THE LIVED EXPERIENCE OF AGGRESSION AND VIOLENCE BY NURSES IN A GAUTENG PSYCHIATRIC INSTITUTION

BY

EMMANUEL BIMENYIMANA

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Supervisor:	**Prof M Poggenpoel**
Co-supervisors:	**Prof CPH Myburgh**
	Ms. Vasti van Niekerk

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ABSTRACT

Violence and aggression in psychiatric hospitals are a worldwide known phenomenon. South Africa is no exception to the rule. Previous researches conducted in psychiatric institutions have mainly focused on the patients, leaving everyone to guess how this violence affects nurses who are in contact with the patients on a daily basis and who are key role-players in the care, treatment, and rehabilitation of the patients under their responsibility.

The research aimed to explore and describe the lived experience of aggression and violence by the registered nurses in a Gauteng psychiatric institution, the essence of this violence, and how nurses cope with this violence, in order to formulate guidelines and recommendations that could assist them to manage violence.

A qualitative, explorative, descriptive, and contextual study design was utilised. Data was collected by means of semi-structured interviews, and naïve sketches. Tesch's method was used for data analysis, here and an independent coder was utilised. The uniqueness of this study was to bring to the surface the other side of violence as it is perceived and lived by the nurses.

The findings show that the nurses face violence on a daily basis. Among the contributing factors there are: the type of patients admitted in the hospital; the staff shortage; the lack of support among the members of the multidisciplinary team

(MDT); and the lack of structured and comprehensive orientation. The consequences of this violence to the nurses are emotional, psychological, and physical and take the form of: fear, anger, frustration, despair, hopelessness and helplessness, substance abuses, absenteeism, retaliation, a development of an "I don't care attitude", injuries, and damage to personal properties such as clothes, and spectacles.

Guidelines as to how to deal with this phenomenon and recommendations for future study were formulated and are presented at the end of the last chapter, Chapter Four.

OPSOMMING

Geweld en aggressie is 'n wêreldwye verskynsel in psigiatriese hospitaal. Suid-Afrika is nie 'n uitsondering nie. Vorige navorsing wat uitgevoer is het hoofsaaklik gefokus op die effek van geweld en aggressie op pasiënte en nie verpleegkundiges nie.

Hierdie navorsing het ten doel om psigiatriese verpleegkundiges se belewenisse van geweld en aggressie in 'n psigiatriese hospitaal in Gauteng te verken en te beskryf. Opgrond van resultate sal riglyne beskryf word en aanbevelings gemaak work om hulle te help om die geweld en aggressie te hanteer.

'n Kwalitatiewe, verkennende, beskrywende en kontekstuele navorsingsontwerp is gebruik. Data is ingesamel deur middel van semi-gestruktureerde en naïewe sketse. Tesch se metode is gebruik vir data-analise en daar is 'n consensus gesprek met 'n onafhanklike kodeerder gevoer. Die uniekheid van hierdie studie is die verkenning en beskrywing van verpleegkundiges se belewenisse van geweld en aggressie in 'n psigiatriese hospitaal.

Die resultate toon duidelik dat geweld en aggressie op 'n daaglikse basis belewe word. Die aanleidende faktore sluit die tipe pasiënte wat in die hospitaal opgeneem word in; die personeeltekort; die afwesigheid ondersteuning van die lede van die multidissiplinêre span, en afwesigheid van gestruktureerde oriënteering. Die gevolge van hierdie geweld en aggressie is emorioneel, psigologies en fisies van aard vir die

verpleegkundige. Dit neem die vorm van vrees, woede, frustrasie, magteloosheid, hopellosheid en hulpeloosheid aan. Verdere gevolge is substans misbruik, afwesigheid van die werk, die ontwikkeling van ‘n ek-gee-nie-om-nie houding, beserings en skade aan persoonlike besittings soos klere en brille.

Riglyne vir die hantering van hierdie verskynsel en aanbevelings vir toekomstige navorsing is beskryf in hoofstuk vier.

CHAPTER 1: OVERVIEW OF THE RESEARCH STUDY

This chapter discusses the background and the rationale of the research study, as well as the conceptual and operational definitions of aggression and violence. Further on, it describes broadly the purpose and the objectives of this research study and, briefly, it discusses the research design, and ethical principles. It ends with the division of the chapters which make up this research study and a conclusion.

1.1 BACKGROUND AND RATIONALE

Violence is everywhere and known to almost everyone, yet its impact on society and individuals needs to be studied in more detail. In the context of South Africa, aggression and violence have become part and parcel of everyday living. Thus, defining the concepts of aggression, violence, and crime distinctively becomes difficult. It is almost impossible to open a newspaper or watch news on television without reading or seeing scenes of violence and aggression. This state of things spares no one as even babies on their mothers' backs are affected (Seale, Eliseev, & Rondganger in "The Star", 11 October, 2006).

Before proceeding with the topic, it is important to start with some conceptual definitions of aggression and violence. While aggression is defined as hostile or destructive behaviour (Thompson, 1996:17), the World Health Organisation (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002: 5) defines violence as "*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation"*. Elsewhere, violence is defined as "*the application of force, action, motive or thought in such a way (overt, covert, direct or indirect) that a person or group is injured, controlled or destroyed in a physical, psychological or spiritual sense"* (Van der Merwe in Steinman, 2003:3).

From the above-mentioned definitions, the researcher intends to use both terms, aggression and violence, interchangeably and alternatively, he is of the opinion that both terms are closely related, and one can easily lead to the other, either as cause or effect. Hostile behaviour can lead to the intentional use of force with intent to harm, just as the intentional use of physical force or power can lead to a destructive behaviour against oneself or against others. The researcher's inclusive working definition of aggression and violence will be any act, word, even attitude, such as intimidating facial expression, that creates fear or negative feelings, leading to, or resulting in, physical or psycho-social unwanted results. Throughout the study, the researcher intends to use the concept "nurse" or "nurses" to mean the psychiatric nurse or nurses registered as such by the South African Nursing Council (Nursing Act 50 of 1978 as amended 2005:31) and Mental Health Care Users (MHCU) will mean any patient admitted in this institution be it forensic or not.

Violence and aggression are a worldwide phenomenon in psychiatric institutions, as reflected by research conducted in countries such as England (Whittington, 2002:819-825), the United States of America (Noble, 2003:389-393), and Australia (Forster, Petty, Schleiger, and Walters, 2005:357-361) bear witness. In South Africa, the research in the hospital environment conducted by Steinman (2003), Kennedy (2004), and Lucas and Stevenson (2006:195-203), among others, show that violence is present and active in health workplace settings.

In her research on workplace violence in the Health Sector, Steinman (2003:27) shows that 61.9% of all the health care workers interviewed had experienced violence of one type or another during the period of twelve months prior to the research study. Further on, she reveals that there are considerable differences in the violence experienced in public health services to that observed in private health services. She states that the combined percentages for health care workers who had been exposed as either direct or witness victims to physical workplace violence in both health care sectors were 30,9%, but within the public sector this figure was 42.5% and 19.2% in the private sector (Steinman: 2003:29). She then concludes with the following statement: "*these*

are alarming figures and more alarming, the huge discrepancy between the two sectors (Steinman, 2003:29)".

Despite all these findings, little has been done in South African psychiatric Institutions with regard to finding out what the nurses' lived experiences of aggression and violence are, and the impact of these experiences on their personal lives and the service they render to the mental health care users or patients.

This study could shed some light on the lived experience of aggression and violence by the nurses working in a Gauteng psychiatric institution, allowing the researcher to identify: the positive points and challenges that these nurses meet in their working environment; the coping mechanisms that they utilise in their daily tasks; the forms in which violence and aggression take place; the impact that these experiences have on individuals' mental health as well as on the nurses' performance of duties with regard to patient's quality of care. In the end, this knowledge would lead to the development of guidelines which will enable those nurses who are struggling with workplace violence to cope and at the same time prevent, where possible, this experience of violence and aggression from recurring, making mental health institutions a suitable environment to work in.

1.2 RESEARCH PROBLEM

The Mental Health Care Act 17 of 2002 (Government Gazette no. 24024) classifies mental health care users in different categories. Among these categories, this research study focuses on Sections 33, 34, and 42. These are: involuntary admitted mental health care users, assisted involuntary admitted Mental Health Care Users; and state patients pending the court's decision respectively. These Mental Health Care Users are admitted on the basis of being a danger to themselves, a danger to others, and/or a danger to others' properties.

Once admitted, these Mental Health Care Users are literally obliged to take medication whether they like it or not. In most cases the family counts on the police for help to bring these Mental Health Care Users to the hospital. The police may have to hand-cuff the Mental Health Care Users against his/her will to go the hospital where he/she is left in the hands of the nurses who are understaffed, and do not have the same means as the police have, bearing in mind that nurses are not trained for man-handling. At this point in time, there is no known general guideline as to how these patients, who are out of touch with reality, should get medication. Any attempt to give them medication may be viewed as an act of aggression to which they will respond aggressively in what they believe to be self-defence. The researcher wonders about what happens when this or similar incidents happen to the nurses on a regular bases in their working environment.

The South African Nursing Council (http://www.sanc.co.za/policyrights), in its document entitled "*Nurses Rights*" states: "*To enable the nurse to provide safe, adequate nursing, he/she has the right to a safe working environment which is compatible with efficient patient care and which is equipped with at least the minimum physical, material and personnel requirements"*. The researcher wonders how safe the environment is, given the example cited above. The researcher then asks the following questions:

- What are the lived experiences of aggression and violence by nurses working in a Gauteng psychiatric institution?
- What can be done to assist these nurses in order to prevent, or to deal effectively with, this violence and aggression in their working environment?

1.3 RESEARCH PURPOSE

The overall purpose of the study is to explore and describe the nurses' lived experience of violence and aggression in a Gauteng psychiatric institution and to describe guidelines to assist nurses to cope with aggression and violence in the workplace.

1.4 RESEARCH OBJECTIVES

The objectives of this research will be to explore and describe the nurses' lived experience of violence and aggression in a Gauteng psychiatric institution in order:

- to understand the lived experience of violence and aggression from the nurses who have experienced it;
- to describe guidelines to assist nurses to cope with aggression and violence.

1.5 PARADIGMATIC PERSPECTIVE

A paradigm is " a set of basic beliefs; it presents a world view that defines for its holder, the nature of the 'world' the individual's place in it, and the range of possible relationships to that world" (Guba & Lincoln in Raymond, 1996:206).

Paradigm implies a commitment to a collection of convictions, which are meta-theoretical, theoretical and methodological by nature (University of Johannesburg, Department of Nursing, 2006:9). In this research study, the Theory for Health Promotion in Nursing, of the Department of Nursing of the University of Johannesburg (2006:1-8), will serve as the point of departure. This implies a holistic approach of the nurse, body, mind, and spirit, and the maximum utilisation of resources, striving for the respect of his/ her rights and his or her place in human society.

In the following section, the meta-theoretical, theoretical, and methodological assumptions will be discussed.

1.5.1 Meta- Theoretical Assumptions

Assumptions are statements that are taken for granted or are considered to be true, even though they have not been scientifically tested (Silva in Burns and Grove, 2005:39). Assumptions influence the logic of the study, and their recognition leads to more rigorous study development. The holistic view of a human being by the Theory for

Health Promotion in Nursing of the Department of Nursing the University of Johannesburg (2006:4) leads to the following concepts.

Person: The whole person embodies dimensions of body, mind and spirit. 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 as well as with patients. ***Body***: The body includes all anatomical structures and physiological reactions to a violent and aggressive environment. ***Mind***: The mind is associated with the capacity and the quality of a person to think logically, association, analysis, judgment and understanding of which the psychiatric nurse is capable. ***Spirit***: It refers to that part of the psychiatric nurse reflecting his or her relationship with God. The spirit consists of two interrelated components, which have an integrated function, namely the conscience and relationship with God and others. In this research study, the spiritual also includes the perception of the psychiatric nurse of the values of others - patients, as well as colleagues - the convictions and ethics that guide and direct his or her work and the motivation that drives him/her.

Environment: The environment comprises an internal and external environment. The internal environment consists of the dimensions of body, mind, and spirit, while the external environment is physical, social and spiritual. The external environment represents the physical structures of the institution, the professional, and social interactions between the nurse and other health care workers and the mental health care users; and the ethics and core values that motivate him/her to believe in the values of people with mental illnesses.

The external environment is as important as the work itself because it can, to some extent, determine the productivity and personal development of the nurse. Each type of environment calls on the individual to possess certain skills and abilities; each individual needs certain things from the environment. If these are not received, a mismatch occurs; the greater the degree of mismatch, the greater the potential for psychological distress (Martin & Swartz-Kulstad, 2000:4).

Nursing: Nursing is an interactive process where the nurse as a sensitive, therapeutic professional, who facilitates the care, treatment, and rehabilitation of the mental health care user, through the mobilisation of resources.

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). This does not mean, however, that nurses who are not managing to deal effectively with violence and aggression will be excluded or regarded as having a mental illness.

1.5.2 Theoretical Assumptions

The theoretical statements are capable of being tested and provide epistemic findings about the research domain. Theoretical assumptions 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, Department of Nursing 2006:12). In order to avoid bias, the researcher enters the field with an open mind and bracketing (Burns & Grove, 2005:729) is implemented when the researcher treats the participants' experiences without any prejudice or preconceived ideas. The findings are contextualised by literature control.

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

Violence: This is the unlawful use of force (Thompson, 1996:1026). In this research study, violence will mean any act, word, even attitudes, such as an intimidating facial expression, that creates fear or negative feelings, leading to or resulting in physical or psycho-social unwanted results. This understanding is also extended to any actions, or inaction, premeditated and done consciously or unconsciously, with the intention to harm, whether physically, emotionally, psychologically, or spiritually.

Aggression: This is a hostile or destructive behaviour (Thompson, 1996:16). In this research study, aggression will mean any behaviour, gesture, verbal or non-verbal communication, with the intention to provoking a negative feeling or negative reaction in

another person. This includes intimidation, threats, swearing, undermining, humiliating, indecent exposure and so forth.

Health care worker: In keeping with the objectives of the study, this term will be applied to any person who works in a Gauteng psychiatric institution and who is in direct/indirect contact with the mental health care users. Hence, even cleaners, though not officially recognised as health care workers, in this research they will be considered as such.

Psychiatric patient / Mental Health Care User: Government Gazette no. 24024, November 2002 refers to a person with mental illness to such a degree that it is necessary for him/her to be detained, supervised, controlled and treated. It includes a person who is suspected of being or is alleged to be mentally ill to such a degree (Allwood, Gagiano, Gmeiner & Van Wyk, (2002:268-70). In this research study, a Mental Health Care Users will mean any person (male or female), aged between 20 and 70 years, admitted because of a mental illness and who has spent at least six uninterrupted weeks in this institution. Keeping the Mental Health Care Act no. 17 of 2002 in mind (Government Gazette no. 24024), the terms psychiatric patients and Mental Health Care Users will mean the same thing.

Psychiatric Hospital / Mental Health Care Institution: According to the Mental Health Care Act no. 17 of 2002 this refers to a psychiatric hospital, recognised by the National Health Authority as such and known to care, treat, and rehabilitate people with mental disorders comprehensively (Government Gazette, 6 November 2002:10). The institution that will be referred to in this research study is a psychiatric hospital. The terms Psychiatric Hospital and Mental Health Care Institution will be used interchangeably and will mean the same thing.

1.5.3 Methodological Assumptions

The methodological assumptions reflect the researcher's views of the nature and structure of the science in the discipline. In this context, current health problems experienced by the South African nurses working in a Gauteng psychiatric institution will be addressed and solutions will be sought. Because of its functional nature, nursing

research is using usefulness as the criterion for validity. The measures to ensure trustworthiness (Creswell, 2003:196) will be discussed in detail in Chapter Two of this research study so that the findings may 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. Although every experience is unique, in this research study inductive reasoning is used, moving from the particular, namely a specific number of nurses participating in the research, to the general, that is, all nurses working in a public psychiatric institution (LoBiondo-Wood & Haber, 1994:39).

1.6 RESEARCH DESIGN AND METHOD

A research design is defined as a set of guidelines and instructions to be followed in addressing the research problem (Mouton, 1996:107). The researcher will utilise a qualitative, explorative, descriptive, and contextual study design. The researcher intends to explore the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution, describing the meaning these nurses attribute to their experiences. This whole experience is viewed in the natural environment where the nurses work. The details concerning these three terms (explorative, descriptive, and contextual) are developed in Chapter Two.

The research is conducted in two phases: in phase one the lived experience of aggression and violence by nurses in a Gauteng Psychiatric Institution is explored and described. In phase two guidelines are formulated to assist nurses to cope with aggression and violence in their workplace.

1.6.1 PHASE ONE: The lived experience of aggression and violence by nurses in a Gauteng Psychiatric Institution

In this phase the fieldwork conducted by the researcher will be described.

1.6.1.1. Population and Sampling

The participants in this research study are nurses who are currently working in the institution where the research is conducted and who meet the criteria set out below.

- ❖ These are nurses who have worked for an uninterrupted period ranging between 18 months and 48 months. This choice was made because the researcher is of the opinion that newly qualified psychiatric nurses need time to marry the theory and the practice of psychiatry, and this may require some time for them before they can settle into practice. However, a long period in the same psychiatric institution may also lead to the "normality" of a status quo, or may be subjected to confabulation: an unconscious filling of gaps in memory by imagined or untrue experiences that a person believes but that have no basis in fact (Sadock & Sadock, 2003:286). Either way, this may influence the individual's perception of aggression and violence, and the person may not give the true reflection of what is really happening. This is why the period has been limited to 48 months.
- ❖ The nurses must be working in a specific Gauteng government psychiatric hospital of a third level.
- ❖ The nurses are those able to speak English as a medium language for interviews purposes and those willing to participate.

a) Sampling: The researcher will use non-probability purposive sampling. The researcher will continue to find subjects until data saturation occurs. The researcher has chosen the purposive sampling because this method will allow the researcher to obtain the information he is seeking (Maxwell,1996:70).

b) Saturation: Data saturation occurs when the information being shared with the researcher becomes repetitive and the ideas conveyed by the participant have been shared before by other participants (LoBiondo-Wood & Haber, 1994:257). The details concerning the criteria and process for selection of participants are discussed in Chapter Two.

1.6.1.2 Data Collection

The collection of data is done by means of semi-structured interviews because the sharing of individual experiences helps the researcher to understand the meaning of nurses' lived experience of violence and aggression, how they adapt, and their hope and possibilities of reconstructing their lives (Burns & Grove, 2005:545).

The researcher will engage the participants to talk freely. The interview will last about an hour. The interviews will be recorded and transcribed. For the details of measures taken to insure the privacy and confidentiality of participants, refer to the ethical considerations later in this chapter and Chapter Two. The researcher will use communication techniques including: clarifying, exploring, validating, minimal verbal responses, open-ended questions, and non-verbal expressions. These will be noted as part of field notes. The following question will be asked to each and every participant: "***How is aggression and violence for you in this hospital?***" An opportunity will be given to those who prefer to write a naive sketch instead of being interviewed.

1.6.1.3 Data Analysis

The task of the researcher is to try to get to the heart of the matter by looking for themes that lie concealed in the unexamined events of everyday life, to find meaningful, shared themes in different people's descriptions of common experiences (Barritt in Leedy, 1997:162). During this process the researcher will break down the data, conceptualise it and put it back together in new ways (Strauss & Corbin, 1990:57). The data will be analysed following Tesch's method (Creswell, 2003:192) and an independent coder will be used. This topic will be discussed in detail in Chapter Two.

1.6.1.4 Literature Control

Literature provides a frame-work to establish the importance of the study, as well as a benchmark for comparing the results of the study with other findings (Creswell, 1994:21). During this process, the researcher will demonstrate the usefulness of the findings compared to what is known already elsewhere, and also because there is no local theory with which to compare these findings. The researcher will also attempt to

show the implications of the findings to the nurses' professional and personal development, and to the institution in which these nurses work. This will constitute the basis of the formulation of guidelines for managing this aggression and violence and to the effective functioning of the institution in which the research study was conducted (Morse & Field, 2002:107).

1.6.2 PHASE TWO: The description of guidelines to assist nurses to cope with aggression and violence in the workplace

The results of phase one will be utilised to derive guidelines to assist nurses to cope with aggression and violence.

1.6.3 Trustworthiness

One of the most serious concerns related to qualitative research has been the lack of strategies to determine the validity of those measurements that led to the development of theory (Burns & Grove, 2005:383). Validity, in qualitative research, is concerned with the accuracy and truthfulness of scientific findings, while reliability requires that a researcher using the same or comparable methods should obtain the same or comparable results (Brink, 2003:124). Therefore, internal validity, or *credibility* and *authenticity,* and external validity, or *transferability* and *fittingness,* will be assessed. *Dependability* will be the further criterion to establish the trustworthiness of the study, where an inquiry auditor will follow the process and procedures used by the researcher (Brink, 2003:125). Confirmability is a measure where the chain of evidence in the research process is assessed in order to guarantee that the findings, conclusions and recommendations are supported by the data and that there is an internal agreement between the investigator's interpretation and the actual evidence.

1.7 ETHICAL CONSIDERATIONS

Although a detailed description of ethical consideration will be given in Chapter Two, the researcher will give a brief description of the principles to follow as laid down by the United Nations Educational, Scientific and Cultural Organisation (UNESCO, 2006)

In this research study, the researcher will adhere to the ***principle of respect*** for the person. The researcher will consider the autonomy and individuality of each participant. The participants will have the right to decide whether they want to participate or not. ***Informed consent*** will be signed after the participants have been given enough information concerning the research objectives and process. The researcher will verify if they really understand what the research entails, offering to answer any questions that the participants may have during the research process. The researcher will make them aware that they are not bound by any contract, that they can withdraw from participating in the research study at any time without fear of persecution or harm, then they will freely and willingly sign the consent.

In this research study ***no harm*** to the participants is foreseen whether on physical, social or psychological levels. However, if re-living some painful memories of violence and aggression should happen to trigger a crisis, a contingent plan is in place: the participant concerned will be referred to professionals for effective professional help. Participants will do so voluntarily, no coercion is used. The participants will only share the information they feel comfortable about sharing; no prying or probing questions will be asked so that both the privacy and dignity of the participants are respected.

No remuneration is planned. Therefore the participants will not gain financially. However, it will be explained that they could benefit indirectly by sharing their experiences may help other Mental Health Care Workers or institutions, who may learn from their strength or improve their way or dealing with violence and aggression based on what may transpire during data analysis.

All the permission needed will be sought from the nurses and hospital authorities before the process of collecting data starts. Anonymity and confidentiality will be respected and the right to privacy of the participants will be considered. This is the reason why no unnecessary questions will be asked and the information given will be handled professionally for the sake of the participants' dignity.

1.8 DIVISION OF CHAPTERS

This research study is divided as follow.

Chapter 1 : Overview of the Research Study

Chapter 2 : Research Design and Method

Chapter 3 : Lived experience of aggression and violence by nurses in a Gauteng psychiatric nurses in a hospital

Chapter 4 : Guidelines and Recommendations

1.9 CONCLUSION

This chapter discussed broadly the overview of the research study, focusing on the background and rationale, the research questions and objectives. In addition, the research design and method have been briefly outlined and the ethical considerations mentioned. The next chapter, Chapter Two will focus, in detail, on the research design and method that will be used in this research study. Ethical measures and measures to ensure trustworthiness will also be discussed.

CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1. INTRODUCTION

In this chapter, the researcher discusses the research design and method of this research study.

A research design is defined as a set of guidelines and instructions to be followed in addressing the research problem (Mouton, 1996:107). The rationale for a research design is to plan and structure a research project in such a way that the eventual validity of the research findings is maximised through either minimizing, or possibly eliminating, potential error (Mouton, 1996:108).

In order to know and understand the lived experience of aggression and violence by the nurses in a Mental Health Care Institution, the researcher intends to use a qualitative design, utilising phenomenology, as the researcher seeks to understand the meaning participants give to their experiences in the context of their working environment, which is a psychiatric institution (Maxwell,1996:17).

2.2 RESEARCH DESIGN

In this research study, the researcher seeks to understand, rather than to explain, or predict, behaviour (Marshall, 1997:46). In doing so, the researcher tries as far as possible to remain objective. Marshall (1997:46) argues that it is important for the researcher to try, as far as possible, to see things through the eyes of the participants whom they are interviewing, trying to put aside the researcher's own values, prejudices and preferences. This is because if the researcher does not, he/she will distort what he/she sees by forcing it to fit into his/her own frame of reference.

Although the researcher works in the same institution where the research is conducted, the researcher's experience is to be put aside in order not to interfere either with data collection or data analysis; in other words the researcher is using bracketing.

Bracketing is the technique of suspending or laying aside what is known about an experience being studied (Burns & Grove, 2005:729). This technique is used in order to avoid bias. Audio-tapes are transcribed by an independent person/researcher and the are kept under lock and key and only the researcher and study supervisors have access to them. This will be stressed again in the topic of ethical principles.

The gathering and analysis of the data involves exploration and description of information in the context in which the participants have perceived violence and aggression, and the meaning they have attached to the latter. An explorative, descriptive and contextual design is utilised in this research study.

2.2.1 Explorative research is most commonly unstructured, informal research to gain background information about the general nature of the research problem. The researcher encourages people to elaborate, provide incidents and clarification, and discuss events at length (Rubin & Rubin, 1995:8). Exploratory studies collect detailed descriptions of existing variables and use the data to justify and assess current conditions and practices, or to make more intelligent plans for improving health care practices. To achieve this, the researcher intends to use interviews during which personal experiences are recorded and later transcribed and analysed.

In this research study, the researcher aims to use communication skills of open-ended questions, clarification, and a listening ear so that the participants can share all their lived experiences of aggression and violence without fear or hesitation. Since very little is known about the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution, the data obtained is to be compared to other research studies done elsewhere in the world, and serves as a ground-breaker for further research for those interested in improving the nurses' working conditions.

2.2.2 Descriptive research is used when there is no theory to work from, or when the researcher is beginning to explore a new area that has not been researched before

(Raymond, 1996:25). As mentioned above, this fits correctly with the research study. The researcher describes the process taken in collecting and analysing the data and the findings are first-hand information with regard to the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution. These findings may in future be used by other researchers to further the research with this topic or to develop a theory on aggression and violence in Gauteng psychiatric institutions.

2.2.3 Contextual research one person's lived experience of aggression and violence is distinct from another's and can be understood by the individual's subjective description of it (LoBiondo-Wood & Haber, 1994:257). In this research study, the researcher respects and acknowledges the individuals' experiences, perceptions and the meaning they attach to their lived experiences of aggression and violence. The researcher tries to identify both what is common and what is different to their lived experiences of aggression and violence. The findings are applicable to the participants and to this psychiatric institution, even though similar experiences may exist in other institutions.

This approach is grounded in the belief that factual objective data do not capture the human experience. The meaning of the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution emerges within the context of personal history, current relationships, and future plans as the individual lives daily life in a dynamic interaction with the environment. The experience of aggression and violence is believed to be a unique personal experience that is context-laden (LoBiondo-Wood & Haber, 1994:257).

2.3 RESEARCH METHOD

This research study is conducted in two phases. In phase one the lived experience of aggression and violence by nurses in a Gauteng psychiatric institution is explored and described to assist nurses to cope with aggression and violence in their working environment.

2.3.1 PHASE ONE: The experience of aggression and violence by nurses in a Gauteng Psychiatric Institution

The phenomenological approach is utilised. Phenomenology refers to a person's construction of the meaning of a phenomenon, as opposed to the phenomenon as it exists external to the person. It is a research method that attempts to understand participants' perspectives on, and views of, social realities (Leedy, 1997:161). The phenomenological method has been the preferred choice in this research study to describe the lived experience of aggression and violence by the nurses in a Gauteng psychiatric institution as no theories have yet been devised to explain the phenomenon (Burns & Grove, 2005:595). Furthermore, the phenomenological method is valuable in ascertaining subjective feelings and experiential meanings (Leininger, 1985:59). Nurses participating in this research study share their own lived experiences of aggression and violence and the meaning they have attached to these experiences. As people differ individually, the same experience can have different meanings to different people, which makes every experience personal (Ermarth in Morse, 1991:56).

The researcher pays attention to the language the participants use, the non-verbal expression, idioms, metaphors, and other figures of the speech participants may use during interviews so as to identify what makes a seemingly common experience of aggression and violence, in the same institution, unique and personal to the individual participants.

2.3.1.1 Population and Sampling

The focus of this research study is on the nurses working in a Gauteng psychiatric institution. The available population is far higher than required for Master's degree dissertation. Therefore, a frame-work on population and sampling method is detailed below.

a) Population

In a research, population refers to the entire group to which the results of the research are to apply (Cormack, 1996:15). In this research study, population refers to all

professional nurses working in a government psychiatric hospital in Gauteng Province. An accessible population is the portion of the target population to which the researcher has reasonable access (Burns & Grove, 2005:342). The hospital was chosen because the researcher is working in this hospital on a full-time basis.

b) Sampling method

While sampling involves the selection of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove, 2005:341), the sampling method is the process of selecting a group of people to be studied (Burns & Grove, 2005:346). In this study, the researcher has chosen the purposeful sampling method and participants are selected deliberately in order to gather important information that cannot be obtained from other choices (Maxwell, 1996:70). Leedy (1997:162) recommends purposeful sampling because phenomenology depends almost exclusively on in-depth interviews, and the purposive choice of participants extends the utilisation of information obtained from the sample.

The criteria for sampling are as follows: participants are nurses who currently work in the psychiatric institutions where the research is conducted, and who have been working there uninterruptedly for a minimum period of 12 months and a maximum period of 48 months at the time of the research. They must be willing to participate and share their experiences freely, sign a consent form, give permission to audiotape the interviews, and they must be able to speak English, since the researcher will interview in English. The reason behind choosing professional nurses is that professional nurses, through their training, are taught and empowered with knowledge and skills related to mental illnesses allowing them to detect the signs and symptoms emanating from Mental Health Care Users, and leading to conflict escalation and violence. These nurses are not only able to identify violence but also to handle, to some extent, violent situations. Furthermore, the researcher is vigilant in choosing the participants as not all participants may have as their objective to share the information, but possibly to verbalise their discontent with institution where they work. Holloway and Wheeler (1996:75) argue that individuals who are willing to talk about their experiences and perceptions are often those persons who have a special approach to their work. Some

have power or status, others are naïve, frustrated, hostile or attention seeking. Therefore, one must remember that these are not the best informants because they may have a mainly negative perception of the institution which they are discussing.

To minimise this risk, the researcher intends to examine the motivation of the participants during the first individual contacts during which the research process is explained to the participants, and to spend time taking cogniscence of participants and their environment. The researcher also enquires what they expect from the research process and the findings of the research study. This gives a clear indication as to why candidates are willing to participate in the research study.

Effective informants must be willing and able to examine critically the experience and their response to the situation and they must be willing to share the experience with the interviewer (Holloway & Wheeler, 1996:75).

2.3.1.2 Data Collection

There are several methodological criteria that ought to be followed during the process of data collection. These include the suspension of personal prejudices and biases, systematic and accurate recording of observations, the establishment of trust and rapport with the interviewee and creating optimal conditions in terms of location or setting for the collection of the data (Mouton, 1996:111). Methods of data collection are the means to answering the research questions, not a logical transformation of the latter (Maxwell, 1996:74). The researcher enters the participants' world with an open mind, creates a trusting relationship before the beginning of interviews. Beside the tape recorder, the researcher use a notebook for field notes and possible documents related to the data are sought from the institution's management. An environment suitable for interviewing and recording is arranged so that the sound of the recording be clear to allow effective transcription. At all times the researcher bears in mind the concepts of confidentiality, respect, and privacy of the participants.

The collection of data in this research study is done through one–on-one semi-structured in-depth interviews. One question is asked to all: "***How is violence and aggression for you in this hospital?"*** Then communication techniques such as

exploring, clarifying, validating, non-verbal communication, observation (in order to keep field notes), and open-ended questions are utilised. As for settings and location, permission has been granted by the management of the institution that interviews be conducted in the wards, where participants work, during working hours. The availability of the room is discussed with the unit manager of the ward prior to the interview process.

The researcher has chosen one-on-one interviews because they can provide rich, meaningful insights into participants' experiences and the meanings they attach to them, their feelings, attitudes and values. Interviews can reveal the discourses and language, verbal and non-verbal, which people use to construct their lived realities (Lee & Stanko, 2003:52). The researcher intends to conduct a one hour interview with each participant and there is the option of a second but shorter interview in case clarification or validation of data collected is needed.

Interviewing offers two important advantages: first the participants are encouraged, by the use of open-ended questions, to highlight self-perceived violence and aggression. Secondly, dialogue between the researcher and participants allows the interaction to move in new and perhaps unexpected directions, thereby adding both depth and breadth to the researcher's understanding of the experience of violence and aggression in this psychiatric institution (Gorman & Clayton, 2005:125). A topic such as lived experience of aggression and violence in a psychiatric institution is "sensitive" and therefore the in-depth interview is the most valuable, and perhaps even the only, data collection method that can yield information that counts as truth (Lee et al., 2003:51).

a) The Role of the Researcher

The researcher enters the participant's world of lived experience of aggression and violence with a sensitive heart and open-mind; creating an environment which is reassuring and conducive to reflective empathy (Gorman & Clayton, 2005:65). The researcher thus becomes simply a part of the setting while remaining detached in order to observe and record what transpires, staying far enough outside events in order to record descriptive data (Gorman & Clayton, 2005:65). Through the entire process the

researcher is a data collecting instrument, and like any instrument, he tries not to be swayed by emotions, beliefs and personal views (Gorman & Clayton, 2005:65). This enables the researcher to enter the world of the participants while remaining objective enough to follow and record the participants' experiences.

b) Observation and Field Notes

While conducting interviews, the researcher keeps a diary in which unusual aspects noticed are written (Creswell, 2003:186). These unusual aspects include verbal and non-verbal clues such as metaphors and changes in tone and facial expressions and these are included in the data for ultimate data analysis.

2.3.1.3 Data Analysis

It is the process of identifying patterns and themes in the data and drawing certain conclusions from them (Mouton, 1996:111).

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 order to achieve this, the researcher must bear in mind that the starting point of phenomenological research is largely a matter of identifying what it is that deeply interests him/her or others and identifying this interest as a true phenomenon, that is, as some experience that human beings live with (Van Manen in Leedy, 1997:161). For the researcher not to be overwhelmed by personal interest, and in order to keep objectivity and reduce bias (Burns et al., 2005:224), an independent coder with academic knowledge and competency in the field is used.

The researcher's task is to try to get to the heart of the matter by looking for themes that lie concealed in the unexamined events of everyday life, to find meaningful, shared themes in different people's descriptions of common experiences (Barritt in Leedy, 1997:162).

During this process, data is broken down, conceptualised and put back together in new ways (Strauss & Corbin, 1990:57). Conceptualising the data becomes the first step in analyzing it. Breaking down and conceptualising the data means taking apart an

observation, a sentence, a paragraph, and giving each discrete incident, idea, or event, a name, something that stand for or represents a phenomenon (Strauss et al.,1990:63).

In light of this, Tesch's method (in Creswell, 2003:192) is applied in the steps described below.

Step 1: The researcher listens to the recorded interviews several times and read attentively the naïve sketches. He then jots down ideas as they come to the mind and compares them to the non-verbal expressions of the interviewees noted during interviews.

Step 2: The researcher picks one recorded interview and tries to understand what the interviewee said and the underlying message.

Step 3: The researcher groups the topics according to the themes and sub-themes in order to get a whole out or parts.

Step 4: At this stage, the topics listed above are abbreviated and put into codes and compared and contrasted in order to ensure that no theme is left behind. Coding represents the operations by which data is broken down, conceptualised, and put back together in new ways (Strauss & Corbin, 1990:57).

Steps 5 and 6: The researcher uses appropriate vocabulary and the most descriptive wording in order to shorten and condense categories. Then a final decision is made for each category, and codes are alphabetised.

Steps 7 & 8: The data material belonging to the same category is assembled in one place. Preliminary analysis is performed and, if necessary, existing data is recorded.

2.3.1.4 Literature Control

Based on what is already known, the findings of this study may affirm, confirm, or even refute the perceptions held by many about violence in psychiatric institutions in South Africa and the reality as it is lived by those nurses working there.

In order to validate the results obtained, a literature control is necessary as a scientific method so that the results of the research may be compared to other research projects previously done in order to identify similarities, differences and the unique contribution of the research (Poggenpoel, 1993:3).

2.3.2 PHASE TWO: The description of guidelines to assist nurses to cope with aggression and violence in a Gauteng Psychiatric Institution

The results of phase one are utilised to derive guidelines to assist nurses to cope with aggression and violence.

2.3.3 Trustworthiness

The trustworthiness refers to gaining knowledge and understanding of the true nature, essence, meanings, attributes, and characteristics of a particular phenomenon under study (Leininger, 1985:68). In order to ensure trustworthiness, the researcher pays attention to the following criteria: credibility, transferability, dependability, and confirmability (Marshall & Rossman, 1999:192-194). In this research study, the researcher uses all the means possible in selecting subjects without biases, in collecting data objectively and in analysing the data with known scientific methods and by using an independent coder so as to increase the credibility of the findings, while mentioning the short-comings involved in the research process.

2.3.3.1Credibility

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 focuses on the points listed below.

a) ***Prolonged engagement with the field***: The researcher spends enough time with the participants on the site (Lincoln & Guba, 1985:302). He explains in detail the process of data collection, through interviews, to the participants so that all the participants' questions may be answered and expectations clarified. He also explains the goals and objectives of the research in order to allow them to understand their role in this research study.

b) ***Reflexivity journal***: The researcher keeps a journal in which all experiences during the interviews, be it the use of metaphors, non-verbal cues, postures, or the feelings of the researcher while interviewing, are jotted down as part of the data.

c) ***Triangulation:*** In order to increase the credibility in this research study, the researcher intends to use various sources and methods (Lincoln & Guba, 1985:305). The process of the data collection involves interviews and naïve sketches writing, observation of participants during interviews, and the use of documents related to the research study available in the institution. The data analysis is done by co-c0ding, that is, the researcher and the independent coder come to the consensus regarding the research findings.

d) ***Member checking***: At the end of data collection and data analysis, before the communicating of the findings, the researcher meets the participants individually and shares with them the summary of what transpired during the data analysis in order to confirm or validate what the participants had shared. The participants are given an opportunity to add or retract the information that might have been mistreated or omitted.

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

2.3.3.2 Transferability

Transferability refers to the instance to which the findings can be applied in other contexts or with other participants (Babbie et al., 2001:277).

a) ***Purposive sample***: Purposive sampling is chosen so as to find the informants who provide the needed information. The criteria have been set and the researcher intends to welcome everyone who meets the criteria until saturation is reached.

b) ***Dense description of demographics of participants***: The researcher intends to use the criteria mentioned (see 1.6.1.1 above). Other information about the participants will be provided in Chapter Three, once these participants have been identified and interviewed.

c) ***Dense description of results supported by direct quotations of participants***: The researcher intends to analyse the data, together with an independent coder, and then present the findings of the research study with verbatim quotations from interviews and naïve sketches. This will be reflected in Chapter Three.

2.3.3.3 Dependability

Dependability refers to the evidence that if the study were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Babbie et al., 2001: 278).

a) ***Step-wise replication of the research method***: Throughout this research study, the researcher intends to describe the steps taken and support them with references to literature. This Chapter Two, in particular, sets out the steps that are to be taken in this research study and further steps will be explained in the chapters where they feature.

b) ***Code – recoding of data***: The raw material, that is the recorded-tapes, the naïve sketches, and the comments of the independent coder are kept in a safe place and locked by the key as a proof of what has been done and they will remain there for two years.

c) ***Dependability audit***: In addition to the independent coder that is used during data analysis, this research study is still to be submitted and evaluated by the research supervisor and co-supervisors before it is also submitted to an outside examiner for a further test of trustworthiness.

2.3.3.4 Confirmability

Confirmability refers to the degree to which the findings are the product of the focus of the inquiry and not of biases of the researcher (Babbie & Mouton, 2001:278).

a) ***Dependability audit of whole research process***: -chain of evidence- the researcher intends to remain faithful to the academic and ethical requirements in conducting a research study. Therefore the outcome of this study is the original work of the researcher. That is why it is the intention of the researcher to keep field-notes, observation and memos, as mentioned above, in order to comply with the above-mentioned four requirements; so as to guarantee that the findings, conclusions and recommendations are supported by the data and that there is an internal agreement between the investigator's interpretation and the actual evidence.

2.4 ETHICAL CONSIDERATIONS

Gorman et al., (2005:43) point out that ethical considerations are very important, given the fact that participants will give in-depth highly personal information, and that the information elicited could potentially compromise either the participants or the organization.

In this study, the principles of ethical standards of human dignity and human rights, benefit and harm, autonomy and individual responsibility, consent, privacy and confidentiality, equity and justice, as stipulated by the United Nations Educational, Scientific and Cultural Organisation (UNESCO, 2006) are adhered to and applied as set out below.

2.4.1 Respect for human dignity and human rights: Every participant in this research study enjoys the respect of human dignity and human rights that is due to his/her. In order to achieve this, the researcher is committed to be honest while explaining the

process of the study; to respect the time of the interviews; to make the place where the interviews are conducted welcoming; to act professionally; and to avoid any behaviour that may compromise the safety or the security of participants as a result of the research study.

2.4.2 Benefit and harm: In this research study no harm is anticipated, and the participants do not benefit financially. However, their contribution in sharing their lived experiences is beneficial to those who may be in the same situation and will certainly add to the scientific knowledge of what is already known with regard to South African nurses' lived experience of aggression and violence in psychiatric institutions. Should any participant experience emotional or psychological problems due to reliving the experience of aggression and violence, the researcher will provide information on how to get professional help.

2.4.3 Autonomy and responsibility: The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy or others, is to be respected (UNESCO, 2006:5). Participants decide which information to share and how to share it; participation itself is entirely the decision of the participant. Nobody is coerced or persuaded against his/her will to participate in the research study.

2.4.4 Informed consent: Scientific research should only be carried out with the prior, free, expressed, and informed consent of the person concerned (UNESCO, 2006:25). Prior to participation, every participant signs a consent form, allowing the researcher to interview and audiotape the conversation. A letter has been drawn up explaining what every participant needs to know and an ethical clearance has been obtained from the University's Academic Ethics Committee. For details see the attached copy (Appendices 1, 2, and 4).

2.4.5 Privacy and confidentiality: The privacy of the persons concerned and the confidentiality of their personal information should be respected. As far as possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to (UNESCO, 2006:28). In order to comply with this principle, the researcher undertakes not to ask participants' names during the recording

of interviews; to keep audiotapes in a locked cupboard and keep the key so that unauthorised people may not have access to these audiotapes. After transcription, independent decoding and examination, the audiotapes will be destroyed two years after the completion of this research study.

2.4.6 Equality, justice, and equity: The fundamental equality of all human beings in respect of dignity and rights is to be respected so that they are treated justly and equitably (UNESCO, 2006:28). In this research study, all the participants share equal chances to participate provided they meet the criteria. However, as not every one who meets criteria can participate due to limited means and the purpose of this study, the first ones to volunteer for participation will be the first ones taken, and no favouritism or unfair treatment is allowed.

2.4.7 Adherence to the respect of the person: The requirements of privacy and confidentiality have to be fulfilled. The researcher does not probe into the life of the participants or ask the questions that do not relate to the objectives of the research; participants may leave at any time of the research without fearing punishment or persecutions. Although this research does not involve health risks, in case reliving the experience of aggression and violence may provoke a crisis, participants will be referred to a professional for help. More on these ethical considerations and particularly on informed consent can be found in the letter addressed to the participants which is reflected in Appendix 4.

2.5 COMMUNICATING THE FINDINGS

The findings are communicated in the form of a narrative that describes a theme or pattern (Leedy, 1997:162). Narrating is the art and skill of taking different experiences and events and putting them together into a single story (Shank, 2002:146-147). The researcher gathers all the collected details into one meaningful work picturing the lived experience of different nurses in psychiatric hospital environment.

2.6 CONCLUSION

This chapter has broadly discussed the research design and the concepts such as explorative research, descriptive research, contextual research, and phenomenology were explained. The processes of data collection and data analysis were detailed, and measures to ensure trustworthiness and ethical considerations were discussed. In the next chapter, Chapter Three, the findings of the research study will be explored and shared, starting with the process that was followed, the description of the themes and categories supported by verbatim quotes and literature control. The chapter will end with a conclusion.

CHAPTER 3: THE LIVED EXPERIENCE OF AGGRESSION AND VIOLENCE BY THE NURSES IN A GAUTENG PSYCHIATRIC INSTITUION: RESULTS AND RECONTEXTUALISATION

> "***Human violence is much more complicated, ambiguous and, most of all, tragic, than is commonly realized or acknowledged" (*Gilligan, 2000:5).**

3.1 INTRODUCTION

In this chapter, the researcher discusses in detail the results of the research study on the lived experience of aggression and violence by registered nurses in a Gauteng psychiatric institution as expressed by participants through interviews and naïve sketches and identified through data analysis. The results were obtained by using Tesch's method (Creswell, 2003:192) of open coding. The findings are presented according to the central theme, the categories, and sub-categories as set out below.

3.2 ANALYSIS OF INTERVIEWS

In this research study, seven in-depth interviews were conducted (Denzin & Lincoln, 1994:365) and, in order to reach data saturation (Shank, 2002:30), three naïve sketches were collected from participants who preferred to write their lived experience of aggression and violence instead of being interviewed.

Among the participants, there were five males and five females. Their ages ranged between twenty three and thirty eight years old. They all met the criteria set in Chapter Two (see 2.1.1b). They all signed the consent form and gave the authorisation for audio-taping the interviews.

All the participants were asked the same question: "***How is aggression and violence for you in this hospital"***? The seven interviews were tape-recorded after a consent form had been signed by the participants. The interviews were transcribed and analyzed. Throughout the process, the interviews were conducted in the hospital, during working hours, after having obtained the permission to conduct the research in this hospital from the Chief Executive Officer (CEO) by a written letter (see Appendix 3). The time of interview was agreed upon between the researcher and the participant at a convenient time for both. Two of seven interviews were conducted at night (between 20:30 and 22:30) because the participants were working night shift.

The interviews were transcribed and analysed, following a phenomenological analysis, field notes and reflective notes from the dairy by Tesch's method of open coding (Creswell, 1994:154) and a consensus was reached between the researcher and the independent coder. The independent coder has a postgraduate qualification and has been previously used by the University of Johannesburg for other studies in qualitative research. Subsequently a consensus was reached between the researcher and the independent coder.

In order to identify the similarities and the uniqueness of the results, to compare and contrast the findings, and to place the results within the context, a literature control is used (Creswell, 1994:161) in the final section. The analysis of the data is supported by verbatim quotes from the participants' interviews and faithful transcription of the quotes from the naïve sketches in order to provide the evidence for the themes and evoke accurately and vividly the participants' world (Rubin & Rubin, 1995:271).

3.3 DESCRIPTION OF THE ENVIRONMENT IN WHICH THE RESEARCH WAS CONDUCTED

The research was conducted in a Gauteng psychiatric institution in which, according to the Mental Health Care Act 17 of 2002 (Government Gazette no. 24024, November

2002), all the patients are admitted involuntarily. Based on the survey conducted by the sociology department in the same institution, there were 820 approved beds of which the average utilisation is 500 per month. There are 840 approved staff establishment of which 570 are filled and 270 posts are vacant. At the time of the research study, there were 89 professional nurses and 15 functional wards. Out of fifteen functioning wards, there are four wards of females and one for adolescent males.

The hospital has two sections: forensic and non-forensic sections. In the forensic section patients can be categorised into:

- observation patients;
- acute state patients; and
- chronic state patients.

The non-forensic section admits acute involuntary mental health care users who, once they recover from psychosis, are referred to the community clinics for further care, treatment, and rehabilitation as part of de-institutionalisation. The section for minors combines forensic and non-forensic male adolescents. All these patients have in common the fact that they were forced to come to the hospital either in police vans or in ambulances referred by general hospitals. At the time of admission all of them were or are classified, after a 72 hours assessment (Government Gazette no. 24024, November 2002), as a danger or a potential danger either to themselves, others, or others' property.

The interviews were conducted in the wards where the nurses where working at a suitable time to both the researcher and the participant. In each ward where an interview took place, a room was offered where it was possible to conduct and record the interview.

3.4 DESCRIPTION OF THE SAMPLE

All the participants are registered professional nurses (Nursing Act 50 of 1978 as amended in 2006, section 31) and have been practising as such for at least the last two

years in the same hospital. Gender wise, out of ten participants, five were males and five were females but this happened without the researcher intending to have half-half of each gender for participation. The first to volunteer were the first taken.

3.5 ANALYSIS OF FIELD NOTES

During the data collection process, the researcher kept the notes from various sources: documenting observation (participant observation), experiential or reflective remarks (Burns & Grove, 2005:549), theoretical and methodological observations (Burns & Grove, 2005:225) which are detailed below.

3.6 THE RESEARCHER'S OBSERVATION DURING THE INTERVIEW PROCESS

During the interviews, the researcher noted that among the participants, some appeared to be nervous at the beginning of the interview, others were calm and collected. As the interview evolved, the participants' emotional and physiological changes occurred such as change in tonality (pitch voice), change in breathing, taping at the table or sinking in the chair.

The researcher also noted that the participants tried to minimise or justify the patients' aggressive and violent behaviour. Participants also showed a feeling of uneasiness when talking about their experiences. Some even seemed to hesitate about what to say and what not to say as if they were ashamed to talk about violence experienced in the ward. The presence of an audio-tape did not go unnoticed either: some participants looked at it before talking or were eager to talk once the tape was switched off, having declared that they had finished sharing their experience. The researcher allowed them to continue talking and the information became part of the researcher's journal as part of field notes. At times, the researcher felt helpless given the plight of the nurses, and

even the hopelessness in their eyes as participants showed that it is “normal” for nurses working in psychiatric institutions to face violence and aggression as part of their job.

There is a possibility that the nurses are already desensitised by this situation. Lupton and Gillespie (1994:165) argue that the frequency and extent of violence experienced lead one to think that they would expect violence, or consider it a likely occurrence. Although two participants expressed an “I don’t care attitude” that derives from exhaustion and despair, others verbalised their determination to patient’s care and a compassionate attitude toward the patients believing that aggression is part of their job.

This is not an isolated discovery as Carlsson, Dahlberg, Lützen, and Nystrom (2004:191-271) in Sweden, found that the caregivers who experienced daily physical and verbal violence felt powerless, and eventually many of them began to accept violence as a part of their jobs. Despite the researcher’s awareness of bracketing at times the researcher felt tempted to ask leading questions because the researcher works in the same institution, but being aware of this fact help to keep the interviews as objective as possible.

3.7 METHODOLOGICAL OBSERVATION

The researcher’s process of observation included participants’ verbal and non-verbal behaviour such as interactions, gestures, routines, rituals, temporal elements, interpretations, and social organisation. The researcher incorporated some combination of these features (Denzin & Lincoln, 1994: 380). Participants were moving in their chairs, at times the researcher was asked to switch the tape off so that a participant could take a little break and when they came back they were more relaxed and ready to talk than they did before the break. While conducting interviews, the researcher used communication skills of exploration, clarification, validation, where necessary, and used some of the institution’s documents related to the subject such as the hospital policies

and procedures followed in dealing with staff assaults, grievance procedures, patients' registry books, and the monthly statistics on admission and absenteeism.

As for the naïve sketches, they were short average three A4 pages, but they were concise and precise to the point of their lived experience and aggression and more metaphors were used giving the script a deeper and rich meaning to the information provided. Probably this is because the participant took time to think about the question and wrote in their own times. The results of the findings are broadly discussed in the following section.

3.8 DISCUSSION OF THE RESULTS

3.8.1 Central Theme

Nurses working in this Mental Health Institution experience an overwhelming level of violence and aggression. This violence is real, active, and extensive. It is expressed verbally, physically, and emotionally, and it has contributing factors and negative consequences. The contributing factors evoked 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.

One of the causes of this violence is the circumstances surrounding the admission process and the types of patients admitted. Most of these patients come in police vans or ambulances from referral hospitals and come handcuffed or heavily sedated. This is because prior to coming here they have been violent to family members or neighbours.

Having lost contact with reality, most of these patients are forced to come to the hospital where they have to be forced to take medication as they do not believe that there is

something wrong with them and that they need treatment. Nurses on the other hand have an obligation to administer medication prescribed by a psychiatrist. The patients view this giving of “unwanted” medication as an act of provocation to which they respond by violence. Therefore their use of violence to protest the unwanted treatment, though beneficial to them, is justified by what McKendrick (1990:14) calls *incompatibility of belief* between the nurses and the patients.

After the analysis of the results, it was found that the lived experience of aggression and violence by nurses in this institution presents a vicious circle where one incident leads to another. This is how the circle of violence can be summarised from what transpired after data analysis:

Staff shortages ⇄ more aggression from patients

Being aggressed ⇄ retaliation

Inability to cope with the situation ⇄ abuse of substances.

Abuse of substances and discouragement ⇄ absenteeism

Absenteeism ⇄ increased staff shortages and violence

The lived experiences of aggression and violence by nurses in a Gauteng psychiatric institution are categorised in a central theme and categories, following Tesch’s method, as illustrated on the next page (Table 3:1).

Table 3:1Summary of the themes and categories identified during data analysis

THEMES	CATEGORIES
1.1 Contributing factors to violence and aggression	1.1 Types of patients admitted and the hospital environment: psychotic patients, violent patients by nature, and criminals. The fact that all the wards are closed wards makes patients feel as if they are in prison. 1.2 Staff shortages: participants said that when there is enough staff on duty the violence decreases as the staff can detect it before it erupts and control the situation. 1.3 Lack of support by the management and the multidisciplinary team (MDT) : each department seems to be doing its own thing without the coordination of the whole. 1.4 Lack of comprehensive orientation: newly employed staff find it difficult to face violence they were never told of and did not expect. They become fearful and this makes them vulnerable, as self-control and logical thinking are compromised.
1.2 The experience of aggression and violence include certain feelings, emotions, and physical consequences such as bodily injuries and damage to property (torn clothes and broken glasses)	1.2. The nurses exposed to this violence experience negative feelings of • Fear , • anger and frustration • Despair • Helplessness and Hopelessness • Apathy / Desensitisation • Resentment • Job dissatisfaction
1.3 The experience of aggression and violence leads to ineffective coping mechanisms	1.3 The nurses' responses to the above emotions are also negative. • Substance abuse • Absenteeism • Violence – in the form of retaliation • Resentment • Apathy – "I don't care attitude" develops.

3.8.2 Analysis of the Central Theme

The lived experience of aggression and violence by the registered psychiatric nurses in a Gauteng psychiatric institution is real, active, and extensive.

Violence is real here: This participant said: "***This thing of patients' rights, that patients have rights to assault us and throwing punches on us it's more than too much… you can handle some but other times it is too much."*** The researcher's intention was not to check whether there is violence or not, previous research have shown that there is violence in hospitals (Martino, 2002). What the researcher wanted to find out was the experience of the nurses about this violence. The participants said that they faced violence on a daily basis and in different ways. ***"Violence is a daily experience in this psychiatric institution, patients keep on fighting each other, or fighting the staff."*** The level and the consequences of violence and aggression in this psychiatric institution need more and intensified research. The reality of this violence is that nurses have come to find it "normal" to work in such environment to the point that they were surprised to hear the researcher asking them about their experience of aggression and violence as if it were not "obvious". Different participants have experienced different forms of violence such as physical, sexual, verbal, and psychological from patients and other staff (Lupton & Gillespie, 1994:165). The sexual violence expressed does not mean that any nurse has been sexually assaulted. However, female staff verbalised feeling uncomfortable when the mental health care users behave inappropriately or use inappropriate language. This is how a participant expressed it, ***"Patients keep on proposing love and passing sexual remarks to the ladies. Some patients even force themselves to touch or kiss ladies that are nursing them. Worse part, you will find patients masturbating in front of the ladies as a result they get scared."***

Nurses deal with this situation in different ways and by different coping mechanisms. Coping is a natural response to stress and frequently it is adaptive. However, some times it can have long-term consequences that are maladaptive (Cherniss, 1980:45-46). This ineffective coping will be explored further in this chapter.

It appeared to the researcher that violence is so common, the participants to this research have their own perceptions of what constitutes violence and focus more on the consequences of violence than violence itself: if you are hit and there is no injury, it is not serious therefore you should not worry about it. If a patient insults you, ignore it and if he goes away that's fine you do not need to think about it anymore. ***"You just shrug off and just ignore it because if you entertain such things it will end up having or becoming a physical thing between you and the patients."***

This state of affairs leads nurses to focus on physical violence and to ignore or play down other forms of violence and aggression. For example when a patient smashes a window and that he/she is not hurt in the process, and the window does not injure anyone, this is not considered as violence, as this will not even be reported to the matrons except for the repair purposes "***About the tearing of the clothes, it was not done to us only. It happens to a lot of people and nothing is done. You report, you write it in matron's report, they don't really do anything until when something happens to the patient."*** The use of abusive language is also not regarded by some participants as violence as they say that it happens over and over. Therefore they tend to believe that "what does not injure you physically, should not bother you". Yet it does not end there because those who admitted having struck the patients, did it because on more than one occasion the patient had said this or that until their tolerance could not take it any longer. They then exploded and attacked the patient. **"*Sometimes, a patient will say something that really hurts and then you get angry at that time but after sometime you just say it doesn't matter. Then there is a point when you are not ok, you just lose it and people can't know who is the nurse and who is the patient."***

Violence is active here: The participants in this research remarked that given the multiple faces of violence in every aspect of their profession, they are surprised to be asked what their experience of violence is because every day is bound to the new face of violence. One of the participants said: ***"…the patient can also attack you so that's the danger, the risk we live with… we expect them maybe to injure you. At the back of our mind we know that it can happen anytime, anyhow.*"** One may wonder

if the fact that the patients are locked inside the ward 24 hours a day is a contributing factor.

May (in Siann, 1985:240) argues that the conflict of interest between the society, represented by the nurses, and the way the patients see themselves locked up as criminals could be another reason to this violence. The patients feel that they are not valued and effective according to the standard that they themselves see as meaningful. They then try to do something that will make them feel valued and, to bring meaning to their social situation, they use violent behaviour (Siann, 1985:207).

Participants in this research tend to associate violence with psychiatric institutions in the same way heat is associated with the kitchen. This participant said: **"*it was not a good feeling but I said to myself: Ok, you have to adjust to the situation these are mentally ill people, they are bound to fight".*** The other one to add**: "*some patients are violent because they are ill, others because they are locked up and others because of family issues. Whichever way you look at it, violence is there*".**

Violence is experienced by the nurses from patients, the members of multidisciplinary team (MDT) and the management, though to a lesser extent, and it crosses the groups. This participant has this to say: **"*Here in the hospital for us we are faced with difficult situations every day. Trauma every day, abuse every day from the patients but then there is not enough support for us."***

Violence is extensive: Because of its extent participants state that no day can go by without experiencing it. This female participant stated: **"*Violence is too much here and now what are you going to do as a female? You feel really helpless*".** The fact that most of the patients are re-admissions can, to a certain level, explain why violence is perpetrated. All these patients have a history of violence and, some of them, while in the hospital, have used this violence to get what they wanted such as cigarettes, respect or fear from fellow patients, and have come to believe that violence pays. They will then use it each time they want something either from other patients, or health workers.

Siann (1985:191) argues that aggressors discover that they can satisfy new and unsuspected needs by becoming aggressive. They start seeing elements of past violent encounters as they approach fresh situations, and begin to respond routinely.

The concern of the researcher, however, is that despite the fact that the nurses are the front line and in this battle, they seem caught in the cage as they have no idea on how to deal with this violence and have come to believe that it cannot be stopped. ***"As long as patients are psychotic, violence won't be stopped". "You see, with psych patients you would expect violence to be there". "I don't think there is any way of controlling violence inside the hospital."***

3.8.3 THEME 1: CONTRIBUTING FACTORS TO VIOLENCE AND AGGRESSION

In this category the contributing factors to aggression and violence in this hospital are discussed based on participants' experiences and the challenges that they meet. The identified causes are grouped in four sub-categories below.

These are:

- type of the patients admitted and the hospital environment;
- staff shortages;
- lack of support by management and Multidisciplinary team (MDT); and
- lack of comprehensive orientation.

The hospital environment, the type of patients admitted, and the process of admission itself are all conducive to violence. Picture a person with mental illness, confused as they are with hallucinations, delusions or even paranoia, seeing a policeman in uniform handcuffing him/her taking them to a strange environment where another person in a different uniform is waiting with an injection to sedate them. Although this may be the best that the community can do, it does not make it easier for the person who is going

through this process. Confused and frustrated, this person may resort to violence (Krahé, 2001:67). In attempting to find solutions to this violence, one must understand what causes it. The following pages will try describe broadly what transpires because violence can be managed only if is understood and its contributing factors are known. Gilligan (2000:92), states that one can learn how to prevent violence if one approaches it as a problem in public health that is a symptom of life-threatening pathology. In this way, the causes of violence can be explained and solutions can be found.

3.8.3.1 The type of patients and the hospital environment

3.8.3.1.a The hospital environment

The concept of type of patients and the hospital environment are linked because throughout the history of psychiatry; people with mental illnesses have been locked in asylums similar to jails far from other people (Uys et al., 2004:4). South Africa was not different from other countries. "*The seriously insane were admitted to the local gaol where they were housed with criminals under the most unsatisfactory conditions. This period was the darkest period in the treatment of the insane in South Africa*" (Searle, 1964:170). This has had consequences that have implications on today's mental institutions. They are built far from people. The new Mental Health Care Act (Government Gazette no. 24024, November 2002) speaks of human rights yet all the patients in this hospital whether forensic or not are forced to stay in closed wards. Some of these mental health care users, especially forensic ones, spend months or years without seeing the sun outside. Ultimately this may create feelings of frustration and anger as the mental health care users view themselves as being in jail, and they may vent their frustration on to the nurses.

3.8.3.1.b The type of patients

All the patients admitted into this hospital have a history of aggression and violence. All of them, forensic or not, are brought in by police vans or ambulances as referrals. The only criterion used to identify them is violence, as before the police were called in or

before they were taken to the nearest hospital by family members they were violent. They come here still out of touch with reality and believing that the police and family members want them jailed here. They are left in the hands of the nurses who now have to face the conflicts the patients had with their family members and the police. This participant said: **"Ano*ther 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*".**

Davis (1997:10) confirms the participant's statement when he states that the common situation in which a person allows him/herself to hurt others is when he/she has first objectified or dehumanised another person. When the patients are forced to be in the hospital, they feel as if they have been dehumanized. They feel as if they are objects and in order to bring back their "humaneness", they use violence. Kelloway, Barling and Hurrell (2006:8) add to the above-statement that people harm others if it will help them achieve some outcome that they value and if the costs are not too high.

3.8.3. 2 Staff shortages

The shortage of staff makes nurses overwork themselves, resulting in tiredness and job dissatisfaction. They then become discouraged and even absent themselves from work. This situation further decreases the already overstretched number causing more stress to those on duty and further absenteeism. This is not only a problem but also a danger because the fewer the staff numbers on duty, the more likelihood of violence. In the end it is not only the quality of care of the patients that is compromised, but also the safety of the nurses is at risk. This is what one of the participants said: "***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***". Another participant mentioned: ***"As you can see today, I am working alone. I am one registered nurse to 35 patients. This shortage is de-motivating."*** On this day, besides the professional nurse on duty, who was a female, there were other two auxiliary nurses on duty. Yet, it

would be an illusion to hope that if a fight broke out the staff would have been able to stop it.

It is no secret that staff shortage in hospitals, whether general or psychiatric, is a nationwide problem. Henceforth Gauteng Province is no exception to this rule. On the 31 December 2006, according to the South African Nursing Council's statistics (http://www.sanc.co.za/stats.htm), the ratio of professional nurses to the population was 1:343. The participants linked the increase in violence to the shortage of staff which creates a vicious circle (see Figure 4.1).

3.8.3.3 Lack of support by management and the multidisciplinary Team (MDT)

The participants expressed their feelings of isolation and dissatisfaction when it came to the support they expect from the management and the MDT. This lack of support is felt in many ways. Despite the shortage, it seems that the rest of the multidisciplinary team expect the nurses to leave the patients and do the work of the MDT, but when they nurses need a hand there is no body to help. This participant said: "***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***". Another one added: ***"Usually the doctors will come and prescribe something but they don't help. You are just left alone there, you don't get help***".

As for management, participants complained that in many instances management is not there to help but to emphasise the mistakes made by the nurses. This participant voiced that ***"When the staff is assaulted management is on the side of the patient***". Another echoed the first saying ***"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*?"** This is also coupled with the fact that, according to some participants, management is distant and does not give credit to the nurses when this is due. This is what one participant had to say "***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." Further on another one said: "***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."***

Perhaps there was not much that the management would have done in this case, however, this kind of rationalisation cannot be an answer to someone who is hurting. The management is expected to be protective of both patients and staff members, supportive and understanding, but the participants to this research think this is not happening.

Surely here is where the intervention from management is needed just to make the employees feel that management takes their concerns to heart. Murphy, Hurrel, Sauter, and Keita (1995:219) argue that the primary aim of most workplace intervention strategies is to improve the adaptability of the individual to the existing work environment by increasing physical and psychological resilience to stress. They believe that inherent in such an approach is a ***"recognition that the working environment is stressful"***.

3.8.3.4 Lack of Structure and Effective Orientation

The researcher believes that there is more to the orientation of newly employed nurses than telling them what they should and should not do. In this institution, the first week of employment is dedicated to the orientation programme and during this time the newly employed staff go through the "dos" and "don'ts" with regard to legal matters. As for what to expect in the wards, this is left to the discretion of the nursing staff in the ward. What seems to be the problem here is that there is no follow up after this initial orientation and despite the differences between wards, the same orientation is applied. The participants in this research believe that the lack of proper and structured orientation leads to frustration and renders newly employed nurses more vulnerable to this violence and aggression.

These are some of their verbalised thoughts: one said **"*I was told by the sisters during orientation that there might be violence but you don't get full orientation*".** Another one said: **"*The time that I was hit nobody helped me. They just said: you don't have to worry, you are not bleeding, it's nothing. In time you will see more*".** Another one added: **"*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… no body said anything to me.*"**

It would be of great value if, once the new nursing staff is employed, to be allocated to a senior nurse for mentoring purposes for at least for six months. This mentor should be chosen based on his or her work ethics and commitment to serve as a role model. The main purpose of this orientation would be not to teach the newly employed nurse, but to help him/her to adjust to the new working environment (Jooste & Troskie, 1995:49).

3.8.4 THEME 2: THE EXPERIENCE OF AGGRESSION AND VIOLENCE INCLUDE CERTAIN FEELINGS AND EMOTIONS

There is no cause without effect or action without reaction. This is also the case with the nurses and their lived experiences of aggression and violence. Nurses go through a series of feelings and emotions after experiencing violence or witnessing it. These include: feelings of fear, anger, frustration, despair, helplessness, and hopelessness. Consequently, some nurses use ineffective coping mechanisms, in order to deal with the situation, such as the abuse of substances, mainly alcohol, absenteeism, and retaliation. They then experience job dissatisfaction, and they resent management and those who seem to be doing well, and then become de-motivated.

3.8.4.1 Negative Emotions Related to Fear

Participants verbalised fear in different ways. The main point is that for some participants this fear tends to dictate their mode of actions and each time they think

about going to work, they sense that the day is going to be another risk of being harmed. Hence the work becomes a burden and the working environment is stressful. One said ***"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"***. Another one said "***If you go to the file and see that they have killed their parents then they threaten you, you end up having fear".***

This feeling has a profound impact on nurses' professional and personal lives. They are not only afraid of being hurt at work, but sometimes this fear follows them at home and becomes their daily companion. This participant said: ***"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***." Another one said: ***"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?"*** This one said: ***"We are in the same boat: it happens to your colleague; next time it is going to happen to you".***

As one can anticipate, this content fear leads to frustration, and sometimes to retaliation. This participant confessed ***"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***." This other one confirmed this "***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".***

This fear hampers further the ability to manage violence effectively as one's focus becomes survival. Unmanageable fear makes the caregivers feel small and helpless, unable to think clearly, while a feeling of powerlessness overwhelms them (Carlsson, Dahlberg, Lützen, and Nystrom, 2004:191-271). The above incidents of nurses retaliating can be explained by what Gilligan (2000:110) calls the "instinct of self-preservation". One of the participants spoke of feeling "ashamed and inadequate" for

being beaten by a patient. Further on Gilligan (2000:110) states that the emotion of shame is the primary or ultimate cause of all violence. The purpose of violence is to diminish the intensity of shame and replace it as far as possible with its opposite, pride, thus preventing the individual from being overwhelmed by the feeling of shame (Gilligan, 2000:111).

3.8.4.2 Anger and Frustration

Participants talked about having the above emotions basically because they find themselves caught between their calling for a caring career, and what they perceive as the ingratitude of some of the patients who use their mental condition as a shield, even when they are aware of what they are doing, and also the lack of support of other team members and management. When the nurses become angry, depending on the target, they do either withdraw and harbour resentment or they strike back in retaliation.

Frieze (2005:83), argues that when someone is victimised, another type of response is to become angry and to fight back. This is exactly what one of the participants did as she gives the account: "***I was writing the report. He came into the office and said: who are you eh… like I was accusing him of something and before I could even look already he hit me. It was bad and I was so angry. I nearly cried. But when I was on my way to the toilet to cry, I decided no. I can give him a klap. I just went in and took him out then I did fight and gave him a bit of his own medicine".*** Feeling angry is mostly the last resort. It is ignited by the fact that nurses try first to use their knowledge, skill and experience and when the situation becomes overwhelming they lose control. This is how they expressed the above emotions: "***At time, a patient purposively will tell you: yes, am sick and I can assault you and there is nothing you can do.***" Another one said "***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".*** Anger may not necessarily be directed towards the person but it helps them to cope with the situation at hand by expressing it or discharging it onto others (Maravelas, 2005:47).

3.8.4.3 Despair

Some of the participants' view is that they have done all they could and now that the result is not what they expected they feel like just giving up. "***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!***" This other one mentioned "***I just say: God help me! Help me so that I can move away before I get carried away*****",** and another participant asked: "***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 him, you know, one on one 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 that person takes a broom and breaks the windows. Then you start all over again".***

Although Snyder (2001:94) argues that humans respond to physical or psychological threats in two ways namely by avoiding the source of the threat or by attacking defensively, it is the opinion of the researcher that there are those who just give up in desperation.

3.8.4.4 Helplessness and Hopelessness

Of all the participants in this research study, there was no one who expressed a hope to see things changing for the better. In this battle that the nurses are faced with in caring for violent patients and alone, it cannot be sufficiently emphasized how they feel. It would be an understatement to express the feeling of hopelessness and helplessness that one reads on their faces as they talk about their experiences. This is how some of the participants expressed it: "***We end up working for the sake of our families as there is nothing we can do to survive.***" Another one said: "***The only thing is like giving medication then we hope the patient will be fine because there are patients who came here and we give them medication. They become better you send them home but they go and do the same thing that they did before."***

Needham, Abderhalden, Halfens, Dassen, Haug and Fischer (2005:296 – 300) found that adverse consequences such as avoiding the perpetrator or the perception of an impaired relationship with the patient involved can lead to nurses doubting their professional abilities or even provoke feelings of being a failure. Sometimes nurses may even ask themselves if they are working in the right profession.

3.8.4.5 Apathy / Desensitisation

Among the many factors that de-motivate nurses, the main one is the multiple readmissions of the same mental health care users over and over that makes nurses feel that they are labouring in vain. Some participants even feel as if they have lost direction, that they no longer know why they are still working as psychiatric nurses. This is what they had to say: ***"I am somehow de-motivated because there is no goal; I ask myself what skills am I taking from here?"*** Another said **"*Every day you come to work, you are de-motivated. You are just working because you have no choice".***

Seeing violence on a daily basis and not being able to stop it has led some nurses to believe that it is pointless to try to change anything. Nurses become desensitised and find the situation "normal". This then defeats the attempt to stop violence. So the apathy here signifies that the nurses are desensitised and feel that it is normal to experience violence in psychiatric institutions. One said "***I developed a don't care attitude because I felt that the management did little or nothing to address the issues***." Another one added: "***You just work until you get used to violence and see it as normal"***.

Lupton and Gillespie (1994:165) discovered that the way many social services staff see their roles leads them to accept a certain level of violence, as normal because violence happens all the time. Further on, Cherniss (1980:5) found that professionals who were working in extremely demanding, frustrating, or boring jobs, became less trusting and sympathetic toward clients. They also became less committed and invested in their jobs.

3.8.4.6 Resentment

Resentment occurs when dealing with the situation becomes difficult and the end to the problem is not at sight. Some nurses resort to keeping everything inside themselves and resenting the person who caused the pain, while waiting for an opportunity to strike back. Most specifically this happens when there is a conflict between a nurse and a member of MDT or management. This one said "***When we had ward meetings I would be excluded, and my suggestions or opinions would be brushed off, I felt angry and harboured deep resentment towards the sister in-charge."***

Siann (1985:264) argues that it is when people feel at risk both psychologically and physically that the displacement of their emotional insecurity on to others becomes particularly rewarding. Resenting other may, for a while, make the nurse forget the real source of the problem.

3.8.4.7 Job Dissatisfaction

Among the things that demotivate nurses, there is the inaction of management, the lack of communication and coordination of activities among the MDT, and the lack of family involvement in the treatment and rehabilitation processes of the patients which makes nurses feel that they are doing the same thing over and over admitting the same patients with no end to this vicious circle. Some participants even feel as if they have lost direction, that they no longer know anymore why they are still working as psychiatric nurses and they doubt their own caring capacity. This is what one of them had to say: ***"I am somehow demotivated because there is no goal. I ask myself what skills am I taking from here?"*** Another one echoed: ***"Every day you come to work, you are demotivated. You are just working because you have no choice****".*

According to Cherniss (1980:6), job dissatisfaction and burnout have similar meanings and both refer to negative changes in work-related attitudes and behaviour is response to job stress. These changes include increasing discouragement, pessimism, and fatalism about one's work; decline in motivation, effort, and involvement in work; apathy; negativism; frequent irritability and anger with clients and colleagues; preoccupation with one's own comfort and welfare on the job; a tendency to rationalise failure by

blaming the clients or the system; and resistance to change; a growing rigidity, and loss of creativity.

3.8.5 THEME 3: THE EXPERIENCE OF AGGRESSION AND VIOLENCE LEADS TO INEFFECTIVE COPING MECHANISMS

In order to cope with the situation, some nurses use inappropriate means to cope such as substance abuse, absenteeism, and become burnout.

3.8.5.1 Substance Abuse

Some of the participants mentioned that in order to cope with the amount of aggression and violence, they drink alcohol on a daily basis, whether they are on or off duties. One must mention, however, that they did mention that they drink in their rooms and not on duty. One nurse said: **"*Maybe that's why in the nurses home there's so many bottles empty everywhere; they drink on an 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."*** There is a need to cope with stress effectively as alcohol worsens the problem. The other reason may be in part because, for those nurses who stay in the hospital premises, because there is little or nothing to take one's mind off the ward environment. This participant said: ***"On days like that, you would like to relax but there is no entertainment in the hospital*".** One wonders if relaxing and drinking play the same role.

Frieze (2005:80) confirms that one of the ways to avoid thinking about a highly stressful event is to get drunk, and he goes on to say that a large majority of people of all ages turn to others to share highly emotional experiences.

3.8.5.2 Absenteeism

Although absenteeism first affects the nurses who are in regular contact with the patients, some nurses absent themselves as a sign of protest and to show dissatisfaction at what is happening. This is how some expressed it: ***"Instead of***

getting moral support from their managers and other members of the team, nursing staff get blamed for each incident that happens. These things end up causing emotional stress to nursing staff and this leads to alcohol abuses and a high rate of absenteeism." The proportion of the professional nurses being absent on a monthly basis is alarming; and, although all the absenteeism cannot be blamed on violence, the latter plays an important role. Moreover, that absenteeism exposes other nurses to the risk of injury. It also costs the hospital money that could be used for other things. During the course of December 2006, a survey done in the hospital on absenteeism showed that absenteeism cost the hospital R 58 333 per month, which mounted to approximately R 700 000 annually. This, again, worsens the situation given the fact that the shortage of nurses is one of the factors contributing to violence in the hospital. This state of affairs needs serious consideration because the more absenteeism there is, the more the few nurses on duty are exposed at the risk of being harmed. Curiously, since the findings of the survey until, almost one and half years later, nothing has been done about the problem.

3.8.5.3 Burnout

Some nurses have come to the point of wondering why they should give their all to the work that is not rewarding. This participant said: "***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"?***

Burnout is viewed as the exhaustion of physical or emotional strength as a result of prolonged stress or frustration (Felton, 1998:237- 250). Although all the participants expressed their willingness to continue working in the hospital, and their dedication and determination to continue giving the best of themselves, they all mentioned that at times they question why they ended up in psychiatric hospital. This calls for action because the consequences of burnout are detrimental both to the nurses and to the institution as a whole. Felton (1998:237-250) found that burnout resulted in lower production, expressed by an "I don't care attitude". This study has shown some similarities to Felton's (1998:237-250) findings: the situation reveals an increase in absenteeism,

behavioural changes, expressed by short-temperedness, and chemical abuse shown by daily alcohol drinking.

3.8.5.4 Job Dissatisfaction

Job dissatisfaction is synonymous with burnout and can be associated, and even sometimes, identified with stress. Stress occurs when there is an imbalance between job demands and the workers' resources for meeting them (Cherniss, 1980:158). This participant stated: ***"It is very challenging and stressful waking up in the morning with intention of going to help patients, whereas these patients are going to fight you. We end up working for the sake of our families as there is nothing we can do to survive."*** Another one added**: "*... 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."***

In a situation like this one, when one start asking him/herself whether he/she made a right choice, a reassurance and sense of being valued are important points. Snyder (2001:290) argues that finding meaning plays a prominent role in individual's adjustment to negative events. In the aftermath of stress situations, people want to understand what caused the events to happen, as well as determine the impact of the event on their lives.

3.8.6 CONCLUSION

The findings of this research showed that nurses are exposed to an overwhelming level of aggression and violence on a daily basis. The study has also shown that this violence does have contributing factors and consequences. Nurses have reached a stage where they can no longer cope anymore with the situation and in order to keep on going, they use ineffective coping mechanisms which over the long term will worsen the matter, decreasing their productivity and compromising the care they render to the patients. In

order to assess the level and the consequences of this violence more studies are needed, as nurses seem to have given up the battle resorting to accepting the status quo. In the next chapter, Chapter Four, some guidelines and recommendations are drawn in order to enable nurses to effectively manage violence and aggression in their working environment.

CHAPTER 4: GUIDELINES AND RECOMMENDATIONS

"Jeanne, soon you will realise that the love of the neighbour is a much heavier burden than the kettle of soup and the basket of loaves. The poor are your masters who can be exigent. The more disgusting and dirty they are, the more unjust and rough, the more love you will have to show them (From the film "Monsieur Vincent")".

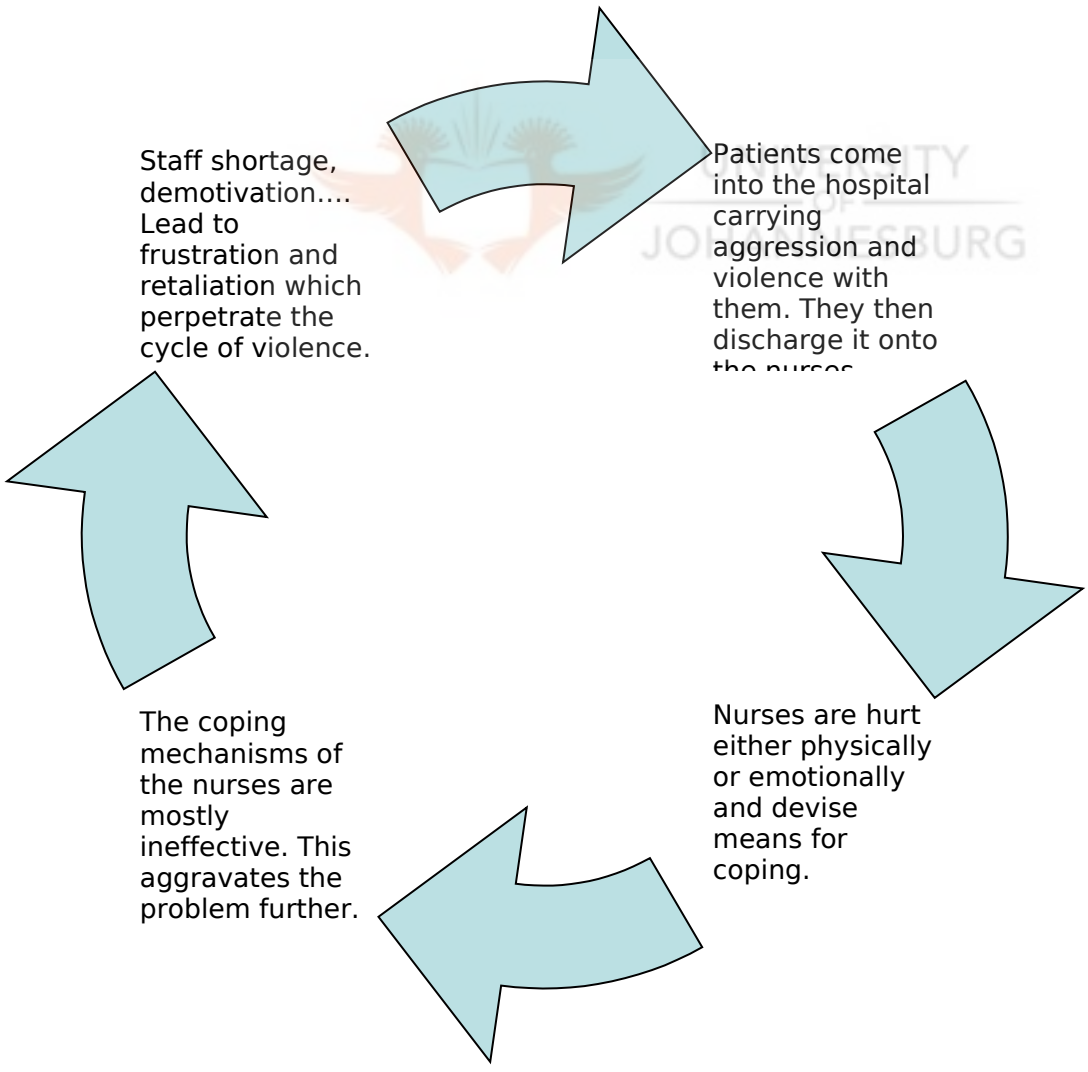
4.1 INTRODUCTION

After having explored the lived experience of aggression and violence by registered nurses in a Gauteng psychiatric institution, and after having discussed the contributing factors and consequences of this violence, the following pages will present the guidelines and recommendations on how this violence can be managed. The last part of this chapter will focus on the evaluation of the strengths and the limitations of this research study, and eventually the chapter will end with a conclusion.

The objective of the research was to understand the essence of this violence from the nurses' perspectives of their lived experiences, and to formulate guidelines to assist nurses to cope with aggression. The previous chapter discussed at length what transpired: the factors leading to, or increasing, violence experienced by the nurses and its consequences. The findings were compared and contrasted with literature control of other research done elsewhere. Based on these findings, it is logical that guidelines should be drawn and recommendations be made in order to manage this violence. The management of aggression and violence will only be effective if the cycle of violence (Figure 4.1) is broken. To break this cycle, a comprehensive approach is needed and this entails revisiting the contributing factors and devising effective means to deal with each one of them.

The patients live in the community where violence and the abuse of substances such as dagga and alcohol are common. Intoxicated by these substances, the patients become violent in a community that hardly understands the role of substance abuses in mental wellness and how to handle a person with mental illness. The community only acts when one of their members becomes violent. The Mental Health Care Users then brings this violence into the institution and discharges it on to the nurses. Nurses experience a range of emotions and deal with this violence mostly with ineffective coping mechanisms. The ineffective coping of the nurses worsens the situation and the vicious circle is perpetrated. Therefore, in order to manage the violence experienced by the nurses, one has to break this cycle starting in the community.

Figure 4.1 ***The cycle of violence***



The effective management of violence in this psychiatric institution must take into consideration the patients' condition, the home environment, health education on the effects of dagga and alcohol consumption upon people living with mental illnesses, hospital environment, and the ability of the nurses to cope with violence and aggression.

The table on next the page (Table 4.1) summarises the themes and categories discussed in Chapter Three and corresponding guidelines to be discussed broadly in this chapter.

4.2 GUIDELINE 1: ADDRESSING FACTORS CONTRIBUTING TO VIOLENCE AND AGGRESSION

Despite the fact that the focus of the research study and guidelines is on nurses, it would be a mistake to think that a lasting solution can be found without considering the patients, their family environment, and the community as a whole, since the violence is first lived and expressed there. The approach to managing violence must not only focus on short term goals but also on long-term goals and the starting point would be to know what violence really is.

Gilligan (2000:92) argues that the only way to explain the causes of violence, so that it can be prevented, is to approach it as a problem in public health and preventive medicine, and to think of it as a symptom of life-threatening pathology.

Table 4.1: challenges and corresponding possible solutions

Themes and Categories	Guidelines
Theme1: **Contributing factors to violence and aggression.** 1.1 Type of patients admitted in the hospital 1.2 Staff shortages 1.3 Lack of support by management and multidisciplinary team 1.4 Lack of comprehensive orientation	**Guideline1: Addressing factors contributing to violence and aggression** 1.1 Facilitation of mental health approach to psychiatric patents 1.2 Facilitation of active recruitment of psychiatric nurses 1.3 Negotiation with management and multidisciplinary team for support 1.4 Request for comprehensive orientation for newly appointed psychiatric nurses
Theme 2: Experiencing aggression and violence includes the following feelings and emotions • Fear and despair • Anger and frustration • Helplessness and hopelessness • Job dissatisfaction	**Guideline2: facilitation of the management of aggression and violence by psychiatric nurses** 2.1 Management of negative feelings 2.2 Management of aggression 2.3 Coping with stress
Theme 3: The Physical consequences of aggression and violence 3.1 Bodily injuries 3.2 Damage to property such as torn clothes and broken glasses	**Guideline 3: Addressing the concerns and trying to find solutions to the problem.** 3.1 Debriefing of psychiatric nurses after incidents of aggression and violence 3.2 Speedy financial compensation

4.2.1 Facilitation of Mental Health Approach to Mental Health Care Users (HMCU).

Limson, in her article of March 2002, in "the Africa's First On-line Science Magazine" (http://www.scienceinafrica.co.za/2002/march/mhic.htm), wrote that one in five South Africans suffered from a mental disorder severe enough to affect their lives significantly. Yet, the magazine continued, "*Thousands of South Africans would rather die than admit that they suffer from some sort of mental illness*". This may essentially be due to the stigma attached to mental illnesses and may also explain why family members fail to visit their loved ones. Ignorance is one of the biggest challenges that whoever wants to facilitate Mental Health Approach to the Mental Health Care Users may face, as Limson **(**http://www.scienceinafrica.co.za/2002/march/mhic.htm), went on saying, "*One of the greatest obstacles to preventing mental illness, and improving services and treatment, is ignorance"*.

There was a general concern among the participants that family members of the mental health care users seem to regard the hospital as a "dumping site". ***"There was a patient who was brought back. When we asked the reason the mother said: no that patient is still sick. When we asked the patient, he said no he was not difficult it's just that he did not want to make his bed, so his mother said he is lazy, he must come back here."*** In order to deal with this stigma, fear and/or ignorance, drastic actions need to be taken by the health department to discover the reasons that push the family members to abandon their own people in the institution. Intensive health education about mental illnesses, their possible causes, symptoms and management, is needed in the communities, as one participant pointed it out: "***Families don't have knowledge and understanding of psychiatry. They don't know why the patients are doing what they are doing, they don't understand the illness. I think education, education, education. Just as there is an HIV-AIDS day, there should also be a Psych day."***

To achieve this, despite the shortage of nurses, there is a need to re-install the community psychiatric nurses and employ more community social workers with clinical experience in psychiatric illnesses. These would liaise with the community leaders and

other influential people such as teachers, pastors, traditional healers, and business people so that a collective plan of action could be taken. Once these influential people had been inspired, the message would be passed on in community meeting, church gatherings and prayers, while local government and the businessmen would assume the financial part of the project. Some of the recovered patients should also be invited to talk to the peers and share their testimony of substance abuse and their life in the hospital. This would make youth aware of what substance abuse can do and the community could be aware that being mentally ill is not the end of the road, given the example of those who are already managing their lives with medication. The relationship between substance abuse and mental illnesses, and the relationship between mental illnesses and aggression and violence must be stressed.

Although the whole problem of aggression and violence and mental illnesses cannot be attributed solely to the abuse of substances, the role that these have played in the lives of the Mental Health Care Users admitted into this institution is considerable. Talking about cannabis, Sonowij (1998:27) states that ingestion of cannabis produces a dose related impairment over a wide range of cognitive and behavioural functions. This statement is confirmed by Parrott, Morinan, Moss, and Scholey (2004:97) who argue that large doses of cannabis can cause acute toxic psychosis.

4.2.2 Facilitation of active recruitment of Psychiatric Nurses

The problem of the shortage of nurses is not limited to this hospital; in fact it is a countrywide problem (http://www.sanc.co.za/stats.htm). However, one cannot fold one's arms and wait for miracles to happen. Empowering the limited number of nurses available would be a large part of the solution. To empower the nurses, one must take into consideration the environment they are working in, their professional and personal development. The report from the exit interviews held by the human resource department of the hospital, shows a pattern of the recurring problem of "inadequate working conditions" as verbalised by the resigning nurses. The human resource officer who provided the information was unable to provide a programme on recruiting and maintaining the nursing staff. Some candidates come for interviews, according to the same human resources officer, and they are given the job, but never come back to take

it because the hospital is far from the city. The nearest banks and shops are about seven kilometers from the institution. This, coupled with the fact that the institution does not have entertainment facilities makes life rather difficult for the nurses who reside in the hospital residence and who do not have their own means of transport. There is a need to find ways to attract more nurses with incentives and bonuses. The hospital needs to compete with other institutions with special offers such as higher wages, rural allowances, and other incentives to motivate nurses.

The other possible way to solve the problem of nursing staff shortages, would be to change the way the institution has been developing its staffs. The institution has a considerable number of Auxiliary nurses who have been working there for the last fifteen years. If these had been encouraged and given the opportunity to further their knowledge, today they could all be professionals. It is then high time for the hospital management to review its policy on staff development by sending a considerable number of its auxiliary nurses to further their studies. The other option would be to send a number of professional nurses for post-basic education and then devise a programme for bridging courses. This option is likely impossible though, because of the shortage of professional nurses.

4.2.3 Negotiation with management and multidisciplinary team for support

In an environment where the stress level is high, the friction between colleagues are the last thing one could wish for. It is no doubt that individual health workers in this institution are doing their best for the good of the patients. What seems to be a problem is a lack of teamwork spirit. According to the nurses interviewed, there is a poor exchange of information and support. This is how one of the participants expressed it: "***Nursing staff are also being emotionally abused by nursing managers and members of the multidisciplinary team. Regarding each and every incident that happens in the ward, the nursing staff are always blamed, instead of getting moral support from their managers or other members of the team".*** The other thing that puzzles the nurses is for example when a psychiatrist prescribes sedation for behaviour control to a patient who is disruptive and who is refusing the injections while the same psychiatrist knows that there are only one or two males in the ward and

he/she will not help to pin the patient down yet expects the treatment to be administered. It is true that he/she may not be obliged by the law to do so but then the prescription becomes ineffective in a situation like this if the treatment can not be administered because of the staff shortage. One is left wondering if it makes sense to the nurses that a psychologist can come to the ward for psychotherapy and expect the nurses to be the ones to call the patient that he/she is going to be dealing with for the next whole hour or so. "***A person will just come to you and give you a piece of paper saying, now I want to see this patient, then it's like we are errand boys for them".***

It is not about who is right and who is wrong. To change this line of action new ways of communicating need to be put in place. Participants verbalised that their observation and report are not taken seriously during ward-rounds while they are the ones who are with the patients all the time. "***You do find that a person is not involved on a day to day basis with the patients, comes once a month to see the patients and then tells you: you must do this and that for the patient that he or she doesn't know".*** The other one added: ***"The patient was aggressive for some time so we suggested to the doctor to prescribe sedation. The doctor was reluctant to sedate him. He ended up causing havoc in the ward and the staff was injured, he went to hospital and he was sutured. Then we started wondering what is the point of reporting what is happening if we are not taken seriously."*** This makes some of them sit back during ward-round and let the rest of the team decide. These suggestions would help.

1. There should be a monthly or so meeting where the representatives of different departments can meet to discuss various issues pertaining to the comprehensive care of patients. In these meetings an evaluation can also be done on what is working and what is not working. This would not only improve the working conditions but also the human relations among these professionals.

2. Evaluate what the different strategies are in dealing with patients and others' violence. If need be help those who really need help. Try to involve the family members more in the care, treatment, and rehabilitation of their members.

3. There should be mechanisms, appropriate to the patients admitted here, to identify the potentially violent patients and nurses needs to be kept updated on any new developments in academic findings. It has been found that ability to intervene successfully in potentially violent situations reduced the level of risk that nurses felt exposed to. They also perceive lower levels of risk when working in a skilled team (Trenoweth, 2003:278-287).

The participants in this research expressed a concern that they feel alone in dealing with the day to day patient's care. A mechanism could be put in place such as a monthly or bimonthly meeting of the top seniors of all the departments such as the nursing department, the psychology department, the occupational therapy department and so forth. In this meeting the objective would be to evaluate the functioning of different department and whether the objectives have been achieved; the challenging and possible solutions; and who does what in the multidisciplinary teamwork. If there are discrepancies then an assessment could be done and a joint plan of action elaborated.

Management should work on the relationships between employees and promote a sense of belonging. Management must meet the nurses half way and not wait for a crisis or pretend to ignore a problem when it is there. Murphy, et al. (1995:128) argue that too often the threat of exposing anxiety about performance or ill health, or fears of incompetence, or any sign that there is something wrong, forces managers to suppress or deny problems until it is too late. And when it is too late, both sides lose. Supervisors who are unwilling or unable to provide adequate support and approval tend to provoke anger in their subordinate. Anger directed at others leads to absenteeism, accidents, sabotage, resistance, scapegoating, internal strife, and even sadistic behaviour.

Constructive relationship are crucial to the mental health of all the workers. McLean (1979:84) argues that good relationships between members of a workgroup are a central factor in individual and organizational health.

The process of sharing information and exchanging resources reduces the sense of isolation that so often characterises work in the human services (Cherniss, 1980:164). A

humane environment is an absolute prerequisite for the healing of violent people Gilligan (2000:51). Communication is to human relations what oxygen is to living things. Nurses appear scared of the environment to the point that they don't even feel safe to use assertiveness. When they are not happy about the situation, they withdraw instead of discussing it. Therefore there is a need to empower nurses in communication skills. And to break the ice, management should be involved in assessing what the nurses need in order to be not only more productive but also self-actualised.

4.2.4 Request for comprehensive orientation for newly appointed psychiatric nurses

Newly employed nurses need to know not only what the institution expect from them and how to be legally covered but also which environment they will be operating in and what they can expect as challenges and problems related to their work so that they can be able to use a variety of skills (Seybolt in Booyens, 1998:375). The orientation of an employee should be individualized in order to develop those specific skill and abilities required for the present placement (Booyens, 1998:375). Given the fact that the institution has different categories of ward (for acute psychotic patients, for chronic patients with mental illnesses and mental retardation, for forensic patients), it is imperative that orientation be specific and diverse otherwise if the necessary attention to supervise the newly employed nurses lacks, even the best training system will not provide optimum results (Booyens, 1998:27).

4.3. GUIDELINE 2: FACILITATION OF THE MANAGEMENT OF AGGRESSION AND VIOLENCE BY PSYCHIATRIC NURSES

In this regard, regular in-service training could be instituted, situational analysis could be done in order to know what individual nurses need to know in their day to day rendering of services to the mental health care users. The plan of bringing in the orderlies should

be executed as soon as possible, as this would send a message to some mental health care users, those who are not psychotic, that the time for violence has gone.

4.3.1 Management of negative feelings

The negative feelings are a result of a hostile environment and ineffective coping of the nurses with the situation. Therefore one of ways to manage these negative feelings would be a modification of the environment in which these nurses are working. This can be done by hiring security personnel specifically in the forensic wards where state patients and observation patients are cared for.

It would be beneficial for orderlies or correctional officers to be deployed in some wards so that the nurses could attend to the nursing needs of the patients without worrying about their own safety and security. One of the participants expressed the following concern: "***Two staff members on night duty were attacked by very dangerous observation patients and were both sent to hospital. After some discussions, it was suggested that correctional service personnel or police officers be allocated to that unit. A delegation from correctional services found that the structure of the unit was not suitable for their personnel's safety."*** This matter needs attention to reassure the nurses of their safety. It is the opinion of the researcher that if it not safe for the police, with their training and equipment, it is definitely not safe for nurses.

4.3.2 Management of aggression

It appears that the best way of managing aggression in this institution is finding solutions to its leading factors. Staff development for example and a change of approach by management may contribute considerably to managing aggression. This may boost the morale of the nurses, who are already demotivated, and counter the absenteeism that seems to be a major factor contributing to violence.

4.3.3 Coping with Stress

Given the environment in which the institution finds itself in, it is not possible to eliminate the stress. However, some actions can enable the nurses to live with this stressful environment. Murphy, Hurrell, Sauter and Keita (1995:221) argue that identifying and

recognising the problem and taking steps to tackle it, perhaps by negotiation, might arguably arrest the whole stress process. In dealing with stress, the focus must be on the holistic approach, that is, not only taking in consideration the working environment of the nurse but also his or her home environment. Murphy, et al. (1996:228) state that workers do not leave their family and personal problems behind when they go to work, nor do they forget job problems upon returning home. Nearly all models of job stress acknowledge the importance of non-work factors, and their interaction with work factors, in affecting health outcomes.

The strategy to deal with the burnout, or at least to tolerate it, is associated with two occupational factors: length of experience and level of burnout (Whittington, 2002:819-825). Prevention and treatment include: greater job control by the individual workers; group meetings; better up-and-down communication; more recognition of individual worth; job redesign; flexible work hours; full orientation to job requirements; available employee assistance programmes; and adjuvant activity (Felton, 1998: 237-250).

To further alleviate job dissatisfaction and stress, Cherniss (1980:158) suggests four types of interventions which are listed below.

1. Reduce or eliminate external job demands.
2. Change personal goals, preferences, and expectation.
3. Increase the worker's resources for meeting the demands.
4. Provide coping substitutes for the withdrawal characteristic of burnout.

This comes back to the comprehensive and teamwork approach to alleviating violence by getting everyone involved in participating, employing more staff, creating an environment that is conducive to personal development, frequent workshops and in-service trainings, and motivating for a raise in remuneration features such as rural allowances and danger allowance for those working in psychiatric institutions.

4.4 GUIDELINE 3: ADDRESSING THE CONCERNS AND TRYING TO FIND SOLUTIONS TO THE PROBLEM

The problem of violence and aggression in this institution is known to everyone, including the patients. What is lacking is an initiative to start searching for solutions.

4.4.1 Debriefing of nurses after incidences of aggression and violence.

The institution does not have a proper program to deal with nurses' stress related problems. It relies on the Gauteng employees' wellness program, called ICAS (Independent Counselling and Advisory Services), that nurses can use for free. However, the participants in this research study said that it is a "faceless" organisation because the initial contact is done on the phone in a conversation with someone one does not know. This participant exclaimed: "***And to think that we have so many psychologists here and then we have to get a psychologist somewhere! Isn't it that funny, ironic? I am working here with so many psychologists but if I need help I have to be calling this ICAS, I have to call somebody, somewhere else."*** Some participants expressed a wish for the institution to have a proper plan in place. "***There are no contingency plans to deal with frustrations, feelings and well being of the staff after these traumatic situations"***. "

This organization (ICAS) renders services to all Gauteng public servants experiencing problems. Therefore, management can improve matters by not waiting until someone experiences a nervous breakdown. There should be opportunities to help nurses to verbalise what makes their work worthwhile, the challenges they meet, the coping mechanisms they use, their visions and dreams. This would be a way of assessing job satisfaction and of helping those who are struggling before it is too late. The support from management would increase the self-confidence of those nurses who have started wondering whether they made the right choice by becoming psychiatric nurses and make them feel appreciated, valued, and that their contribution is meaningful. This

support is stressed because management consists of nurses whom the nurses in wards would like to emulate.

Snyder (2001:290) argues that finding meaning plays a prominent role in an individual's adjustment to negative events. In the aftermath of the stress situations, people want to understand what caused the events to happen, as well as determine the impact of the event on their lives. When staff members begin to react adversely to job stress, counselling with focus on one's response to work presents another potentially valuable staff development method (Cherniss, 1980:163).

4.4.2. Speedy Financial Compensation

Participants voiced the concern that once their property has been damaged by the mental health care users, or once they are injured, it takes too much time before they are compensated. The nursing management could negotiate with the human resource Department responsible for processing the document so that a time frame could be agreed upon as this would give the nurse victim of this aggression an indication on how to follow up, and to know how things are progressing.

4.5 OTHER IMPORTANT MATTERS TO BE EXAMINED

4.5.1. Staff Recreation

It was mentioned above that some of the staff members use alcohol as a mechanism to cope with violence and aggression. Some other ways that would help them to cope effectively with violence would be to have access to recreational facilities such as a gym that is functioning and, social gatherings. Cultural activities such as folk dancing, choirs, and social clubs need to be given a place. This will help the nurses to relax after work and take away the idea of using substances in order to cope. If not, the danger is that ultimately either the nurses will be depressed or will develop addictive behaviours. Mclean (1979:24) argues that some coping strategies may be helpful only if applied in

the short-term such as drinking alcohol. However, such behaviour could become a desperate and compulsive habit with debilitating social and health consequences.

4.5.2 Training in Self-defense

The goal of this training should not be misunderstood or misused. The purpose of the training would be to empower the nurses with some skills to deal with the violence patients when they have to. Knowing that not only they can identify the symptoms of violence but also that they could contain it physically may enhance nurses' confidence and decrease anxiety that hampers their ability to think logically in times of crisis. The remark of Wilder and Sorensen (2001:29) is valuable when they say that "*any time a person is hospitalized, they are taken out of their normal lifestyle, removed from their normal environment, put into an environment in which they are perceived as knowing nothing, forced on to schedules that they may or may not appreciate, and required to submit to care they may not appreciate*". The nurses are well placed to understand that the violence which started at home will continue in the hospital. Otherwise, they just have to listen to Davis (1997:25) who invites one to look around and realise that people who are violent at work are the same people who are violent at home, on the road, and in the grocery store.

4.6 EVALUATION OF THE STUDY

A sample of ten professional nurses working in closed wards, no matter how comprehensive it can be, will not represent the whole view of the lived experience of aggression and violence held by all the nurses in Gauteng psychiatric hospitals, far less all those in the country. For this reason, the researcher recommends that more studies be done in different institutions with bigger samples. It is quite possible that a study conducted in an open and less crowded psychiatric institution may yield different results. That is why the findings here are contextualised to the environment and situation in which the research study was done.

4.6.1 Strengths

This study explored and described the lived experience of aggression and violence by nurses in a Gauteng Psychiatric institution by means of in-depth interviews and life sketches. A phenomenological approach revealed the different emotions the nurses working with psychiatric violent mental health care users experience. The study also described the perceived contributing factors to the violence in this institution and showed the negative consequences of this violence to the nurses, such as the use of substances. The standard means of conducting a research study were used, and findings were contextualised and supported by a literature control. Suggestions and recommendations were drawn from the lived experience of aggression and violence by these nurses. It is the desire and the hope of the researcher that more research will follow and that those involved in policy- making will take heed and view the findings of this research as a break-through on the emotional state of nurses working in a high risk violent environment and the challenges which they currently face.

4.6.2 Limitations

This research was done in a psychiatric institution with closed wards. It is one of the kind as there has not been any research on the nurses' lived experiences of violence and aggression in psychiatric institutions in South Africa. Hence this made it difficult as there were not enough theories or literature to analyse and compare the findings with. While the findings are contextualised within this institution, and given the fact that the researcher works in this hospital, an element of bias cannot be totally excluded, though there was no intention on the side of the researcher to be biased. The researcher and participants communicated in English which is not their first language. The richness of expression of what nurses do feel may have been hampered by limits imposed on the expressions of feelings by having to use a foreign language.

4.6.3 Suggestions for Further Research

The researcher would like to recommend further studies/researches in this field in order to cover the following issues:

1. the impact of violence and aggression in psychiatric hospital on the professional and personal levels of the nurses;
2. The long-term consequences of aggression and violence in psychiatric institutions with regard to the quality of care;
3. The lived experience of aggression and violence in open and semi-open psychiatric hospitals; and
4. Causes and reasons behind the psychiatric patients' attacks on the nurses.

4.7 CONCLUSION

The purpose of this study was to examine the lived experiences of aggression and violence by psychiatric nurses in a Gauteng psychiatric public institution, the essence of this violence, and how nurses experiencing this violence cope with the situation, so that guidelines could be drawn to help those nurses struggling and prepare those contemplating working in a psychiatric institution. A range of factors leading to this aggression and violence has been discussed in detail. Guidelines and recommendations have been drawn. It is therefore hoped that more research will follow and that a solution will be developed to end this plight of nurses who are exposed to violence on a daily basis. The hope is that there will be a positive end which is the holistic balanced mental, physical, and psychosocial well-being of all those involved in this special calling.

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APPENDICES

APPENDIX 1:

THE ETHICAL CLEARANCE FROM THE FACULTY OF HEALTH SCIENCES

ACADEMIC ETHICS COMMITTEE

UNIVERSITY OF JOHANNESBURG

APPENDIX 2

CLEARANCE FROM THE FACULTY OF HEALTH SCIENCES

HIGHER DEGREE COMMITTEE

UNIVERSITY OF JOHANNESBURG

APPENDIX 3

LETTER TO THE CHIEF EXECUTIVE OFFICER OF THE HOSPITAL

15 March 2007

Sterkforntein Hospital

Private Bag X 2010

KRUGERSDORP

1740

Dear Sir/Madam

REQUEST FOR CONDUCTING A RESEARCH STUDY

My name is Emmanuel Bimenyimana. I am currently registered with the University of Johannesburg for the Masters Degree in advanced Psychiatric Nursing Sciences. In order to fulfill all the requirements for this degree I am involved in a mini-dissertation, supervised by Prof M Poggenpoel and co-supervised by Prof CPH Myburgh, and Ms. V van Niekerk.

The title of the research study is "THE LIVED EXPERIENCE OF AGGRESSION AND VIOLENCE BY REGISTERED PSYCHIATRIC NURSES IN A GAUTENG PUBLIC PSYCHIATRIC HOSPITAL".

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

The research process consists of an in-depth audio-taped interview with individual participants, lasting about one hour. After the collection of data, the audiotapes will be transcribed and analysed by an independent coder and researcher's supervisors analysis as required by academic standards.

The research proposal was submitted to the ethical committee of the University of Johannesburg and ethical clearance has been granted. The period of interviews is scheduled to be three months starting from the first interview, which of course will follow your permission.

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 decoding;
- 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 professional help is planned;
- Audiotapes will be stored in a locked cupboard and the key to the cupboard will be kept personally so that unauthorized people may not have access to them;
- After the transcription, independent coding, and examination, the audiotapes will be destroyed
- 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.

APPENDIX 4

LETTER OF INVITATION TO

THE PARTICIPANTS

15 March 2007

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 the Masters Degree in advanced Psychiatric Nursing. In order to fulfill all the requirements for a master's degree, I am currently doing a research project to which I would like to invite you to participate.

Your contribution, as participants, will be highly appreciated and will make a difference in the live of many other professionals who may learn from your own experiences. The title of the research project is "THE LIVED EXPERIENCE OF AGGRESSION AND VIOLENCE BY REGISTERED NURSES IN PSYCHIATRIC INSTITUTIONS IN GAUTENG".

My study supervision is Professor M. Poggenpoel and Prof. C.P.H. Myburgh and Mrs. Vasti van Niekerk are co-supervisors; all the three being lectures at the University of Johannesburg.

The rationale behind the choice of this topic and the conducting of this research project is twofold. Firstly, it is no secret for any one that workplace violence found in other areas is also met in psychiatric environment. Yet the extent to which this violence affects the professional nurses in psychiatric institutions and the impact it has to the work and their individual and personal lives is not known. Therefore, this research would shed some light on to what exactly is happening regarding lived experience of aggression and violence. Secondly, by exploring the means that some nurses use to cope with aggression and violence, by detecting the problems encountered by professional nurses would enable the researcher to devise, based on the findings, guidelines that may help all those who work in psychiatric institutions on how to deal with aggression and violence.

In this research, no financial gain is foreseen. The advantage of participating in this research is that the participants will make their voices heard, and the findings, as said above, will increase the knowledge on how to deal with aggression and violence in psychiatric institution, specifically in the context of the hospital in which the participants work.

Ethical standards will be adhered to, in other words, all the participants will

- Freely sign an informed consent before the beginning of interviews
- No name will be mentioned during interview or after, during transcription and decoding;
- All information received will be treated professionally with respect to confidentiality and privacy;
- 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.
- 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 Photostat.

Should you have any question to ask or should you need more clarifications, contact me on the following addresses.

Post: Emmanuel Bimenyimana

PO Box 2296

Florida

1710 or Phone

Cell: 0827397912 (from 19:30 to 21:30 ONLY)

Alternatively, email to bem_manuel@yahoo.co.uk

APPENDIX 5

CONSENT FORM FOR PARTICIPANTS

CONSENT FORM TO PARTICIPATE IN THE RESEARCHER STUDY

I (Name in full)_____have read and fully understand the content in the request letter to participate in the research study on "The lived experience of aggression and violence by registered psychiatric nurses in a Gauteng public psychiatric hospital."

Further on, I confirm that I give the permission freely, knowing that the information given to the researcher will be treated confidentially 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 persecution

I have had enough time to ask questions and the answers have been satisfactory. I also consent for audio-taping of the interview.

Participant:

Name:…… Signature…… Date……/……/ 2007.

I, Emmanuel Bimenyimana, hereby confirm that the participant mentioned above has had the opportunity to ask questions regarding the research study and information regarding audio-taping, privacy, confidentiality, and anonymity has been provided.

Researcher:

Name…….. Signature…… date:…….

APPENDIX 6

THE AUTHORISATION LETTER FROM THE CEO TO CONDUCT THE RESEARCH IN THE HOSPITAL

APPENDIX 7

PROTOCOL FOR INDEPENDENT CODER

FOR DATA ANALYSIS

Tesch (in Creswell, 2003:192) provides a useful analysis of the process in eight steps.

1. The researcher obtains a sense of the whole by reading through the transcriptions carefully. Ideas that come to mind may be jotted down.
2. The researcher selects one interview, for example the shortest, top of the pile or most interesting and goes through it asking: “What is this about?” thinking about the underlying meaning in the information. Again any thoughts coming to mind can be jotted down in the margin.
3. When the researcher has completed this task for several respondents, a list is made of all the topics. Similar topics are clustered together and formed into columns that might be arranged into major topics, unique topics and leftovers.
4. The researcher now takes the list and returns to the data. The topics are abbreviated as codes and the codes written next to the appropriate segments of the text. The researcher tries out this preliminary organising scheme to see whether new categories and codes emerge.
5. The researcher finds the most descriptive wording for the topics and turns them into categories. The researcher endeavours to reduce the total list of categories by grouping together topics that are related to each other. Lines are drawn between categories to show interrelationships.
6. The researcher makes a final decision on the abbreviations for each category and alphabetises the codes.
7. The data belonging to each category is assembled in one place and a preliminary analysis performed.
8. If necessary, existing data is recorded by the researcher.

APPENDIX 8

EXTRACT FROM A SELECTED INTERVIEW

TRANSCRIBED (semi-structured) PHENOMENOLOGICAL INTERVIEW

RESEARCHER: How is aggression and violence for you in this hospital?

PARTICIPANT: It is very traumatic. It is still happening the patients when they come here they are very psychotic so they are very violent. I have experienced violence a couple of times. At one stage, what happened was that the patient was so psychotic and he wanted some money that he didn't have so he started attacking me and I was bitten. The patient was HIV- positive. I had to go to the hospital and it was very difficult.

RESEARCHER: Tell me more about how this happened and how you dealt with it.

PARTICIPANT: Oh! It's just… they take your blood for HIV and then you go to a general hospital, they check if you are not hurt or sick anywhere and then you come back and then you fill in some forms , there are some forms that you fill in for injury and then you are given ARVs. You get ARV's for a week and then that was it. No follow up, nothing until today. I thought the hospital was going to follow up but it didn't. I was not given the information and I thought that was it. I even didn't get the result of the test.

RESEARCHER: How does this make you feel?

PARTICIPANT: I just thank God ……. My job. I don't know … I was not happy with the situation. I thought they don't care so I started wondering why I should care about the hospital and that attitude, why should I care because people don't care about me.

RESEARCHER: And you said there are a couple of incidents besides that one.

PARTICIPANT: There is a lot! When you have to restrain a patient you know other staff members because they know nothing is going to be done if they get hurt so if you restrain so they just go away then you will find that you will be left, it's you and a couple of people left to restrain so it's hard. In both incidents that occurred. And it's funny because I have never been… I just don't know … I just can't explain it. I just come to work; not every day is the same. Some days are fine….

RESEARCHER: So far you are mentioning physical violence, I wonder if it is the only type of violence you experienced?

PARTICIPANT: Oh! Verbal abuse is also there, verbal aggression you know. Patients are very, very abusive and you must just take it because you work here. Some other things… because you are a human being they hurt you. They really do hurt you so… you know there was an incident where I reported that I can't handle. A patient was

very rude and was an Afrikaner and calling us kaffirs. You know it was like that so I reported it and they told me… uh…they told me that this patient is sick, he doesn't know what he is doing so I must just not take it too hard whatever he is saying because he is sick. But it's very difficult for me to take that a patient calling you kaffir. It's not nice. Yeah that time I was quite upset a lot but the patient eventually left and I was fine.

Most of the time you find also that the family is still angry so they become aggressive towards them and they retaliate and if you have got a psych number how can I call this if you were admitted once at (X-hospital) or any psych institution you must know that you will come back over and over again if you start saying no you start being aggressive other people come here being fine you know it's just that they had a fight , a simple person that a normal person can have but for them they will say no he is being psychotic they think that so I think education, education, education.

You must be a very strong person to work here. You must be strong in every way and not take things lightly and not take everything to heart. You must just be a relaxed person and you must know that you are working with people who are not in their right frame of mind. You must know that anything can happen, anything. You must be alert at all times, you …because you don't know today they are fine and tomorrow something else so be really alert and not be a serious person because if you are, you will take things to heart and you will end up being hurt. Patients are very funny, so you call those patients nearby and sit with them, you know, I just talk with them and understand. You must have a lot of one on one with them and understand where they came from, how they became sick and then that's the only thing that will help you

cope you know understanding the patients and then also knowing what you came here to do, knowing your work, knowing a lot of things updating yourself going to in-service that helps you.

RESEARCHER: You stated above that you went to tell “them” that you cannot take it. Who are you referring to when you use “them”?

PARTICIPANT: I am referring the management. Obviously anything that happens you tell the management. The management knows that the patients are sick but they want the patients to have rights and patients and other times you can’t have rights and be sick if you are not in your right frame of mind because… telling you please do this, please do that, and then you won’t do it. I don’t think you can do other things and not be responsible you can’t have the right and not be responsible so they expect us to give the patients rights and the patients are not responsible for their rights that they have been given. So they don’t understand the whole situation and the works it’s very difficult. So they stand with the patients. A patient can come with a bruised arm and say that a nurse did this to me, they will take it to… and they know that the patient is sick, the patient can lie, but they will make you feel as if you did something wrong to the patient. They do have a procedure that they follow: they will come and interview you, they will interview the patient, and but making you feel as if you did something wrong. You know it’s not like they come being neutral. They came with the mind that you did something to the patient so it’s very difficult.

… at times, staffs can also be aggressive and violent but not…they don’t provoke the patients I have never seen a case where they provoke the patient. Usually it’s the patients that provoke the staff

and the staff try to defend themselves but sometimes you will find that a staff member came, you know, came to work not in his good frame of mind maybe they are sleepy or something having family problems and then you find that maybe you won't answer the patient nicely you will answer back. I do find cases like that.

You do also find conflicts among the multi-disciplinary team especially when a person is not involved on a day to day with the patient, comes once a month to see the patient and tells you; you must do this and that for the patient then is a conflict because you can't tell me, I have stayed with the patient on a day to day and then you must tell me that I must do this or OT (occupational therapy) work because, you know, they don't understand especially people… the OT and the psychologist they give you tasks: please do this for the patient and only to find out you have got how many patients in a ward 25 when there is only 4 of you. Yeah I don't think they understand the situation that is going on at work. There are lots of conflicts that way.

RESEARCHER: What do you think should be done to stop or at least decrease this violence in the hospital?

PARTICIPANT: I don't think it can be stopped because most of the patients when they came here they are very violent so stopping it I don't think it's an option; but reducing it, having a balance ratio patient-nurse and having qualified people, having enough staff I think that will help reduce the violence but stopping it I don't see that happening. They just have to open more schools for nurses and increase money in psych institutions. I don't know because I think if they are doing

something, that thing is not working. This environment is very tough, if you are not strong you will leave.

After the incident of being bitten by an HIV-positive patient, I was ready to leave. I had already applied in lots of places I don't know what stopped me. Maybe things got better I don't know but I was ready to go. I was on my way out I don't know what stopped me… may be is a fear of the unknown going to a new place… I do understand those who leave and I even sympathise with them because it's not easy to work like this… you can't give quality care when you are not motivated.

The management should learn how to say thank you. You know, if you have done something nice, they must just thank you. You know and show you that they appreciate what you are doing and not every time there is a problem, you find 6 or 7 matrons coming to your ward if there is just a small problem but if you did something nice nobody will call you and say "eish thank you for doing this and that"; and even if it's above or not within your scope of practice they won't say thank you or please keep it up you know so it's things like that simple things because I can't say money because it's not all being controlled by them, yeah, and showing appreciation for what you are doing and letting you know that they can see what you are doing if you are working and nobody tells you that you are doing a good job, yeah, you are de-motivated.

RESEARCHER: I know we are talking about violence. However, I would like to ask you: what are the good things that happened to you since you started working here?

PARTICIPANT: Good things? I don't know what thing there is. Nothing that I can think of on top of my head. Good thing hey! …maybe seeing a patient go home but they come back after 3 months or so but 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 maybe that's the best.

RESEARCHER: Your experience of aggression and violence, does it have anything to do with you being a female or does it happen in the same way to males and females who work here?

PARTICIPANT: I think it's in the same level. But when you work with females they fight more than males. If you are a female in male ward, it is very difficult; but if you are female working in a female ward it's not that bad because you can contain them but being a female and containing a psychotic male… it's very difficult. The psychotic lady will shout before they can start a fight so you can give them injection but males fight to kill. Males fight once but in females you can stop a fight at 9H00 then 12H00, then later, the same person can be involved in ten fight a day for the same thing but males when it ends, it ends.

RESEARCHER: Anything you would like to add to what you have just shared?

PARTICIPANT: We need enough staff, people should be allocated in a ward that they like; because when you work in a ward you do not like, I think

this also adds to stress. This thing or rotating because there is shortage here and there, working one night here, one night there, it makes people unhappy. If they can let you work in the same ward for a year, a ward that you choose, may be if they can give three choices I think it can ease things. They just put you where there is a shortage, they don't care whether you like it or not. They just say we need a professional nurse there and they take you, without considering your type, you height, whether you like it or not. When you complain about things they say: we will deal with it, we will look into it. You know it has been years since like they say we will deal about it and you know nothing has been done. They just want you to fight and other people are not good at shouting or screaming; if you scream and shout you get your way and then will listen to you but if you are quiet they won't.

I also wish families were involved but they don't have knowledge and understanding of psych; they don't know why the patients are doing what they are doing; they don't understand the illness so it's very difficult for them to come and visit after the patients had broken the windows at home, you know, so find that those who come to visit they come and criticize their family members and in my ward, there is a patient the mother wants nothing to do with the patient so she dumped the patient here and I don't see what we can do. So there is no family involvement in many cases and you find that the patients become more aggressive and more sick if they are not visited by their family members…. It's very rare to find a patient and family who comprehend each other. Most of these patients stay here for years, you know…. It is not even easy to educate the family because most of them they come still being angry for broken windows at home so they are not even willing to listen to what you say but we try and give health education especially when they come to take patients for weekend. But you

find that they don't understand. I think mental illness should be part of public knowledge; now if you come to this hospital and go back they will be speaking about you, that you are a mad person, that you are taking medication, it's like a taboo. A simple fight that any other normal person could have will bring back a patient here because the family thinks he is mad. So I think education, education, education. As there is an HIV-AIDS day there should also be a PSYCH day.

RESEARCHER: Thank you for sharing your experience and I wish you well hoping that things will improve so that you stay here.