

Nurses' experiences of hostile behaviour from mentally ill patients in the psychiatric ward of a general hospital

by

ISAAC CHIMEDZA

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SUPERVISOR: Prof J E MARITZ

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DEDICATION

I dedicate this dissertation to my wife, Tapiwa, for being my pillar of strength and support. I love you sweetheart.

DECLARATION

I declare that **NURSES' EXPERIENCES OF HOSTILE BEHAVIOUR FROM MENTALLY ILL PATIENTS IN THE PSYCHIATRIC WARD OF A GENERAL HOSPITAL** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



SIGNATURE

20 February 2014

DATE

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I would like to thank The Almighty God for the grace to conduct this study against all odds.

Special thanks to my supervisor, Prof. J. Maritz for your patience, advice, guidance and inspiration throughout this journey.

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ABSTRACT

The purpose of this qualitative, explorative, descriptive and contextual study was to explore and describe nurses' experiences of hostile behaviour from mentally ill patients in the psychiatric ward of a general hospital and to propose recommendations to the hospital management to support nurses who experienced hostile behaviour from mentally ill patients. Purposive sampling was used to identify the twelve nurses who participated in this study. Data were collected through in-depth face-to-face interviews, drawings and field notes. The data were analysed using Tesch's descriptive method of open coding and the findings revealed that nurses experienced verbal abuse, physical abuse and sexual harassment from mentally ill patients, and had varied negative and positive responses to these forms of hostile behaviour. Main challenges were identified and recommendations were made to the hospital management to support nurses who experience hostile behaviour from mentally ill patients.

Keywords: nurses, hostile behaviour, experiences, mentally ill patients, psychiatric ward

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nurses are often exposed to hostile behaviour from patients in clinical settings (Inoue, Tsukano, Muraoka, Kaneko & Okamura 2006:29). Hahn, Zeller, Needham, Kok, Dassen and Halfens (2008:431) found that nurses are more exposed to patient hostility than any other health professional. Hostile behaviour may be characterised by verbal abuse, threatening aggressive behaviour, uncooperativeness or behaviours that have been defined as undesirable. These behaviours are often in violation of established norms (Schultz & Videbeck 2005:225).

The experience of hostile behaviour has the potential to have detrimental effects on the psychological, social, emotional and physical wellbeing of nurses (Inoue et al 2006:33). Hostility towards hospital staff has however only recently begun receiving general attention in developing countries (Talas, Kocaoz & Akguç 2011:197). In Namibia, much has been reported on gender-based violence (WHO 2005:39). However, no studies have been done on hostile behaviours at workplaces like general hospitals in Namibia. More so, no research has been done in the psychiatric units of these hospitals. The context of this study is a psychiatric ward in a general hospital in Namibia, sought to create awareness regarding these experiences.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Roche, Diers, Duffield and Cathing-Paul (2010:14) noted that the popular press worldwide provides a picture of decline in basic societal civility. Bullying is discovered in schools and on the internet and rudeness is all too often the order of the day in service negotiations. According to WHO (2009:1), domestic violence and gender based hostilities are a major public health and human rights problem throughout the world.

In Namibia, there are great concerns about the escalating levels of hostile behaviour among citizens. On a daily basis one reads in newspapers about crime and hostile behaviour in the communities. A Namibian newspaper "The Namibian", reported that

there is an increase in violent crimes in the country ranging from rape, murders, culpable homicides, suicides, armed robberies and stock theft (Kisting 2011:2).

There is a growing concern worldwide about the increase in workplace hostilities. Beech and Leather (2006:29) found that certain occupational groups have an increased risk of exposure to workplace hostilities. They concluded that nurses and other healthcare professionals are second only to security staff in terms of their likelihood of experiencing workplace hostilities. Child and Mendes (2010:90), and Demir and Rodwell (2012:380) also reported that nurses have been the recipients of an alarming increase in workplace violence.

Hostile behaviours in the community may also spill over to the hospitals. Hahn, Muller, Needham, Kok, Dassen and Halfens (2010:3544) state that hostile behaviour from patients is a serious workplace problem for nurses and is not restricted only to high risk areas like emergencies and psychiatric wards. In a study of policy implications and recent trends in the international migration of nurses, Buchan, Kingma and Lorenzo (2005:3) reported that nurses are three times more likely to be the victims of violence than other health personnel. According to Pai and Lee (2011:1409), patients are the most frequent perpetrators of hostile behaviour towards the nurses, with verbal abuse the most common form of this behaviour.

Hahn et al (2008:431) found that 50% of healthcare professionals in Switzerland (Europe) general hospitals have experienced verbal patient-visitor hostility. Another study in Europe by Duxbury (1999:111), sought to explore nurses' experiences of patient aggression encountered in the acute inpatient general and mental health settings. Though the study did not incorporate face to face interviews for further exploration, a method to be used in this study, it was found that nurses from both settings experienced hostile behaviour of a similar nature from patients, which was frequently verbal abuse and minor injuries. However, Mckenna, Poole, Smith, Coverdale and Gale (2003:62) reported that in New Zealand mental health settings were most at risk of all types of hostile behaviours, from patients to nurses (especially those who are in their first year of practice). Furthermore, Merecz, Rymaszewska, Mościcka, Kiejna, and Jarosz-Nowak (2006:447) comparing different specialties, concluded that work in mental health care was significantly more frequently connected with a risk of violent acts than work in other medical facilities. Psychiatric settings, which

are often closed, locked and often set limits on patients, are quite different from other departments in a hospital (Patton 2003:982).

In Southern Africa there are few recent studies on the healthcare professionals' experiences of hostile patients. In a study done at a psychiatric hospital in South Africa, Tema, Poggenpoel and Myburgh (2011:923) concluded that in South Africa hostile behaviour from patients in forensic wards was consistently experienced by psychiatric nurses. This hindered therapeutic relationships as the nurses experienced being disempowered. Another study at an urban-based general hospital in South Africa by Mavundla, Poggenpoel and Gmeiner (1999:40), found that the experience of nursing hostile mentally ill people was predominantly perceived as a negative experience.

1.3 RESEARCH PROBLEM

Hostile behaviour from patients constitutes a major problem within the health care setting. Foster, Bowers and Nijman (2007:147) calculated that in any given 12-month period, nurses working in acute psychiatric units in the United Kingdom had a 1 in 10 chance of being injured as a result of patient hostility.

I am an occupational therapist and have been working at a specific general hospital since 2007. I have witnessed diverse forms of hostile behaviours by patients towards professional nursing staff. As part of my duties I attend several ward rounds, including the psychiatric ward round, as well as interacting with many nurses. Some nurses share their daily encounters with patients in different hospital settings with me. It would however seem that only serious cases are reported. For example one in which a mentally ill patient physically and verbally assaulted a nurse and a security staff member (Anonymous. 2012: Personal interview, 12 May. Oshakati).

Ferns (2011:5) confirm my observation when he identified that nursing staff personally experience, witness or are aware of hostility by patients, especially high levels of verbal abuse, but very few have been reported. Beech and Leather (2006:30) and Talas et al (2011:202) also concluded that patient hostility towards nurses in general hospitals are under-reported.

Experiencing hostile behaviour may have a number of negative effects on the individual nurse. Inoue et al (2006:35) found that when nurses working in psychiatric departments were exposed to hostility by patients, they often experienced a severe psychological impact, such as stress and burnout, resulting in diminished job satisfaction.

Though there has been extensive literature concerning the prevalence of workplace (hospital) hostility around the world, little has been done and is known about how it affects the individual nurse's personal and professional lives in the Namibian context, which was the focus of this study.

If the problem of patient hostility is not addressed it can lead to the nurses living in fear, hopelessness and helplessness, which can subsequently affect the quality of care they provide to their patients. Tema et al (2011:916) pointed out that the workplace should be a source of joy, however it can turn into a source of frustration. As Le Roux and De Klerk (2007:87) put it, feelings are contagious and other staff members may also become affected. This can result in burnout, unplanned sick leaves and even a high staff turnover leading to poor service delivery.

In light of the above problem sketched, this study wished to answer the following research questions:

- How do nurses experience hostile behaviour from mentally ill patients in a psychiatric ward of a general hospital?
- What can be done by hospital management to support nurses who experience hostile behaviour from mentally ill patients?

1.4 RESEARCH OBJECTIVES

The objectives of this study are:

- To explore and describe nurses' experiences of hostile behaviour from mentally ill patients in a psychiatric ward of a general hospital.
- To propose recommendations to the hospital management to support nurses who experience hostile behaviour from mentally ill patients.

1.5 SIGNIFICANCE OF THE STUDY

Through this study, awareness could be created as nurses could narrate their personal and professional experiences of hostility from mentally ill patients through their lived stories, and the forms in which hostile behaviour is manifested.

According to the Namibian Labour Act 11 of 2007, Part 4 Section 39 (Namibia 2007: 46), the employer has the obligation to provide a working environment that is safe and without risk to the health of employees as well as provide the employees with the necessary information and training to work safely and without a risk to their health. The findings of this research could be used to create awareness of the different rights and obligations of employers and employees with regard to occupational safety of health care workers, nurses in this instance. Awareness would also be created on the channels to be followed by nurses who feel unsafe or dissatisfied with their working conditions, or those who would have gone through health problems (physical or psychological) due to working with hostile psychiatric patients.

Exploration of the problem would help in formulation of recommendations for hospital management to provide support systems for nurses who experience hostile behaviour from mentally ill patients. Hospital managers may use the findings of this study to plan and implement appropriate support systems for the nurses who undergo different forms of hostile behaviour by mentally ill patients. Finally, the findings will add to the body of knowledge regarding the phenomenon under study.

1.6 DEFINITIONS OF TERMS

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

1.6.1 Hostile behaviour

Hostile behaviour may be characterised by verbal abuse, threatening aggressive behaviour, uncooperativeness, or behaviours that have been defined as undesirable. These behaviours are often in violation of established norms (Schultz & Videbeck 2005:225).

Hostile behaviour in this study refers to incidences where nurses are abused (verbally and/or nonverbally), threatened or assaulted by mentally ill patients in circumstances related to their work in the psychiatric unit.

1.6.2 Nurse

A nurse is defined as a person who practices the art and science of promoting, restoring and maintaining the health of clients founded on a knowledge base supported by evidence based theory (White, Duncan & Baumle 2011:45).

In this study a nurse refers to a person registered by the Nursing Council of Namibia as a qualified professional nurse according to the Nursing Act Number 8 of 2004 (Namibia 2004:15) and who is working in a psychiatric ward of a general hospital to promote health in mentally ill patients.

1.6.3 Experience

According to Beard and Wilson (2002:13-14), experience is best defined as “the fact of being consciously a subjective state or condition; of being affected by an event, a state or condition viewed subjectively; and knowledge resulting from actual observation or from what one has undergone”.

For the purpose of this study experience refers to the personal experience of the nurses with regard to their feelings and thoughts gained through their interaction with hostile mentally ill patients.

1.6.4 Mentally ill patient

Frisch and Frisch (2006:4) define a mentally ill patient as an individual in a state which shows deficits in functioning, cannot view self clearly or has a distorted image of self, is unable to maintain personal relationships and cannot adapt to the environment.

In this study, a mentally ill patient is a person receiving care, treatment and rehabilitation services at a psychiatric ward at a hospital, who can present with hostile behaviour in response to a real or perceived situation due to his/her mental status, and

this behaviour may be directed towards nurses because of their regular interaction with such patients.

1.6.5 Psychiatric ward

The Mental Health Act of South Africa (South Africa 1973:573), which is still operational in Namibia, defines a psychiatric ward as a place at which provision has been made for the detention or treatment of persons who are mentally ill and includes any other place designated by the minister as a place for the reception and detention of two or more persons suffering from mental illness and in respect of which a licence has been granted under the Act.

In this study a psychiatric ward is a sub-unit of a general hospital that specialises in the treatment, rehabilitation and care of inpatients and outpatients with acute and chronic mental disorders, such as clinical depression, schizophrenia, substance abuse, psychosis and bipolar disorders, among others.

1.6.6 General hospital

According to Benatar, Doherty, Heunis, McIntyre, Ngwena, Pelser, Pretorius, Redelinghuys, Summerton (2004:460), a general hospital is an institution that offers health care services for people with a multiplicity of health problems on the same site.

A general hospital in this study is a health care institution providing patient treatment with specialized staff and equipment which is set up to deal with many kinds of disease and injury, including psychiatric illnesses.

1.7 RESEARCH DESIGN AND METHOD

1.7.1 Research design

A qualitative, explorative, descriptive and contextual design was used in this study. All matters related to the design and methods are discussed in full in chapter two.

1.7.2 Research methods

This section briefly describes the research method used during the planning and implementation of this study. Each aspect of the method is fully discussed in chapter two.

1.7.2.1 Population and sampling

The target population was 33 nurses who were working in the psychiatric department of the hospital. Purposive sampling was used and 12 nurses participated in the study.

1.7.2.2 Data collection

Data were collected through in-depth face-to-face interviews, drawings and field notes until saturation was achieved, meaning that no new information emerged.

1.7.2.3 Data analysis

Data were analysed thematically using Tesch's inductive method (Creswell 2009:185-187).

1.7.3 Ethical considerations

Nursing research is a procedure that utilises human beings as participants. The researcher has to consider certain ethical issues in order to ensure that the rights of the participants are observed (Burns & Grove, 2009:184). The following ethical issues were considered and are discussed in detail in chapter two: informed consent, right to self-determination, right to fair treatment, right to privacy, protection from discomfort and harm and confidentiality.

1.8 MEASURES TO ENSURE TRUSTWORTHINESS

According to Tappen (2011:153-161), trustworthiness of this design is what persuades others that the findings reported are worth paying attention to. These measures are

described as credibility, dependability, confirmability and transferability. Each measure is discussed in full in chapter two.

1.9 SCOPE OF THE STUDY

Due to the qualitative nature of the study and the small sample size, the findings of this study will not necessarily be generalisable to other settings although all efforts were made to ensure the transferability of the findings. The study is contextual in nature.

1.10 STRUCTURE OF THE DISSERTATION

Chapter 1: In Chapter One the research problem and its background information, as well as the purpose, objectives and significance of the study is discussed, key terms are defined, and the research design, methodology and scope of the study is described.

Chapter 2: In Chapter Two the research design, methodology, study population, sample, process of data collection, analysis and ethical consideration are described.

Chapter 3: In Chapter Three the research findings, data management, analysis and interpretation are presented. A discussion of findings in relation to existing information in the literature was considered.

Chapter 4: In Chapter Four the conclusion and limitations of the study are presented and recommendations are made for practice and further research.

1.11 SUMMARY

In this chapter the introduction, background, research problem, purpose, objectives and significance of the study were outlined. The researcher defined key terms, discussed the research design and methodology, as well as the scope and structure of the study.

CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In this chapter I discuss the research design and method used in this study. A qualitative, explorative, descriptive and contextual design was used to gain an in-depth understanding of the phenomenon of nurses' experience of hostile behaviour from mentally ill patients in the psychiatric ward of a general hospital.

2.2 RESEARCH DESIGN

Macnee and McCabe (2008:195) define research design as the overall systematic plan for acquiring new knowledge or confirming existing knowledge. A qualitative, explorative, descriptive, and contextual design was used in this study.

According to Burns and Grove (2009:717), qualitative research is a systematic, interactive, subjective approach used to describe life experiences and give them meaning. In this study, I sought to explore and describe the experiences of nurses of hostile behaviour from mentally ill patients in a psychiatric ward at a general hospital. The strength of qualitative research lies in people being studied in their natural setting, with in-depth data about the phenomenon under study being gathered (Ngako, van Rensburg & Mataboge 2012:7).

An explorative design is used to examine a little understood issue or phenomenon (which in this study is the nurses' experiences of mentally ill patients' hostility) to develop preliminary ideas by adopting an investigative stance (Neuman 2011:33-34). According to Polit and Beck (2012:21), exploratory qualitative research is designed to shed light on the various ways in which a phenomenon is manifested.

Neuman (2011:35) defines a descriptive study as one in which the primary purpose is to "paint a picture" using words or numbers and to present a profile, a classification of

types or an outline of steps to answer questions such as who, what, when, where and how. In this study this design was used to describe how nurses experience patient hostility and to describe what the support systems are for nurses who experience hostile behaviours from mentally ill patients.

A contextual design is meant to describe a phenomenon within a certain context (Tappen 2011:160). In a contextual design we study a phenomenon because of its intrinsic and immediate contextual significance. It involves far more than the physical environment. It requires an understanding of data and observations obtained from participants within the social meanings that form it. Words and behaviours cannot merely be described, but must be understood as to why it takes place and under what circumstances. In this study the phenomenon of hostile patient behaviour was described within the context or circumstances of the psychiatric department of a general hospital. I did not try to control the context of the study, but tried to capture the context in its entirety, allowing participants to describe their experiences within the context in which they took place.

2.2.1 Context and research setting

I will provide a brief description of the context and research setting. The psychiatric ward is situated on the outskirts of the main general hospital and has two admission wards for male and female patients, plus an outpatient clinic. The wards are adjacent to each other, only separated by a nurses' station. There are 60 beds (the capacity is 30 beds per ward) in each ward, as well as an open space for patients to rest and play some indoor games. The department is not built to acceptable standards and plans are in place to upgrade it to meet international standards. Patients are admitted from clinics and hospitals which are within the catchment area of the hospital. Nurses are the first healthcare providers to come into contact with these patients.

2.3 RESEARCH METHOD

Research methods are sets of specific techniques for selecting cases, measuring and observing aspects of social life, gathering and refining data, analysing the data and reporting on results (Neuman 2011:2).

2.3.1 Population and sampling

Babbie (2007:190) notes that a “population is a group or collection that a researcher is interested in. It is the theoretically specified aggregation of study elements”. The population comprised of 33 nurses who were working at the psychiatric department at the general hospital at the time of data collection.

Sampling is the process of selecting cases to represent an entire population so that inferences about the population can be made (Polit & Beck 2012:275). In this study I used a non-probability sampling approach, which according to Macnee and McCabe (2008:123) uses approaches that do not necessarily ensure that everyone in the population of interest has an equal chance of being included in the study. Purposive sampling was applied in which I consciously selected the participants to include in the study (Burns & Grove 2009:306). Polit and Beck (2012:279) define purposive sampling as that sampling that uses the researcher’s knowledge about the population to select sample members who are knowledgeable about the issues under study. This sampling method concurs with Poggenpoel, Myburgh and Morare (2011:952) who also used purposive sampling in their study on registered nurses’ experiences of interaction with patients with mental health challenges in medical wards in South Africa. The sample size for this qualitative study was twelve and it was determined through saturation of data by the nurses who met the inclusion criteria. Tappen (2011:118) emphasises that most qualitative samples involve a small number of cases who can provide rich qualitative data in the area of study.

The target population was constituted by nurses who met the following inclusion criteria:

- registered with the Nursing Council of Namibia;
- relevant working experience of at least one month at the psychiatric department. Poggenpoel et al (2011:951) and Modise (2012:46) in their different studies interviewed nurses who had at least one year of experience working at the psychiatric units. This study sought to include the newly recruited nurses as they have potential vulnerability to hostile behaviour by patients due to their limited working experience; and

- have encountered a hostile mentally ill patient during his or her career at the hospital psychiatric unit, in order to report personal experiences.
- able to communicate in English.

Exclusion criterion was participants who:

- have never encountered a hostile mentally ill patient during his or her career at the psychiatric ward.

2.3.2 Data collection

Data were collected through in-depth individual interviews with open-ended questions, naïve sketches and field notes.

2.3.2.1 Interviews

Several previous studies (Chambers, Ryan & Connor 2001:100; Ferns 2011:85; Poggenpoel et al 2011:951; Nau, Dassen, Halfens & Needman 2007:937; Deans 2004:33; Currid 2009:42; Kindy, Petersen & Parkhurst 2005:171) used audio recorded semi-structured interviews to collect data about the experiences of nurses of aggressive and hostile mentally ill patients. Some previous studies (Inoue 2006:30; Lin & Liu 2005:775) were conducted using questionnaires and scales, rather than through direct interviews, which gave participants few opportunities for personal expression of their experiences.

A research interview is a short-term, secondary social interaction between two strangers with the explicit purpose of one person obtaining specific information from the other (Neuman 2011:305). An interview is a flexible tool for data collection that enables multisensory channels to be used, that is, verbal, nonverbal, spoken and heard (Cohen, Manion & Morrison 2007:349). According to Hansen (2005:97), an interview is a tool used to gain insight into the ways that people make sense of the world and is used where small numbers are involved and where the data required relate to individual experiences. One of the advantages of the interview technique is that it permits the participant to describe detailed personal information (Creswell 2008:226). Other characteristics are that the interviewer (researcher) controlled the topic, direction and

pace, and contained all irrelevant diversions. This method was non-judgmental and allowed only the participant to reveal their feelings and opinions about their experiences with hostile psychiatric patients.

Informed consent was sought and given by the nurses and the hospital management after approval to conduct the study was granted by the Ministry of Health and Social Services of Namibia and from UNISA Ethics Committee. Each nurse was taken to a quiet room at the psychiatric ward which was free from disturbances and a 'Do not disturb' notice was put on the door. The room was comfortable (free from stress or anxiety) enough for the potential participant to concentrate and feel confident about discussing the study. I then clearly provided information about the research process and explained the content of the consent form including the benefits and the risks involved. I repeated the information and asked questions to check if the participant understood the information. The participant was given an opportunity to seek clarification on certain areas of possible concern. After receiving adequate information about the study and having had time to consider his or her decision, the participants then signed the consent form together with a witness (sister in charge).

Thereafter the date and time of the interview was agreed upon. Interviews were done outside working hours on times convenient to the participants. The participants were made comfortable (made to feel at ease and free from stress or anxiety) for the duration of the interview session (Polit & Beck 2012:537). Participants (designated as P1 to P12) were interviewed individually and a digital audio recorder was used to capture the entire session. Bell (2005:164) states that in a one to one interview, tape recording is useful to check the wording of any statement the researcher might wish to quote, to enable the researcher to keep eye contact with the interviewee and to help when doing the analysis. There may be a need to listen to the tape several times in order to identify categories.

I approached the participants with an attitude of openness and respect in order to establish trust and rapport. I used the facilitative communication techniques suggested by Okun and Kantrowitz (2008:75-79), such as probing, reflecting, summarising, clarifying, paraphrasing, minimal verbal response, eye contact, listening and silence, in order to gather in-depth data. Bracketing and intuition were used to avoid biases. Bracketing means the researcher suspends what is known about an experience being

studied, and intuition means the researcher focuses all awareness and energy on the subject of interest (Burns & Grove 2009:562).

The interviews were recorded on a digital audio recorder and transcribed verbatim. With the research objectives in mind, the researcher asked the following central question during each interview: What are your experiences of hostile behaviour from mentally ill patients?

I conducted a pilot interview before commencing with interviews in order to test the feasibility of the questions planned for the interviews. An expert researcher was consulted on the pilot interview to give the necessary advice on the appropriateness of the follow-up questions. According to Teddlie and Tashakkori (2009:203), a pilot interview is a stage of the project in which a researcher collects a small amount of data to 'test drive' the procedures, identify possible problems in data collection protocols and set the stage for the critical study. The pilot interview produced rich data and was analysed as part of data gathered in this study.

The total interview time was 248 minutes, 54 seconds. Although the data was sufficiently rich, the length of the interviews were at times short since most participants were not able to adequately express and elaborate in English, a second language of all of them. They revealed this after the interview and it was noted as field notes. This prompted the use of drawings from eight of the participants to triangulate the findings.

Data were collected until saturation took place, which occurred at interview ten. Thereafter, two additional interviews were done in order to confirm that no new information emerged.

2.3.2.2 Drawings

Drawing as a projective technique was developed by psychologists for patients who either resist to reveal or who are unable to become aware of their underlying motives, urges and intentions (Bergh & Theron 2003:291). Drawing is used as a way of self-expression and self-exploration in experiences that are difficult to verbalise (Visagie, Gmeiner & Van Wyk 2002:42). Additionally, drawing as a projectory technique is used

for inferring underlying motives, urges or intentions that cannot be understood through direct questioning.

Data were collected in English, from all the participants. Due to difficulties in expressing themselves in English, a second language for all the participants, they were requested to make a drawing that describes their experiences with hostile behaviour from mentally ill patients. This complemented the interviews and field notes, similar to that used by Moagi, van Rensburg and Maritz (2013:360), where participants were asked to complete drawings in addition to focus group interviews and naïve sketches. Eight participants managed to summarise their experiences in the form of drawings.

2.3.2.3 Field notes

Field notes are defined by Creswell (2009:182) as descriptive, demographic and reflective notes. Field notes were taken for each interview and marked according to the corresponding transcripts. These notes helped to prevent me from forgetting crucial aspects of the interviews that might affect the research findings and that assisted me in analysing the data. I picked interesting information that the participants said before or after the formal interview. I also noted the non-verbal cues and behaviour of the participants to add to the richness of the descriptions. The field notes totalled eight pages.

2.3.3 Literature control

The literature is reflected after data collection in the discussion of the findings, as comparisons with the major findings of this study with previous studies (Creswell 2008:90). The literature control helped me to clarify emerging findings.

2.3.4 Data analysis

According to Polit and Beck (2008:507), data analysis is a process of organising, providing structure and eliciting meanings from research data. The audio-recordings for the interviews were transcribed verbatim for the purpose of analysis by myself and the independent research expert. Analysis involves breaking up the data into manageable themes, patterns, trends and relationships. Sub categories were then identified from

within the major categories. As stated in Macnee and McCabe (2008:72), as categories are developed through analysis, they are used to collect additional data, which is then coded and categorised again until data saturation occurs.

Data were analysed using Tesch's inductive method (Creswell 2009:185-187). The method includes eight steps:

1. Carefully read all transcriptions and write down ideas as they come to mind.
2. Pick the most interesting and/or the shortest interview. Go through it, find the underlying meaning and write it down in the margin.
3. Conduct the procedure for several participants. Make a list of all topics that emerge and cluster together similar topics. Form these topics into columns of major topics, unique topics and leftovers.
4. Abbreviate the topics as codes. Write down the codes next to the appropriate segment of the text. Place a bracket around them.
5. Find the most descriptive titles for the topics and turn them into categories. Reduce them to get five to seven themes, to be able to write a detailed report.
6. Make a final decision on the abbreviation for each category and alphabetise these codes.
7. Group the data material belonging to each category in one place and perform a preliminary analysis.

The data analysis tends to be an on-going process, taking place throughout the data collection process.

In this study, an experienced person in qualitative research was appointed as an independent co-coder. The transcripts, drawings and field notes were sent to the co-coder. The co-coder and I analysed the data independently, followed by a discussion in order to reach consensus on the categories that emerged from the data. The co-coder and I brought along the themes and categories we had reached independently. These were subsequently compared in order to find the similarities and differences of the themes, categories and subcategories and then these were finalised as agreed upon.

2.3.5 Ethical consideration

Ethical conduct of research should start from the identification of the topic down to the publication of the study. Burns and Grove (2009:184) point out that nursing research is a procedure that often utilises human beings as participants; hence the researcher has to consider certain ethical issues in order to ensure that the rights of the participants are observed. This study received ethical clearance from University of South Africa (UNISA), ethical clearance number HSHDC/155/2013 (see Annexure A), Ministry of Health and Social Services, Namibia, Reference number 17/3/3 (see Annexure C) and from the hospital management (see Annexure D).

2.3.5.1 Right to self-determination

According to Burns and Grove (2009:189-190), this right holds that because human beings are capable of controlling their own destiny, they should be treated as autonomous agents who have the freedom to conduct their lives as they choose without external control. This was done by informing the participants about the proposed study and allowing them to voluntarily choose whether to participate or not. There was no form of coercion and participants suffered no harm if they chose not to participate. In addition, they had the right to withdraw from the study at any time without penalty. There was no covert data collection.

2.3.5.2 Right to fair treatment

Each person must be treated fairly and receive what he or she is due or owed (Burns & Grove 2009:198). No financial rewards were given for participating in this research. Selection of participants was fair according to the eligibility criteria and set appointments were adhered to.

2.3.5.3 Right to privacy

Privacy is an individual's right to determine the time, extent and general circumstances under which personal information will be shared with or withheld from others (Burns & Grove 2009:194). No information was gathered about participants without their knowledge. They had the right to decide the extent of information to give or withhold.

The information consisted of attitudes, beliefs, behaviours and opinions. The identity of the participants was safeguarded through not mentioning their names, and omitting or deliberately presenting in pseudonyms the participant's person-specific titles and events which could make them easily identifiable. The interviews took place in a private venue and I acted with sensitivity to all matters shared.

2.3.5.4 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the principle of beneficence, which holds that one should do good, and above all, do no harm (Burns & Grove 2009:199). In this study research participants could 're-live' the experience and could experience psychological discomfort (mental distress or unease). In the event that the participants experienced psychological discomfort through re-living their experiences, as the researcher I remained supportive. The interview could be stopped until such time as the participant felt ready to continue. In situations where the participant could not continue with the interview, the interview would be stopped. Further, support would be offered through referral of those nurses who needed specialist attention (debriefing or counselling) from a social worker and/or psychologists without any cost to the participants. However, there was no need for such a referral.

2.3.5.5 Right to confidentiality

Confidentiality refers to the researcher's management of private information shared by a subject that must not be shared with others without the authorisation of the subject (Burns & Grove 2009:196). To maintain confidentiality, all data and records were kept in a locked place in my office and were only accessible to me. Records stored on a computer hard drive were password protected and will be erased using commercial software designed to remove all data from the storage device six months after the completion of data analysis. The USB drives were physically destroyed. A record stating what records were destroyed, when and how I did so, was kept. I (and not another person) transcribed the information to ensure confidentiality. Data collected underwent group analysis so that no one individual's responses may be recognised (Burns & Grove 2009:197).

The rights of the institution were protected by fully disclosing the nature of the study and the researcher's responsibility to the institution. A letter of approval to conduct the study at the institution was granted. The hospital's name was not mentioned in reporting.

Participants did not incur any financial costs in this study and no incentives were given for participation.

2.4 MEASURES TO ENSURE TRUSTWORTHINESS

According to Tappen (2011:153-161), trustworthiness of this design is what persuades others that the findings reported are worth paying attention to, that they are credible, dependable, confirmable and transferrable to other situations. He further describes these measures as follows:

2.4.1 Credibility

Credibility refers to the demonstration, in one or more ways, that the research was designed to maximise the accuracy of identifying and describing whatever is being studied, especially as judged by the groups of people being studied (Brown 2005:32). Credibility can be enhanced by:

- Prolonged engagement – I spent five years in the clinical field in which the research was conducted and built rapport with many of the participants.
- Triangulation - investigator triangulation was used in which an independent expert was used to develop coding schemes and then compare the codes produced. Triangulation was achieved by using interviews, field notes and drawings during data collection. Moagi et al (2013:360) obtained triangulation by using multiple methods of data collection, namely, drawings, naïve sketches, focus group interviews and field notes.
- Member checking - data were constantly checked with the participants and the final report will be taken back to participants.
- Peer examination – an independent expert coded the data.

2.4.2 Dependability

Dependability refers to accounting for all the changing conditions in whatever is being studied, as well as any changes in the design of the study that were needed to get a better understanding of the context (Brown 2005:32). It can be enhanced by:

- Code-recode procedure: An independent expert was involved in data coding.
- Question checking was done with an expert (supervisor) in research methodology.
- Inquiry audit involved enlisting an outside expert to verify the consistency of agreement among data, research methods, interpretations, and conclusions.
- Description of the research methodology – all the steps, strategies and procedures for gathering and analysing data were clearly described.

2.4.3 Confirmability

Confirmability entails full revelation of the data upon which all interpretations are based, or at least the availability of the data for inspection. In other words, the reader of the research report should be able to examine the data to confirm the results or interpretations (Brown 2005:32). An audit was done by an independent expert researcher. The transcriptions were verbatim.

2.4.4 Transferability

Transferability involves demonstrating the applicability of the results of the study in one context to other contexts (Brown 2005:32). A purposive sample of nurses was used. A detailed description of the sample and the context in which the study was conducted enables others to decide the extent the findings may be transferred to other individuals and other situations.

2.5 SUMMARY

In this chapter the research design, the research method and measures to ensure trustworthiness are outlined. In the following chapter the findings of the individual interviews, field notes and the drawings will be described, and the themes and

categories that emerged from the data in relation to relevant literature, will be discussed.

CHAPTER 3

FINDINGS AND DISCUSSION

3.1 INTRODUCTION

In the previous chapter the research design and method used in this study were discussed. In this chapter the focus is on a description of the demographic profile of the target sample, followed by the findings and a discussion of the findings.

3.2 DESCRIPTION OF THE DEMOGRAPHIC PROFILE OF PARTICIPANTS

The target population consisted of nurses registered with the Nursing Council of Namibia who had relevant working experience of at least one month at the general hospital psychiatric ward and who had encountered a hostile mentally ill patient during his or her career in the ward, in order to report personal experiences. The total number of participants in this research was twelve. Data were gathered using in-depth individual interviews with open-ended questions, drawings and field notes. The following table is a summary of the characteristics of the sample:

Table 3.1: Demographic profile of participants

Sex (n)	Male	3
	Female	9
Age (years)	Range	25-62
	Mean	45.5
Race	Black	12
Education	Diploma in Nursing	6
	Certificate in Nursing	4
	Diploma in Nursing plus Postgraduate Diploma in Psychiatric Nursing	2
Experience in psychiatry (years/months)	Range	9 months - 32years
	Mean (years)	10.7

The participants were predominantly female (75%) with a mean age of 45.5 years. They were all black with an average experience in psychiatry of 10.7 years. Only two (16.7%) participants had a postgraduate course in psychiatry, almost similar to 16% of participants in Maguire and Ryan (2007:123). The figure is relatively higher compared to findings by Arabaci and Olcay (2012:3) and Kamchuchat, Chongsuvivatwong, Oncheunjit, Yip and Sangthong (2008:203) who stated in their studies that only 1.0% and 3.5% of the nurses completed postgraduate education to become specialised psychiatric nurses respectively. In Leung, Peter, Spurgeon and Cheung (2007:48), the proportion of nurses with postgraduate psychiatric training was 5.9%. Unfortunately, the two in the current study, who are both above 50 years of age, account for a very small portion of the total mental health workforce at the hospital under study. This is of concern considering that Hanrahan and Hartley (2008:110) concluded that the average age of a psychiatric nurse is 52 years, which means that without an infusion of new graduates and specialising nurses, the mental nursing workforce at the hospital under study could become significantly thinner in the next 10 to 25 years. The other concern is that most nurses are nearing retirement, which is 60 years in Namibia (Public Service of the Republic of Namibia 2003:104), creating an urgent need for young mental health nurses to join the field of psychiatry.

3.3 DISCUSSION OF FINDINGS

During data analysis three main themes were identified relating to nurses' experiences of hostile behaviour from mentally ill patients. Tesch's inductive method of analysis (Creswell 2009:185-187) was used. Participants identified two main forms of hostile behaviour, namely verbal and physical hostility with three examples of sexual harassment. Nurses had a varied response (negative or positive) to hostile behaviour. Their responses included emotional, behavioural, adaptation and coping, physical, social, and in some, positive reactions. A number of challenges were identified as well as needs that could be addressed in future. The needs will be addressed under the recommendations in chapter four. The themes, categories and codes identified are reflected in Table 3.2. Each theme is discussed with verbatim quotes from the participants in italics.

Table 3.2: Themes and categories of nurses' experiences of hostile behaviour

Central storyline		
<p>Participants identified two main forms of hostile behaviour namely verbal and physical hostility with three examples of sexual harassment. Nurses had a varied response (negative or positive) to hostile behaviour. Their responses included emotional, behavioural, adaptation and coping, physical, social and in some a positive reactions. A number of challenges were identified as well as needs that could be addressed in future.</p>		
Theme	Category	Code
Types of hostile behaviour experienced	Verbal abuse	In the form of shouting, use of bad or foul language and insults Underreported
	Threatened or actual physical abuse	Biting, slapping, fist fights, kicking, scratching, pushing, pulling and breaking of belongings
		Often results after verbal abuse escalates
		Sexual harassment
Nurses' response to hostile behaviour	Emotional response	Anger, fear, annoyance, frustration, disappointment, terrorised, terror, stress, crying
	Behavioural, adaptation and coping responses	Ignore Retaliates either verbally or physically Accepting patient's condition and 'taking it easy' Professional exit behaviour Demotivation Positive self-talk
	Social response	Fear outside of the institution Support through communication with others
	Positive response	Enjoys the experience
Main challenges	Lack of training Lack of counselling and support Lack of reporting Lack of physical protection Lack of adequate human resources	

3.3.1 Theme 1: Types of hostile behaviour experienced

The first theme referred to the types of hostile behaviour experienced by the participants. It would seem as if the participants mostly experienced verbal abuse, followed by threats or actual physical abuse and sexual harassment. Abbas, Fiala, Rahman and Fahim (2010:36), Daffern, Mayer and Martin (2006:93), Hahn et al (2010:3538) and Poggenpoel et al (2011:955), similarly cited that verbal abuse was the most common form of abuse, followed by threats of physical aggression and actual physical aggression. These types of hostile behaviour from mentally ill patients are compatible with other previous studies which showed that a few, but significant number of participants experienced verbal abuse and sexual intimidation or harassment in addition to the ones mentioned before (Chen, Hwu, Kung, Chiu & Wang 2008:292; Inoue et al 2006:33; Maguire & Ryan 2007:123; Nijman, Bowers, Oud & Jansen 2005:225). The categories are discussed below.

3.3.1.1 Mostly verbal abuse

All the participants experienced verbal abuse on a regular basis, some on a daily basis. Merez et al (2006:444) also observed that verbal aggression was experienced by 100% of psychiatric nurses. Verbal abuse, according to Kamchuchat et al (2008:202), refers to the use of upsetting comments that are known, or that ought to be known, to be unwelcome, embarrassing, offensive, threatening or degrading to another person, including swearing, insults or condescending language. Participants mentioned that they were shouted at and insulted. Some of the participants said:

'First she just came and say no, I just want you to give me my medications. Then I told her that my dear, we are just using order, one by one, we cannot just give you medications at the same time. Then she said 'no no no, you meme, you even slept with my husband (laughing). She was shouting at me, shouting at me. Sooo, then I, I, I really that time I wanted to go out and the sister in charge just told me that I should just stay and continue' P1.

'Sometimes they are just talking and shouting, yeah, and maybe they can also mention your name. When you say no you did not do well when you said that then they shout more at you. Yeah' P4.

'Yes, especially yesterday there is a patient come from the community, he come here, he come straight in the, in the male side. He started eee, started switch off the lights and shouting to me...Aah that is the, that is the one daily, daily, aaah. Every day. They just shout at you, insult you. Every day' P11.

The participants also mentioned the use of derogatory, offensive, unwelcome and threatening communication:

'Sometimes they can umm, abuse you or use some abusive language towards a nurse. Most of them they are not beating you but using abusive language. Yes...Yes yes, it's like, it's like they were just talking something bad about my appearance, even though maybe it's not true. This one was using bad language towards me. He said '.....'(vulgar local language)' P12.

'About my experiences, even today I have been insulted, I have shouted by a patient. The patient is calling me names like longman, you know (laughing) you know. I am really tall but you know I am not ready to be called something like that. You see, we are suffering here' P3.

'Physical no, but I meet patients who are using bad words to me. But because I know that they are patients who are suffering from mental illness, having hallucinations, hearing voices telling him or her to do this or that, or to insult people or to beat. I know he or she don't want to do that by himself but it's the illness causing that' P9.

Kamchuchat et al (2008:202) and Merezcz et al (2006:448) confirm these findings where they found that verbal abuse was the most common type of hostility, followed by physical abuse and sexual harassment.

Verbal abuses were the most underreported if not unreported types of hostile behaviour. Findorff, McGovern, Wall and Gerberich (2005:399) defined under-reporting as when an individual is victimised and does not report the event to an employer, police or through other means. The study shows that participants felt it was pointless to report verbal abuses since no action was taken regardless of the effects of such experiences on the victims:

'Nooo. Because every now and then you get insulted. I don't know if they are supposed to be reported, I don't know about it. Maybe if you are injured by a patient that's when they take action. Mostly, most of the time you get insulted, you get beaten by these patients but nothing is done about it...You don't need even to report it because most of the time you leave a report when you get insulted, there is nothing they (superiors) can do really' P2.

'Aaah my dear, after that there is no answer, no change. I reported before and nothing done. Now you can't think of reporting. Because you report, there is nothing. What is the use for reporting if there is no change?' P11.

Literature confirms that nursing staff personally experience, witness or are aware of hostility by mentally ill patients, especially high levels of verbal abuse, but very few have been reported (Beech & Leather 2006:30; Talas et al 2011:202; Ferns 2011:5).

The verbal abuse was often followed by threats of physical abuse or actual physical assaults.

3.3.1.2 Threats or actual physical abuse

Martino (2002:12) defined threat of physical abuse as the promised use of physical force or power (such as psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences to the targeted individuals or groups. Some participants described threats of physical violence from patients:

'Sometimes you get threatened verbally by patients that if I find you outside when I am discharged I will deal with you' P3.

'He was refusing also to be given injection. After that we explained to him what the procedure is but he still refused. Yeah, after that one then he tried to beat the nurses saying you cannot admit me. Here when you tell a patient that they are going to be admitted most of them used to refuse to be admitted. That one then became aggressive; he wants to beat the nurses there, especially me. He came straight to me, it was only other nurses who intervened then we managed to overpower him' P6.

'He was insulting us and he was threatening also to beat everybody who try to come near him. Only that there were other nurses and we managed to to to, I mean, to restrain him' P6.

This finding is supported by Abbas et al (2010:36) who also found the experience of being threatened with physical violence by mentally ill patients common among nurses. Some of the threats escalated and became actual physical abuse, described by Kamchuchat et al (2008:202) as the use of physical force against another person or group, that results in physical, sexual or psychological harm and includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching, among others. Participants reported experiencing mainly beatings, biting, kicking, scratching, pulling, pushing and breaking of belongings. Physical abuse often results after verbal abuse has escalated, as happened with one participant:

'There was a patient who was verbally abusive to me, physically that one came later. There was a patient on this B side, the female side, I think she has been here for how long? Maybe she has been coming in and out four or five times since last year. Every time she sees me she starts insulting me, accusing me of stealing her husband and doing all sorts of things (laughing). Even if I did not go inside, I'm just there at the nurses' post, if she sees me then she starts, 'you stole my husband and you are sleeping with my husband'. Then one day I told her, 'listen, you must stop insulting me, you don't know me and you must stop that nonsense of yours'. Then she started saying, 'yeah, you even stole my clothes', (laughing). Then one day she said, 'I will beat you up' and I said ok if you beat me up I will also beat you up. Then she started beating me...'
P2.

Another nurse was bitten by a hostile patient:

'He bite me on the first three fingers and injured me... Anyway before he injured me we were struggling to take him out because he is a very strong guy, he is even taller than me. Very strong, so we informed the security guard from the main hospital gate to come and assist us. The security were scared of the guy so we tried and when we tried I catch the guy and no one was helping me there. Everyone is trying to run away' P3.

One participant reported being kicked by a patient:

'That day the patient we were busy giving the patient the medication and there was a patient who was busy walking around up and down. When we, when I called him to come and get his treatment he just come and kick me here on the chest (pointing at the chest). Then as from there it was so painful I can't even breath. Then I came out of the ward, then I was seen by the doctor. Then the doctor give me to be x-rayed. Luckily enough there was no fracture but it was muscle tissue injury' P4.

Some patients used their fists against nurses:

'Yeah I also remember one male patient. Most of the male patients they are very aggressive. Yeah. He was running away from the ward, then me I was with the cleaners supporting me to collect him to bring him back to the ward. That time the patient was very aggressive, then unfortunately the cleaner clapped him. Then when he turned he is just seeing me whilst the cleaner is on that side. Then he beat me with a fist. That time I suffered a fracture of the nose bone. I was having a fracture here (pointing at the nose)' P4.

'One case is when one patient beat me in the face with a fist (pointing at forehead) (inaudible), I just keep quiet. I didn't do anything, she was just aggressive' P10.

'I was beaten; I was beaten physically by a male patient. You know we were interviewing that patient with the doctor in the consulting room. Then the patient grabbed my pen, then I told him to bring my pen back, and he didn't want then I took my pen back. Then he stood and gave me a fist here (pointing at the forehead) on my face. I was bleeding, I was bleeding' P12.

Two participants reported being pulled and scratched by patients:

'That seclusion room there is no, there is no, no..., it is open when you observe the patient there is no screen to protect you. When you try to observe the patient, he is already near the window in the corner. When you try to greet him, he just pulling me, pulling my arm. He tried to scratch me, luckily the skin was intact. There was no laceration or open wound' P7.

'So maybe if, maybe if somebody beats me or somebody, like the other month, when? August. I was scratched here by a patient (pointing at forearm, though with no signs anymore of injury, but then I am used to it' P2.

Pushing was also common, as one nurse put it:

'Yes, there was one patient, maybe after two months when I start working here. I was starting to give medication. When I opened the container with the medication, she just pushed me. When she push me I, this kacontainer for medication fall down. Then she tried to pick up the medication because she want to commit suicide' P7.

Some nurses lost their personal belongings as described below:

'There was also one time when my spectacles was broken, yeah, by the patient. The patient was aggressive and broke my spectacles but I just went to to to...to I mean to buy new ones by myself. I didn't get any support from somebody else' P6.

'...some patient came and bite her finger. But until now there is no change. And the other nurses they are lost watches, necklaces, earring but there is no change, but they are reported, nothing is done' P11.

Breaking of personal belongings is also classified as physical attack, defined as the direct or indirect application of force by a person to the body of, or to clothing or equipment worn by, another person, where that application creates a risk to health and safety (WorkSafe Victoria 2003:18).

Abbas et al (2010:40) reported that 7.4% of physical attacks that happened to nurses resulted in injuries. Hahn et al (2010:3542) reported 0.8% compared to 58.3% (7) found in the current study where seven nurses sustained various physical injuries from hostile mentally ill patients. These injuries were a serious occupational hazard since they required medical attention.

Foster et al (2007:147) calculated that in any given 12-month period, nurses working in acute psychiatric units in the United Kingdom had a one in ten chance of receiving an

injury as a result of patient hostility. This is similar to what Hahn et al (2010:3542) and Green, McIntosh and Barr (2008:20) also reported.

3.3.1.3 Sexual harassment

Talas et al (2011:198) defined sexual harassment as being subjected to unwanted sexual jokes, stories, questions, or words; being unwillingly asked out; receiving unwanted mail or telephone calls; being shown someone's body sexually; having their body touched; or experiencing an attempted assault. Female and young nurses appeared to be exclusively the victims of sexual harassment or intimidation, with one participant being subjected to unwanted sexual words, as she put it:

*'Last week Wednesday morning, because now I am working at the male side, I was coming out of the male side nee, when his guy said, 'aaah, you. You are so beautiful, let us go and f*** each other there'. Then I said 'you, who do you think you are?' He started pulling me nee, then I turned back and I slapped him' P2.*

Another participant experienced an attempted assault when one patient nearly kissed her when she was still young:

'I saw the patient near to kiss me... especially that time when we were very young. Maybe you attract him, he try maybe to touch you' P5.

One patient abused a nurse by touching her body:

'Like most of the time they see you as a new staff, they used to beat you maybe on the buttocks or breast' P8

It would seem that this hostile behaviour normally happens when there are no male nurses around, as indicated by the follow-up statement from participant 2:

'You cannot really be with those very aggressive patients alone. There has to be another male nurse there with you' P2.

Previous studies have shown that the majority of female respondents felt they had been sexually harassed at least once during a year's time (Nijman et al 2005:225; Tema et al 2011:919). During the interviews one quarter of the respondents (all female) reported experiences of sexual harassment. The figure might be an underestimation considering that it is not easy to share such private information with others. Chen et al (2008:292) reported an even lower proportion of nurses (10%) who reported sexual harassment.

3.3.2 Theme 2: Nurses' response to hostile behaviour

The nurses' response to hostile behaviour from mentally ill patients were varied (negative and positive) and are categorised as emotional, behavioural, adaptation and coping, social and for some, positive.

These responses can be noted in the two drawings presented below of a negative and a positive response:

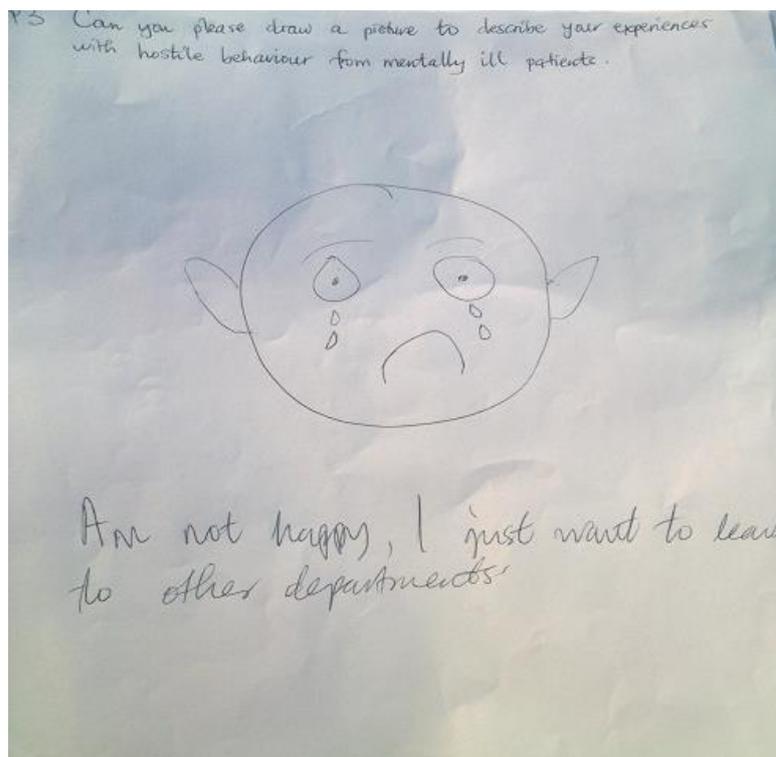


Figure 3.1: Negative response (P3)

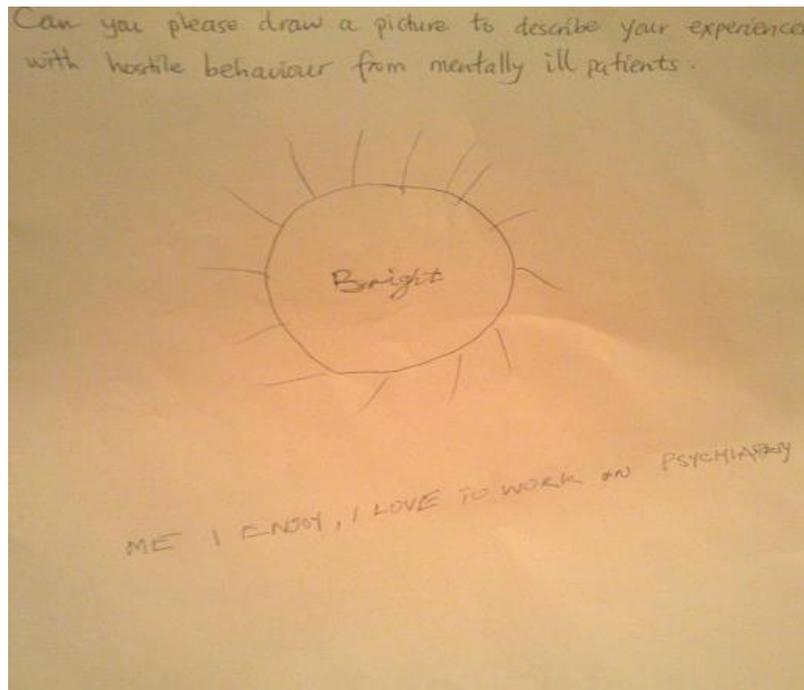


Figure 3.2: Positive response (P5)

3.3.2.1 Emotional response

This category reveals a wide range of responses from the participants which were subcategorised as unhappy, angry, fearful, annoyed, disappointed, terror and stressed. Chen, Wang, Lew-Ting, Chiu and Lin (2007:314) and Talas et al (2011:200) in their studies reported that the most common reported reactions to violence by psychiatric nurses were fear, shock, sadness, anger, disappointment and disgust. Deans (2004:34) confirms by concluding that participants experienced a range of negative emotions, including fear, anger, frustration, guilt, humiliation and embarrassment, in response to workplace aggression.

Participants expressed anger after their experiences with hostile behaviour from patients. Johnson (2006:306) states that anger is a defence, an emotional reaction that occurs when people are frustrated, thwarted or attacked. Some of the participants reported their angry responses to patients' hostile behaviour:

'Last week. I was coming, it was (inaudible, laughing). I am very sorry because I get very irritated and very angry when someone insults me' P2.

'I know that this patient is a psychosis patient. What can you do? But when I start working, oh I was very angry. It's Ms (name mentioned) who called me and explained to me, try to help me' P11.

From the above statements one would say that the hostile behaviour from patients evokes angry emotions in psychiatric nurses.

Fear stood out as the most prominent emotional feeling experienced by the participants. They felt scared to interact with patients after incidents of hostile behaviour. One participant, whose voice was high for most of the interview as observed in the field notes, stated:

'After I reported ummm, I was unfortunate the nurses I was working with they are new to the system so they did not take proper action. They only told me to go to see the doctor at casualty. I could not go alone, anyway I was supposed to be accompanied by a nurse. I asked if I could be accompanied by a nurse because personally I was not feeling well. I was very stressed, I was even scared...Just to hear that you are bitten by a mentally ill patient is scary, yeah it's scary, it's something...I work in fear, that's why I will ask to be allocated to other departments. No one cares' P3.

'It was very very difficult, I was even afraid of working here, I was afraid of working with these patients. Even to go inside alone, I wouldn't go inside alone. I was really fighting to work with female patients rather than male patients' P12.

One participant mentioned that they work like soldiers, and emphasised this feeling by drawing a picture of a fearful soldier anticipating attack as indicated below:

'Anyhow, especially when you are working here in ward 16, you are not working like a nurse. You are working like a soldier or you are working like a security guard' P11.

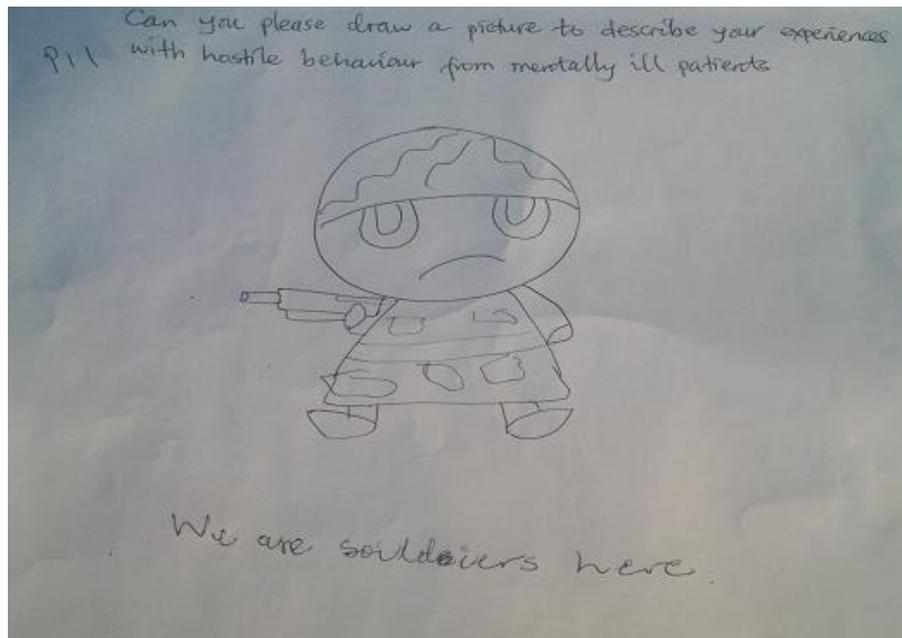


Figure 3.3: Working like soldiers (P11)

It's interesting to note that some nurses were even afraid of the patients before they interacted with them (patients), as one puts it:

'Yeah, when I came here even the first day I came here when I was seeing those nurses, I mean the patients there, I was even afraid to go inside there but later I was used to them and I was going there. Yeah' P6.

Tema et al (2011:920) confirmed that fear is the most experienced feeling by nurses. Similarly, in a study by Carlsson, Dahlberg and Drew (2004:538) on violence and aggression in mental health nursing, it was found that nurses who had encountered aggressive mental health care users on a previous occasion experienced fear and anxiety related to working with these patients.

As a result, fear may complicate and exacerbate other work stressors, resulting in participants experiencing stress. Stress is defined by Lazarus and Folkman (1984:19) as a particular relationship between the person and the environment that is appraised by the person as being taxing or exceeding his or her resources and endangering his or her well-being.

One participant reckoned feeling very stressed after an encounter with a hostile patient:

'Personally I was not feeling well. I was very stressed...it really affected me emotionally' P3. He added 'Yeah it affected me personally and socially, ummm. Ever since I got bitten no one cares about me, even the doctor didn't care. He was laughing at me. So later, so when I got bitten he refused to give me the treatment so then the next day I came back to demand for antibiotic. The other doctor said I should go and look for the doctor who treated me first, then I was having some forms to be filled. Everyone seems to refuse, the nurses don't want to fill the form, the doctor doesn't want to fill the form. I was even more stressed' P3.

Other participants indicated how they were mentally affected by the incident of hostility from a patient:

'I was thinking about the incident and ooh, I was mentally also affected' P1

'Yeah, personally I was feeling bad although I was also trained that sometimes you will be injured by the patient' P4

'Personally, yes sometimes you can feel bad but then it won't last long because you know it's just the illness making the person to insult you or to say bad words to you' P9

'Sometimes, sometimes really I couldn't, I couldn't feel much upset because I know those patients are having those abnormal behaviours and then you expect them to behave like that. But there is a certain time when I also felt bad as a person even though you know it's their behaviour' P12

According to Shen, Cheng, Tsai, Lee and Guo (2005:224), it is likely that even the threat of being attacked has become an important source of stress among nurses in psychiatric institutions. A significant relationship was found by Humpel and Caputi (2001:401) between the emotional competency and the length of time in mental health nursing. Emotional competency could be an important component in the explanation of why stress decreases as experience increases. This tallies with the findings of this study that most nurses experienced stress when they were relatively new at the mental health unit and tend to adapt to stress with more work experience:

Another finding by Martino (2002:26) noted a vicious cycle in which workplace violence was recognised as an important generator of stress disorders and the accumulation of

stress in demanding health occupations like nursing, can be in turn a generator of violence. However, this study did not seek to address the determinants of hostile behaviour from mentally ill patients.

One participant also felt annoyed by hostile mentally ill patients when she was new at the psychiatric unit:

'Aaah I felt bad. You know I am not used to this ward at that time. They (patients) can make you annoyed if you are new. Ummm. They can make you annoyed if you don't know them before. Ummm' P1.

Receiving no support from management also elicited feelings of disappointment from one participant:

'After that incident, for example I cried in front of my seniors, it was not professional. It was because of frustration. That was not my aim really to cry but because I felt disappointed, I felt alone no one cares' P3

The same participant described an extreme emotional reaction, not reported in previous studies, when he stated that he felt terrorised by working with mentally ill patients who presented hostile behaviour:

'Continuing working here to me, I feel, I feel terrorised or something (terrorised) by patients. Yeah. Maybe in future I get injured I will go through the same experience, the same bad experience. It's very terrifying. I work in fear, that's why I will ask to be allocated to other departments. No one cares.' P3.

It is worth noting that there was one participant who reported responding to hostile behaviour from patients by crying. This was mainly due to lack of support from management after a physical abuse incident with a patient, in which he was injured. The drawing below of a tearful person confirms the unhappiness experienced by the participant:

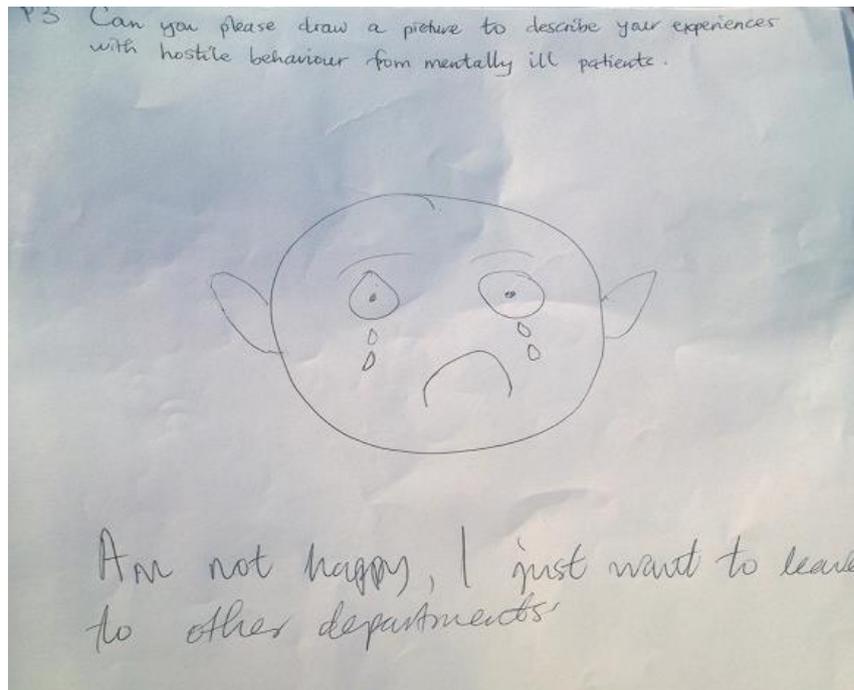


Figure 3.4: Crying (P3)

This was a unique experience of patient hostility with no precedence in literature.

The participant recalled:

'After that incident, for example I cried in front of my seniors, it was not professional. It was because of frustration. That was not my aim really to cry but because I felt disappointed, I felt alone no one cares, I cried in front of my seniors. I went there to the administration. So that's the thing' P3.

He also believes that anyone who goes through his experience can also be emotionally affected and respond by crying:

'No one cares. Because if you get injured my friend, you are bitten by a patient, you need counselling, emotionally you are already affected. But if you are dealing with your case alone, how? Only if I am, only because I am a man I am strong. If it was a woman she will be just crying there' P3.

Needham, Abderhalden, Halfens, Fischer and Dassen (2005:289) argued that nurses' reactions to patient aggression are complex and encompass a broad spectrum of non-somatic reactions, with predominantly reported consequences being crying, anger, fear or anxiety and guilt among others.

Tema et al (2011:916) pointed out that the workplace should be a source of joy, which can however turn into a source of frustration. In a study in Taiwan by Chen et al (2007:315), it was found that some of the emotional feelings observed include worry, fear, anger, sadness and shock. This was also indicated by Le Roux and De Klerk (2007:87), when they observed that feelings are contagious and other staff members may also become affected. This can result in burnout, unplanned sick leave and even a high staff turnover, leading to poor service delivery.

As alluded earlier, psychiatric nurses faced with hostility from patients experience negative feelings of fear, anger, stress, terror, disappointment and annoyance. They then use coping, behavioural and adaptive mechanisms to deal with the hostility from patients.

3.3.2.2 Behavioural, adaptation and coping responses

Considering that verbal abuses are so frequent and yet most underreported, it can be argued that since the participants know that nothing will be done even after reporting, they devised some adaptation and coping mechanisms to deal with the effects associated with the verbal, as well as physical, abuses. The responses employed were ignoring, retaliation, accepting patient's condition and taking it easy, professional exit behaviour, de-motivation and self-counselling.

a) Ignoring

Nurses used this skill to deny the patients of the much needed attention when presenting with hostile behaviour, especially those who verbally abuse or physically threaten nurses. The following were some of the responses:

'At first I was like I cannot be here being insulted every day by these people. But I got used to it and it doesn't bother me. Sometimes you just ignore them' P2.

'Personally, yes sometimes you can feel bad but then it won't last long because you know it's just the illness making the person to insult you or to say bad words to you. So I just ignore it because I know the person is sick' P9.

'Yeah but we can just keep quiet there, yeah. If you keep quiet they will keep quiet also. If you answer back then they will continue insulting you' P6.

'Sometimes from there I just take it simple and only ignoring him even as he is just talking to me, I say as you know, I don't want to talk to you. Yes' P8.

'(laughing) Anyhow I know that that patient is, he is, she is not in good mind and I ignore it. Yes' P11.

Empirical findings by Talas et al (2011:200) revealed that nurses adapted to the patients' verbal hostility by using the method of 'doing nothing and keeping silent', which is to ignore them. Tema et al (2011:921) observed that nurses hid their frustration and fears by rationalising that the only thing they should do is to love their patients. This response came in the form of pretence, acting as if the nurse does not hear anything despite being provoked, in order to continue with their duties and avoid clashes with the patients. However, instead of ignoring, some nurses retaliated to patients' hostile behaviour.

b) Retaliation

It was interesting to note that some nurses responded to hostile behaviour by in turn becoming verbally or physically abusive towards patients. When the nurses become angry with patients' behaviour, they strike back in retaliation. It would then seem that when someone is victimised, another type of response is to become angry and to fight back. One participant said she physically retaliated by beating a patient who had beaten her:

'There was a patient who was verbally abusive to me, physically that one came later. There was a patient on this B side, the female side, I think she has been here for how long? Maybe she has been coming in and out four or five times since last year. Every time she sees me she starts insulting me, accusing me of stealing her husband and doing all sorts of things (laughing). Even if I did not go inside, I'm just there at the nurses' post, if she sees me then she starts, 'you stole my husband and you are sleeping with my husband'. Then one day I told her, 'listen, you must stop insulting me, you don't know me and you must stop that nonsense of yours'. Then she started saying,

'yeah, you even stole my clothes', (laughing). Then one day she said, 'I will beat you up' and I said ok if you beat me up I will also beat you up. Then she started beating me and I beat her back. From that day every time she sees me, 'ah how are you my nurse, how are you my friend'. She stopped it' P2.

The same participant slapped another patient who was sexually harassing her:

*'Yes I did. Last week. I was coming, it was (inaudible, laughing). I am very sorry because I get very irritated and very angry when someone insults me. Honestly. Last week Wednesday morning, because now I am working at the male side, I was coming out of the male side nee, when his guy said, 'aaah, you. You are so beautiful, let us go and f*** each other there'. Then I said 'you, who do you think you are?' He started pulling me nee, then I turned back and I slapped him. Then he was like, 'what? You are beating me, (inaudible, laughing). Apparently it's me who want to beat him'*

To avoid a repeat of sexual harassment, another nurse retaliated by beating the perpetrator:

'Yes like ummm, one day, yeah they used to. Like most of the time they see you as a new staff, they used to beat you maybe on the buttocks or breast. If they start like that you have to assault them. Because if you just keep quiet they just keep repeating that thing. Yes. And one thing I know, those patients if they see that this one if I beat her she will beat me back, they will not repeat again. But if he beat you and you just keep quiet, they will repeat it' P8.

Another participant revealed that nurses sometimes become verbally abusive towards patients when they experience work pressure due to a shortage of staff or just to retaliate to the hostile patients.

'Even the nurses we are not many and the patient is too much. Sometime you are six and like the past three months on the male side you are having 120 patients, sometimes you become aggressive like them (laughing)' P8.

'One day the patient just start to (insulting vernacular word) me, then from there, me I don't, (laughing) I just only answer him back saying 'no, you too'. From that moment he

just only say 'no, that girl was insulting me' because he know really what he was doing that day. Yaah' P8.

However, there is an ethical dilemma associated with retaliation since it is illegal as the two participants put it:

'No it's not allowed, it's not how we are supposed to handle these patients but some of these patients nee, they come here thinking 'yes I am a patient I can do whatever I want, I can insult them, I can beat them'. But some of the patients after you know, maybe you slapped them a bit then they realise, ok, maybe next time I must not do that because after that the patient will behave nicely, there will be no problem' P2.

'We are not supposed to beat back, but the thing is not simple as in the book. Because in the real situation even when I came here, I saw some assaulting the patients and I said aaah these people, they are not good. But if you work very closely, day by day, you will see that this is the way to go. Because some of the patients take advantage of being mentally ill. Because they used to say, 'no, if I beat you, I am not going to the prison because you will never see the mentally ill person being jailed'. They know, sometimes they do the thing and they know what they are doing' P8.

Inoue et al (2006:29) stated that exposure of psychiatric nurses to patients' physical or verbal aggression, presumably has an effect on the mental health of the psychiatric nurses themselves. As one participant put it, sometimes because of shortage of staff, the nurses can become as aggressive as the patients, leading to a vicious cycle. Bjorkdahl, Olsson and Palmstierna (2005:225) added that psychiatric nurses who use punitive control methods may inadvertently model the aggressive style of behaviour that they are trying to eliminate among the patients. There is not much literature reporting this phenomenon of nurses retaliating to the verbal or physical abuse of patients, as indicated in this study. This is a new dynamic area that needs to be explored further.

c) Accepting a patient's condition and taking it easy

Most nurses have come to accept the patients' condition of mental illness and they 'take it easy or simple' when patients present hostile behaviour towards them. This is what some of the participants had to say:

'Anyway I take it like the patient is sick. Sometimes you can see that this patient is no more sick but he still insults me, shouting at me. You can no more take that the person is sick. Now he is fine but he is calling you those names. Sometimes you just accept the condition, it's a matter of being strong emotionally and psychologically. Yeah, you have to take it easy' P3.

'Personally, yes sometimes you can feel bad but then it won't last long because you know it's just the illness making the person to insult you or to say bad words to you. So I just ignore it because I know the person is sick' P9.

'As I said earlier, as a professional nurse we have learnt about these signs and symptoms of those mentally ill patients, their abnormal behaviour. You know some of them are hearing voices, visual hallucinations and so on. Once a patient becomes hostile towards me, it doesn't affect me much because I expect them to behave like that. Even, yes, sometimes as a person you can really feel bad but having that expectation of such behaviour doesn't affect me much in my duties. I just take it easy' P12.

However, it is worth noting that some stable patients will continue to present with hostile behaviour under the guise of being mentally ill.

Perhaps as posited by Jonker, Goossens, Steenhuis and Oud (2008:492), aggressive incidents, particularly verbal ones, is such a common occurrence that nursing staff have somehow become insensitive to their occurrence and now see them as routine, as one participant put it:

'Anyhow, maybe...me I am not worrying about insulting from the patient. I don't care because you can come here and insult me non-verbally and I can't feel anything. Yeah, it means I accept their condition, yeah...you can come and insult me there and I feel like music...because I know the patient is sick' P4.

d) Professional exit behaviour

Professional exit behaviour was common, especially during the early days of working in psychiatry. After constant physical and verbal abuse some nurses experienced a desire to resign or to be relocated to non-psychiatric units:

'My friend I never cried but that time, you know, I got injured on the 7th, this month, I have been dealing with the case until last Monday. I think it was on the, ummm, on the 23rd. it really affected me emotionally. I even demanded that maybe I can be allocated to other departments. Because my friend if you get injured here, no one cares. So what is the use? Most people so far have demanded to go to other wards. Because the problem is here is people cannot understand you. Here we are really struggling with patients, you get injured no one care' P3.

The same participant reported diminished job satisfaction due to his negative experiences with hostile patients, which he described as being terrorised:

'Continuing working here to me, I feel, I feel terrorised or something... (terrorised) by patients. Yeah. Maybe in future I get injured I will go through the same experience, the same bad experience. It's very terrifying. I work in fear, that's why I will ask to be allocated to other departments' P3.

He seemed to have been affected to such an extent that he drew the face of a sad person crying with the words, *'I am not happy, I just want to leave to other departments'.*

Other participants reported their wish to be relocated within their first few months in the ward due to fear of working in psychiatry:

'On my side as I moved into this ward, at first I was so scared of the patients. There was a time when we were giving these medications and the patient totally refused to take her medication. She wanted to beat me up simply because according to her she said I was forcing her to take her medications. But I wasn't. And from there she started insulting me using these bad words. So I felt so bad and I wanted to go out of this ward' P1.

'Yeah, when I came here I was thinking maybe it's better to be removed from this ward. Yeah, when I came here even the first day I came here when I was seeing those

nurses, I mean the patients there, I was even afraid to go inside there but later I was used to them and I was going there. Yeah...I was thinking maybe I will not go back there because of fear' P6.

'Aye, I was not feeling well. That time I was new here. I was thinking it's better to go to some other departments because it was not safe. I was just maybe two months here. I just start this year, in January. But then I just say ahh, the patient is sick' P7.

Working in fear would cause a staff member to underperform. This is supported by Inoue et al (2006:33), who observed that while nurses are in a position in which they must provide mental health care to their patients, it seems important for them to direct their attention to their own mental health and to actively care for themselves and their co-workers. Similar findings were also reported by Kindy et al (2005:173) in their study on nurses' experiences in psychiatric units with high risks of assault.

Those who couldn't cope with the hostile behaviour of some of the psychiatric patients or with the lack of post-incident support, were in the process of requesting for transfer to other wards when these data were gathered and they had less than five years of experience. According to Chan, Luk, Leong, Yeung and Van (2008:894), nurses are more likely to stay in their jobs when they are older, have worked in specialised clinical areas and have more years of experience. This is echoed by these findings in which the mean age of the nurses is 45.5years with an average experience in psychiatry of 10.7 years.

Ito, Eisen, Sederer, Yamada and Tachimori (2001:234) found that job dissatisfaction, lack of support from supervisors and the perceived risk of workplace assault or actual assault among nursing staff was related to their intention to leave their job, which resonates with the findings of this study.

e) De-motivation

Some participants indicated their low morale, especially after the recording of the interview, and expressed their desire to be offered emotional support by the management to boost their morale as they are working in a stressful environment:

'No, I didn't. Not even counselling' P1.

'I didn't receive any counselling' P3.

'No support. No encouragement, nothing...no one wants to come here, I felt alone no one cares, I cried in front of my seniors. I was frustrated. I went there to the administration' P3.

'I don't know of any support here. There is no counselling, nothing' P7.

Participants also described how the management ignored or failed to take any action after they reported their experiences with hostile patients, and their tone of the voice (as indicated in field notes for participant 4) indicated that they were demoralised. Some participants stated:

'...most of the time you leave a report when you get insulted, there is nothing they (superiors) can do really' P2.

'Yes I reported and they said there is nothing we can do' P6.

Dornyei (2005:143) defines de-motivation as specific external forces that reduce or diminish the motivational basis of a behavioural intention or an ongoing action. Tema et al (2011:920) supports this by stating that a lack of support by management impacts negatively on the quality of the psychiatric nurses' working lives.

O'Brien and Cole (2004:90) agree that patient aggression increases staff shortage, which in turn can negatively impact on the organization's capacity to meet patient needs and provide quality care. They further indicate that a shortage of staff can lower the morale (demotivate) of psychiatric nurses and the productivity of those who remain to provide care.

Ngako et al (2012:6) concur with the findings of this study in that participants working with mental health care users felt demotivated and experienced burnout. This could lead to the ineffective management of emotional reactions, that ultimately compromises quality nursing care. Below is a drawing that shows a participant who was de-motivated and had burnout, and who wanted to work in wards other than the psychiatric one:

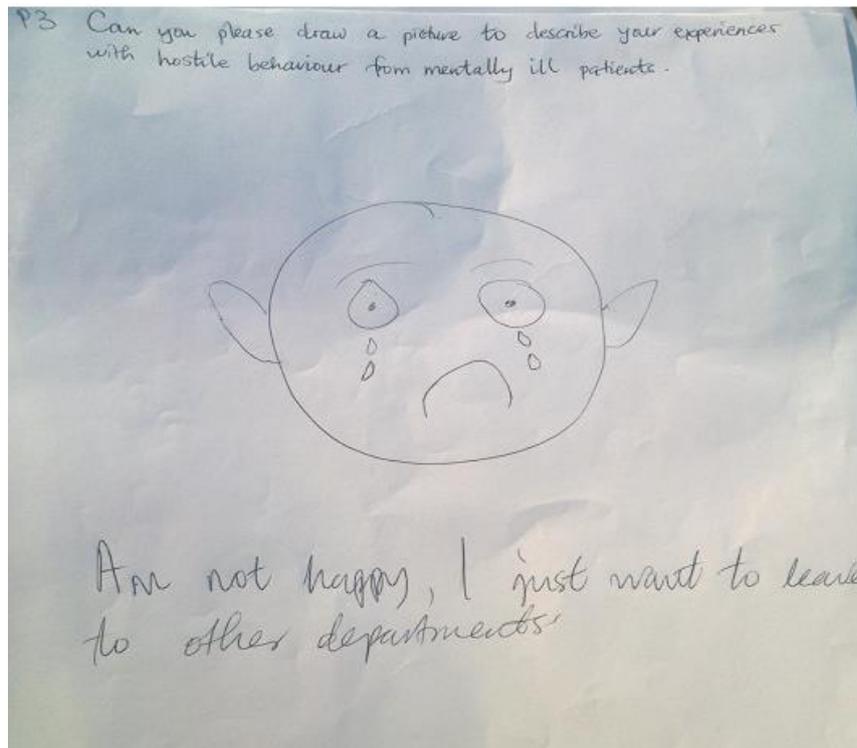


Figure 3.5: De-motivated (P3)

f) Positive self-talk

Positive self-talk is not a common feature among nurses working with mentally ill patients. However, one participant said she can counsel herself after an experience with hostile patients:

'Can you remember the PMTCT when it came to Namibia for the first time? I was one of those people who were elected to go for the pilot study there and then we were taught how to do the counselling. So for myself I can even, even though they say the doctor cannot treat himself or herself, me myself sometimes I can counsel myself' P1

It was not clear how effective positive self-talk was. Few literatures address this phenomenon. In a study aimed to understand how youth might use self-leadership through self-coaching to provide self-support during a traumatic event, Jooste and Maritz (2014: in press) observed that participants used different self-coaching strategies as a process of adaptation. As found in this study, the authors also found that participants initiated the self-coaching process through positive self-talk, which may also have been a strategy to reduce anxiety.

According to Deans (2004:35), being expected to cope regardless of circumstances can be a devastating experience for nurses as it has the potential to create and sustain negative emotions. However, the majority of the nurses interviewed in this study have adapted to the hostile environment, as evidenced by their long stay in the psychiatric ward.

McKenna et al (2003:58-59) state that new graduates in mental health services were more likely to report having experienced most of the categories of threats or violence. This study supports that finding since most respondents could not cope with hostile patients in their first year but later developed coping skills as indicated by some:

'At first I was like I cannot be here being insulted every day by these people. But I got used to it and it doesn't bother me' P2.

'It affected me because that time I was new here. I was thinking now maybe it's not better, I mean it's not good for me to go back there' P6.

Tema et al (2011:921) noted that bottled negative emotions have prolonged after-effects, hence the need to talk to others, as suggested by the coping mechanism below.

3.3.2.3 Social response

Hostile behaviour from mentally ill patients has social implications on the nurses involved. Some lived a life of fear outside of the institution after a patient threatened to *'deal with him'* after discharge for perceived wrong-doing or mistreatment:

'Anyway, it affects you socially; even outside there you are not having that freedom to walk around freely. My friend I don't walk freely in (his residential town) the patients are all, once they see you they will beat you up seriously. Of course I was not beaten before but I met some outside there they threaten you...(the reason being that) maybe for example the doctor just prescribed an injection for him, then you inject him for example, from there he has a revenge that you caused pain to him, what what, this guy injected me if I see him outside, I will take a revenge' P3.

Few studies have reported incidences of stalking of mental health nurses. Sandberg, McNiel and Binder (2002:227) reported that patients who stalk clinicians do so because they feel misunderstood, wronged, or mistreated. Threats by patients post-discharge can cause the nurses to have an expectation of future hostility from a patient, which can lead to more fear on the part of the nurse. It can be devastating for a nurse to experience hostile behaviour from patients at work as well as at home, which might require change of place of residence.

Some participants received social support through talking with colleagues and family members. One nurse indicated how her family was somehow also affected after sharing with them about an incident with a hostile patient at work, though she felt relieved after the discussion:

'Yes, I was thinking about the incident and ooh, I was mentally also affected. I just told the story to my kids and they were just laughing and they were sort of, sort of counselling and some of them they were saying that 'no meme, it's better for you to talk to your boss to tell them that you are no more going to work in that ward because it's too dangerous'. Then I told them what about the others, if I leave what about my colleagues, can they all quit from that ward because of that condition? Then they said 'yes meme it's better'. I felt relieved by discussing it with my kids, and the following day I came back to work' P1.

Other participants said:

'No, you cannot take the thing that when you go home you say no I am not feeling ok because I am insulted by the patient. Or even it happen he beat you, you cannot go home and start crying saying, 'oh I was beaten by the patient'. You just go over it by discussing with colleagues or family, that's all' P8.

'No you just talk it, you can just talk to your, to your colleagues and then it just goes off. Yeah' P12.

The field notes show that some participants (for example P3, P11 and P12) felt better by sharing their experiences in the interview and that it gave them a platform to ventilate their feelings.

This highlights the importance of psychiatric nurses sharing experiences with colleagues in order to cope with hostile behaviour in their work setting. Inoue et al (2006:33) showed how important family support is in relieving the psychological impact of being exposed to verbal abuse or violence by mentally ill patients.

According to Tema et al (2011:921), in their study participants bottled up their feelings but later poured out their hurt emotions onto their families and colleagues.

3.3.2.4 Positive response

It seems that although most of the participants reported that they experience patient hostility on a regular basis, some still held positive attitudes. They still felt proud to work with such hostile patients. In fact, twenty five percent (3) of the respondents described positive experiences and attitudes and felt proud to work with hostile patients. Responding to the question of how the hostile behaviour from patients has affected her professionally, one participant, who looked happy throughout the interview as reflected in the field notes, remarked:

'Ummm, not really. I think I am actually enjoying it.... Yaa I don't have a problem with it. Most nurses in this hospital nee, they don't want to come and work here. If you run away because another nurse got injured, who will come?...When they told me I am going to work here I almost cried, I was scared but now I actually enjoy it' P2.

She also drew a picture of a happy face, captioned *'no worries, I am enjoying it'*:

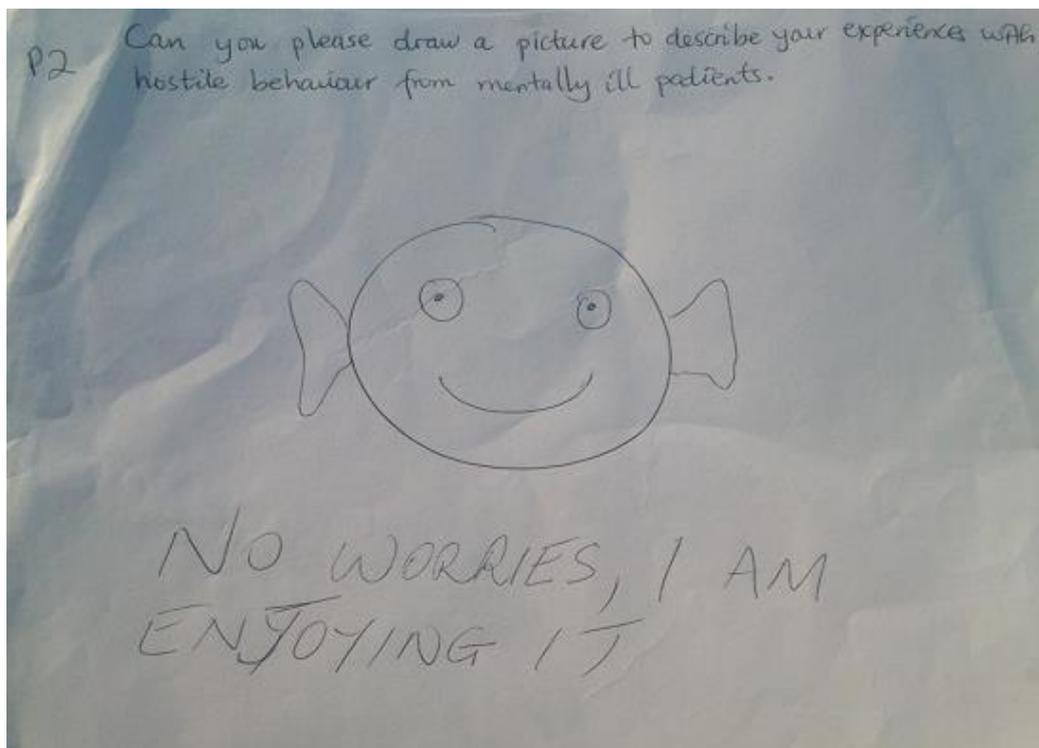


Figure 3.6: Enjoying the experience (P2)

The other two participants said:

'That time I could feel very bad, yeah, ... when I choose to learn this I was having one of my family member who was having this kind of illness now I am having a desire to find what happen even in the mind what makes him see the things which is not there, yeah yeah, it is my desire to learn psychiatry' P4

'No, it is not affecting me. Me I enjoy to work with these patients, you know she can use abusive language to me, after some minutes you are free. Yeah' P5. She also elaborated this with a drawing of a bright sun with the words *'me I enjoy, I love to work in psychiatry'*.

The following drawing indicates that some participants loved and enjoyed their experiences with hostile patients:

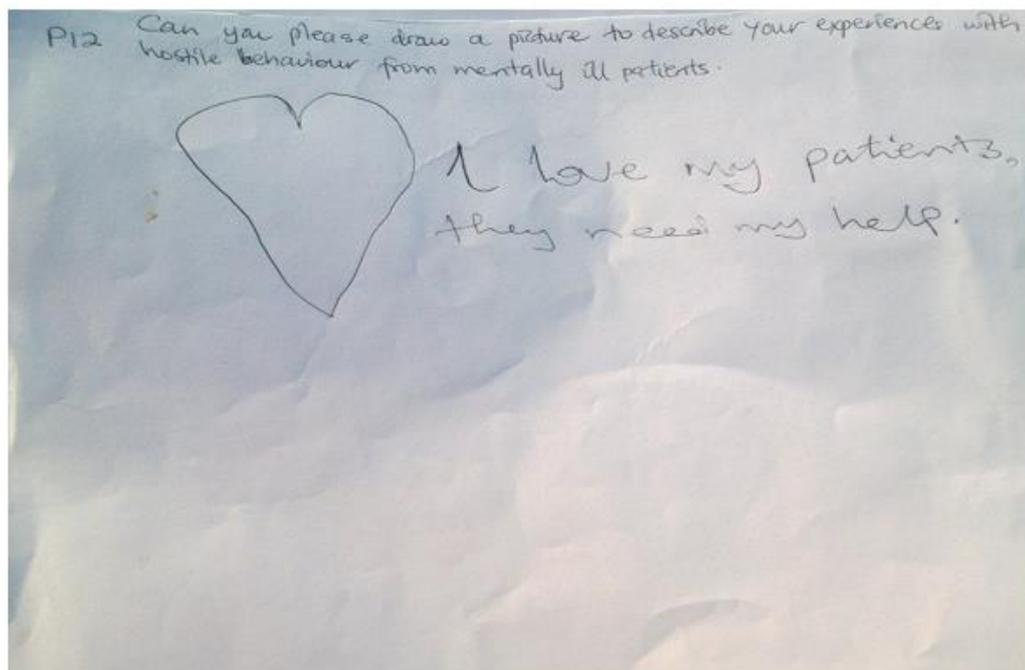


Figure 3.7: Loving the experiences (P12)

Björkman, Angelman and Jönsson (2008:170) conducted a study on attitudes towards people with mental illness, and concluded that health professionals should develop positive attitudes towards mental health care users. Despite feelings of fear when presented with patient hostility, Rocca, Villary and Boggetoi (2006:590) reported that psychiatric nurses hold a positive attitude towards aggressive patients and suggested that this is due to their training, experience and commitment to the provision of care to this group of patients. The authors also highlighted that a well-trained or experienced nurse can manage the situation even if he/she is disturbed by counter-transference feelings such as anger, hostility, hate or fear. This concurs with these findings in which participants 4 and 5, who had positive responses, both had postgraduate training in psychiatry plus 30 years and 32 years of experience in psychiatry respectively.

3.3.3 Theme 3: Main challenges

The participants identified a number of challenges namely lack of training, lack of counselling and support, lack of reporting, lack of physical protection and lack of adequate human resources.

3.3.3.1 Lack of training

The nurses felt that their negative experiences were linked to their lack of knowledge and skills in handling hostile mentally ill patients. They felt that they lack certain skills to effectively manage hostile behaviour perpetrated by patients towards them. Only 16.7 percent (2) of the participants received specific postgraduate training in psychiatry. The following were some of the comments:

'you know some umm, our categories we were just given a bit of about psychiatry. We were not taught much about it in detail' P1.

'No. It (training) was mainly about medication, we didn't get any training about how to handle these people. When they told me I am going to work here I almost cried' P2.

'My friend, enrolled nurses don't get that training. I was just allocated here and then I just copied from my colleagues who were already working here. I did not get any formal training on handling aggressive patients' P3.

'Yeah, just in general but not in detail. Yeah. We were just given in general when we were in training but my training was some years back now. I cannot recall what we were told there even now. It's way back now, yeah' P6.

'Maybe some talk so that we can get more knowledge on how to handle the patients. Like here some nurses are not trained in mental health, they just come straight here without any knowledge' P7.

'It (training) was only the basic, yeah. So we need some more training if they think we have to work in psychiatry. Even a workshop, because you just only come here, and nobody care, because they are regarding you maybe as your patients' P8.

The following drawing confirms the lack of knowledge and skills by the participants:

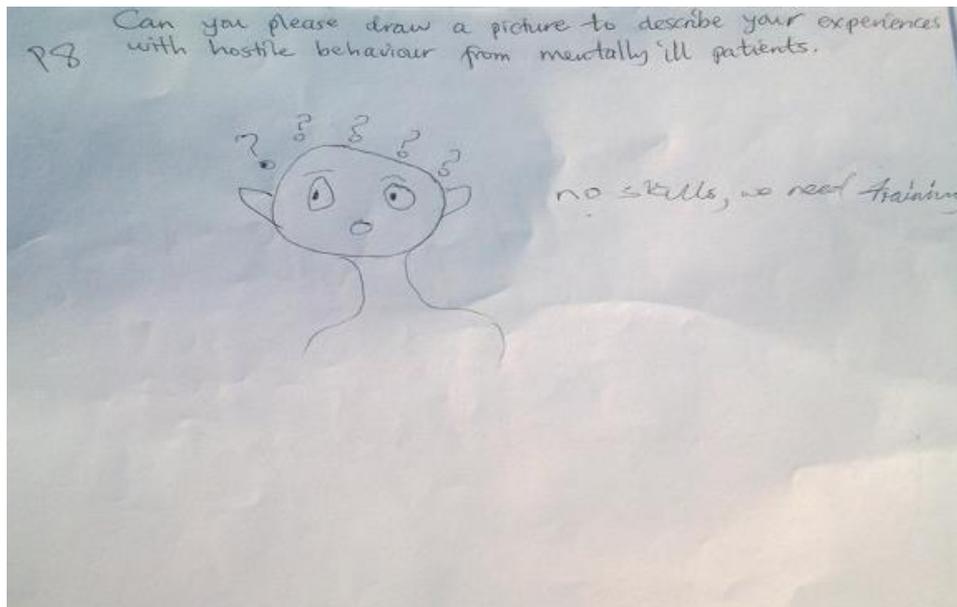


Figure 3.8: Lack of skills and knowledge (P8)

The nurses are not well-trained in mental health care. As a result they are deficient in knowledge and skills towards nursing psychiatric patients. Poggenpoel et al (2011:956) and Tema et al (2011:920) also related the lack of psychiatric skills to the negative experiences by nurses interacting with aggressive mentally ill patients. Jenkins and Elliot (2004:622) identified dealing with physically threatening and demanding patients to be the most stressful aspect for unqualified staff.

Research has considered the impact of education on nurses' experiences with hostile behaviour from patients, and a low level of nursing education was found to be associated with higher rates of assault (McGill 2006:50; Needham et al 2005:296). The more staff without psychiatric training there are in a ward, the higher the risk of experiencing hostile behaviour from mentally ill patients. The nurses need to be well equipped in order to manage hostile patients effectively.

McGill (2006:50) further emphasises that the management of aggressive patients is not a matter of intelligence, but a matter of educational opportunity to develop that intelligence into competence for practice in psychiatric nursing. The lack of skills might then lead the nurses to have feelings of fear of patients due to their inadequacy. Secker, Benson, Lipsedge, Robinson and Walker (2004:172) supported these findings by concluding that lacking the skills necessary to rapidly identify and defuse patients'

aggressive behaviours had left psychiatric nurses with feelings of incompetence, demonstrated by symptoms of anxiety, frustration and fear.

3.3.3.2 Lack of counselling and support

After experiencing all the emotional responses discussed earlier, there is need for post-incident counselling and support for the nurses involved. However lack of such support was cited by the participants as one of the main challenges they face:

'Aaah nooo, there is no something(counselling) like that here...Maybe there is but I don't know it. Maybe there is some procedure or something written down, it's only that blacks we don't read (laughing). We have not seen it happening' P1.

'I cannot really say because maybe after being insulted or after being (pause), someone is supposed to come to talk to you and say 'no patients are just like that', this and that. But, is there something like that? I don't know, something like that, I don't know' P2.

'Aaah, since I came here I have never heard something like that, you are just allocated to ward 16 and you work, nothing. No support. No encouragement, nothing. No support like maybe the patient has been, the nurse has been bitten by a patient and something has to be done like ummm, if you beat a patient even the minister will come here, but if the patient beats me nothing will be done. How do we really understand that people. Anyway I have never heard anything like support for nurses in ward 16' P3.

'Which support? For us? I don't know of any support here. There is no counselling, nothing. After whatever happen you just continue with your work, no one will come to talk to you to counsel you. Whether those who report, nothing happens, you just come back and continue' P7.

'There is nothing, because even those who maybe they are assaulted and need to be treated, those who are supposed to walk with you and maybe give you moral support, they just only leave that nurse alone struggling to go to this doctor or what. Because there is a paper that needs to be filled, everybody is afraid to fill, they say maybe he will make a mistake and the nurse become frustrated. I think there is need for counselling,

giving moral support, yeah. But again in the ward there is no one to do counselling, here you have to cope with your own stress' P8.

'Aah, nothing. There is nothing, there is no support (laughing). Sometimes other colleagues just help to isolate the patient if they see that he want to beat me, that's all' P9.

Another participant lamented the lack of support from some psychiatric doctors as well:

'You know we were interviewing that patient with the doctor in the consulting room. Then the patient grabbed my pen, then I told him to bring my pen back, and he didn't want then I took my pen back. Then he stood and gave me a fist here (pointing at the forehead) on my face. I was bleeding, I was bleeding. What made me feel very bad, it's not because I was beaten, but that doctor with whom I was working didn't respond, even rescuing me. He was just sitting there looking at me.... I was expecting the doctor just to hold the patient so that he will stop beating me or to tell him not to do that' P12.

'Ever since I got bitten no one cares about me, even the doctor didn't care. He was laughing at me.' P3

Chen et al (2007:314), Kindy et al (2005:172) and Tema et al (2011:922) support the aforementioned findings as they also found that nurses expressed more concern about lack of support from peers, physicians and administrators. Currid (2009:42) confirms that a lack of support in the work environment is a source of stress.

3.3.3.3 Lack of reporting

The nurses reported physical abuse only when there was a physical injury, in which case nothing more than medical attention was done. Verbal abuse, which is the most frequent form of hostile behaviour, was largely unreported because participants felt it was a waste of time since nothing would be done afterwards. Management was seen as helpless and sometimes uncaring when it comes to its response to their reports. The following are some of the responses from the participants:

'Nooo. Because every now and then you get insulted. I don't know if they are supposed to be reported, I don't know about it. Maybe if you are injured by a patient that's when they take action. Mostly, most of the time you get insulted, you get beaten by these patients but nothing is done about it...You don't need even to report it because most of the time you leave a report when you get insulted, there is nothing they (superiors) can do really' P2.

'Yeah, but not reporting like I want something to be done to him, but just only mentioning the thing to my supervisor. Insults are everyday. Like one musician sing a song and mention my name, now whenever the patient sees me they sing that insulting me and trying to provoke me (laughing). But most of the time nothing will happen if you report, because they say, no you know this is a sick patient' P8.

'Aaah, now you see, you know that this patient is insulting because he or she is psychotic. When she is stable, she is your friend. There is no need to report, nothing will be umm, will be umm, done. Yes... Aaah my dear, after that there is no answer, no change. I reported before and nothing done. Now you can't think of reporting. Because you report, there is nothing. What is the use for reporting if there is no change?' P11.

Lack of reporting of incidents of hostility by patients was found to be common among the participants, as confirmed by Talas et al (2011:202). Several studies concur with these findings whereby there is generally a lack of reporting of verbal abuse among nurses because often no action is taken by the superiors (Deans 2004:35; Ferns 2006:41; Pawlin 2008:16). Lanza (2011:547) also highlighted that a lack of support from managers appears to be responsible for inducing fears in nurses for reporting assaults by patients.

Maguire and Ryan (2007:125) concur with these findings when they concluded that reporting seems to be reserved only for the most serious incidents of violence. Instead of reporting incidents of hostile behaviour from patients, the nurses have developed coping and adaptive mechanisms in the absence of any action from the management.

According to Maguire and Ryan (2007:121), under-reporting may be related to the professional socialisation of healthcare workers into an ethos of compliance and an acceptance that the job is accompanied by unpalatable but inevitable facets such as

aggression and violence. The following statement by one of the participants supports this belief:

'Yeah, personally I was feeling bad although I was also trained that sometimes you will be injured by the patient' P4.

Though not mentioned by the participants, research done by Lanza (2011:547) identifies that one of the reasons for under-reporting of aggressive incidents is the fear of being blamed for not being able to prevent the incidents.

3.3.3.4 Lack of physical protection

It appears from the responses below that the nurses are concerned about their physical protection whilst on duty. This protection can be in the form of trained security guards manning the ward, whose absence poses a big challenge to the nurses:

'For us not to be attacked by patients we must be protected either by security guards to be in the ward so that we can be safe because most of the time when we call and if the patient is very very much strong and you know we don't have a lot of men here. Women are, are just women so we need a security guard' P1.

The absence of more male nurses also presents a safety challenge and it will be discussed further in the next section. Some participants said this of the lack of male nurses:

'We need more male nurses in this ward, but now we are not getting them, especially after hearing those things that are happening here' P2.

'We have said it long time, we need more male nurses. Even cleaners we need more male cleaners in order to help us. We complain a lot about that but nothing happened. Sometimes they say male nurses are few in the profession' P4.

Child and Mendes (2010:93) reported that the prominent presence of security personnel has been shown to reduce the rate of assaults in wards. Research done by Secker et al (2004:173) confirms that the patients' aggression threatens the safety of psychiatric nurses in the work place.

3.3.3.5 Lack of adequate human resources

Lack of adequate human resources is a universal challenge in health care. However, the situation is even direr in psychiatry, with fewer male nurses. Most participants felt that the increased workload which is shared by a small number of psychiatric nurses, seems to have emotional and psychological impacts on their carers (psychiatric nurses). This results in psychiatric nurses finding it increasingly strenuous to deliver patients' care to the required standard. The participants stated that:

'Even the nurses we are not many and the patient is too much. Sometime you are six and like the past three months on the male side you are having 120 patients' P8.

'Most nurses in this hospital nee, they don't want to come and work here. If you run away because another nurse got injured, who will come? Especially this year we were supposed to receive maybe three new nurses and they refused to come. So if you go to other wards, who will be here? No one' P2.

From the field notes, one participant (P8) also emphasised that staff shortage at some point do lower the staff morale.

Namibia is one of many African countries faced with human resources challenges in the health sector, especially the shortage of nurses and doctors (Nembwaya 2013:1). Drury, Frances and Chapman (2009) noted that globally the nursing workforce is ageing with fewer young people entering the profession to replace the larger number of older nurses due to retire in the coming decades.

Though there is no scientific evidence, there is generally few men in the nursing profession in Namibia and the mental health unit under study is no exception (Anonymous. 2014: Personal interview, 12 May. Oshakati). All female participants indicated that they are victims of hostile behaviour from mentally ill patients mostly when they are without the company of male nurses. One participant noted that some of the patients start to be hostile once they realise that there are no male nurses around:

'We need more male nurses in this ward. Of course with the male patients sometimes they do like this, if they realise that there are no male nurses in the ward, then they start to misbehave because they know what can you do you are just women' P2.

There is a general belief that male nurses' mere presence acts as a deterrent to hostile behaviour from the patients, as one participant stated:

'That's why here in (name of hospital) we are not having many male staff nurses because there where we were trained, when the female nurses walk inside or wherever, you are supposed to walk with the male nurses, yeah, in order to protect you. That's why here you find women they are beaten by patients' P4

Tema et al (2011:919) made the same observation that aggression is often displayed when there are no male nurses in the ward. Chen et al (2007:315) concluded that accompanying male staff might be useful for preventing violence. The shortage of male nurses at the ward under this study exposes the female nurses to a higher risk of hostility from patients.

Inadequate human resources can be exacerbated by some staff members who take sick leave after sustaining injuries due to physical abuse. This is what some of the participants expressed:

'Then I was given two days, three days sick leave. I felt bad because you are no more going to work, you are on sick leave, you can't do anything anymore because you are feeling pain, headache. You can't, yeah, then when the pain goes down then you overcome it and come back to work' P4.

'After forcing him to get his injection, then he refused to be, I mean to go in the single room. After that when we trying to put him in the single room that's when I got injury on my left hand. That time I can remember it was in 2008, no 1998. I was treated also, I was given some days off by the doctor because I end up going to casualty for treatment' P6.

'I reported the case to the nurse in charge, I was sent to casualty for some treatment, I was given some painkillers, antibiotics also, I was also, doctor prescribed dressing to be

done. Fortunately I was not sutured, only dressing was done then I was given a sick leave' P12.

This is similar to findings by Chen et al (2008:290), James, Isa and Oud (2011:132) and Nijman et al (2005:222), where there was an average of five sick leave days per nurse who had encountered physical violence with psychiatric inpatients. Bowers, Allan, Simpson, Nijman and Warren (2007:76) reported that psychiatric nurses' annual leave and vacant posts are associated with higher levels of patient aggression. O'Brien and Cole (2004:90) agree that patient aggression increases staff shortage, which in turn can negatively impact on the organisation's capacity to meet patient needs and provide quality care. They further indicate that a shortage of staff can lower the morale of psychiatric nurses and the productivity of those who remain to provide care. However, Ng, Kumar, Ranclaud and Robinson (2001:524) found no association between staff-to-patient ratio and the occurrence of violent incidents in psychiatry, contrary to what participants in this study reported.

3.4 SUMMARY

In this chapter the demographic profile of the participants was described, followed by a discussion of the themes and categories that emerged from the data in relation to existing information in the literature.

Recommendations, conclusion and limitations of the study are presented in the next chapter and recommendations for practice and further research are made.

CHAPTER 4

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

4.1 INTRODUCTION

The first objective of this study was reached, namely to explore and describe the nurses' experiences of hostile behaviour from mentally ill patients in a psychiatric ward of a general hospital. Participants identified two main forms of hostile behaviour, namely verbal and physical hostility, with three examples of sexual harassment. Nurses had varied responses (negative or positive) to hostile behaviour. Most participants felt that they are working in an unsafe environment where they are exposed to verbal and physical abuse by the patients under their care. They indicated that the situation is made worse by their lack of training to effectively manage hostile patients. The nurses also indicated their response to hostile behaviour as emotional, behavioural, adaptation and coping, physical, social and some positive. The participants noted the main challenges they face, which are lack of training, lack of counselling and support, lack of reporting, lack of physical protection and lack of adequate human resources.

The second objective was to propose recommendations to the hospital management to support nurses who experience hostile behaviour from mentally ill patients. The recommendations discussed in the next section will be based on the main challenges identified by the participants, the needs identified by participants as well as relevant literature.

This study thus concludes with this chapter, in which limitations are discussed and recommendations for clinical practice and further research are made.

4.2 RECOMMENDATIONS

Participants mentioned a number of challenges such as lack of training, lack of counselling and support, lack of reporting, lack of physical protection and lack of adequate human resources. They identified the following needs; namely training, counselling and support, physical protection by trained security, more male nurses, special allowance and infrastructural adjustments.

4.2.1 Training

Just over eighty-three percent (10) of the participants in this study indicated that they either received basic or no training at all in handling psychiatric patients during college training or at work. All participants proposed systematic training of all staff which includes in-service training and workshops to equip them with skills and knowledge on handling hostile mentally ill patients:

'I just want like for everyone who is here, for the nurses, should maybe organise teachings on how to handle these mentally ill patients. The reason why most people don't want to come here is because they are scared. They are scared of being bitten/beaten, insulted. Some of them say that we are also behaving like our patients, that's what they say. But then these people are just like any human being, mental illness can happen to anyone. There is need for more trainings even for the whole hospital so that they change their attitudes towards mental illness' P2.

'Yeah, just in general but not in detail. Yeah. We were just given in general when we were in training but my training was some years back now. I cannot recall what we were told there even now. It's way back now, yeah. If we can get some trainings here maybe from somebody maybe who is working also in psychiatry in Windhoek, I think it's better. Like the new nurses also when they are coming here they need also to get some training on handling these patients, I think it's better also...Yes in-service training yeah, because sometimes people like new nurses coming fresh, fresh from school, they don't know how to handle these patients. That's why I said its needed. Yeah' P6.

'Maybe some talk so that we can get more knowledge on how to handle the patients. Like here some nurses are not trained in mental health, they just come straight here without any knowledge' P7.

Another participant suggested a training workshop on mental health:

'I also think even a training is needed to the nurses working in psychiatry. Yes...Because we are just ordinary nurse, we need training in handling mental patients...It was only the basic, yeah. So we need some more training if they think we have to work in psychiatry. Even a workshop, because you just only come here, and

nobody care, because they are regarding you maybe as your patients (laughing). Even the management, if they have a relative here, they just say, 'I have just come to see that patient of yours' and it's his sister (laughing)' P8. She further described the need for training by drawing a picture of a confused person with many questions depicted by question marks all over the head.

The call for training psychiatric nurses is supported by previous studies which also recommended periodic in-service training and refresher courses for psychiatric nurses. These studies noted that staff members who participated in training on how to prevent or manage aggression experience less inpatient violence and that there was a decline in the frequency of aggressive incidents (Chen et al 2008:292; Child & Mendes 2010:92; Gerard, Theo, Dassen, Burgerhofi & Midelel 2006:49, Nijman et al 2005:225; Poggenpoel et al 2011:957; Tema et al 2011:922). A structured assessment of the short-term risk of violence in acute psychiatric wards by Abderhalden, Needham, Dassen, Halfens, Haug and Fischer (2008:48) and Bowers, Brennan, Flood, Lipang and Oladapo (2006:170) found that nurses' training reduces severe events of patient aggression (adjusted risk reductions of 41% and 53% respectively).

McGill (2006:41) emphasised that psychiatric nurses should be able to manage patients' aggression in ways that minimise danger to themselves and their patients. Nurses who have sufficient knowledge and skills may have more confidence in managing hostile behaviour from mentally ill patients than the untrained and unskilled ones. In their study, Kamchuchat et al (2008:206) concluded that training of nurses is an essential element of an effective violence prevention program and could reduce the risk of verbal abuse by forty per cent. Teo, Holley, Leary and McNiel (2012:1093) observed that the level of training confers an advantage in the accuracy of risk assessments for violence and that structured methods have the potential to augment training in a way that may improve the accuracy of risk assessments.

According to Zauszniewski (2009:113), mentorship involves an experienced nurse who guides mentees in development and examination of their own personal growth and professional development. Periodic in-service training and refresher sessions by the trained and senior nurses can go a long way in empowering nurses with skills and knowledge needed to manage hostile behaviour from mentally ill patients.

However, on the contrary Needham, Abderhalden, Halfens, Dassen, Haug and Fischer (2005:653) and Bowers, Nijman, Allan, Simpson, Warren and Turner (2006:1025) found that a training course in aggression management on mental health nurses' perceptions of aggression had no positive effect, though the participants considered it to be of great practical value.

It is also recommended that pre-placement training be done during induction period since most nurses had bad experiences during their first few months of working in psychiatry before they developed coping mechanisms. Training should cover nurses communication skills, conflict resolution skills, and how to recognise potentially hostile situations among other areas of need.

Nau et al (2007:944) posited that there is insufficient training for dealing with patient violence in nursing education. It is therefore recommended that this training be incorporated into the nursing undergraduate curriculum.

4.2.2 Counselling and support

After realising the lack of post-incident counselling and support, the nurses expressed a need for such services:

'I haven't seen something like that here, maybe I think maybe it's something to take it up. Maybe something happens to you after you recover, I think it's possible maybe to get something like counselling so that when you came back from work (sick leave) maybe you can cope with your work' P6.

'Yes we need the support like a counsellor so that even once every month our staff can be counselled. Here it's not like other departments, there is a lot of risks, it's not like others' P7.

'There is nothing (support system), because even those who maybe they are assaulted and need to be treated, those who are supposed to walk with you and maybe give you moral support, they just only leave that nurse alone struggling to go to this doctor or what. Because there is a paper that needs to be filled, everybody is afraid to fill, they say maybe he will make a mistake and the nurse become frustrated. I think there is

need for counselling, giving moral support, yeah. But again in the ward there is no one to do counselling, here you have to cope with your own stress' P8.

'Yes I think that nurse need counselling about the situation because really sometimes you feel very very bad if you are bitten by unknown person, you don't know how is the status, you don't know the other diseases he is suffering from. You need to be counselled so that you can feel a little bit better. Yes' P9.

Some suggested a post-incident support group within the ward to help fellow nurses who fall victim to any form of hostile behaviour from patients. The hospital does not have any programmes to support staff with work-related problems. The following were the suggestions:

'I don't know whether (pause), maybe I think maybe we can organise our group to support each other or discussing the issues or I don't know. Because always you report it there is no change...We don't know because now we accepting working in that situation. Of course we need counselling' P11.

'There is nothing but I think there should be an organised group of some experienced nurses who can counsel or the nurses who are experiencing that behaviour from mentally ill patients. Because sometimes when, when such people talk to a person who was affected, make him or her understand that because these patients are mentally ill patients that's how they behave. To make that person understand. Some of these nurses did not undergo this training of psychiatric but they are still working here in our psychiatric department. They don't have that umm, that ummm, that ummm, they don't have that ummm, yeah knowledge, yeah. Even to those who are having that knowledge you also need to be counselled so that they will have that peace of mind and then you continue working with those patients without having the fear of being beaten the other day' P12.

Currid (2009:45), Kindy et al (2005:172) and Tema et al (2011:922) support the aforementioned suggestion as they also found in their study of nurses' experiences in psychiatric units with high risks of assault, that nurses expressed more concern about lack of support from peers, physicians and administrators. Furthermore, Chen et al (2007:314) and Deans (2004:35) pointed out that effective interaction between the

nurse who has been a victim of aggression and a senior staff member is essential to the nurse resolving concerns regarding future role, feelings of self-esteem, guilt and anger. As supported by Chen, Hwu and Williams (2005:146), Hahn et al (2010:3543) and Poggenpoel et al (2011:957), management and social workers at the institution under study can arrange one-on-one and group debriefing sessions regularly so that the nurses may have the opportunity to ventilate their feelings experienced after interaction with hostile mentally ill patients. Exposure of nurses to hostile behaviour by psychiatric patients may negatively affect the former's mental health. Therefore, if nurses receive emotional support in the form of debriefing sessions, it will enhance the quality of care they provide to their patients as well as maintaining their (nurses') mental health status. Inoue et al (2006:30) revealed that patients' aggression may lead psychiatric nurses to experience psychological and emotional wounds that may linger and interfere with normal work and leisure lifestyle for months or even years after the incident. There were no participants in this study who indicated an immediate need for referral, though post-traumatic stress cannot be ruled out in the long run.

4.2.3 Physical protection by security

It would seem from the responses below that nurses need assurance of their safety when dealing with hostile patients, hence the need for trained security officers to be allocated to the unit:

'For us not to be attacked by patients we must be protected either by security guards to be in the ward so that we can be safe because most of the time when we call and if the patient is very very much strong and you know we don't have a lot of men here. Women are, are just women so we need a security guard' P1.

Intervention of untrained security guards is often unhelpful. With regards to the training of security guards, two participants stated that:

'We also need more manpower to be allocated here, sometimes you are just female nurses here and you are admitting an aggressive patient. We need trained security officers, another one was beaten by a patient because he is not trained' P9.

'Ok, by manpower it includes more male nurses, it also includes ummm, let me say security guards who are trained. They need to be trained. It's not like the security guards we are having here, they just come here, when they come here for handling aggressive patients they don't know how to handle the patients. So the security guards need also to be trained so that when they come here they know what to do. Because sometimes we are only having one male nurse and the female nurses then we have to call the security guards but they are not trained. They need to be trained and they have to be here 24 hours if it is possible' P12.

Child and Mendes (2010:90) and Demir and Rodwell (2012:380) reported that nurses have been the recipients of an alarming increase in workplace violence. Kindy et al (2005:174) concluded that improving safety in psychiatric facilities will serve to enhance interest and retention in this valuable nursing specialty, and thus improve the care given to clients. Tema et al (2011:922) also recommended security officers to be attached to a psychiatric ward to ensure the safety of patients and staff.

Mental health nurses who are working without security officers' support may feel ill equipped to handle the hostile patients alone. According to Lamb, Weinberger and DeCuir (2002:1269), there is a need for better training for all law enforcement officers on mental illness, on how to best meet the needs of persons with mental illness, and on how to use mental health resources. A key part of such training is learning how to manage patients who present with hostile behaviour.

Abbas et al (2010:37) and Child and Mendes (2010:93) reported that the prominent presence of security personnel has been shown to reduce the rate of assaults in wards. It is also recommended that ward orderlies be incorporated in the staff establishment to help in enhancing security of nurses.

When hospitals are safer for staff, they will also be safer for patients. When the safety of nurses is guaranteed, it may attract more nurses to work at the psychiatric unit. Farrell, Bobrowski and Bobrowski (2006:779) concluded that in order to ensure that adequate numbers of psychiatric nurses are available, it is time that nursing managers, administrators and the profession examine patient aggressive behaviour towards psychiatric nurses in order to ensure a safe and supportive work environment.

4.2.4 More male nurses

All female participants indicated that they are victims of hostile behaviour from mentally ill patients mostly when they are without the company of male nurses. One participant noted that some of the patients start to be hostile once they realise that there are no male nurses around:

'I think anyone can be unlucky with those patients and be insulted or injured. Of course with the male patients sometimes they do like this, if they realise that there are no male nurses in the ward, then they start to misbehave because they know what can you do you are just women...we need more male nurses in this ward, but now we are not getting them, especially after hearing those things that are happening here' P2.

There is a general belief among the nurses that male nurses' mere presence acts as a deterrent to hostile behaviour from the patients as one participant stated:

'Yeah, personally I was feeling bad although I was also trained that sometimes you will be injured by the patient. That's why here in (name of hospital) we are not having many male staff nurses because there where we were trained, when the female nurses walk inside or wherever, you are supposed to walk with the male nurses, yeah, in order to protect you. That's why here you find women they are beaten by patients...we have said it long time, we need more male nurses. Even cleaners we need more male cleaners in order to help us' P4.

Tema et al (2011:919) made the same observation that aggression is often displayed when there are no male nurses in the ward. Chen et al (2007:315) concluded that accompanying male staff might be useful for preventing violence. The shortage of male nurses in the ward under this study leaves the female nurses at a higher risk of violence as indicated by the concerned voices from the following participants:

'We also need more manpower to be allocated here; sometimes you are just female nurses here and you are admitting an aggressive patient' P9.

'I think we need, ummm, manpower. We need manpower, this will make patients frightened and this will also prevent this physical abuse. Yeah...Ok, by manpower it

includes more male nurses... I think it's the same, yeah it's the same. But if there are more male nurses, patients you can observe they are more frightened to injure someone or to beat someone' P12.

Male nurses are fewer in the profession as indicated by one participant:

'We have said it long time, we need more male nurses. Even cleaners we need more male cleaners in order to help us. We complain a lot about that but nothing happened. Sometimes they say male nurses are few in the profession' P4.

There is no literature to indicate why there are so few male nurses in the profession. It is likely because the profession is traditionally regarded as feminine. It is recommended that the nurses can raise more awareness of their profession to encourage more males to join the nursing profession.

4.2.5 Special allowance

Most of the nurses pleaded for the return of the special allowance (danger allowance) which was scrapped by the government some years ago. They believe that it can boost their morale and motivate them to perform better under the current conditions of hostile behaviour from mentally ill patients:

'Yeah, like what I said before, yeah, if maybe there is something like psychiatric allowance, something like that, yeah. When you are coming here, you know that there is that allowance. Its covering something like that. When you get an injury, or something is broken by the patient, you know this money is covering this. I think people will be motivated also to come here. Yeah. Like now there are a lot of nurses here they are saying they want to be removed from the ward , but if you remove all the nurses from the ward, who is going to work here. Maybe the ward is going to close. But maybe if there is something that we can maybe motivate them so that they can work here. Yeah' P6. He emphasised his point by drawing a huge Namibian dollar sign when asked to indicate his experiences with hostile patients in pictures.

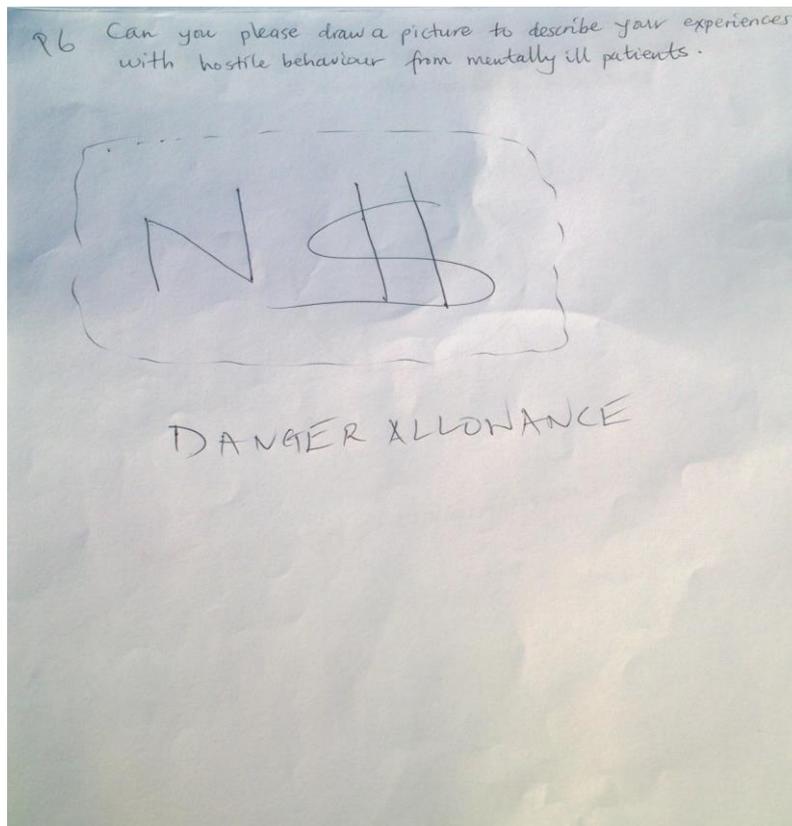


Figure 4.1: Special allowance(P6)

'We must also be given some allowance for nurses who are working here so that others will be willing to come work here' P3.

'Here it's not like other departments, there is a lot of risks, it's not like others. We also need allowance because we are in a higher risk area. Yes...it won't change but just to motivate us to continue working in this environment' P7.

'We also need some allowances just to encourage us and motivate us to work. We have some staff who are bitten by patients. Yes' P9.

Besides addressing the general shortage of staff in psychiatry, some participants believe that a special allowance can also lure the much needed male nurses to come and work in the mental health unit:

'And also another thing is I think can also fit, they need to introduce also this allowances when you are working in this, umm, such a ward. Allowances which can encourage staff to work in such a situation. Because now many nurses everybody is just saying I don't

want to work in this ward, maybe if there is an allowances it can encourage male nurses and other nurses to work in this situation' P12.

Participants voiced the concern that once their property has been damaged by the mentally ill patients, or once they have been injured, they do not receive any compensation. The allowance could go a long way in helping them to replace their personal belongings and motivate them to continue working under such difficult conditions.

One participant said:

'When you are coming here, you know that there is that allowance. Its covering something like that. When you get an injury, or something is broken by the patient, you know this money is covering this. I think people will be motivated also to come here...Some recommendations were made like to give an allowance to nurses working specifically in psychiatry, maybe to motivate people to come here. Or when you get injured, because sometimes you get injured and your things like your spectacles or watch they get broken, then you get compensated' P6.

Awosusi and Jegede (2011:590) in their study in Ekiti State, Nigeria, concluded that there is a significant difference between motivational incentives and job performance of nurses. This would imply that the poor motivation of nurses affects the level of their job performances and a special allowance could encourage them to work in the psychiatric unit.

According to Ayub and Rafif (2011:345) income and money are strong stimulators, so they can be used for creating a better work environment and higher job satisfaction among nurses. The management is encouraged to advocate for a special allowance for nurses working in the risky area of mental health.

Gieter, Cooman, Pepermans, Caers, Bois, and Jegers (2006:7) indicated that nurses value not only financial rewards, but also non-financial and psychological rewards. Leung et al (2007:74) posited that in order to motivate psychiatric nurses in acute wards, management must continuously give feedback regarding their efforts, make regular contact with them, perceive their skills as important, and recommend further

training. Selvam (2008:16) supports this by indicating that the number one thing that can motivate psychiatric nurses at work is not money or time off, but effective communication. She felt that the ability to convey ideas clearly, openly and honestly, and discussing their goals and objectives can motivate psychiatric nurses. It is therefore recommended that management can consider non-financial and psychological rewards for nurses working in psychiatry.

However it is not clear whether monetary or non-monetary rewards for psychiatric nurses can reduce the incidents of hostile behaviour from mentally ill patients or whether they can alleviate the effects of an experience of hostile behaviour from patients.

4.2.6 Infrastructural adjustments

The psychiatric department where the participants work is divided into two big wards, the male and the female side. There are no demarcations to separate patients according to their conditions and levels of recovery. This was a concern for some of the participants:

'Maybe what I can add is that, as I have heard that they are going to be building a new building for psychiatric patients, as a mental health unit, if possible they have to have a separate space, just to divide the hostile patients from the others. Because sometimes we are having sick patients there, old patients there, sometimes we are also having some depressed patients, and sometimes we are also having our own staff, they need to create a separate space so that we divide all those patients according to their conditions. I also want to emphasise that they need to build more seclusion rooms where we can keep those hostile patients which is well ventilated' P12.

'We need new building for psychiatric, special for psychiatry because there is many cases here, those who are aggressive. We need more seclusion rooms. We need separate rooms, especially for the alcohol, the chronic schizophrenia, acute psychosis, depression, ummm, and for observation sick patients also. We need those things' P10.

Other participants added that the ward is too small and overcrowded:

'There is a lot of things to be done here. The ward is too small and the patients are so many. And I think this ward need to be divided into different sections, the alcoholic, suicide, the acute, minor under 12 years, chronic patients all are under one section' P9.
'Here it's overcrowded here, we attend to outpatients also here and they insult us as well. But we are used' P7.

Physical spaces are the aspect of care most clearly remembered by discharged psychiatric patients. Some patients would have relapsed, therefore remembering the confined environment can trigger hostility in them. Overcrowding in a closed ward frequently results in competition for limited resources, which leads to fights and arguments between the patients. This echoes with studies by Ng et al (2001:524) and Cornaggia, Beghi, Pavone and Barale (2011:18), which suggested that overcrowding is significantly associated with violent incidents by patients, in particular, verbal aggression. The male and female wards at the mental health unit under study have a capacity of 30 patients each but most of the time there are over 80 patients on the male side and over 50 on the female side according to Anonymous (2014:Personal interview, 12 May. Oshakati). Currid (2009:43) reports on the experiences of stress amongst nurses in an acute mental health setting in London, where it was found that there was a shortage of beds and that demand outweighed availability.

From the field notes, one participant (P4) had a feeling that this arrangement, where patients are mixed in a small ward, exacerbates hostile behaviour from them (the patients). She felt that the environment in which psychiatric patients are nursed is not therapeutic, making the patients more aggressive. Olver, Love, Daniel, Norman and Nicholls (2009:209) noted that the physical environment of long-stay psychiatric rehabilitation wards may influence aggressive behaviour in chronically ill patients and that a wholesale move to a brand new building or substantial refurbishment of an existing facility had modest effects on outcomes, including staff satisfaction. In line with Child and Mendes (2010:93) who advocated for environmental modifications, research done by O'Brien and Cole (2004:90) highlighted that a lack of research-based prevention of patient aggression has left thousands of psychiatric nurses working in hazardous conditions with few reliable resources at their disposal to prevent and

effectively manage aggression towards themselves and their co-workers or patients in health care settings.

It is recommended that management may design and implement protocols and guidelines for nurses on the management of hostile behaviour from patients, safety and security for nurses and patients, post-incident care or support in line with the Namibian Labour Act 11 of 2007, Part 4 Section 39 (Namibia 2007:46). It states that the employer has the right to provide a working environment that is safe and without risk to the health of employees, as well as provide the employees with the necessary information and training to work safely and without risk to their health. This would also offer the mental health nurses with channels to air their occupational grievances.

4.3 LIMITATIONS OF THE STUDY

This study has some limitations. Firstly there is a high possibility of recall bias considering that the data was collected retrospectively and some of the participants have more than thirty years experience working in psychiatry.

A small sample size of nurses was used, thereby limiting the study's generalisability. However, saturation was reached and twelve participants is an acceptable sample size for a qualitative study of this nature.

The interviews were conducted in English which is not the first language of most participants. This could have made it difficult for some participants to express themselves clearly. This could possibly also explain the short length of the interviews.

Not much has been done to study the psychiatric nurses' experiences of hostile behaviour from mentally ill patients in Namibia. As a result there was little local literature to compare the results with.

4.4 FURTHER RESEARCH

Future studies should be undertaken on the possible confounding factors contributing towards hostile behaviour from patients. This includes the reasons behind psychiatric patients' attacks on the nurses. Needham, Abderhalden, Meer, Halfens, Dassen, Haug

and Fischer (2004a:599) argue that the best predictors of patient hostility are disorder-related variables such as schizophrenia, mania, substance abuse and personality disorders.

Other data gathering methods could have enriched the data as well as the research findings. For example, additional focus groups could be used in future studies as some people can express themselves better in a group setting.

There is not much literature reporting this phenomenon of nurses retaliating to verbal or physical abuse by patients as indicated in this study. It is a new dynamic area that needs to be explored further. Further studies can also be done on the effectiveness of self-counselling, since little literature was found describing this coping mechanism. Future studies might also explore nurses' experiences in other psychiatric settings, like the forensic one.

4.5 CONCLUSION

The researcher observed that hostile behaviour from mentally ill patients is a significant problem experienced by psychiatric nurses. From this first study to be done in Namibia, it has emerged that nurses experience verbal abuse, physical abuse and sexual harassment from patients under their care. The exposure to these hostilities resulted in emotional, behavioural, adaptation and coping, physical, social and positive reactions from the nurses. The nurses were aware of their or facility's shortcomings but did not have a platform to narrate their experiences and ventilate their feelings. They were appreciative of having to take part in this study as this would make their challenges heard.

It's interesting to note that the study has revealed some issues not previously reported in literature about nurses retaliating to verbal or physical abuse by patients and some nurses resorting to positive self-talk after experiencing hostile behaviour from mentally ill patients. The challenges faced by the psychiatric nurses, namely lack of training, lack of counselling and support, lack of reporting, lack of physical protection and lack of adequate human resources provided a background to make recommendations about training, counselling and support, physical protection by trained security, more male nurses, special allowance and infrastructural adjustments. These recommendations

could make the management more responsive to the needs of psychiatric nurses who face hostile behaviour from patients on a daily basis. Providing all necessary support to nurses will improve the quality of care they render to the patients, thereby facilitating job satisfaction amongst the nurses.

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ANNEXURE B
LETTER TO REQUEST PERMISSION FROM THE MINISTRY OF
HEALTH AND SOCIAL SERVICES

[REDACTED]
[REDACTED]
[REDACTED]

18 October 2012

The Permanent Secretary
Ministry of Health and Social Services
Windhoek

Dear Sir

REF: REQUEST FOR PERMISSION TO CONDUCT A STUDY AT THE
[REDACTED] HOSPITAL, [REDACTED]

I wish to kindly request for your permission to conduct a study titled: "Nurses' experiences of hostile behaviour from mentally ill patients".

I am an Occupational Therapist at the aforementioned hospital undertaking a part- time Masters degree at the University of South Africa (UNISA). I am currently working on a dissertation, which is in partial fulfilment of the Masters in Public Health degree programme.

The main purpose of this study is to explore the nurses' experiences of hostile behaviour from mentally ill patients at [REDACTED]. It is intended that the findings of this study will be used to make recommendations to the hospital management to support nurses who experienced hostile behaviour from patients.

There are no foreseeable risks associated with participating in this study. However the participants may 're-live' their experience and experience psychological discomfort

(mental distress or uneasy). If this occurs, further management will be offered through referral of those nurses who will need specialist attention (counselling) from social workers and psychologists without any cost to the participants. A confidential report detailing the management of such participants will be forwarded to your office by the researcher in consultation with the social workers and/or psychologists.

Attached please find the research proposal, data collection tool and consent letter.

Thank you

Yours faithfully

.....

Isaac Chimedza

ANNEXURE C
ETHICAL APPROVAL FROM MINISTRY OF HEALTH AND SOCIAL SERVICES


REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia
Enquiries: Mr.M.Simasiku Ref: 17/3/3

Ministerial Building
Harvey Street
Windhoek

Tel: (061) 2032125
Fax: (061)272286
E-mail: msimasiku@minhs.gov.na
Date: 13 March 2013

OFFICE OF THE PERMANENT SECRETARY

Mr. Isaac Chimedza
[Redacted] Hospital
[Redacted]
Namibia

Dear Mr. Chimedza

Re: Nurses experience of hostile behaviour from mentally ill patients at [Redacted] Hospital.

1. Reference is made to your application to conduct the above-mentioned study.
2. The request has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data collected must only be used for purpose stated in the proposal and the permission requesting letter;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission to be sought from the Ministry for the Publication of the findings.

Yours sincerely,

MR. ANDREW NDISHISHI
PERMANENT SECRETARY

"Health for All"

ANNEXURE D
APPROVAL FROM HOSPITAL MANAGEMENT


REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH & SOCIAL SERVICES

[Redacted]

[Redacted]

Enquiries: Ref: 7/3 Date: 24 April, 2013

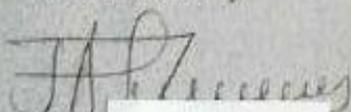
Mr. I Chimedza
Private Bag [Redacted]
[Redacted]

APPLICATION TO CONDUCT A STUDY: NURSES EXPERIENCE OF HOSTILE BEHAVIOUR FROM MENTAL ILL PATIENTS AT [Redacted]

Your letter on the above issue refers.

The [Redacted] Management granted you a permission to conduct your study on condition that you must adhere to the rules and regulations of the institution and the Ministry.

During your study period, you must be under the supervision of the Medical Officers and Registered Nurse in charge of the sections concern.

Yours Sincerely

DR. J. [Redacted]
[Redacted]

ACTING MEDICAL SUPERINTENDENT



ANNEXURE E

CONSENT LETTER FOR PARTICIPANTS

College of Humanities and Social Sciences
Department of Health Studies
P O Box 392
UNISA

Dear Research Participant

REF: REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

I, Isaac Chimedza, am a Principal Occupational Therapist currently enrolled for Masters in Public Health at the University of South Africa. In partial fulfilment of this degree I am conducting a research project entitled “Nurses’ experiences of hostile behaviour from mentally ill patients at a general hospital”. The purpose of this study is to explore in detail the nurses’ experiences of hostile behaviour from mentally ill patients.

You are invited to participate in this study so that you may share your personal experience with hostile behaviour from psychiatric patients and make some recommendations. You have been selected to participate using the purposive sampling technique which uses the researcher’s knowledge about the topic to select participants. I would like to schedule an interview with you at your convenience. You will be part of the participants who will take part in this study through individual interviews which should last for approximately an hour per person.

I undertake to safeguard your anonymity by omitting the use of names and job-specific titles in all reports and publications. Confidentiality will be ensured by the use of codes instead of names and by not availing your information to irrelevant people. Your participation in this study is voluntary and you may withdrawal from the study at any stage without any penalty and without any obligation to explain. The benefit you will get through this research is that you will be able to share your experiences of hostile behaviour from mentally ill patients. Your concerns will be heard and strategies may be developed to remedy the situation based on the experiences shared. The findings will

be disclosed to the hospital management and the ministry of health for implementation of recommendations. You will also receive feedback on the research upon its completion.

There are no foreseeable risks associated with participating in this study. Should you however experience any discomfort (mental distress or uneasy) resulting from sharing your experience you will be provided with the name of a professional person who would conduct a debriefing interview with you at no cost to yourself. You will receive no form of reimbursement.

All data and records will be kept in a locked place in the researcher's office for two years after research completion. The office will be only accessible to the researcher. Audio recordings will be erased from the recorder. Records stored on a computer hard drive will be password protected by the principal researcher and will be erased using commercial software designed to remove all data from the storage device. The USB drives will be physically destroyed. A record stating what records were destroyed, when and how the researcher did so will be kept.

Should you have any further questions, feel free to contact

Mr Isaac Chimedza (Researcher)

[REDACTED]

[REDACTED]

[REDACTED] Namibia.

Tel: +264813577632

Email: isaacchimedza@yahoo.co.uk

ANNEXURE F

DATA COLLECTION INSTRUMENT

Interview Schedule

Research Title: Nurses' experiences of hostile behaviour from mentally ill patients.

Date of interview:

Time of interview:

Length of Interview:

Interviewee:

Interviewee's age:

Interviewee's experience in years:

Interviewee's educational level:

Interviewee's sex:

Interviewee's race:

Setting/ward:

Interview questions guide

- How was it for you when a patient was hostile towards you? Probe questions follow:
- How has this affected you personally?
- How has this affected you professionally?
- Did you report the incidence? If yes which channels did you follow to make the report? If no, what are the reasons for not reporting?
- What action was taken to address the issue?
- What support systems are available for nurses who experience hostile behaviour from patients?
- What actions need to be taken given your experiences?

ANNEXURE G

TRANSCRIPT OF THE SAMPLE INTERVIEW

Date of interview: 30 September 2013
Time of interview: 2100hrs
Length of Interview: 30 minutes 16seconds
Interviewee
Interviewee's age: 25
Interviewee's experience in psychiatry (years): 1 and a half
Interviewee's educational level: Certificate in Nursing
Interviewee's sex: Male
Interviewee's race: Black

Interviewer: Good evening Sir.

Participant: Good evening Sir.

Interviewer: Let me start by asking you, how was it when a patient was hostile towards you?

Participant: Yeah, it's an incident that took place in our ward here. It happened that we were just, ummm, a patient was just making noise inside there. He was aggressive and shouting demanding to be given his clothes to go home. So it wasn't like he was straight to me, he was just aggressive in general. So we went to take him out because he was disturbing other patients there. Then he happened to bite me.

Interviewer: Where did he bite you?

Participant: He bite me on the first three fingers (*showing the healed wounds*) and injured me.

Interviewer: Very sorry. So what happened after that?

Participant: After that? Anyway before he injured me we were struggling to take him out because he is a very strong guy, he is even taller than me. Very strong, so we informed the security guard from the main hospital gate to come and assist us. The security were scared of the guy so we tried and when we tried I catch the guy and no one was helping me there. Everyone is trying to run away.

Interviewer: Who else were you with besides the security? Don't mention the names.

Participant: We were two nurses and three securities.

Interviewer: Ok.

Participant: Yes. That's it. And then ummm, so what happened later is that when I got injured I reported to my senior. I just showed him immediately when I got bitten. Because as far as I know, our procedure is if you happen to get injured, for example you got injured by a needle, you got injured any kind of injury immediately you report to your senior. I reported to my senior.

Interviewer: So tell me, now it's healed but how was the injury that time?

Participant: Yeah it was very painful, bleeding, some open bleeding wound. Yeah very painful.

Interviewer: Ok. Ok. So after you reported what happened?

Participant: After I reported ummm, I was unfortunate the nurses I was working with they are new to the system so they did not take proper action. They only told me to go to see the doctor at casualty. I could not go alone, anyway I was supposed to be accompanied by a nurse. I asked if I could be accompanied by a nurse because personally I was not feeling well. I was very stressed, I was even scared.

Interviewer: What were you scared of at that moment?

Participant: Just to hear that you are bitten by a mentally ill patient is scary, yeah it's scary, it's something,

Interviewer: Ok. So you went to casualty alone then?

Participant: No, I did not go alone. I personally asked another nurse to go with me to casualty and we saw the doctor. The first doctor I find there was also like the nurses here. I don't know, people really don't understand the procedure. He only, he was not serious. I talked to him, that I have been bitten by a patient and the doctor started laughing. I was sick, I was paining, I told him I was paining. He only gave me TT, tetanus (*inaudible*) instead of giving me an antibiotic or any analgesic for pain. Yeah I demanded for at least analgesic but he refused. I was paining my friend.

Interviewer: Ok. Explain to me what is the channel for reporting such incidents?

Participant: Anyway, the proper procedure is for example if you get injured you report to your senior, the senior will take it up, can help you fill in the forms, everything. Yeah it's the senior who is responsible to deal with everything. I am not supposed to go to administration, only my senior is supposed to take up the thing. That's the procedure. I cannot go and negotiate with the doctors, someone must be with me.

Interviewer: Ok. Tell me, how did that whole experience affect you personally? You said you were stressed, can you please elaborate.

Participant: Yeah it affected me personally and socially, ummm. Ever since I got bitten no one cares about me, even the doctor didn't care. He was laughing at me. So later, so

when I got bitten he refused to give me the treatment so then the next day I came back to demand for antibiotic. The other doctor said I should go and look for the doctor who treated me first, then I was having some forms to be filled. Everyone seems to refuse, the nurses don't want to fill the form, the doctor doesn't want to fill the form. I was even more stressed.

Interviewer: What kind of form was that?

Participant: Those forms, it's a kind of procedure you know. If you happen to be injured on duty you have to follow the procedure. First you inform the in-charge, then you go to the doctor, then there are forms to be filled. Those forms will be taken to the ummm, ummm, infection control office, some have to be taken to the social security, just in case you lose any part. For example I was bitten on my finger, maybe in future I lose those fingers then I will be compensated.

Interviewer: Ok. What was done to the patient?

Participant: To the patient? Unfortunately I was just alone dealing with my case, no one seemed to care. The patient, even the doctor they were informed that that patient injured a nurse. So the first doctor who saw him just discharged the patient, he didn't even write the date for follow up.

Interviewer: Which doctor is this one now?

Participant: The psychiatric doctor. The other day I came to ask for the patient maybe to get tested, the patient is already discharged. Then I asked if he can help me trace the patient and they refused. The doctor refused then I traced the patient myself. Later he came and then I took him to CDC. Yeah.

Interviewer: To get tested?

Participant: Yes to get tested.

Interviewer: So now it looks like no one was cooperating with you?

Participant: No one was cooperating my friend.

Interviewer: How did all that affect you personally?

Participant: My friend I never cried but that time, you know, I got injured on the 7th, this month, I have been dealing with the case until last Monday. I think it was on the, ummm, on the 23rd. it really affected me emotionally. I even demanded that maybe I can be allocated to other departments. Because my friend if you get injured here, no one cares. So what is the use? Most people so far have demanded to go to other wards. Because the problem is here is people cannot understand you. Here we are really struggling with patients, you get injured no one care.

Interviewer: Ok. Tell me, how did it affect you professionally as a nurse after that incident?

Participant: After that incident, for example I cried in front of my seniors, it was not professional. It was because of frustration. That was not my aim really to cry but because I felt disappointed, I felt alone no one cares, I cried in front of my seniors. I went there to the administration. So that's the thing.

Interviewer: Ok. But are you discharging your duties well as a nurse, is it affecting you when you meet the patients every time you are on duty?

Participant: Continuing working here to me, I feel, I feel terrorised or something.

Interviewer: Terrorised by whom?

Participant: By patients. Yeah. Maybe in future I get injured I will go through the same experience, the same bad experience. It's very terrifying. I work in fear, that's why I will ask to be allocated to other departments. No one cares. Because if you get injured my friend, you are bitten by a patient, you need counselling, emotionally you are already affected. But if you are dealing with your case alone, how? Only if I am, only because I am a man I am strong. If it was a woman she will be just crying there.

Interviewer: Did you receive any counselling?

Participant: I didn't receive any counselling.

Interviewer: Do you think you need to see a counsellor?

Participant: It's too late to get counselling, it's already too late.

Interviewer: Why do you say so?

Participant: That time is when I needed a counsellor, someone to talk to me and accompany me to the doctor and administration.

Interviewer: Ok. What actions do you think need to be taken given your experience with hostile psychiatric patients?

Participant: Maybe I was just unfortunate, your day, you don't know when your day will come so there is nothing I could do. For now what I could suggest is that we need some more in-service training for people to understand, the doctors should understand, the nurses must understand the procedure if a colleague got injured on duty.

Interviewer: In your training as a nurse, did you receive any training on hostile patients?

Participant: My friend, enrolled nurses don't get that training. I was just allocated here and then I just copied from my colleagues who were already working here. I did not get any formal training on handling aggressive patients. We need in-service training as well on that. I suggest again that something should be given to nurses so that it can motivate

them to work in ward 16 (*mental health unit*) because no one wants to come here. We really need manpower but some people I heard they refuse to come here when the change list comes out. The problem is I got bitten because we were just two, the securities are also not trained to handle these patients.

Interviewer: Ok. Was this the only incidence of hostile behaviour from patients towards you?

Participant: yeah, many things happen here. One day I got beaten by a patient there, sometimes you get threatened verbally by patients that if I find you outside when I am discharged I will deal with you.

Interviewer: Can you elaborate on your experiences with verbal abuses from patients.

Participant: About my experiences, even today I have been insulted, I have shouted by a patient. The patient is calling me names like longman, you know (*laughing*) you know. I am really tall but you know I am not ready to be called something like that. You see, we are suffering here.

Interviewer: Did you report the incidences of verbal abuse?

Participant: No, it's a waste of time my friend, people don't care. We are just helpless.

Interviewer: So those threats and verbal insults, how do they affect you again?

Participant: Anyway I take it like the patient is sick. Sometimes you can see that this patient is no more sick but he still insults me, shouting at me. You can no more take that the person is sick. Now he is fine but he is calling you those names. Sometimes you just accept the condition, it's a matter of being strong emotionally and psychologically. Yeah, you have to take it easy.

Interviewer: What do you mean by taking it easy?

Participant: Yeah you don't need to like fight back, just ignore. That's the way to work with these mentally ill patients.

Interviewer: Ok. How else do these verbal insults affect you?

Participant: Anyway, it affects you socially, even outside there you are not having that freedom to walk around freely. My friend I don't walk freely in (*his residential town*) the patients are all, once they see you they will beat you up seriously. Of course I was not beaten before but I met some outside there they threaten you.

Interviewer: But why would a patient want to beat a nurse who is taking care of him?

Participant: Maybe for example the doctor just prescribed an injection for him, then you inject him for example, from there he has a revenge that you caused pain to him, what what, this guy injected me if I see him outside, I will take a revenge.

Interviewer: Ok. What support systems are there in place to support nurses who experience hostile behaviour from patients?

Participant: Aaah, since I came here I have never heard something like that, you are just allocated to ward 16 and you work, nothing. No support. No encouragement, nothing. No support like maybe the patient has been, the nurse has been bitten by a patient and something has to be done like ummm, if you beat a patient even the minister will come here, but if the patient beats me nothing will be done. How do we really understand that people. Anyway I have never heard anything like support for nurses in ward 16.

Interviewer: What actions do you think need to be taken given your experiences?

Participant: We must be given some in-service training. We must also be given some allowance for nurses who are working here so that others will be willing to come work here. We need more manpower, more male nurses should come here to support. Counselling should be done during the procedure, it must be part of the procedure.

Interviewer: Ok. Is there anything else that you might want to add concerning your experience with hostile patients?

Participant: Ummm, nothing else. Anyway I would like to thank you nee, for your effort. At least maybe with your research in future someone somewhere will understand the situation in ward 16.

Interviewer: Thank you very much for your time.

Participant: Thank you.

ANNEXURE H

LETTER FROM THE EDITOR



Between The Lines
Leatitia Romero
Professional Copy-Editor, Translator and Proofreader
(BA -Languages and Literature)

Cell: 083 236 4536
Fax: 086 690 4787
leatitiaromero@gmail.com

PO Box 8431
Halfway House
1685

23 October 2014

To whom it may concern:

I hereby confirm that I have edited the thesis of ISAAC CHIMEDZA, entitled: "NURSES' EXPERIENCES OF HOSTILE BEHAVIOUR FROM MENTALLY ILL PATIENTS IN THE PSYCHIATRIC WARD OF A GENERAL HOSPITAL". Any amendments introduced by the author or supervisor hereafter, is not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations made by the editor, and remains the author's responsibility at all times to confirm the accuracy and originality of the completed work.

Editing Service Performed:

Technical editing:	Format and appearance Table of contents Tables and figures consistency Content consistency - numbering and headings Bibliography and reference list consistency
Language editing:	Punctuation Spelling and grammar Suggestions to enhance clarity of unclear sentences

Leatitia Romero
(Electronically sent – no signature)

Affiliations

PEG: Professional Editors Group
English Academy of South Africa
SATT: South African Translators' Institute