participants gained a better understanding of the environment and their active or passive role in the management of aggressive incidents. This change led to improved teamwork and as a result, the quality of patients’ care also improved. The maximisation of human potential and utilisation of available resources, coupled with the effort made by the advanced psychiatric nurse practitioner, made a difference in changing workplace environment. The management supported the effort by allowing the advanced nurse practitioner to bring the model to the psychiatric nurses and by allowing the participants to use their own initiative and innovation in bringing about the change.

In implementing the model to facilitate the effective self-management of aggression, the psychiatric nurses saw their attitude and behaviour towards the patients changing. This was enabled by an increased awareness on what was supposed to be done and how it was supposed to be done. The more the psychiatric nurses felt they were doing the right thing, the less frustrated they became in dealing with aggressive incidents constructively. Drach-Zahavy, Goldblatt, Granot, Hirschmann and Kostintski (2012:44), found that many acts of aggression on wards occurred following frustration, rule imposition by staff, or following misinterpretations of the patient. As a result, both staff and patient were coping with a perceived threat presented by the other in the interaction, in the context of uncertainty about the other’s behaviour (Drach-Zahavy, Goldblatt, Granot, Hirschmann, & Kostintski, 2012:44). Once the threats had been alleviated on both sides, the environment became less threatening and patients became less aggressive. Drach-Zahavy, Goldblatt, Granot, Hirschmann and Kostintski (2012:50) argue that the healthcare
providers’ attribution of their own as well as the patients’ controllability triggered four distinct experiences of the aggressive event: power struggle, therapeutic encounter, inverse power encounter, and victim-to-victim encounter.

A high-level of controllability suggested that the healthcare provider perceived that they had power to modify or prevent the aggressive encounter while high-level patient controllability denoted patients who behaved with deliberate aggression to pursue their drives and to have their way, and to reestablish justice in the situation (Drach-Zahavy, Goldblatt, Granot, Hirschmann & Kostintski, 2012:44-46).

The change of environment is not magical. It requires both staff and patients to work tirelessly on their commitment to sustain and enhance the achieved results. This implies that psychiatric nurses should consistently be aware that the challenge of aggression is still there and improve on their skills, as different patients bring in different types of aggression. Thompson (2009:3) believes that greater awareness brings self-confidence a tremendous source of strength enabling one to operate from a much stronger position. Self-awareness also enables one to face the world objectively, having a clear acknowledgment of what is happening (Kabat-Zinn in Ben-Shahar, 2011:51).

Being in control of the situation is vital in the self-management of aggression as it reduces stress and allows one to focus. Prilleltensky and Prilleltensky (2006:115) are of the opinion that the stress of a job does not depend on the nature of the job as much as it depends on whether workers believe that they have the ability to control the stressful aspects of the job. Being in touch with oneself and the environment is key to a life of choice and freedom. According to Prilleltensky and Prilleltensky (2006: 116), human beings strive to have control over their lives and destinies and this can only happen in environments where voice and choice can be exercised. This participant said:

“Overall I feel that a whole lot has changed in my working experience.”

Another one stated:
“This is the right direction we are moving in provided management show commitment and dedication to the well-being of the hospital.”

In concluding, the researcher encourages the participants to be aware that the effective self-management of aggression is a lifelong process. In this struggle, psychiatric nurses should take joy in maximising their potential to the fullest extent and a sense of fulfilment for being all that they can be (Johnson, 2006:399). Because, as Ben-Shahar (2011:106) puts it: “to fail and succeed is part of a full and fulfilling life, and to experience fear, jealousy, anger, and at times, to be unaccepting of ourselves is simply and perfectly human”.

5.6 SUMMARY
In Chapter Five the implementation of the model to facilitate effective self-management of aggression experienced by psychiatric nurses from patients was discussed. The implementation of the model and its evaluation by the participants were also discussed with accompanying verbatim quotes and relevant literature. In the next chapter, Chapter Six, limitations and recommendations of this research study are discussed.
CHAPTER SIX: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In the previous Chapter Five, the implementation of the model to facilitate effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution was described, as well as the participants’ experience of the model. This chapter aims at providing conclusions, limitations and recommendations. The conclusions are based on the process of the model development and implementation. The limitations focus on the challenges that the researcher encountered during the research study and the impacts these may have had on the findings. The recommendations state what the researcher believes should be done, by relevant stakeholders in the future, for further improvement of the effective self-management of aggression that will also lead to better mental health of the psychiatric nurses and better service delivery.

6.2 CONCLUSION OF THE RESEARCH STUDY

The overall purpose of the research study was to develop, describe, implement, and evaluate a model that can be used as a framework of reference for the advanced psychiatric nurse practitioner in the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution as an integral part of the mental health of psychiatric nurses exposed to aggression by patients. The objectives of the model were to analyse the findings of a research project conducted by myself to identify, define and classify concepts to be utilised in the model; to describe relationships between concepts; to develop a model to facilitate effective self-management of aggression in a psychiatric institution and to implement and evaluate the model and to formulate recommendations.

“Life is a mixture of great joy and great sadness, of hope and despair. Finding a balance between positive and negative can be very difficult, but it is a very worthwhile process” (Thompson, 2009:85)
In order to achieve the above-mentioned objectives, I used a qualitative, exploratory, descriptive, contextual and theory-generating design. For the model development, four steps were utilised. The first step entailed concept analysis, which involved the identification and definition of the central concepts. The second step comprised the classification of the concepts and the establishment of the relationship statements between the concepts. The third step focused on the description of the model and step four described the implementation of the model and the experiences of the psychiatric nurses who participated in the research study and who implemented the model. A brief description of these four steps is provided in the following paragraphs.

**Step one:** during this step that comprised the concept analysis, the central concept was identified and defined. The identification of the central concept was based on the findings of my Master’s research study, “The lived experience of aggression and violence by psychiatric nurses working in a psychiatric institution” (Bimenyimana, 2008:37-54). Different themes and categories were analysed. Based on the analysis, it was found that psychiatric nurses working in this psychiatric institution experience a high level of aggression. This aggression takes all forms from verbal aggression and threats to physical assaults and damage to properties. In order to cope, some psychiatric nurses retaliate, others absent themselves from work claiming that they are sick even when they are not. Other choose to abuse substances such as alcohol and marijuana while others prefer to develop an ‘I don’t care attitude’ and do not get involved at all with the patients. All these means are judged to be ineffective as in the end the aggression is still there. This showed that there was a need for effective self-management of aggression and to arrive at this effectiveness some help was needed. The central concept of the model was then identified as “The facilitation of effective self-management” of aggression by psychiatric nurses. After the central concept had been identified, it was then defined by the use of dictionaries (both hard copies and online dictionaries) and other sources from different disciplines such as psychology and other social sciences that treated the above-mentioned concept. The dictionaries defined the concept in its general usage, while the subject definition focused on the meaning in relation to this research study. The concept facilitation of effective self-management of aggression was then defined as “a dynamic interactive process through which the advanced psychiatric nurse practitioner
guides and provides assistance to the psychiatric nurses in order to make it easier for them to take actions for the needed change. Psychiatric nurses are facilitated to utilise operative means and to take responsibility aiming at producing the intended result, that is, the management of aggression. Through the process, the psychiatric nurses are able to regulate their emotions and to take control of the workplace environment in effectively self-managing aggression from patients”. After the definition of the central concept, the concept’s essential and related attributes were also defined. Later on, relationships between the statements were identified and described.

Step two: during this step, the concepts were classified and the relationships between the concepts were established. The interrelatedness of the concepts, based on their definitions, to form the whole of the model was described.

Step three: during this step, the model for the facilitation of effective self-management of aggression experienced by the psychiatric nurses working in a psychiatric institution was described. The model that served as a framework of reference to the advanced psychiatric nurse practitioner, was described in two phases: phase one described the structure of the model and phase two described the process of the model. The structure of the model described the purpose of the model, the assumptions on which the model was developed, the theoretical definitions of the model and the relationship statements. This structure was evaluated by my research supervisors and by a panel of academic researchers. Suggestions were made and followed until there was an agreement on the final structure was reached. The process of the model described the three phases that the researcher used for model implementation. These three phases were: the relationship phase, the working phase and the termination phase. I took the initiative and engaged with the psychiatric nurses in the workplace environment to participate in the model implementation. This was the beginning of the relationship phase of the model for the facilitation of effective self-management of aggression experienced by the psychiatric nurses working in a psychiatric institution. After obtaining all the legal and ethical clearances from the relevant authorities: the psychiatric institution and from academic institutions concerned, the researcher embarked on a process of creating rapport and building a trusting relationship. The researcher used formal and
informal, individual and group meetings to convey the message of hope to prospective participants.

The relationship phase engaged the psychiatric nurses on the road to self-discovery. This was achieved through engaging the psychiatric nurse participants to redefine the concept aggression in the context of their workplace: what it meant, how it occurred, what its possible causes were, how it was managed, and how it affected them and their work. The new understanding of the concept aggression and the challenges in self-managing it effectively were identified. Psychiatric nurses were also challenged to check whether their current belief, understanding, and reaction to aggressive incidents decreased or increased the likelihood of recurring aggression. Through interactive discussion, the psychiatric nurses discovered that there were alternative means that they had not yet tried in dealing with aggression. This phase ended when psychiatric nurses believed that aggression could be managed effectively and that they had what it takes and were willing and committed to trying new means or strategies in dealing with aggressive incidents.

During the working phase, the psychiatric nurses implemented the model based on identified challenges and the strategies to counter these. The four identified areas where improvement was needed were the understanding of self and the impact of being or not being aware of one’s reactions in the face of aggression; communication was also identified as a challenge where some attitudes from the staff not only fuelled but also provoked patients; the ineffective management of stress and conflicts also affected their reactions reaction when dealing with aggressive incidents. Psychiatric nurse participants had six months to try these alternative ways or strategies in dealing with aggressive incidents effectively. After this period, they were asked to share their experience with the researcher through naïve sketches as this was the preferred method by the participants.

During the termination phase the psychiatric nurses who had actively participated in the implementation phase and were willing to share their experiences were given an opportunity to do so. They were enthusiastic and confident and gave positive feedback. As they shared their experiences, the advanced psychiatric nurse practitioner affirmed them and started the closing stage. As the psychiatric nurse
participants showed a sustained commitment to holding on to the expertise gained and to improving where improvement was still needed, the advanced psychiatric nurse slowly withdrew from the process so that psychiatric nurses could take control and ownership of the effective self-management of aggression and decide on the way forward.

**Step four:** during this step the focus was on the implementation of the model and the participants’ experiences after the implementation. Practically, step four was included gradually in step three. The reason for this is because the exchange of information, the assistance and the guidance provided by the researcher did not happen in one day. It was a process involving three months preparation and six months implementation. When the psychiatric nurses were aware of what was wrong in communicating with the patients, for instance, they did not wait for aggression to happen so that they could use the skill, but rather used the skill to prevent the incident from originating there. The implementation consisted of putting to good use the alternative means that had been identified as possible answers to the challenge of aggressive incidents. This started happening in the relationship phase when the focus was on understanding aggression in the context of the psychiatric institution.

When the six months for effective implementation had elapsed, the researcher collected the data using naïve sketches as these appeared to be the best way to get the psychiatric nurses’ experiences with the model. Data was collected from those participants who had initially given consent for interview and the sharing of their experiences. It was initially planned that I would do focus group but due to the shortage of staff in the wards that hampered the availability of enough participants for interviews, the participants and I opted for naïve sketched. These naïve sketches were written on the ward level by all the participants in the same ward. When the naïve sketch was ready, the leader in the ward phoned the researcher and the researcher came and collected it. Some of these naïve sketches were typed others were hand written. The researcher typed them all in one document and a copy was sent to the independent coder for data analysis purposes. At the end of data analysis, independent coder and I met after having exchanged electronic mails. During the face to face encounter, the independent coder and I discussed the themes and categories and came to a consensus. The results showed that psychiatric nurse participants had benefited from the model implementation mainly
based on introspection and self-awareness. This self-awareness enabled them to see objectively what was happening in the workplace, and to recognise their involvement or non-involvement in dealing with aggression. The psychiatric nurses then used their strengths and worked on their weaknesses. The results were encouraging: the psychiatric nurses gained confidence in handling aggressive incidents, there was improvement in team work and this led to an improvement in patients’ care and their mental status. The evaluation of the implementation by the participants was done based on their experience during implementation and outcomes as discussed in Chapter Five, paragraph 5.4. The objective of the model was to facilitate the effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution. This goal was reached as the nurses gained power to control the workplace environment, which enhanced their confidence. With enhanced confidence, psychiatric nurses’ mental health improved, the teamwork improved, the patients’ care improved and aggression was reduced.

6.3 LIMITATIONS

Various limitations linked to the research study range from the structural environment where the research was done to the collection of data from the participants. Some of these limitations were discussed in Chapter Five, especially those with regard to the focus group meetings and data collection methods. The discussion below is for other previously unmentioned limitations.

6.3.1 Structural environment

Structural environment in this case means the structure in which the institution functions that does not facilitate professional nurses to attend meetings. The shortage of staff, mostly the psychiatric nurses, is a constant problem. In a ward of 40 patients one finds for example that there are five professional nurses who are shift workers. Among the five, there is one on night duty and one on night-off for seven days. The three professional nurses left work alternatively. The maximum one can have would be two psychiatric nurses per shift. With patients’ care, administration and supervision of juniors and the teaching of students, and the attendance of ward round, it becomes quite difficult for them to attend meetings. The
fact that the researcher had to meet them in action deprived them of a calm and quiet environment, away from the patients, where they could relax and feel comfortable.

6.3.2 Type of participants

I would have preferred to have all the prospective participants in the same room at the same time in the beginning of the model implementation and at the end for evaluation. This would have increased the richness of each participant’s experience in group participation. The researcher cannot be sure that he got the best that the institution possesses. The meeting with the participants in their unit was not ideal either. Due to the level of noise in acute units, at times the environment was not favourable for interpersonal dialogue. The postponing and the constant repetition of the same information to different psychiatric nurses working in same wards might have limited or distorted information that had already been passed on to others before. In the end, the researcher’s choice of the participants was limited to the available psychiatric nurses.

The exclusion of other categories such as cleaners, who were mentioned as lacking in information about mental health illnesses, limited the information to psychiatric nurses. The experience of these other categories might have added another dimension as they also interact with patients on daily basis. Yet, the direct involvement of those not trained in mental health nursing and their interaction with the patients can make or break the psychiatric nurses’ efforts to self-manage aggression effectively.

6.3.3 The workplace environment for the researcher

The fact that the researcher is working in the same institution was a challenge and a limitation. In the beginning the psychiatric nurses were skeptical of the researcher’s motive. Some participants initially thought that the researcher was acting as an informer for nursing management while others thought that now they had an opportunity to get even with management hoping that I was on ‘their side’. Some members of management also questioned why the researcher chose their institution. I faced the challenge head on and stayed as objective as I could. It is also not easy
to have a total bracketing when one asks a question and the participant replies: “How can you ask that that question? You know how it is here”?

6.3.4 The working environment of the participants

The participants, regardless of their gender, worked in male units be it in forensic or acute. This limited the data collection to the aggressive incidents from male patients only. The experience of female aggression in the institution would have added to the research findings. The male psychiatric nurses, in this institution, are not allowed to work in female wards. Their experience of aggression is consequently limited to male patients only. Therefore, the researcher does not know whether the implementation of the model in female wards was effective as those participating there did not share their experiences.

6.3.5 The use of English as medium of communication

The use of English, which is not the first language, for both the advanced psychiatric nurse practitioner and psychiatric nurses, may have limited the richness of expressing what a person feels in his/her first language. Some thoughts and feelings cannot be translated from one language to another. The language spoken in the area is Sitswana. The researcher would have loved to discuss issues with participants in Sitswana, but he does not understand it.

6.3.6 The scarcity of information on aggression self-management in the South African context

There are very limited sources of information in Chapter One regarding aggression and its self-management in the South African psychiatric institutions. Even with the help of qualified librarians the researcher could not obtain the information he needed. The supporting literature that was used during the discussion of the research results is based on international findings and is limited, given the fact that the context may differ in a number of ways.
6.3.7 The method of data collection

I would have preferred to conduct a focus group or conducted in-depth interviews where I would have explored, clarified and probed. I have already mentioned that at the end of the implementation, when the participants were given options to choose from, they decided to write naïve sketches at ward level. There is a possibility that the participants might have edited their experiences while writing the naïve sketches. The participants reported mostly positive experiences as if there have not been any challenges. I would have explored on this during in-depth interviews.

6.3.8 The researcher serving also as interventionist

The purpose of starting an enterprise or a project is to see it succeed. The purpose of developing a model is to bring an answer to inherent challenges. It is difficult for the researcher to develop a model and evaluate its implementation without a potential possibility of bias. It is therefore recommended to future researcher who may use the model to be aware of the above remark.

RECOMMENDATIONS FOR NURSING PRACTICE, EDUCATION AND RESEARCH

The recommendations about the model to facilitate effective self-management of aggression experienced by psychiatric nurses working in the psychiatric institution where the research was conducted are made to the nursing practice, nursing education and nursing research.

6.4.1 Recommendations for psychiatric nursing practice

Working with psychiatric patients is physically, mentally, and emotionally exhausting. When these psychiatric patients are aggressive, it becomes even more exhausting. The model for the facilitation of effective self-management of aggression experienced by psychiatric nurses working in a psychiatric institution can help in reducing some levels of aggressive incidents. In an environment where the shortage of staff is also a problem, the model can enable psychiatric nurses to utilise constructively the human resource and material at their disposal for the improvement of their mental health and the quality of care to the patients.
This model can also be included in the induction programme for the newly appointed psychiatric nurses. Mentoring them from orientation onward will have a lasting result as they will self-manage aggression effectively from day one, or at least they will learn how it is managed effectively. This research study showed that when psychiatric nurses are able to deal with aggressive incidents positively, they take initiatives, readjust to the environment, and patients respond positively to the psychiatric nurses’ interventions. The outcome is that aggression is reduced, patient care improved, and psychiatric nurses experience better mental health.

To sustain the gains of this research study, there is a need to improve communication at all levels: from the nurses to the senior nursing managers. During the model implementation and evaluation, it became very clear that some psychiatric nurses either do not know how to channel their feelings or the environment is not open enough to allow the expression of feelings. The model would help in facilitating awareness of self and environment and helping those who lack skills in conflict management and stress management. What affects the psychiatric nurse emotionally will definitely affect them professionally. Workshops and in-service training are needed in line with the model so that care providers can be assisted.

The wards are overcrowded with patients. Mixing recovering patients with florid psychotic ones hampers psychiatric nurses’ efforts in providing a better and improved quality of care to the patients. When the focus is on preventing injuries and damage to patients and properties, there is little time left for health education on life skills and compliance. There is a need for reinstating community psychiatric nurses as these can be a link between the clinics and the hospital and could reduce a number of unnecessary admissions and relapses of those patients who would be rehabilitated in the community if they were properly followed. This would reduce the ward load of psychiatric nurses in the psychiatric institution.

Lastly, it is a fact that no amount of knowledge, skills and competence can enable one person to accomplish a task meant for two people. While the researcher acknowledges the problem of staff shortage, he recommends that those with power and responsibility use all means possible, first to retain the experienced psychiatric nurses they have, and then try to recruit more. One psychiatric nurse cannot run
individual and group therapy and at the same time, supervise juniors, teach students, and still do administration and fulfil all other requirements.

6.4.2 Recommendations for psychiatric nursing education

The model to facilitate effective self-management of aggression experienced by psychiatric nurses in a psychiatric institution is recommended to be part of the curriculum in training institutions. The practical relevance of the model could assist students during their practical training in the institution. This model has shown that part of succeeding in self-managing aggression is being in touch with self and environment, and knowing the interaction between the two. This model could prepare students to their future role as professional nurses and empower them on how to manage stress and conflict in the workplace environment, starting with effective communication.

6.4.3 Recommendations for the psychiatric nursing research

It is recommended that this model be used in other areas such as private settings or other institutions where psychiatric nurses are faced with the same problem of ineffective self-management of aggression.

It is also recommended that the model application be researched further with different contexts and different methods.

The participants in this research study stated that the model improved nurse-patient relationship, made the patients recover more quickly and enhanced teamwork. Further research in these areas is recommended.

Finally, I would recommend that further research be done to elucidate what creates concern in some psychiatric nurses about the environment they are working in while others are unmoved and seem to experience as normal what everyone else finds abnormal.

6.5 SUMMARY

This chapter’s aim of justifying the study, the purpose, and the objectives of the research study has been achieved through the discussion in detail of the mentioned subtitles. The model to facilitate effective self-management of aggression
experienced by the psychiatric nurses from the patients was developed, implemented, and evaluated. The limitations and recommendations of this research study were also highlighted.

6.6 ORIGINAL CONTRIBUTION

The developed, implemented and evaluated model is a significant contribution to the body of knowledge of psychiatric nursing and mental health. The model to facilitate effective self-management of aggression experienced by psychiatric nurses in a psychiatric institution offered alternative means in dealing effectively with aggression. As a result, it enabled psychiatric nurses to grow personally and professionally. The psychiatric nurses who participated in this research study were able to assess aggressive incidents timeously and to act decisively. This enhanced their confidence, they worked as a team, and spent more time with the patients. Patients appreciated the care provided, became more trusting and less aggressive. The results were job satisfaction, self-discovery and an improvement in the quality of patient care. The focus became better mental health for all in spite of the existence of aggression.

6.7 CONCLUSION

Aggression in the institution is real and affects psychiatric nurses physically, psychologically, emotionally, and spiritually. It hampers psychiatric nurses’ efforts in rendering the best kind of care to the psychiatric patients. The model to facilitate effective self-management of aggression has proved that it can bring relief to the psychiatric nurses if it is implemented with willing and committed psychiatric nurses. The participants in this research study stated that the alternative means used in the implementation enabled them to be closer to the patients and to treat them with respect and dignity. The patients responded by decreasing the frequency of aggressive incidents and getting better more quickly. Teamwork improved and everyone was satisfied. It is hoped that the psychiatric nurses will hold on to the gains they have made and take them to the next level.
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www.performwell.org


ANNEXURE A

APPLICATION LETTER REQUESTING PERMISSION TO CONDUCT A RESEARCH PROJECT IN THE PSYCHIATRIC INSTITUTION
24 February 2010

To the Chief Executive officer of Sterkfontein Hospital
Private Bag X2010
Krugersdorp
1740

Dear Sir/Madam

Re: Request to conduct a Research Study in your Institution

My name is Emmanuel Bimenyimana. I am currently registered with the University of Johannesburg for the doctoral degree in advanced Psychiatric Nursing Sciences. In order to fulfill all the requirements for this degree, I intend to conduct a research study and write a thesis supervised by Prof M Poggenpoel and co-supervised by Prof CPH Myburgh, both professors at the University of Johannesburg.

The title of the research study is "A MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY NURSES IN A PSYCHIATRIC INSTITUTION".

I hereby request authorization to conduct this research within the jurisdiction of your hospital, which research intends to enable nurses faced with the challenge of handling aggression and violence to manage it effectively. I will request permission from those professional nurses willing to participate in this research study, once I have got yours.

The research process consists of three phases of which the first deals with the description of a conceptual framework; the second with description of the model; and the third with implementation and evaluation of the model.

In order to fulfill the implementation and the evaluation of the model, individual interviews and focus groups will be utilized and be audiotaped with permission of the participants. These will be approached in due time, once all the required procedures have been met.
The research proposal was submitted to the ethical committee of the University of Johannesburg and ethical clearance has been granted before proceeding with the research. The period of implementation will be six months. The duration of the research study is three years starting from the registration day.

I undertake to adhere to ethical standards and academic requirements of research projects. The following principles will be respected:

- Participants will freely sign an informed consent before the beginning of interviews
- No name will be mentioned during interview or after, during transcription and coding;
- The audio-tapes will be kept under look and key. Only the researcher, the supervisors, and the independent coder will have access to the audio-tapes. The audio-tapes will be destroyed two years after publication of the research.
- All information received will be treated professionally with respect to confidentiality and privacy;
- In this research study no harm is foreseen, however, should the reliving of the experience of aggression and violence provoke a crisis, referral to a psychotherapist help is available;
- Participants may decide to withdraw from the study at any time without fear of persecution or punishment.
- The results of the study will be made known to the participants and a copy will be made available to the nursing management of your institution.

Please indicate your response in writing as this constitutes a legal proof that permission has been granted to conduct the research study in your institution.

Thank you in advance for your cooperation and assistance.

Yours truly,

Emmanuel Bimenyimana.

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Fax: 011 951 8205
Email: emmanuel.bim@gmail.com

Promoter: Prof. Marie Poggenpoel, PhD, RN
Professor: Nursing Science
Department of Nursing Science
Faculty of Health Science
University of Johannesburg
Telephone: 011 559 2880

M.Comm, D ED, HED
Professor: Psychology of Education
Faculty of Education
University of Johannesburg
Telephone: 011 559 2860
ANNEXURE B

THE PERMISSION GRANTED TO CONDUCT THE RESEARCH STUDY
Dr. M.R. Billa  
Chief Executive Officer  
Sterkfontein Hospital  
KRUGERSDORP  
1740  

Dear Dr. Billa  

STUDY: A MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY NURSES IN A PSYCHIATRIC INSTITUTION  

The above study was approved in 2009. Permission is still granted that Sterkfontein Hospital be used as a site for the above research. However, since this is a research project involving voluntary participation, we cannot guarantee participation of staff.

Thank you.

..............................................

DR. U. SUBRAMANEY  
PRINCIPAL PSYCHIATRIST / CLINICAL HEAD  
03/03/2011  

Approved.

..............................................

DR. M.R. BILLA  
CHIEF EXECUTIVE OFFICER
ANNEXURE C

ETHICAL CLEARANCE FROM THE ETHIC COMMITTEE OF THE UNIVERSITY OF JOHANNESBURG
FACULTY OF HEALTH SCIENCES
ACADEMIC ETHICS COMMITTEE

AEC77/02-2010
17 September 2010

TITLE OF RESEARCH PROPOSAL: A model to facilitate effective management of aggression and violence experienced by psychiatric nurses in a psychiatric institution

DEPARTMENT OR PROGRAMME: D. CUR Psychiatric Nursing

RESEARCHER: BIMENYIMANA, E STUDENT NO: 820205123

SUPERVISOR: Prof M Poggenpoel

CO-SUPERVISOR: Prof CPH Myburgh

The Faculty Academic Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the University of Johannesburg.

The attached recommendations were made by the committee which will improve the quality of your proposal.

Please make these changes and corrections to the satisfaction of the supervisor/s.

The AEC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

Prof. Karien Jooste
Chair: Faculty of Health Sciences: Academic Ethics Committee
ANNEXURE D

CLEARENCE FROM HIGHER DEGREE COMMITTEE OF THE UNIVERSITY OF JOHANNESBURG
FACULTY OF HEALTH SCIENCES
HIGHER DEGREES COMMITTEE

HDC69/02-2010
17 September 2010

TITLE OF RESEARCH PROPOSAL: A model to facilitate effective management of aggression and violence experienced by psychiatric nurses in a psychiatric institution

DEPARTMENT OR PROGRAMME: D. CUR Psychiatric Nursing

RESEARCHER: BIMENYIMANA, E STUDENT NO. 920205123

SUPERVISOR: Prof M Poggenpoel

CO-SUPERVISOR: Prof CPH Myburgh

The Faculty Higher Degree Committee has scrutinised your research proposal and confirm that it complies with the approved research standards of University of Johannesburg.

The attached recommendations were made by the committee which will improve the quality of your proposal.

Please make these changes and corrections to the satisfaction of the supervisor/s and submit a corrected copy of the proposal to the Faculty Research Administrator.

The HDC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

Prof. Heidi Abrahamse
Chair: Faculty of Health Sciences HDC
ANNEXTURE E

CLEARENCE FROM WITS ETHICAL COMMITTEE
M110114

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R/14/49  Mr Emmanuel Bimenyimana

CLEARANCE CERTIFICATE

PROJECT

M110114
A Model to Facilitate Effective Management of Aggression Experiences by Nurses in a Psychiatric Institution

INVESTIGATORS

Mr Emmanuel Bimenyimana.

DEPARTMENT

Faculty of Health Sciences

DATE CONSIDERED

28/01/2011

DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE

01/04/2011

CHAIRPERSON

(Professor PE Cleaton-Jones)

*Guidelines for written ‘informed consent’ attached where applicable

cc:  Supervisor:  Professor Marie Poggenpoel

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.  I agree to a completion of a yearly progress report.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

Marie Poggenpoel 10/05/11  Supervisor

(Emmanuel/ Bimenyimana)
ANNEXTURE F

INVITATIONAL LETTER TO THE PARTICIPANTS
Dear Colleague professional Nurses,

INVITATIONAL LETTER TO PARTICIPATE IN THE RESEARCH

My name is Emmanuel Bimenyimana. I am a professional nurse like you and currently I am registered with the University of Johannesburg for a doctoral degree in nursing (PhD). In order to fulfill all the requirements for this degree, I am currently doing a research project to which I would like to invite you to participate.

The research project’s topic is ‘A MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION AND VIOLENCE BY NURSES WORKING IN PSYCHIATRIC INSTITUTIONS’. My study supervisor is Professor M Poggenpoel and Prof. C.P.H. Myburgh is the co-supervisor both being professors at the University of Johannesburg.

Your contribution, as participants, will be to implement and evaluate the model at the end of the implementation. The evaluation of the model will be by individual and focus group interviews. Participants are requested to give permission for the interviews to be audio-taped.

In this research, no financial gain is foreseen. The advantage of participating in this research is that the participants will explore new ways of dealing with patients’ aggression; hence empowering themselves and helping others in the future who may have been in similar situations.
The following ethical standards will be adhered to:

- Freely sign an informed consent before the beginning of interviews
- No name will be mentioned during the interview or after, during transcription and coding;
- All information received will be treated professionally with regards to confidentiality and privacy. In the focus group interviews, the researcher will ensure confidentiality himself and request participants to adhere to the respect and confidentiality of discussed matters;
- In this research project no harm is foreseen, however, should the reliving the experience of aggression and violence provoke a crisis, referral to professional help is planned;
- Participants may decide to withdraw from the study at any time without fear of persecution or punishment;
- Audio-tapes will be kept under lock and key. Only the researcher, the supervisors, and the independent coder will have access to the audio-tapes. The audio-tapes will be destroyed two years after publication of the research;
- 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 where participants can obtain a copy.

Yours truly

E BIMENYIMANA

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Cell: 0827397912  
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Promoter:  
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Department of nursing Science  
Faculty of Health Science  
University of Johannesburg  
Telephone: 011 559 2860

Professor: psychology of Education  
Faculty of Education  
University of Johannesburg  
Telephone: 011 559 2860
ANNEXURE G

EVALUATION QUESTIONNAIRE TO THE PANEL OF EXPERTS
### Evaluation of the model

**A MODEL TO FACILITATE EFFECTIVE MANAGEMENT OF AGGRESSION EXPERIENCED BY PSYCHIATRIC NURSES FROM THE PATIENTS - B. Emmanuel**

<table>
<thead>
<tr>
<th>CONCEPTS</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Clarity</strong></td>
<td><strong>Semantic clarity and consistency</strong>&lt;br&gt;  - Are concepts meaningful and helpful?&lt;br&gt;  - Are the concepts used consistently?&lt;br&gt;<strong>Structural clarity and consistency</strong>&lt;br&gt;  - Do the concepts provide a structural map?&lt;br&gt;  - Can the structure of the model be comprehended?</td>
</tr>
<tr>
<td><strong>2. Simplicity</strong></td>
<td><strong>Is the number of concepts limited to a minimum?</strong>&lt;br&gt;  - Can concepts be combined without losing theoretic meaning?</td>
</tr>
<tr>
<td><strong>3. Generality</strong></td>
<td><strong>To whom and when can the model be applied?</strong>&lt;br&gt;  - Does the purpose of the model apply only to a specific situation in nursing?</td>
</tr>
<tr>
<td><strong>4. Accessibility</strong></td>
<td><strong>Are the concepts within the realm of nursing?</strong>&lt;br&gt;  - To which degree are the concepts grounded in empirically identified phenomena?</td>
</tr>
<tr>
<td><strong>5. Importance</strong></td>
<td><strong>Does the model have the potential to influence nursing actions?</strong>&lt;br&gt;  - Do I like this model?&lt;br&gt;  - Why?&lt;br&gt;  - Does the model guide nursing practice?</td>
</tr>
</tbody>
</table>
ANNEXURE H

CONSENT FORMS
CONSENT FORM TO PARTICIPATE IN THE RESEARCHER STUDY

I, ___________________________ hereby attest that I have read and fully understand the content in the request letter to participate in the research study "The model to facilitate effective management of aggression and violence by nurses working in psychiatric institutions".

Further on, I confirm that I freely give the permission to be interviewed, knowing that the information given to the researcher will be treated as confidential and anonymously even though the final result of the research study will be made public to the academic world by the University of Johannesburg.

I also know that at any time I may withdraw my consent participation without fear of any penalty. I have had enough time to ask questions and the answers have been satisfactory.

Participant:

Name: ___________________________ Signature: ___________ Date: __________/________/2010.

I, Emmanuel Bimenyimana, hereby confirm that the participant mentioned above has had the opportunity to ask questions regarding the research study and information regarding ethical standards of privacy, confidentiality, and anonymity has been provided.

Researcher:
CONSENT FORM FOR AUDIO-TAPING

I ___________________________ hereby attest that I have read and fully understand the content in the request letter to participate in the research study "The model to facilitate effective management of aggression and violence by nurses working in psychiatric institutions".

I freely give the permission to be interviewed and audio-taped, knowing that the information given to the researcher will be treated as confidential, and anonymously even though the researcher’s supervisors and the independent coder will also have access to information provided. I also know and understand that the results of this research study will be made public to the academic world by the University of Johannesburg.

Signed at __________________________ on this __________ day of __________________________ 2010
ANNEXTURE I

NAÏVE SKETCHES
Main question was: “What was your experience like when using this model implementation in dealing with aggression”?

1) Was the model understandable?

2) Was the model easy to implement?

3) Was the model relevant?

4) Was the model useful?

5) What is your overall impression of the model?

In order to stay faithful to the participants’ versions, I have not edited their naïve sketches which follow below.

SKETCH 1

The implementation of the model was understandable and we used it on a daily basis by working together as a team and reminding each other to follow it when we felt we were not doing what is required before we got used to it.

We applied this model on a situational circumstance where we taught ourselves to talk and address the patients with respect even when they displayed aggressive behaviour trying to understand what triggered the behaviour and how best we could solve that problem.

We were able to use this model in our ward and now we are used to it; for example patients are treated with respect, ward rules and expectations are clearly explained on admission and constant reminder during breakfast; things like when to smoke and how to address problems without being aggressive. We also planned in-service training list for presenting these topics on the ward level.

This model is very useful in a sense that patients are more relaxed they are able to report if there is something wrong, either with fellow patients or they feel ill-treated by staff members. Even as staff we are more open, work as a team and able to communicate more.
Some areas of the model worked more than others such as in-service training because people became aware of how to handle day to day problems in the ward rather than becoming tired and developing “uncaring” attitude. Relevant topics are discussed.

Those areas where the model worked less were, among others, teamwork spirit is still a problem even though we started with monthly meetings after the ward round where we share ideas, raise concerns and try to iron-out problems. Some multidisciplinary team (MDT) members feel they are too “special” or highly qualified to interact with other categories and their say is final even though they don’t spend most of the time with patients.

Overall I feel that a whole lot has changed in my working experience, before this model we were working as we see fit but not doing the right thing. But now we can communicate better amongst ourselves and towards the patients.

I would like to see this model in a more formal or adopted and recognized as official in our institution to help on a day-to-day running of the wards.

The model is very useful and even where it is less adaptable at the moment due to the leadership styles in this institution can work if only our managers can really have a look at them and do an introspection into their leadership styles and change where possible like a) criteria used in grouping the patients in a ward, b) how they handle incidents and debriefing to learn from those incidents that are scaring and intimidating them resulting in staff resigning.

SKETCH 2

The implementation of the model helped us to understand better the situation we are in and what to do when dealing with aggression and violence. We all come across all the problems that the model mentioned on a daily basis. In some cases, some elements of the model are more workable than others from the ward level. For example: where respect is concerned, we are able to work on that in the ward by updating our patients and treating them with dignity. However, handling aggressive patients is not easy; for instance a patient starts to break windows without prior signs
so there is really no time to explain the rules to him but to try and stop them by asking them to stop which in most cases they do not even look at staff.

Also in case of mixing better patients with sick ones, it was not easy to solve in the ward because patients are unpredictable, they can be well behaved today, tomorrow they change and those who are stable will be frustrated.

In our ward we felt that this model is adaptable to the ward routine and we used it effectively though we had limitations as some of the hospital protocols are imposed on us in the ward; no one consults people in the ward before finalizing them; in turn we asked for meeting with our Assistant Manager (AM) once a month to try and voice our concerns but still we feel that what the AM wants goes without our consent. We are able to respect and care for the patients better and we improve ourselves through ward in-service.

The model was accepted by all the staff in the ward and it helps where we try the method of changing how we deal with choosy patients, we ask the one who the patient likes or respects to remind them of ward rules when they start to be problematic to avoid further annoying patients.

Again, on communication skills we encourage each other to think before we talk to patients and to walk away if angry than saying something that is unprofessional.

In general, we felt that this tool is very useful, that it can work as a hospital thing and will definitely change for better. People resign every month because of things not being done correctly here. For example team work spirit is non-existent. When doctors come to the ward they demand things to be done as they wish even though they are not with patients all the time overlooking nursing reports and suggestions.

We have every discipline in the ward coming in when they want, and all of them expecting nurses to help in either interpreting or being a body-guard to them as if we are not scared of patients; at the same time nursing management up there say observation patients must be out in the yard the whole day which is very difficult ending up in conflict of interest, staff absenting themselves etc.

There is no debriefing at this hospital when there is an incident, all management cares about is patients and asking for statements and then giving warnings for everyone. For instance one observation patient decided to jump the wall while
everyone was watching helplessly but at the end is warning. We ended up no knowing whether we were trained to jump or to nurse and that frustrates us. Instead of management coming up with a solution about how to build a wall or how to guard the observation patients, they blamed us saying we must be more vigilant why not bring securities for that? OM in our ward does not have a say on how we would like to work but says yes to whatever managers suggest which makes it difficult to work.

We were unable to structure for disciplinary measures and correct those patients who deliberately break the law. There is only repeats of one or two in-service training like calming and restraining that does not work at all in real life situation. They do not focus on important things like teamwork involving all MDT members and basics to auxiliary and enrolled on psych so that they can be able to handle patients as they do not have psych training. This actually made me angry as I really wanted to make the model work for me and for others but being the only one wanting and having my big bosses on my back made me realize that there is still a long walk to doing what is right here.

In conclusion, caring attitude even for the staff from management can be very encouraging. Staff experience traumatic events when in the hospital, working or residing in hospital premises, but nobody cares instead gossip comes from the management offices, criticizing which lower their morale. We are all working here, not doing each-others favours but wellbeing of patients, so working as a team.

Caring attitude can make this environment favourable to work in. I know I was supposed to be saying things related to how I used this model but I cannot hide that it opened my eyes and made me realize that I have been facing violence not only from the patients but also from my seniors yet I never noticed it. Now that I have noticed it, thanks to this model, I feel frustrated as the things that the model requires do not need really an external intervention to be done. I hope to improve once my emotions have cooled down. As for now that is all I could say.

**SKETCH 3**

The model was flexible most of the times we tried treasuring the patients for instance in case of respect, when the food was late, they thought it was our fault because
they could not understand why the food was late. So we tried involving them by reassuring time and again informing them on the delay at the kitchen also gave them smoke but explained that we were not breaking any rules but rather being lenient because of the delay which won’t be an everyday thing. They understood but psychiatric patients like testing limits which we have been consistent.

To adapt the model to the ward environment was easy because we sat down as a team and agreed on what to do. It made a huge change because it is psychiatric patients’ only way of not being aggressive and when they need time out is by smoking.

When it comes to administering meds we did not encounter any problems because we have made it a point that we don’t argue with patients; we give them patient an option if he refuses oral medication he gets an injection so at least they know what is at stake and it has been working so far.

In stable patients, it is still a challenge because we have few activities in the ward and we have done our all to request them and still not successful and rehabilitation wards are full because there is quite a huge number of patients being admitted. We tried our means to occupy them as much as we can by involving them in occupational therapy (OT).

We do involve general workers in in-service training and educate them with regard to how to handle and respect a psychiatric patient as they are human beings and the strategy is working.

The mental health care act, when it was reviewed, helped a lot of people because patients now are being treated with compassion although sometimes the patients might have said hurtful things to you. But at the end of the day we remember that we are dealing with human beings who are not mentally well.

As for good communication, this is quite a challenge because at the end of the day we are all human beings. So we still need to do more in-service trainings and time for the model to be efficient and adapted well. The problematic is that some psychiatric nurses feel they work hard in the ward but another psychiatric nurse does nothing and earns more money. The psychiatric nurse that does not earn much feels demotivated and absent themselves from work; others end up resigning. So people
should be given incentives and also reviews the occupational specific dispensation (OSD) so everyone should be productive. Managers are also not interested in the nurses but focus more on patients this leaves some psychiatric nurses resentful. So a lot of work still needs to be done. Also we do have meeting with management but most of the time they make decisions and are defensive and you start probing.

In the ward, we do not have a problem with teamwork as everyone is involved and the doctors appreciate the input of any nurse. The only problem is consistency amongst the nurses towards patients. Because of this problem of consistency among staff members, change is difficult and patients are divided. Also patients become manipulative as they know which side to pick. Reinforcement is needed here.

People have grown professionally and the hospital made sure they appoint someone for wellness but most people don’t use the resources because they feel there is still a lack of confidentiality so the deal with their issues their own way.

Recommendations

In-service training needs to be continuous, there is a lot of favouritism in the hospital and other peoples’ opinions are not taken into consideration. The staff needs to be educated continuously on consistency as it is still a challenge. Management needs to be supportive and also give incentives for the hard workers. People will be motivated to work more. Overall most of the model implementation worked although some parts needed to be adjusted to the ward environment. However, some need time to work as people take their own time to adjust. But this is the right direction we are moving in provided management shows commitment and dedication to the wellbeing of the hospital and its personnel.

SKETCH 4

Although this model helped me to grow, it took me time to really appreciate it as I went through a number of crises. Firstly, when I accepted to participate in the research, I did not entirely because I wanted to contribute but rather because I wanted something to get evaluated better in my performance management development programme (PMDS) and also was curious: I wanted to see how the
researcher will fail and I would be a witness as we had tried many things without succeeding.

I then took the model implementation read it in my own time and decided to discuss it with my fellows during the ward meeting. As I expected, most of the professional nurses were like me: they believed that it was another way of wasting time as theories do not apply when it comes to aggressive psychotic patients. As we finished the meeting I started wondering why I had brought the model in first instance if I didn’t believe it could work.

Could it work? Should it work? I remembered that when I was discussing it with Mr. Bim (the researcher) he asked me if I wanted to spend the rest of my working days in Sterkfontein in fear or despair because of the dangers at work. Then I decided that I was going to literally use it and then show him how impossible it was to make this model implementation work.

The first thing I did was to observe what was happening around me: what every professional nurse was doing so that I could report accurately. Then a patient came to ask for more food, the psychiatric nurse pushed him harshly and the patient started swearing at her. I intervened but later on asked myself if the situation would not have been otherwise had the nurse not pushed him. Them I really saw that may be we were not treating the patients as it should when respect is concerned.

I started being polite to the patients and found that actually it was not hard. Patients started reporting incidents to me whether related to fellow patients or staff. I gained their trust.

Before I knew it I was in conflict with other professional nurses as I started telling them that this is not nice… you should have treated the patient this way and so forth. I became frustrated as I realised that all along I had been doing the work alone and it never crossed my mind.

I stayed at home for two days reporting sick without being sick. Then again it didn’t feel alright to stay at home because I was doing worse than they did. I didn’t even want to mention it to the management as it would have escalated although I realised there is no teamwork. I decide to go alone and do what I have to do.
I then continued using the model. Some elements of the model worked better others could not work. You cannot expect management to take you for debriefing or listen to your side of story when there is an incident because all they know is that you must work and not complain. How can we have a good teamwork while managers gossip about us and favour their friends and relatives?

Anyway, I don’t want to talk about politics. I am even over all those things because, as Mr. Bim said, I can’t spend the rest of my days here complaining. I now do what I believe is right and I have seen result. I can be alone at night with 70 patients and I will not be afraid because I have managed to show to the patients that I am here for their own good and that they need me more than I need them. This is something I never thought it was going to be fine in my lifetime! When a psychotic patient wants to attack me, other patients are there to protect me as if they are my bodyguards.

The model is workable, adjustable, and useful. The sickness of Strerkfontein is just inconsistency and negativity that are orchestrated by laissez-faire management.

I recommend this model and have no doubt that in a well-functioning hospital it would make life easier for everyone. I have grown and I also hope that others will one day realise that they need to change. For now I just do what I do well: nursing the patients and I am happy about it as I do not anymore work up in the morning wondering whether I should go to work or not. If it happened to me, as they say, it can happen to anyone.

SKETCH 5

The model implementation as it was explained to us, we decided that as professional nurses we were not going to implement it effectively if the rest of the nurses (ENs and ANs) did not participate. We then discussed it with these two categories. It seemed to be difficult for them to understand as we emphasised what was expected from them such as respecting patients so that they respect you.

As we are different as people, some made effort and made the model to work others were less enthusiastic. There were those nurses who were negative uttering statements like, “it will never work”.

258
Among those who seemed to understand and were willing to implement the model, it was easier though inconsistency was visible; and this more evidently during the shift changes.

It took a while to see nurses adjusting to planned model interventions, as most of the people needed a push to carry out duties. e.g. detailed delegation and follow up on improving teamwork. Stipulating orders on notices boards on what must be done with education information for patients to improve their insight.

At the end of the trying nurse-patient relationships were improved and therefore aggression was reduced, as there was more communication and respect between two parties (Nurses and Patients).

This model equipped us with skills and knowledge on how to work with psychotic patients. It does not mean that we didn’t know a thing but hearing it again from a different source and not from the management, it gave us a challenge that had to be dealt with positively. Patients on the other hand felt more comfortable on being given education, and treated more like human beings, than labelled mentally ill people.

We did not succeed in every intervention that we used. For instance, we failed with regard to enforcing order and discipline: nurses seemed to overdo measures when enforcing order, then patients felt threatened and that made them more aggressive. Here am talking about a specific area: putting patients in seclusion for more than eight hours after breaking the rules it felt more like punishment than corrective measure.

There should be a psychologist for debriefing but we do not have one allocated to the staff. That is why despite that we work with them when one needs it, you are on your own. So there is still no support or help after incident.

All in all, the implementation of this model was worthwhile because:

- Incidents reduced: e.g. physical fights among the patients; as previous months the stich pack was used every week in suturing injuries, now it stays intact-unused for close to two months
- Few threats by the patients who seem to lack insight and see no reason to be in hospital
• More patients getting better fast and granted leaves of absence (LOAs) and statistics of those doing well outside increasing.

**SKETCH 6**

While we were using this model, it still depended on the situation we were facing. The assessment by the leader gave the indication on what to do and not to do. At times, the assessment was not a guarantee that things would improve. We also realised that we needed to improve our skills especially in the area of “psychiatric emergencies” → fights among the patients; patients against staff; patients against properties. For me as an individual I was able to make the model work. I was able to diffuse aggression by showing them love and understanding of their concerns. Love is a greater motivation. Love is caring. When the aggression is completely caused by being totally out of touch = the best thing was manhandling, giving sedation and seclusion as per presentation. This was done in time before damage to property or injury to staff and other patients occurs.

As for giving them smoke in their own time and being flexible in letting them smoke more, I was against it because smoking is against health works responsibilities. Smoking must be stopped in all hospitals = it is one of the things that causes aggression when one patient does not have cigarettes and sees others smoking.

Mind set and attitude changing occurred when staffs were fulfilled/satisfied. Often people are reluctant to work or cooperate because of being inadequate.

**SKETCH 7**

At the beginning, the model was implemented to manage the aggression experienced by psychiatric nurses in the wards, through interactions with patients and other healthcare professionals. In the ward I am working, I introduced the model to my colleagues and discussed with them on how to implement it. Some strategies of the model implementation were understandable, workable and easily to be implemented. There were positive outcomes that benefited both patients and staff members after the implementation.
Model interventions used are:

- Respect
- Caring attitude
- Installing a democratic, participating management
- Regular in-service training
- Proper debriefing after an accident

**How the model was implemented**

- To establishing good relationship with the patients
  - Patients were treated as individuals, every procedure done on them explained eg: giving of injection,
  - Patients were always addressed relevantly not according to their diagnose or labelled as mentally ill patients
  - Patients’ concerns addressed accordingly without being ignored or shut down
  - Patients’ records or any information was not shared by anyone who is non MDT members and patients were explained, on admission in the ward, that confidentiality will always be maintained at all times

- To understand behaviours and conditions of psychiatric patients
  - Monthly in-service trainings about psychiatric conditions and antipsychotic medication were given to staff members and recorded to ensure that they understand patients’ conditions and behaviours
  - Improved patients were identified and reported to MDT and advocated to be transferred to rehabilitation wards (with less noise) or to be granted LOA

**Outcomes**

- Patients gain self-worth and less frustrated, and display less aggression
- Patients behaviours are not aggravated to an extent of adverse effects like breaking windows or suicidal threats.

**Caring attitude**

- Showing caring and loving attitude-
- Patients were listened to, and encouraged to express their concerns
- Monthly health education to improve patients’ insight was given and recorded
- More time was spent with the patient in group activities

-Having teamwork spirit

- In wardrounds, other MDT members were asked to allow nursing personnel to be given chance to interview patients
- Team building activities like having tea together with all MDT members during ward rounds breaks was advocated to and was successfully implemented
- In any crisis or intervention like restraining of patients, nursing staff were encouraged to participate and assist to avoid adverse effects

-Disciplinary measures to patients who deliberately break the law

- During daily orientation patients are reminded of acceptable behaviour in the ward and limit setting is ensured at all times
- Ward program is clearly explained to patients including how they are reviewed by the doctors

Outcomes

- Patients began to develop trust towards nursing professionals, and became co-operative and less aggressive
- Patients had no chance of taking advantages of the situation as they knew the consequences of their behaviours

Regular in-services training

- The hospital offer in-service training regularly and those who attend give feedback
- In the ward in-service training is provided on monthly rotation basis by nursing staffs, so every staff has a chance to teach others
Outcomes

- Nursing staff are well informed and have better understanding on how to manage and decrease aggressive behaviours in the ward.

Effectiveness of the model

- It was easy to implement the above strategies as they are the therapeutic skills that are applied daily in the nursing care and are part of scope of practice.
- There is already a proper debriefing procedure in the ward.
- Installing a democratic, participating management: long term plan is needed to deal with the management that has either autocratic or laissez-fair approach and as an individual it is more difficult to change the hospital management style. It needs all those who are concerned to work together and change the situation.

Recommendations

The discussed model is workable, it is observed to reduce incidents of aggression by patients towards nurses. I, therefore, recommend it to be practiced as protocol in psychiatric nursing to prevent severe aggressive behaviours of patients resulting in damaging of properties or injuries to staffs and patients.