

22-98

PERCEPTIONS OF VIOLENCE OF NURSES WHO WORK
AT THE PSYCHIATRIC HOSPITAL IN THE STATE OF BAHRAIN.

MARIAM ALI AL MULLA

SCHOOL OF NURSING STUDIES
UNIVERSITY OF WALES COLLEGE OF MEDICINE

DISSERTATION SUBMITTED TO THE UNIVERSITY OF
WALES, CARDIFF, IN ACCORDANCE WITH THE
REGULATIONS IN PARTIAL FULFILMENT FOR THE
DEGREE OF MASTER OF NURSING.

APRIL, 1992

DEDICATION

Dedicated to my husband, Mohamed, my brother Ahmed
and my son, Ali.

No.

1

1

2

3

4

24

DECLARATION

24

26

28

I declare that the work presented in this
dissertation is entirely my own independent
investigation and has not previously been
submitted, nor concurrently being considered
for any other degree.

28

31

34

36

37

37

8

9

2

0

8

9

Signature of candidate:.....

5

7

8

9

Mariam Al Mulla

0

1

April 1992.

2

7

LIST OF TABLES

Page No.

3.1.1	Reported Incidents Occurring at the Psychiatric Hospital.	27
3.4.1	Number of selected nurses from selected areas	33
4.1	Ages of the subjects	43
4.2	Education of the subjects	43
4.3	Number of years in the service	44
4.4	Number of physical assaults by patients	45
4.5	Category 1: Definition of violence	46
4.6	Category 2: Causes of violence	49
4.7	Category 3: Nurses' role to prevent violence	55
4.8	Category 4: Doctors' role to prevent violence	62
4.9	Category 5: Administration's role to prevent violence	65
4.10	Category 6: Recommendations and suggestions	70

LIST OF FIGURES

Page No.

Figure 1. The Continuum of Coping Responses related to feelings
of anger. 5

Figure 2. Map of the State of Bahrain showing the approximate
position of the Psychiatric Hospital. 25

ABSTRACT

The aim of this study is to explore and describe perceptions of violence of some of the nurses who work at a Psychiatric Hospital in the State of Bahrain.

A qualitative research approach, with an exploratory descriptive design was used. Twenty-one nurses were selected by simple random sampling from seven areas of the Psychiatric Hospital. An interview, with an interview guide, was used to collect the data.

Eight major categories were identified from the interview guide, which yielded thirty-one sub-categories. The findings will be presented from a content analysis of the interview material. The major findings were that most of the subjects defined violence as the use of physical force and many used the word "aggression" to define violence. This was supported in the literature.

The majority of the subjects identified the following as causes of violence: mental illnesses, such as schizophrenia, mania, etc., unmet needs and demands of the patients, environmental factors, such as noise, overcrowding and lack of occupational and recreational facilities and nurses' attitudes and approaches towards the patients. Also, patients' characteristics, such as attention-seeking, demanding and lack of confidence, were linked with violence.

Many of the subjects felt that nurses play an important role in preventing violence and recommended that all nurses should be trained in how to deal with violent patients. Communication was also seen as important in order

to prevent violence and one subject reported that the language barrier for non-Arabic speakers was a problem.

Of the 21 staff nurses interviewed, 18 had experienced physical assaults by a patient at least once. The feelings reported by some of the subjects were "sadness", and "being threatened". This was supported by a study conducted by Lanza (1983) in order to find out nurses' responses in social, emotional and biophysiological functioning. The majority of the subjects in this study reported that, if they had the chance to choose where to work, they would choose to work with non-violent patients. The reasons why were not investigated in depth, due to time limits.

Based on the findings, recommendations are made in order to make improvements in practice, education and further research in this area.

ACKNOWLEDGEMENTS

I should like to express my sincere appreciation and gratitude to a number of people.

My deepest gratitude and thanks go to my supervisor, Professor Bryn Davis, for his comments and constructive criticism, and his lovely personality which gave me the courage, motivation and enthusiasm to complete my work.

I am indebted to all the nurses who participated in the study, as without their co-operation it would have been impossible to carry out the study.

My sincere thanks go to the Government of Bahrain, Ministry of Health and College of Health Sciences for sponsoring my education.

I am grateful to Mr. Faisal Al Hamer, Dean of the College of Health Sciences for supporting my study.

I am also grateful to the British Council in the State of Bahrain, for paying the fees of my studies at the University of Wales College of Medicine.

My thanks and gratitude to Ms. Layla Abbas, the Senior Nursing Officer at the Psychiatric Hospital, for her help and support and also to all the administration staff at that hospital for allowing me to conduct my study and facilitating this by providing a room in which I could conduct the interviews.

Sincere thanks go to Mr. Michael Lehane and Dr. Homa Darmani for their time

and efforts in validating the analysis.

I should also like to extend my thanks to the staff and the administration of the Whitchurch Hospital in the U.K. for allowing me to conduct the pilot study.

Sincere thanks go to the staff of the main library and to all the staff and Faculty of the School of Nursing Studies, University of Wales College of Medicine, for their help and support.

Sincere thanks go to Mrs. Eileen Parker for typing this thesis and for her patience in reading my difficult handwriting.

I am grateful to Dr. Naima Al Gaseer, for sending me the required information from Bahrain, and to Dr. Fariba Al Darazi, for her support and encouragement. Thanks also to my friends Miss Irmgard Bauer and Miss Basima Al Aliwat for their help and encouragement.

To all my colleagues, family and friends in Bahrain and elsewhere for the continuous support.

Finally, my sincere thanks and indebtedness to my husband, Mohamed, and my son Ali, for their love and patience. To my brother, Ahmed, for his sacrifice in being away from his friends, staying with me and tolerating my son and myself in a difficult time.

To my parents, my sisters Najat and Fatima, and my nephew Jamal for their love and support.

CHAPTER 1.

INTRODUCTION

Violence has been cited as a problem, in general hospitals as well as in psychiatric hospitals. Although many articles have been identified in the literature on violence, research into the topic related to nurses' attitudes, perceptions and reactions is limited.

1.1 The Aim of the Study

The aim of this study is to explore and describe nurses' perceptions of violence in a Psychiatric Hospital in the State of Bahrain. The literature review suggests that there is under-reporting of violent incidents. Violence is a problem which faces staff as well as patients, A violent patient could injure himself, other patients or members of staff. The after-effect of violence could range from minor to major injuries and this could result in both physical and psychological trauma.

Not only do nurses deal with patients who suffer from different conditions, such as medical, surgical and psychiatric problems, they also provide care to suicidal, aggressive, depressed, homicidal, pre-and post-operative patients, as well as the terminally ill. However, there are little empirical data available that indicate the frequency of violence among nurses (Poster and Ryan, 1989).

In this study, violence will be any physical harm or injury to self, another person or property by a psychiatric in-patient.

Different definitions of violence, the causes, incidence and theories of

aggression, will be presented, in order to gain more insight into the concept of violence and aggression. The methodology and the analysis of the data used will be explained.

Finally, the limitations of this study, and the recommendations for further study will be presented, based on the findings. It is hoped that this study will give a clear picture of the concept of violence from the subjects' point of view. This is important in order to plan changes in relation to practice, education and further research.

1.2 The Need for the Study

From the incident forms of physical violence which have occurred at a Psychiatric Hospital in the State of Bahrain, there had been an increase in the number of incidents reports. In 1989, there were 32 reported incidents, while in 1990, the number had increased to 50 incidents.

Although there are many articles in the literature that discuss violence, nursing research on violence is limited and there has been no research on violence carried out in the State of Bahrain.

Perceptions of violence and what violence means, might influence nurses in reporting all violent incidents and might influence their approach towards a violent patient. Lion, Snyder and Merrill, (1981) indicated that there is under-reporting of violent incidents. They stated that five times more incidents occurred than were reported.

It has been indicated that "nurses' attitudes towards patients were influenced by whether they (patients) were seen as being aggressive,

unco-operative, demanding, complaining, unpleasant, indifferent, malingering or understanding and grateful" (Ritvo, 1963, cited by Davis, 1984, p. 70).

It is anticipated that the findings from this study will increase knowledge on violence in order to predict, manage and prevent violence in the Psychiatric Hospital in the State of Bahrain. Also, the findings might suggest changes in the psychiatric nursing programmes taught to the nursing students, in order that they may deal more effectively with violent patients.

1.3 Research Objectives

1. To identify the demographic characteristics of the subjects, such as age, education, number of years in service, etc.
2. To identify the nurses' perceptions of violence
3. To explore nurses' perceptions of the definition, causes and prevention of violence.
4. To describe these perceptions
5. To explore some of the literature which might or might not support the findings.

CHAPTER 2

LITERATURE REVIEW

Although there is evidence that violence within hospital settings does exist and many health workers receive injuries ranging from mild to severe, the literature on violence is not extensive, especially that dealing with nurses' perceptions, attitudes and reactions.

A computer search of Nursing and Allied Health from 1983 to 1991 has located 312 citations on violence. Of these, only six were related to staff attitudes, responses or reactions and only four dealt with nurses' reactions to violence. All four articles were written by the same author, and for this reason, some of the literature to be referred to will be fairly elderly, going back to the 1930's.

In this chapter, the definition of violence by different authors will be looked at, and in order to gain insight into the concept of violence, causes, incidence of violence and the importance of nurses' attitudes and perceptions related to violence will also be discussed.

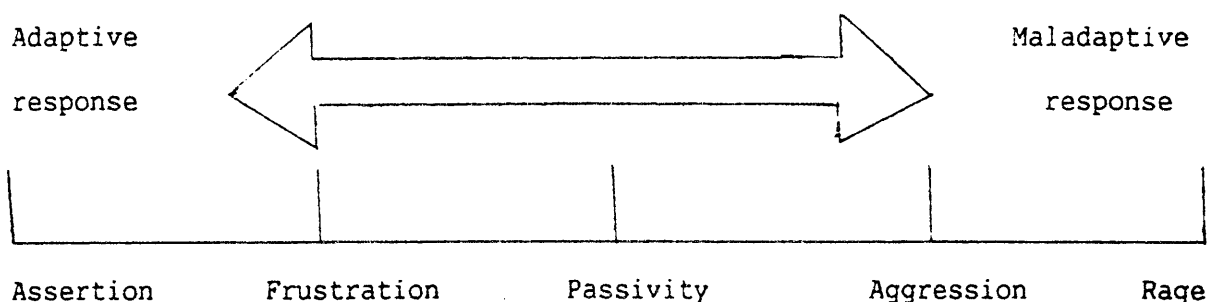
Some of the aggressive behaviour might lead to violence or hostile aggression, which is defined as "aggression whose primary aim is to inflict injury", (Atkinson et al, 1990). For this reason, theories of aggression will be presented with some studies related to the causes of aggression.

2.1 The Concept of Violence

Some authors have viewed violence as the use of physical force (Siann, 1985; Sugden et al. 1986; Haber et al. 1982 and Penningroth 1975). Others used many words to describe violence, some of which are: to destroy, harm, injure and damage (Penningroth, 1975; Haber et al, 1982; Sugden et al, 1986). Often aggression is used synonymously with violence. Sugden et al (1986) indicated that "violence usually means aggressiveness". It could be assumed from this definition that the authors did not differentiate between aggression and violence.

According to the continuum of responses to anger by Stuart and Sundeen (1991) it consists of five stages. At one point is the adaptive response and at the second stage is the maladaptive response. Rage is the last stage and at this point violence may occur (Stuart and Sundeen, 1991, p. 542). Aggression comes one stage before rage (See figure 1). It has also been suggested that there are many manifestations of anger, the first of which is violence. It could be argued that there is strong relationship between aggression and violence, as aggression might sometimes lead to violence as in figure 1.

Figure 1: Continuum of coping responses related to feelings of anger, (Stuart and Sundeen, 1991, p. 542).



According to Atkinson et al (1990) anger is an emotion and aggression is an emotional reaction to anger. It has been stated that: "Anger, hate and rage are internal emotional concomitants of aggression" (Campbell, 1989, p. 797).

In the Psychiatric dictionary, violence has been defined as:

"Physical aggression; wilful physical harm inflicted by a person or group on itself or on another person or group. Violence represents the extreme pole of the aggressive spectrum of behaviour, characterized by an explosive, sudden quality and the use of force to injure or destroy an object, a person or an organization".

(Campbell, 1989, p. 797).

Penningroth (1975) stated that "Violence is any self or other destructive physical behaviour"(p.807). It could be argued that the term "destructive" was not clearly stated as, in some definitions, violence includes physical acts, and although slapping, scratching and pulling of hair are physical acts they are not destructive. This again is arguable, as different things might have different meanings for different people according to the situation, culture and place. What might be considered as violence in one culture or in one setting might not be considered so in another. For this reason, violence should be clearly and specifically defined in such a way that it could be measured, for the sake of researchers and in order to report violent incidents accurately in a hospital setting.

For the purpose of this study, the following operational definition will be used: Violence is any physical harm or injury to self, another person or property by a psychiatric in-patient.

2.2. Theories of Aggression

In this section, a brief description of the following theories of aggression will be presented:

Psychoanalytical theory; frustration - aggression theory; behaviouristic theory; social learning theory and humanistic theory.

a) Psychoanalytic theory:

Freud (1933) argued that many of our reactions are determined by instincts. These are life instincts (Eros) and death instincts (Thanatos). Aggression emerges from death instincts. Freud's theory was based on observations that were made on neurotic patients (Nye, 1986). This could be questioned as generalisation to normal individuals cannot be made unless observation is made on normal people and comparisons made between both groups.

Nye (1986), indicated that Freud's theory is not easily validated because it is not feasible to investigate the death instinct and find out whether aggression has emerged from it or not. One could argue that if, according to Freud, aggression is innate and emerges from the death instinct that everyone has, does a newborn baby become aggressive? Also, Freud's theory ignores individuals' capabilities to reason, control and choose. This contradicts existensialism, which stresses that people have the freedom to choose.

b) Frustration - Aggression Theory

Frustration has been defined as "Blocking of goal-directed activity" (Kagan, 1991, p. 707). Kagan cited Berkowitz (1969) who indicated that frustration can cause "physiological arousal", which is called "anger" if this leads to aggression. He further argued that aggression can result from anger only when there is a suitable "target". Frustration is always followed by aggression and when frustration occurs, aggression results, (Dollard et al, 1939). This was called the frustration-aggression hypothesis. Dollard et al gave examples such as that withdrawal of food from a hungry dog produces more "growling and baring of teeth" than withdrawal of food from a less hungry dog. In humans, they argued that, when a hungry child is sucking a milk bottle and this is suddenly withdrawn, a more aggressive response is produced than with a similar withdrawal from a child who is less hungry.

Aggression can occur without any previous frustration, but it can occur in children after viewing aggressive television programmes (Bandura 1977, cited by Tajfel and Fraser 1978).

In a study conducted on young boys, it was found that "aggression was lower in a frustrating than in a non-frustrating situation" (Lange 1971, cited by Tajfel and Fraser 1978, p. 415). This argument does not support Dollard et al's frustration - aggression hypothesis which has been mentioned previously. However, frustration should not be ignored, as it has effects on aggression and violence, and this needs further study.

c) Behaviouristic Theory

Behaviouristic theory stresses the importance of the environment, past and present history of the person and the reinforcements he uses. Nye (1986) argued that Skinner indicated that the above factors are important in order to study destructive behaviour. He argued that the more a destructive behaviour is reinforced the more it is likely to occur. He also indicated that all people are controlled by their environment (Nye, 1986). Nye criticised Skinner for not acknowledging the "effect of internal motives" on destructive behaviour. However, Skinner stressed the importance of hereditary factors on an individual's behaviour.

It could be argued that, if an individual is controlled by his environment, this denies his ability to control his behaviour and to choose.

d) Social Learning Theory

This stresses the importance of learning through observation and imitation and the reinforcement received during the display of aggressive behaviour.

Radford and Govier (1991) indicated that literature showed that there is a relationship between watching violent television programmes and aggressive behaviour in children. This depends on the presence of an adult, who comments on the programme and the reinforcement received during the display of aggression.

In a study of nursery school children who watched a film in which adults exhibited aggressive behaviour, the same film with different endings was shown to three groups of children of the same age. The first group watched

an ending in which the adults aggressively kicked and punched a doll called "Bobo Doll". They were called "champion" and rewarded for their behaviour. The second group saw an ending in which the aggressors were "scolded" and "spanked" and called "bad persons". The third group saw an ending in which there was neither punishment nor reward. After the film, each child was given a Bobo Doll and allowed to play alone. Those children who had seen the adults rewarded, imitated the aggressive behaviour more than all the other groups. Those who saw the adults punished, played with the doll less than the other groups. When the researcher offered sweets to the children in the second group for every behaviour from the film that they could perform, the results for those children rewarded were similar to those of the other children, (Bandura, 1965, cited by Bernstein et al 1991, p. 282).

Many correlational studies have been conducted in different countries. One study followed children from the age of 8 to 30 years. Those who watched violence on television were found to conduct more violent crimes as adults and were more likely to abuse their children physically. Similar results were found in many countries, such as the United States, Australia, Poland, etc. (Bernstein et al 1991).

It could be argued that although these studies are important and yielded significant findings, this does not indicate that viewing violent programmes causes violence. One should consider the biological and genetic aspects as well as the motivation of these children. Their personal qualities which made them watch these films until the end, and what attracted them to aggressive acts should also be considered.

e) Humanistic theory

Rogers discussed "highly social beings" who are fully functioning and are aware of their feelings and actions. These people, according to Rogers, are less likely to be aggressive. He acknowledged that people have the "ability to reason" and act according to the situation, and he considered people as good and needing close interpersonal relationships. He also stressed the importance of unconditional, positive regard, which is when an individual's "experiences are valued by others, by accepting and prizing" (Nye, 1986, p.111). Rogers argued that an individual who receives unconditional positive regard can function better (Nye, 1986)

Nye (1986) indicated that some individuals despite the love, affection and freedom they receive, still become "selfish" and "maladjusted". If one agrees with Rogers that human nature is good, why do some people do bad things and commit crimes? This is arguable because we have to define what is bad, and to find out what causes these crimes. An individual might be good, but due to uncontrollable reasons he commits such acts and we cannot therefore label him as bad.

It could be concluded that each theory stresses an important factor that should be considered while studying violence. All the theories could influence violence and aggression in one way or another, although observation, environmental factors, reinforcement, imitation and social learning are seen to have more influence on one's behaviour. For example, boys tend to be more aggressive because this is reinforced by parents, as well as society, and also through watching aggressive films. It could be that an aggressive person watches aggressive films more than a non-aggressive person. This needs further study to find out the effects of

reinforcement, imitation and observation of aggressive behaviour on one's behaviour.

Atkinson et al (1990) reported that social learning theory argues that people are learning through "observation, imitation and reinforcement."

Animal Studies and Aggression

Animal studies showed that norepinephrine increases aggression (Stuart and Sundeen, 1991). Atkinson (1990) indicated that, in animals "stimulation of a specific region of the hypothalamus produces aggressive behaviour" (p.424). In higher mammals, aggressive behaviour is controlled by the "cortex". Another factor that also has effects on such behaviour is "experience" (Atkinson, 1990).

Although these studies on animals showed a relationship between norepinephrine and aggression, the results should not be generalised to include human beings and further studies need to be conducted on humans to find out whether similar results could be obtained.

2.3 Causes of Violence

Causes of violence are numerous. According to Kronberg (1983) violence can occur due to biological factors, chromosomal abnormality, hormonal factors, neurotransmitters, epilepsy and psychiatric disorders, such as schizophrenia and mental subnormality. In this section, the relationship of some factors related to the occurrence of violence and aggression will be discussed. These factors are biological, environmental, hormonal, schizophrenia, drugs and alcohol.

a) Biological Factors

Lorenz (1966) indicated that aggression is an instinct and it builds up from an accumulation of energy. In his study of coral fish he indicated that "there is a connection between colouring, aggressiveness and sedentary territorial habits" (Lorenz 1966, p. 13). He gave an example of a coral fish which is coloured when young and plain at sexual maturity and, when young, it displays more aggression than after reaching adulthood. Lorenz (1966) further indicated that lower animals, such as bees, termites and ants, recognise a member of their group by smell and are aggressive towards strange intruders into their sites.

In humans, most studies on twins showed that anti-social behaviour was higher among monozygotic than diazygotic twins (Slater and Cowie, 1971, cited by Menuck and Voineskos 1981). However, it could be argued that such studies were mainly dependent on institutionalised individuals, which might have some bias in the sampling.

b) Environmental Factors

The literature indicated that socio-environmental deprivation can produce alterations in general behaviour. In adult volunteers complete socio-environmental deprivation can produce symptoms such as "sleep disturbances; regression; altered consciousness and personality changes" (Valzelli, 1981, p. 41).

Aggressive behaviour was cited to be associated with socio-environmental deprivation in humans as well as in fish and animals, such as rats and mice (Valzelli, 1981). Davis, Harris and Shelby (1974) cited by Valzelli (1981)

indicated that prolonged isolation showed increased aggressive behaviour in fish.

c) Hormonal Factors

In most mammalian species, it was found that males are more aggressive than females. One possible reason which was postulated was that oestrogen could inhibit aggressive behaviour. However, studies which were conducted showed that when oestrogen was administered to male mice at weaning age it did not reduce the fighting which resulted from isolation but it did reduce fighting in mature male mice (Terdiman and Levy 1954, cited by Goldstein 1974).

Lactating mice produce more violent attacks than virgin or pregnant animals. "Urine of lactating mice carries an odorous factor that can be isolated by clone-chromatography and which, when applied to the skin of non-lactating animals, stimulates aggressive attacks by either grouped females or castrated males" (Mandel et al, 1981).

Testosterone was also found to be associated with aggressive behaviour. When testosterone was administered to sexually immature mice, it lead to fighting earlier than in untreated mice (Goldstein, 1974). Goldstein further argued that, in order to make such conclusions, one should consider and control other variables, such as the amount of the hormone, the duration, stress and genetic factors of the subjects.

In humans, a study was conducted to find out the production rates, metabolic clearance and plasma testosterone level in three groups of different ages. One group consisted of 18 healthy young males aged 17 - 28 years, the second consisted of healthy older males aged 31 - 66 years and

the third consisted of 6 psychiatric patients aged from 19 - 58 years. It was found that the production rates of testosterone correlated with the level of hostility and correlated also with age. There was less hostility among older men, (Persky, Smith and Basu 1971, cited in Goldstein, 1974, p.15).

d) Schizophrenia:

It has been indicated that the majority of assaultive patients are schizophrenic (Albee, 1950; Fottrell, 1980; Itil 1981 and Tardiff, 1983). A study of 916 subjects from four in-patient psychiatric services in France indicated that paranoid schizophrenia was associated with crime (Addad et al, 1981).

In a survey of 115 psychiatrists at the University of Maryland School of Medicine, 68 assaults were reported. The majority of patients who assaulted psychiatrists were diagnosed as having schizophrenia (Madden, Lion and Penna, 1976). It could be argued that during the above study the majority of in-patients are suffering from schizophrenia, as was indicated in the above study, although it was not clear in some other studies.

Lion and Reid (1983) reported that, in their studies, they found that there was an increase of verbal or physical in-patient aggression with paranoid schizophrenia, while in a fourth study, they found there was no increase of such behaviour with patients with a similar diagnosis.

It has been reported also that symptoms such as hallucinations and delusions were found to be associated with assaultive behaviour (Kelly, 1982; Kronberg, 1983 and Tardiff, 1983). As these symptoms are commonly seen

in schizophrenia, this could suggest that assaultive behaviour is common in schizophrenic patients.

It could be concluded that there are many factors that contribute to the causes of violence. Exact ones are difficult to trace. Studies showed that there is an association between violence and mental illness, such as schizophrenia, and its symptoms, such as delusions and hallucinations.

e) Drugs

Drugs, such as Mescaline are found to elicit violence in animals. Schwartz et al (1956) found that, with the administration of Mescaline in cats by intraventricular injection "paroxysms of violent scratching were caused (Schwartz 1956, p. 60). This was supported by Haley (1957) on his study on mice.

Other drugs, such as Amphetamines, were cited as "permitting aggression, increasing activity and emotional lability, heightening paranoia and leading to homicidal acting out" (Rockwell, 1972, p. 53).

Lysergic Acid Diethylamide (LSD) was found to produce "hyper-excitability and aggressiveness" in mice when administered by intracerebral injection at a dose of 5 μ g (Haley, 1957, p. 108). Also, Schwartz et al (1956) found that LSD produced restlessness in cats when it was administered by intraventricular injection at a dose of 15 μ g.

It could be argued that the findings of the above studies are not exactly the same. This might be due to the use of different animals, different doses and different sites. This could indicate that generalisation to human

beings cannot be accepted unless these drugs are tested on humans, and such studies impose ethical questions.

f) Alcohol.

Several studies have indicated that there is a strong relationship between alcohol use and assaultive behaviour. For instance, Shaws (1982) stated that at least 50% of violent acts are associated with alcohol use. Kagan (1991) also reported that aggression can occur even with small doses of alcohol. In a study of sample of 484 community-based subjects (normal people) it was found that excessive alcohol use is associated with aggressive behaviour (Johnson et al, 1985).

It has been indicated that with alcohol use, aggression and violence are "most likely to occur", (Powers and Kutash 1978, p. 326). They stressed that the premorbid personality of the person and the amount of alcohol should be considered. The amount of alcohol could be calculated through the blood level: "Blood alcohol content of .10% to .35%" (Powers and Kutash 1978. p. 326).

It has also been indicated that aggression can occur "When the level of alcohol rises and the person tends to lose insight and to become less inhibited. Judgement is impaired and the person may become more impulsive and reckless. Irritability and aggression are easily evoked in response to perceived slights" (Ironbar and Hooper, 1989, p. 559).

Marjot (1982) argued that violence may occur in an alcoholic person because some alcoholics also abuse drugs, which may be prescribed by a doctor in order to reduce associated symptoms. Such drugs could cause "outbursts of

violence" (Marjot, 1982, p. 290).

On the other hand, Murdoch, Pihl and Ross (1990) argued that the evidence from literature neither reveals that those who drink alcohol engage more in violent acts, nor that those who engage in violent acts drink excessively. However, it indicated that "an intoxicated person is more likely to be caught when he engages in violent acts" (Murdoch, Pihl and Ross, 1990, p. 1067).

Alcohol was cited by some authors to be associated with violence, which also includes family members, such as in child abuse and wife battering. In the Psychiatric Dictionary, it has been indicated that "wife battering can occur with alcohol or other substance abuse" (Campbell, 1989, p. 802). In a study of one hundred wives who had physical injuries, in forty four cases the injuries occurred from a drunken husband. In twenty-two cases, the husband was a "heavy drinker" (Murdoch, Pihl and Ross, 1990). Murdoch, Pihl and Ross also stated: "It has been estimated that 30% of child abuse cases involve alcohol; however, most reports are based on subjective impressions and case reports" (p.1066).

It could be concluded that alcohol is associated with violent behaviour and crimes. However, as indicated earlier, drunken people are more likely to be caught while committing violent acts. Other reports suggested that wife battering and child abuse are more common with the use of alcohol, but this information is usually obtained from the victim and such reports might be given if the victim has a negative attitude towards alcohol and/or a poor relationship with the assailant.

This suggests that further studies could be undertaken, based on obser-

vation. Also the effects of alcohol and violence could be studied, whilst other factors, such as mental illness, stress, pre-morbid personality, the use of drugs, etc. are controlled, in order to find out causal relationships between alcohol and violence.

It seems that many factors are associated with violence. All of these are important and should not be neglected when considering the causes of violence. With factors such as biological, environmental and hormonal, as well as mental illness, drugs and alcohol, when two or more of these factors are combined, there might be a higher chance of violence occurring, and this needs further investigation.

2.4 Incidence of Violence

"Although nurses are the largest group of health professionals and spend the most time with patients, there is little empirical data available about the incidence of patient assaults on nursing staff", (Poster and Ryan, 1989, p.316). Carmel and Hunter (1989) reported that in a one-year study of staff injuries in a large Forensic State hospital, they found that 121 staff members sustained 135 injuries and all the assaulted were nursing staff. This is supported by Brown (1988) and Miller (1991) who argued that violence towards nurses is common.

Lion, Snyder and Merrill (1981) reported that 203 assaults upon 800 nursing staff during one year were found from incidents reports. They indicated that there were five times higher incidents than were reported. The possible reasons they gave for this under-reporting were:

1. "The effort required to fill out an accident report.

Many staff were inured to violent patients brought in by the police and took it as a matter of course that there would be violent episodes.

The feeling of many staff members that the reporting of violence represented a performance failure.

4. The staff might also fear an investigation into whether they had hit the patient in self defence".

(Lion, Snyder and Merrill, 1981, p. 497).

Others argued that because nurses spend most of their time with patients, they are available targets for displacing hostility and/or pent-up emotions (Ochitill 1983 and Morton 1986). On the other hand, some authors indicated that incidences of violence upon nurses were infrequent (Kalogerakis, 1971) while Whitman, Armo and Dent (1976) reported that attacks on a therapist were infrequent.

However, it is not only nurses who are the target group for patients' violence among professionals, but also others, such as psychiatrists. Madden, Lion and Penna (1976) surveyed 115 psychiatrists and found that 42% had been physically assaulted by patients.

Another study was conducted with a sample of 31 residents from second and third year programmes at the Los Angeles County University of Southern California Medical Center. Fifteen of the 31 residents (medical staff) had been physically attacked at least once during their residency programme (Ruben, Wolkon and Yamamoto, 1980). The previous studies have shown that the incidence of violence is increasing and affecting many people.

Poyner and Warne (1986) indicated that assault can occur at any place in

which "could serve the public". This is an important issue that should be considered regarding professions such as nursing, medicine, accountants, shopkeepers and transport, all of whom are in danger of being assaulted.

On the other hand, a survey of one thousand people included professional workers who spent "the majority of their work at their offices, professional workers who spent a substantial amount of their work life away from their offices, carers, retail workers and office workers". The results showed that physical attacks were reported by one in twelve respondents, with a total of ninety incidents indicated by 81 of the subjects, (Stockdale and Phillips, 1989, p. 213.)

Violence can affect both the victim and the employing agent. The victim might suffer physical as well as psychological trauma and the employing agent might be affected in terms of absenteeism of employees. This might lead to shortage of staff and also compensations for the work incidents. In a study of sixty-one nursing staff, the total number of sick days used by the subjects was ninety-four (Ryan and Poster, 1989).

From the previous studies, one can conclude that violence is a job hazard for nurses, paramedical and medical staff. The after-effect of violence can be absenteeism from work and physical as well as psychological trauma. It could cost the employing agent for repairing or replacing the damaged object and/or to compensate the injured staff.

2.5 Attitudes and perceptions

"Attitudes involve the individual's perception and evaluation of the situation and of the people in it" (Altschul and Sinclair, 1986, p. 148).

Altschul further indicated that attitudes have three parts which are inter-related. These are; the "affective component", which deals with feelings, the "cognitive component" which refers to knowledge and understanding (perception) and the "behavioural component" which relates to actions.

As perception is the cognitive component of the attitude and as this research is dealing with nurses' perceptions, this section is thought important to be presented.

Ruben, Wolkon and ~~and~~ Yamamoto, (1980) reported that residents (medical staff) who had been hit by patients reported that they believed they had contributed to the assault by frustrating the patient. From this study, it seems that the residents' behaviours and actions might be influenced by their attitudes towards their patients. If one agrees with the previous statements, according to Altschul and Sinclair this attitude consists of feelings, perceptions and actions. Thus, the residents might behave in a way towards the patients that leads to violence on the part of the patients. It has also been indicated that perceptions can influence nurses' behaviour towards their patients (Kelly, 1982 and Davis 1984).

Finally, Edwards and Reid (1983) indicated that staff attitudes can "predispose violent behaviour". Therefore, one should consider nurses' perceptions and attitudes as important factors which could reflect their behaviour towards patients and could provoke destructive behaviour.

In conclusion, violence and aggression are inter-related, as aggression might sometimes result in violence. Aggression was viewed by Freud as instinct which has resulted from the death instinct; was seen by Skinner as

behaviour that is influenced by the environment as well as reinforcement; and was viewed by Rogers as occurring in individuals who are not fully functioning. According to Rogers, people who are fully functioning and are less aggressive are "those people who are more in touch with their deep inner experiences and who have clearer perspectives on the world around them" (Nye 1986, p. 143).

There are many factors which were found to be associated with violence, some of these being: biological, environmental and hormonal factors, mental illnesses such as schizophrenia; drugs, such as Amphetamines and L.S.D, and alcohol.

There are many theories that explain aggression. Psychoanalytic theory explains aggression as internal instincts, while social learning theory views it as learning by observation and imitation. Frustration theory, however, suggests that aggression always follows frustration, although it is important to note that frustration is not always the cause. In order to view an aggressive or violent patient, all the theories and causes which are thought to be associated with violence and aggression should be considered because each one has its own value.

In the literature there is little evidence that suggests that nurses are the most commonly attacked professionals, and staff attitudes were seen as a factor that could provoke violence in some patients.

CHAPTER 3.

METHODOLOGY

3.1 Setting for the Study

Data were collected at a psychiatric hospital in the State of Bahrain. Bahrain is a State which consists of thirty-six islands situated in the Arabian Gulf and Manama is the capital city. The population of Bahrain, according to the Statistical Abstract (1986) is 489,881, and approximately 322,543 are Bahraini. The language of the majority is Arabic and the dominant religion is Muslim.

Health services in Bahrain started in the 1900's. Medical care is provided free to all inhabitants of Bahrain and the Government has adopted the World Health Organisation goal to achieve Health For All in the Year 2000.

The total land area of Bahrain is 692.52 square Km. The climate is cool in winter, with sparse rainfall and hot in summer, with high humidity.

The study was conducted at the only psychiatric hospital in the State of Bahrain, which is located in the Manama City (Figure 2). The hospital consists of 180 beds, distributed in nine areas, these being: acute male ward, acute female ward, sub-acute male ward, sub-acute female ward, long-stay male ward, mental subnormal male ward, long-stay and mental subnormal female ward, psychogeriatric ward and drug addiction unit.

The study sample was selected from seven of these nine areas, i.e. acute male ward, acute female ward, sub-acute male ward, sub-acute female ward, long-stay male ward, mental subnormal male ward and long-stay and mental



Figure 2 .

State of Bahrain. Location of the Psychiatric Hospital.



Manama City



Approximate position of the
Psychiatric Hospital.

sub-normal female ward. The reason for selecting these areas was that there were 32 incidents reported on the incidents forms of that hospital in the year 1989. The highest number (eight) was from the long-stay male ward and another eight cases were from the long-stay and mental subnormal female ward, followed by the acute male and acute female wards.

In 1990, the total number of reported incidents was fifty and the highest number (thirteen) was from the mental subnormal male ward, eleven cases were from the long-stay male ward and eleven other cases were reported from the acute male ward, followed by the acute female ward and sub-acute male ward (Table 3.1.1).

3.2. Access to the Study Sites and Participants

Official permission was sought by sending letters to the following:

The Principal Nursing Officer (P.N.O.) Salmaniya Medical Centre, and through her, the Senior Nursing Officer (S.N.O.) of the Psychiatric Hospital was informed, (Appendix C). Another letter was sent to the Chairman of the Psychiatric Hospital, (Appendix E).

The nurses were informed initially through the Senior Nursing Officer of the Psychiatric Hospital, followed by letters, which were sent to the selected sample. In the letters the researcher explained the purpose of the study and sought their willingness to participate, (Appendix F).

TABLE 3.1.1

Reported incidents which occurred at the Psychiatric Hospital

Wards	1989	1990
Acute male	6	11
Acute female	5	5
Long-stay male	8	11
Mental subnormal male	1	13
Long-stay and mental subnormal female	8	1
Psychogeriatric	1	1
Sub-acute Male	2	5
Sub-acute Female	-	2
Drug addiction unit	1	1
Total	32	50

3.3. The Study design

A qualitative research approach with an exploratory descriptive design was used. The study could have been conducted by using quantitative research, through the use of a questionnaire or rating scale. This method was not used, however, because although questionnaires are less costly and need less time in order to obtain data (Polit and Hungler 1987). There are also some weaknesses with the use of questionnaires, these being that they are unable to probe a topic in depth without becoming lengthy, some items may be misunderstood, the researcher cannot observe the subject's non-verbal cues and the researcher does not have the opportunity to interact with the subject (Treece and Treece, 1986, p. 278).

A rating scale was not used because it would have been time-consuming to construct and to measure its reliability and validity and the researcher had a short time only for the construction of the study instrument and the data collection. Also, the use of a rating scale might not have included enough alternatives or might have included suggested answers. For these reasons quantitative research was not used.

3.3.1. Reasons for choosing a qualitative approach

Qualitative approach:

A qualitative approach is defined as "an approach to the study of the social world which seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied", (Bryman, 1988, p. 46).

Qualitative research is interested in values, beliefs, attitudes and perceptions of individuals. It is concerned with individuals' feelings and reactions. In this study, nurses' perceptions are of interest to the researcher so this approach was thought to be applicable.

An exploratory descriptive design was chosen because no previous research had been conducted relating to patients' violence in the State of Bahrain, so this approach was used in order to gain insight and increase knowledge about nurses' perceptions of violence.

Exploratory research is defined as "Formative studies to gain new insights, discover new ideas, and/or increase knowledge of a phenomenon" (Burns and Grove, 1987, p. 746). There are different approaches for using qualitative research, the major approaches being:

1. Phenomenology:

It has been indicated that phenomenology is "that kind of thinking which guides one back from theoretical abstraction to the reality of lived experience" (Field and Morse, 1985, p. 27). Field and Morse further indicated that by using a phenomenological approach the researcher is usually after the "essence of meaning" of the phenomena. The pioneer of phenomenology was Edmund Husserl (1906).

A phenomenological study could be done in various ways, but the steps of the method presented by Spiegelberg are as follows:

1. "Investigating particular phenomena. This includes intuiting, analysing and describing.

2. Investigating general essences
3. Apprehending essential relationships among essences
4. Watching modes of appearing
5. Watching the constitution of phenomena in consciousness
6. Suspending belief in the existence of the phenomena
7. Interpreting the meaning of phenomena."(Spiegelberg,1982,p. 682)

2. Grounded Theory:

Grounded theory is defined as "An interactive type of analysis/data collection based on a phenomenological perspective in which the researcher interacts with the site and subjects until testable hypotheses or theories are developed", (Roberts and Burke, 1989, p. 361).

Grounded theory was developed by Glaser and Strauss (1967). They argued that it is important to have theoretical sampling when using a grounded theory approach. Theoretical sampling was defined as "the process of data collection for generating theory whereby the analyst collects, codes and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges", (Glaser and Strauss 1967, p. 45). In grounded theory, data is collected, transcribed and every piece of the data is compared with other data until no more new data can be obtained.

3. Ethnography:

Ethnography is defined as "A systematic process of observing, detailing, documenting and analyzing the life ways or particular patterns of a culture

(or subculture) in order to grasp the life ways or patterns of the people in their familiar environment" (Leininger, 1985, p. 35). Leininger (1985) further indicated that review of literature is important at the beginning of a study. This approach was first used by Franz Bopas (1920). In ethnography, participant observation is important as a data collection tool.

According to Burns and Grove (1987) data analysis in ethnography is conducted through "clarifying, extending and interpreting" the field notes. Categories are developed and "patterns of behaviour are identified" (p.89).

After describing briefly the different approaches of qualitative research, it seems that this particular research does not fit exactly into one approach and could be a mixture of more than one approach. For this reason, this study is simply called a descriptive qualitative study.

3.4 Data Collection Procedure

Simple random sampling was used to draw the sample. This is one type of probability sampling. Three nurses were randomly selected from each of the seven selected wards.

Probability sampling was chosen for this study because, with the use of such sampling, bias could be reduced (Brink and Wood, 1988). With random sampling, the researcher cannot decide which person he is going to include or which one is better for the study (Burns and Grove, 1987). The researcher cannot exclude people from the research because he does not like them, or because they disagree with him. Theoretical sampling was not used because the researcher had only a short time to conduct the interviews. It would have been time-consuming to analyse the data to see whether it was

sufficient or whether the sample needed to be increased.

According to Polit and Hungler (1987) a random selection process is "one in which each element in the population has an equal independent chance of being selected (Polit and Hungler, 1987, p. 214). On the other hand, probability sampling is sometimes inconvenient for certain researchers, for example in a Census in which the whole population are the subjects or when many of the selected subjects refuse to participate, in which case the researcher might choose his sample through non-probability sampling.

The sample consisted of twenty-one staff nurses (male and female) out of the total number of 83 staff nurses who worked at the psychiatric hospital in the State of Bahrain during the data collection period. It was decided at the commencement to interview twelve nurses, but the number was increased to twenty-one because, after interviewing eight subjects, the researcher felt that the information obtained was not rich enough. Although the researcher did not analyse the data, it seems as if this approach is similar to theoretical sampling. Then the researcher sought advice from research experts, who advised her to increase the number of the subjects in order to obtain richer data. Twenty-one nurses were selected, three from each of the seven areas (see Table 3.4.1).

The sample was selected by giving a number to all the staff nurses in each of the selected areas. The numbers were put in a bag and, with eyes closed, the researcher withdrew one at a time until three numbers were obtained. After selecting each number, the researcher put the number back with the rest before selecting a second one, in order to give an equal chance to all to be selected. The procedure was repeated until twenty-one subjects were selected.

TABLE 3.4.1: Number of Selected Nurses from Selected Areas

Research Wards	Total No. of nurses in each ward	No. of selected nurses	%
Acute male	10	3	30
Acute female	8	3	37.5
Sub-acute Male	6	3	50
Sub-acute Female	7	3	42.8
Long-stay male	8	3	37.5
Mental subnormal male	6	3	50
Long-stay and mental subnormal female	10	3	30
Total	55	21	38

A face-to-face interview with an interview guide was used. The interviews were in English, with the exception of a few Bahrainis who used Arabic language occasionally, and this was then translated into English. The English language was used as an interview media because the sample consisted of three nationalities, these being Bahraini, Philipino and Indian, all of whom speak English. The Bahraini sample had had at least ten years of formal English during their school and college training. The length of the interviews ranged from 15 to 60 minutes, with a mean of 28 minutes. An example of one interview will be given in the appendices (Appendix G).

An interview is defined as "Interaction in which two or more people are brought into direct contact in order for at least one part to learn something from the other" (Brenner, Brown and Canter, 1985, p. 3).

3.4.1. Strengths and Weaknesses of the Interview Technique

Brenner, Brown and Canter (1985) and Burns and Grove (1987) indicated that, with interviews, response rates are higher and can be obtained directly. They also indicated that the interview is an appropriate method for "children, illiterate and blind people". The main strengths are:

- With interviews, explanations can be obtained from the interviewer, when needed.
- The information obtained from interviews can be rich and yield more meaning.
- It could be used to identify perceptions. Polit and Hungler (1987) suggested that an interview could be used to identify "patients' perceptions, feelings, thinking, beliefs, attitudes and opinions".

However, there are some weaknesses in using an interview as a data collection method and these are:

- The interviewer could bias the data obtained by suggesting answers to the interviewee.
- With the unstructured or semi-structured interview, there could be bias in the research results through the researcher's interpretation of the data.

Treece and Treece (1986) argued that it was time consuming to conduct semi-structured or unstructured interviews.

- It is also costly to conduct interviews, especially with a large sample.

Brenner, Brown and Canter (1985) indicated that, with interview, the subjects might not be able to remember all the past events at the time of interview.

From the above strengths and weaknesses, it could be concluded that, through an interview, a researcher could explain to the subject, when needed, but not suggest answers. The researcher could avoid or decrease bias in interpreting the data by putting all he knows about the topic aside and concentrating on what the subject has already said. Also, the researcher could ask a colleague who was not involved in the study to identify themes and suggest categories independently and to compare what he had found with the researcher.

Regarding the weakness that the subject might forget past events, which has already been mentioned, it could be argued that this could also happen with other methods. This could be overcome by asking the subjects, for example,

to note down what they do and to refer back to this when needed, but this could only be practical when a researcher plans what he is going to investigate ahead of time and discusses the proposed plan with the area of his investigation.

It has been indicated that "despite the advantages of questionnaires, the strengths of interviews far outweigh those of mailed questionnaires" (Polit and Hungler, 1987, p.243)

3.5. Description of the research instrument

A face-to-face interview with an open-ended interview guide and a questionnaire for the collection of demographic data were used. The interview guide consisted of nine questions, the first being related to the definition of violence; the second about the causes of violence; the third dealt with the nurses' role to prevent violence; the fourth dealt with the doctors' role to prevent violence, the fifth dealt with the administration's role to prevent violence and the sixth explored the feelings of the subjects towards violent patients. This question was not answered by all the subjects but this could be because English is a second language for all the subjects. For this reason, another question was included, the seventh question, i.e. if a choice was given to the subjects, would they choose or not choose to work with violent patients? The eighth explored how much training the subjects had in relation to violence and the last question dealt with recommendations and suggestions related to the prevention and management of violence (Appendix A).

The demographic questionnaire consisted of questions related to the sex,

age, number of years in service, education and number of previous physical assaults, if any.

3.6. Pilot Study

The interview guide was tested in a pilot study of two nurses working in a psychiatric hospital in the United Kingdom prior to the actual study. The main purpose of the pilot study was to gain experience in interviewing techniques and to check the validity of the interview guide. Based on the pilot study, minor changes were made in the interview guide.

3.7. Validity and Reliability of the Research Instrument

The interview guide had a face validity as little was known in relation to this topic. It has been said that: "When little or nothing is known about the variable being measured, the level of validity obtainable is called face validity" (Brink and Wood, 1988, p. 167). Brink and Wood further indicated that "When the concept of a trait being measured is not a stable one, the reliability of an instrument cannot be tested by repeated measures" (p. 174).

In this study, validity was tested by checking that relevant answers to the questions and information related to the research topic were given. Validity was also maintained by referring some of the answers back to the subjects during the interview, to make sure that the researcher understood what the subjects meant.

Reliability in content analysis is obtained through "Agreement between two or more persons analysing the same data" (Brink and Wood 1988, p. 205). In

this research, this was assured by reaching an agreement between the researcher and two colleagues who identified similar key words, categories and sub-categories. The reliability was further enhanced by sticking to the same questions and using consistency in the tone of voice, being relaxed, giving the same instructions and using the same physical environment for all the subjects. It has been indicated that "interviewers can bias the responses by the tone of voice used in asking the question, by gestures and by facial expression" (Gorden, 1987, p. 94)

In qualitative research, each interview is unique, and consistency can be obtained through analysing the data. It has been indicated that, in qualitative research, reliability can be obtained through "identifying and documenting", "recurrent themes", "values", "world views" and "experiences" (Leininger 1985, p.69). Reliability and validity in this study will be developed further in the data analysis section.

3.8. Ethical Consideration

All the subjects were informed about the purpose of the study. They were informed that the interviews would be tape-recorded. Their willingness was sought before conducting the interviews and they were informed that they could withdraw at any time during the interview.

Anonymity and confidentiality were maintained by not using names or any other identification throughout the study.

3.9. Data Analysis

In this research, a simple content analysis was used by counting the occurrence of key words and themes in the obtained data. Content analysis has been defined as "the systematic and objective procedure used to identify and analyze significant written, verbal or visual data in order to tabulate, classify, summarize and compare the contents" (Seaman, 1987, p.334).

In this research, data analysis was divided into four stages and these stages will be discussed in this section.

The First Stage

The tape recordings were listened to carefully and the data were transcribed manually word by word. The lengths of pauses were denoted by the use of hyphens. A few hyphens were used to denote short pauses (---) and a larger number of hyphens were used to denote long pauses (-----).

Having transcribed all the tapes, the data were read and re-read by the researcher in order that she should be familiar with the data.

The researcher used the questions that were asked during the interview as main categories, then sub-headings and key words were identified from the data. Ten different colour pens were used. Each colour was used to identify one question in the transcribed data and the key words that belonged to that question. All the identified data were underlined with the ten different colours so that the researcher could identify the data easily.

Codes were given to each question by using letter words which arose from the question itself, for example, for the word 'violence' the code was 'vio' (see appendix B). A code is defined as "a category derived from the research question and the key variable of the study, or it may emerge from the data (Woods and Catanzaro, 1988, p. 442).

The left margin in the text was used for writing the identified data and the right margin was used to write comments.

The Second Stage

Another person who was a psychiatric nurse and was not involved in the research was given another copy of the transcribed uncoded data and was invited to identify subheadings and key words independently. Then, the researcher, together with the other person involved, went through all the data in order to find out if they identified similar key words. The data that were identified were very similar and an agreement was reached about all the data.

In content analysis, reliability can be demonstrated if there is an agreement between the people who analysed the same data (Brink and Wood, 1988).

The Third Stage

The researcher went through the data and the data were re-written onto A3 sheets. Each category and its key words that were identified from all the subjects were transferred together. This was carried out for all the major categories.

A number code was given to each statement/theme under each category. Similar statements received the same code number in order to assess the occurrence of similar themes with all the subjects. At this stage, the researcher identified the subcategories and themes in all the data.

The Fourth Stage

Another colleague who was not involved in the study and who had experience of research was given a copy of all the data which had been given number codes and was asked to read through and to suggest subcategories under the identified major categories.

The frequency of recurring key words was selected as subcategories. Then agreement was reached by both the partners regarding the subcategories. The agreed list was then checked by the researcher's supervisor. The total number of the subcategories that were identified was thirty one.

The validity and reliability of the study were checked with two colleagues, who went through the data and identified key words and subcategories independently and reached an agreement with the researcher.

CHAPTER 4

PRESENTATION OF THE DATA

In this chapter, the findings will be divided into two parts. First, the demographic data will be presented, followed by the data that have emerged from the main categories.

I. Demographic Data

a) Age

Seven of the subjects' (33.3%) ages ranged from 20 - 25 years. Four of the subjects' (19%) ages ranged from 26 - 31, five (23.9%) ranged from 32 - 37, four (19%) ranged from 38 - 41, and only one subject was over 41 years of age (see Table 4.1).

b) Sex

Twelve of the subjects (57.1%) were females and nine (42.9%) were males.

c) Education

Six of the subjects (28.6%) had an Associate Degree (A.D.) or Registered Nurse (R.N.) qualification. Seven subjects (33.3%) had R.N. or A.D. plus Diploma in Psychiatric Nursing (D.P.N.), six subjects (28.6%) had R.N. or A.D. plus six months course in Psychiatric Nursing, which is offered at the Psychiatric Hospital, two of the subjects had R.N. with a Bachelor's Degree in nursing plus a six months course in psychiatric nursing (see Table 4.2).

Table 4.1 Ages of the Subjects

Age	Number of participants (n)	%
20 - 25	7	33.3
26 - 31	4	19.0
32 - 37	5	23.9
38 - 41	4	19.0
Over 41	1	4.8
Total	21	100

Table 4.2 Education of the subjects

Education	n	%
Associate Degree (A.D.)	6	28.6
R.N. or A.D. + Diploma in Psych. Nursing.	7	33.3
R.N. or A.D. + 6 months Psych. Nursing course	6	28.6
R.N. + Bachelor Degree in Nursing + 6 months Psych. Nursing course	2	9.5
Total	21	100

d Number of Years in the Service

Ten of the subjects' (47.7%) work experience ranged from 1-5 years. Eight of the subjects' (38%) work experience were over 10 years. Two (9.5%) had work experiences from 6-10 years and one subject had worked less than one year, (Table 4.3).

Table 4.3 Number of years in the service

Years of experience in the service	n	%
less than one year	1	4.8
1 - 5 years	10	47.7
6 - 10 years	2	9.5
Over 10 years	8	38
Total	21	100

e Number of Physical Assaults

Thirteen of the subjects (62%) reported that they had been assaulted physically by patients between 1-4 times. Four (19%) had had between 5-10 physical assaults by patients and another four (19%) reported that they had not experienced any physical assault by patients (Table 4.4)

Table 4.4 Number of Physical Assaults by Patients.

No. of Physical Assaults	n	%
None	4	19
1 - 4	13	62
5 - 10	4	19
Total	21	100

f Experience of Physical Assaults

The subjects were asked about their experiences of physical assaults, if any. They reported that the seriousness of incidents ranged from minor, such as scratching, pulling of hejab (cover used for the hair, head-kerchief) and pulling of hair, to major ones such as a blow to the eye and fracture of nose.

Many of the subjects indicated that they were physically attacked by a patient while either restraining or while giving him/her a P.R.N. injection. (P.R.N. = pro-re-nata = as necessary).

II From the interview guide, the following emerged as the major categories:

- definition of violence
- causes of violence
- nurses' role to prevent violence
- doctors' role to prevent violence
- administration's role to prevent violence
- recommendations in order to reduce or prevent violence
- feelings towards violent patients
- the choice between working with violent or non-violent patients.

From these major categories 31 sub-categories emerged. These will be presented in this section:

Table 4.5: Category 1 Definition of Violence.

Major Category	Sub-category
Definition of violence	verbal
	physical
	aggression
	emotion

Four sub-categories emerged from this category these are:

categories that emerged from each will be presented in this section.

Table 4.7: Category 3: Nurses' role to prevent violence:

Major Category	Sub-category	Sub-sub-category
Nurses' role to prevent violence	- Nurses' qualities	- Communication
		- Staff's attitudes
		- Flexibility
		- Knowing the possible causes
	- Training for the staff	
	- Therapies	- Physical
		- Chemical
		- Psychological
		- Occupational and recreational
	- Safety of the environment	
	- Nursing interventions	

When the subjects were questioned what they thought nurses could do to prevent violence the following sub-categories emerged:

a) Nurses' qualities:

Many subjects felt that nurses' qualities such as communication, attitudes, flexibility and knowledge were important in order to prevent violence. Each of these qualities will be presented in this section.

Communication:

Many subjects indicated that nurses should communicate with patients. One felt that the most important role was communication. This was expressed as follows:

"I think number one is proper communication..."

Another said:

"Communicate nicely and be friendly with them (patients)"

One subject identified the language barrier as a problem to non-Arabic speakers in order to understand patients fully and meet their needs.

The Staffs' attitudes to Patients

Many subjects felt that nurses should have a positive attitude towards patients. The staff should accept patients as human beings. One subject stated:

"Proper treatment by the way of behaving towards them, just accept them (patients) as persons".

It has also been suggested that the nurses' approach towards patients should be calm and gentle, but at the same time, firm.

Another subject indicated that some nurses would ignore the patients and would not respond to them. This was expressed as follows:

".. and also maybe the attitude of staff because some staff, usually especially when they know the patient.. they will give some ignorance..."

Flexibility

Flexibility is another issue which was recurrent in the data. A few subjects indicated that hospital rules should be flexible and that patients should be able to choose. The following were comments made by some of the subjects:

"Routines and rules should be modified so that the patient can (----) have choice".

and

"We have to be flexible"

and

"The bathtime, make it convenient according to the patients' convenience..... relax the rules somewhat".

Knowing the possible causes

A few subjects indicated that nurses' knowledge about the causes of violence was important in order to be able to prevent it. This was expressed as follows:

"First we should know why the patient became violent"

and

"..observe for what reason she (patient) is doing this, suddenly... becomes violent..."

b. Training for the Staff

A few subjects revealed that nurses should be trained in psychiatric nursing so that they could deal with psychiatric patients. One subject stated:

"I think the most important things the staff ...They should be specialised in the field. They should have full knowledge of taking care of psychiatric patients..."

Another said

"To have the knowledge to be able to deal with them (violent patient) properly..."

c. Therapies

This sub-category includes four types of therapies which were recurrent. These will be presented in this section.

Physical Therapy

A few subjects indicated that nurses should use restraint in order to control violence. They suggested the use of restraint when a patient was

unmanageable. The following were some comments made:

"..if we cannot manage the patient, we have to restrain the patient..."

and

"If he (patient) becomes violent and we cannot manage, we should restrain him".

One subject indicated that nurses used P.R.N. injections and restraint immediately when a patient started shouting and they used it as punishment rather than controlling his behaviour. This was expressed as follows:

"Sometimes the staff, even though the patient is not aggressive or he is aggressive but we can manage him. They (nurses) will give him P.R.N. and restraint to punish the patient and not to control his behaviour".

Chemical Therapy

Nearly half of the subjects indicated that when a patient became violent, they gave P.R.N. injections. One stated:

"Sometimes we use medications, tablets, P.R.N. injections"

This subject did not see a P.R.N. injection as a must when a patient was violent.

Another indicated that it is a must to restrain and give a P.R.N. injection when a patient is violent. This was expressed as follows:

"With the help of staff, we should restrain and give P.R.N..."

Another subject expressed that "P.R.N." or "restraint" or "seclusion" were used to prevent violence, but these should only be initiated by doctors' orders.

Psychological Therapy

A few subjects maintained that psychological therapy, such as "behavioural therapy" "reality orientation" and "psychotherapy" could be used in order to prevent violence.

Occupational/Recreational Therapy

Many subjects suggested that there should be more activities in the wards in order to divert the patients' minds, occupy them and provide recreation for them, so that their tension could be released. This was expressed as follows:

"Of course, more activities to divert his (patient's) mind".

and

"They should give recreation so they can divert their (patients') minds".

d. Safety of the Environment

A few subjects suggested that the environment should be kept safe by removing dangerous articles that could be used as weapons. One stated:

"If a patient becomes violent, we have to remove all the articles that they might use as weapons and we are not allowing them to keep glasses, knives, soap and shampoo.."

Another said:

".. things like chairs to keep them away from patients when they are violent or starting to be violent, sharp instruments also..."

e. Nursing Interventions

Many subjects stressed that the following nursing interventions were important in order to prevent violence. These are:

"Close observation", "group discussion"..etc..

Other recurring statements were:

"Call for help" and "do not approach the patient alone".

Table 4.8: Category 4: Doctors' Role to Prevent Violence

Major Category	Sub-category	Sub-sub-category
Doctors' role to prevent violence	- Therapies	- Physical - Chemical - Psychological
	- Doctors' qualities	- Communication - Attitudes - Passive roles

When the subjects were questioned as to what they thought doctors could do to prevent violence, the following sub-categories emerged:

a. Therapies

Under this sub-category, three types of therapies emerged:

Physical therapy

Many of the subjects stated that doctors used restraint in order to prevent violence. One subject stated:

"Medical most of the time restraining the patient".

It has also been indicated that restraint is used when P.R.N. injections fail to control violence. This was expressed as follows:

"Sometimes, doctors will advise to restrain the patient because injections will give a poor effect for the patient".

One subject indicated that electro-convulsive therapy was also helpful in preventing violence.

Chemical therapy

The majority of subjects indicated that doctors use tranquillisers and P.R.N. injections in order to prevent violence. The following were comments made by some of the subjects when they were asked about the doctors' role:

"Tranquillisers like Largactil, Melleril"

and

"Write for her (patient) P.R.N. like Largactil or Haloperidol for relaxation and to calm her down".

and

"Sometimes they (patients) are becoming frequently violent. They (doctors) will increase the medicine, sometimes P.R.N. injection"

Psychological therapy

Only one subject indicated that the doctors' role in preventing violence included "psychotherapy" and "group therapy".

b) Doctors' qualities

Under this sub-category, the following were suggested as important in order to prevent violence:

Communication

Many subjects reported that doctors must sit and talk with the patients and listen to their problems because doctors are closer to the patients than nurses.

The following were comments made by some of the subjects:

"..to sit with him (patient) to talk with him at least, because he (patient) feels that doctors are more close to him than staff or the nurses".

and

"Doctors have to talk with him (patient) to find out problems..."

Doctors' attitudes to patients

A few subjects indicated that doctors should co-operate with patients and should not make promises to patients if they are not sure they can keep their promises. One subject gave an example of a doctor promising a patient

to see him the next day and then not coming. The patient waited for him and became upset and could have become violent.

Passive role

One subject indicated that doctors had no role in preventing violence, saying:

"But I don't think they (doctors) can help the matter".

Table 4.9: Category 5: Administration's role to prevent violence

Major Category	Sub-category	Sub-sub-category
The Administration's role to prevent violence	- Environment	
	- The nursing staff	- Training
		- Sufficient staff
	- Communication	
	- Knowing the cause of violence	
	- Passive role of the administration	
	- Flexibility	
	- Delegation of authority	

When the subjects were asked what they thought administration could do to prevent violence, the following sub-categories emerged:

a) Environment

A few subjects felt that administration's role was to provide a large and good environment for the patients. It was expressed as follows:

"Provide environment good area, big open area, not crowded"

Another subject indicated that administration should provide occupational and recreational facilities for the patients. This was expressed as follows:

"Make things available for the patients, keep them occupied, such as T.V. or music. They (patients) like music, they become quiet when they listen to music"

Another said

"They (administration) can provide some other channel for violent patients.. provide some other activity for the patients".

b. The Nursing Staff

Under this sub-category, the following were found to recur:

Training for the Staff

A few subjects indicated that nurses, practicals (enrolled nurses) and others should be prepared to deal with violent patients by being given in-service education and courses in psychiatric nursing. The following were comments made by some of the subjects:

"To provide more lectures on how to deal with violent patients..."

and

"Giving in-service education like study about violence, lectures, because mostly in our group now most of us are not really psychiatric nurses..."

and

"I think they (administration) must give classes to their staff how to approach violent patients, especially to practicals (enrolled nurses) and auxiliaries (nursing aids)..."

To have Sufficient Staff

This point also came up under the category of nursing staff. A few subjects indicated that administration's role was to provide sufficient staff in order to prevent violence. This was expressed as follows:

"Because now we...lack of staff, I think enough staff (----)"

Another stated:

"Violence can be prevented if they have sufficient staff, especially in the acute ward".

c Communication

Communication was another sub-category that emerged under the administration's role to prevent violence. A few subjects felt that proper communication should be available between administration, staff, patients and patients' families.

One subject stated:

"Proper communication with staff...."

Another said

"Some nursing officers who go around and see the patients can talk with them so they will settle down because they (nursing officers) know better than us..."

d Knowing the Cause of Violence

A few subjects felt that the administrative staff should investigate after a violent incident had occurred, in order to ascertain the causes. This would help them to prevent violent incidents. One subject said:

"..they (administration) will see the causes from how this happened (violence) and they will do something to solve the problem which is causing violence."

Another reported:

"..they (administration) can investigate to find out what

a - Verbal

When the subjects were asked what violence meant to them, many indicated that violence was when a patient shouted or screamed.

One of the respondents stated:

"Violence means the patient becomes very irritable, she will shout, scream ..."

Another also said:

"... violence, the patient will suddenly be disturbed, shouting, beating..."

b - Physical

The majority of the subjects felt that violence was when the patients attack others physically.

One of the subjects stated:

"Violence means sudden outburst of temper or anger which is characterised by attacking physically or hitting with an object."

Another indicated that violence is when a patient physically attacks others and causes damage to objects:

"... shouting, pulling, beating (----) breaking things (----)."

It has also been reported that violence means:

"attacking physically, causing injury to staff or co-patients or to the furniture in the ward, physical assault..."

c Aggression:

The word aggression came up frequently - many subjects indicated that violence meant aggression and others said that violence was an "aggressive attack". One subject said:

"Violence means when the patient becomes aggressive ..."

Another stated:

"It is the aggressive behaviour of the patient ..."

Another also said:

"Violence is just like aggressiveness, because aggressiveness and violence are almost the same ..."

d. Emotion:

Many subjects also linked violence with emotion. They used words such as "normal emotion," "specific emotion," "release tension," "sudden out-burst of anger" ... etc. to describe violence.

Table 4.5: Category 2: Causes of Violence:

Major Category	Sub-category
Causes of violence	- Mental illnesses - Unmet needs and demands - Environmental factors - The family and friends - The patients' attitudes and characteristics - The staffs' attitudes and approaches - The hospital rules - Physical problems - Frustration - No specific cause

The subjects were questioned about the causes of violence, and in general the following causes were identified by the subjects:

a - Mental illnesses:

The majority of the subjects reported that mental illnesses or their symptoms can cause violence. One subject stated:

"Schizophrenic, they are hearing voices and they are becoming violent ..."

Another said:

"The main causes they (patients) are hallucinating, auditory or visual. They (patients) may think I am coming to attack them and as a defence they will attack."

Another also said:

"Some patients due to delusion (----) mostly parenthood schizophrenia and mania patients."

b - Unmet needs and demands:

Many of the subjects indicated that when patients' needs and demands were not met by the staff, they became violent. Comments such as the following were made:

"... sometimes they (patients) want to take a bath and staff will say 'No not now', afterwards we will give soap and this one and they will be irritable and disturbed ..."

Another indicated that some patients demanded cigarettes and, if the staff did not give them, they became disturbed.

c Enviromental Factors:

Many of the subjects indicated that the enviroment was not suitable for the patients.

One subject stated:

"Of course the enviroment causes them (patients) to become violent. The situation is not suitable ..."

Another said:

"Even nurses talking loudly especially night time."

It was also indicated that in the acute ward there was only one hall which was used for recreation and dining purposes. It was a smoking area also and when non-smokers sat and watched television, they became irritated by the smoke.

d The Family and Friends:

Half of the subjects felt that patients' families and friends could provoke violence. A few subjects indicated that some of the patients' families did not respect the patients.

Others commented that some families were neglecting their patients, leaving them in the hospital and were not willing to take them for short breaks. The following were comments made by some of the subjects:

"... some families also are not willing to take their patients. Sometimes we are calling to come and take the patient for one day, but they are not willing."

and:

"Sometimes visitors do not come to visit their patients for one month or two months."

and:

"One cause is due to family negligence ..."

e Patients' attitudes and characteristics:

The majority of the subjects felt that the following attitudes and characteristics of the patients could cause violence:

"attention-seeking behaviour," "demanding", "defending oneself", "feeling unsure", "being upset". Other characteristics that were cited were "lack of confidence" and "escaping tendencies".

The following were comments made by some of the subjects:

"...they (patients) may think I am coming to attack them, as a defence they will attack."

and:

"Sometimes attention seeking behaviour, feeling that they do not get proper attention suddenly they ..."

and:

"... they are insecure like that one or they are upset..."

f The staffs' attitudes and approaches:

A few of the subjects reported that negative attitude of staff and wrong approaches could cause violence.

One subject expressed the following:

"I often observe this in the ward - wrong approaches to the patients."

Another stated:

"Sometimes the staff will be the cause of violence."

and said:

"They (staff) sometimes are stubborn with the patient ..."

Another subject commented:

"Some staff they will also irritate some patients, they will say some words or some, in my experience, will say something to the patient, that will irritate her."

g - The hospital rules:

A few felt that rigid rules and restrictions of the hospital could cause violence.

One subject said:

"Strict rules, strict routine ..."

A few subjects gave an example of bath-time to be one of the strict rules. They said that patients had to take daily baths and they had no choice about the bath time.

One subject commented as follows:

"... no freedom, not much freedom."

h Physical problems:

A few felt that physical problems, such as hypoglycaemia, epilepsy and sleeplessness, and after heart attacks patients could become violent.

i - Frustration

A few subjects reported that frustration could cause violence.

j. No specific cause

One subject felt that sometimes violence could occur when no obvious cause could be identified.

Prevention of Violence:

The question on prevention was divided into three parts. The first dealt with the nurses' role in preventing violence, the second was the doctors' role in preventing violence and the last, the administration's role in preventing violence.

Administration specifically meant here the Senior Nursing Officer, the Chairperson and the Administrator of the Psychiatric Hospital. The sub-

is the cause of violence. If their illness is the cause nothing could be done but in the rules, it should be investigated, especially if damages occurred such as to property or person.."

e Passive Role of Administration

Almost half of the subjects felt that administration had no role in preventing violence. The following were comments made by some of the subjects:

"Administration.. I do not think they can or do help much in this (---)..."

and

"I do not think administration can prevent violence"

and

"Even though no role ... staff only can prevent violence".

f Flexibility

One subject felt that the rules were rigid and needed to be flexible. This was expressed as follows:

"The rules should be more flexible".

g. Delegation of authority

One subject recommended that administration should delegate authority to the staff in order to take action independently.

No Answer

One subject did not answer the question because she was nervous. It could be that this topic was a sensitive one to her.

Table 4.10: Category 6: Recommendations and Suggestions

Major Category	Sub-category	Sub-sub-category
Recommendations and suggestions	- The environment	- Structure
		- Safety
		- Occupational/ recreational facilities
	- Therapies	- Physical
		- Psychological
		- Family
	- The staff qualities	- Communication
		- Flexibility
	- The nursing staff	- Training

When the subjects were asked if they had any recommendations and suggestions, the following sub-categories emerged:

The environment of the hospital
therapies
the staff qualities
the nursing staff.

These will be described in this section.

a) The Environment of the Hospital

Under the environment, the following will be discussed:

structure
safety
occupational/recreational facilities.

Structure

Many subjects suggested a change to the physical environment of the hospital. One felt that larger space was needed in order to separate the violent patient from the rest of the patients. This was expressed as follows:

"Then this ward I think but not possible to have a big separate room, if the patients get aggressive and some other patients can make them, sit in that hall and let them, become quiet..."

Another suggested having a quiet and less congested ward. It was recommended that there should be more single rooms in order to seclude violent patients. These rooms should be uncongested of equipment. This was expressed as follows:

"More single rooms for violent patients and should be prepared for violent patients - not too much things. The room we have is small, no place for us to go here and there for restraining the patient..."

Safety of the Environment

Half of the subjects felt that the hospital wards were not safe and recommended they should have a safe environment. The following are examples made by some of them:

"The ward is not safe to keep disturbed patients or violent patients because all the surroundings are dangerous, like glasses or objects which are very easy for a patient to reach and injure himself..."

and

"I feel this glass window is not at all safe because when the patient becomes violent, he goes towards the window with sandals in his hands. He will try to hug the window. They can put unbreakable glass. This is not at all safe".

Occupational/Recreational Facilities

Many subjects recommended having more occupational and recreational facilities. One indicated that patients need activities in order to divert their minds and these are not available on the wards. This was expressed as follows:

"We should switch his (patient's) mood, by diversional activities that are lacking so far."

Another subject suggested supplying a video and cartoon films to the mentally subnormal ward because those patients liked cartoon films.

Another stated:

"In the ward, they (patients) are just lying down, they do not have indoor games ...they do not have anything".

b. Therapies

Under therapies, three types emerged. These were:

Physical therapy

Psychological therapy

family therapy

These will be discussed in this section.

Physical therapy

One subject suggested that restraint should be used to prevent violence.

This was expressed as follows:

"Restraint is not practised often but it should be tried to avoid such things".

Another indicated that with the help of male staff only then they could manage to restrain the violent patient. This was expressed as follows:

"..if there is emergency only we want male staff, we cannot manage with female staff, always when a patient is violent, we are calling male staff... we cannot tie (restrain) alone".

Psychological Therapy

One subject suggested the use of "behavioural therapy" and to perform psychological assessments for all patients because these are very important.

Family Therapy

One subject suggested that patients' families should be given "family therapy" or "counselling".

c. The Staff Qualities

Under this sub-category, the following emerged:

Communication

Many of the subjects suggested that staff, such as social workers, doctors and nurses, should talk with patients and their families. One subject stated:

"I suggest to talk with his (patient's) family because he likes to go on leave and his family only with difficulty they take him..."

Another said:

"Here is an open ward and I suggest that when the patient becomes violent, I wish the doctor comes and talks with the patient and calms him down..."

It has also been suggested that there should be a link between doctors,

social workers and the Ministry of Labour and Social Affairs, in order to arrange a monthly income for the psychiatric patients while they were in hospital.

Flexibility

A few subjects recommended that freedom should be allowed so that patients could go out of the wards and wear their own clothes. One subject said:

"Not to remove his (patient's) clothes immediately
... leave him with his clothes".

Another stated:

"To allow some freedom for patients, because there is
so much rules and so much restrictions..."

It was also recommended that a patient should be assigned to his favourite staff, so that he would not become suspicious if another member of staff was assigned to him.

d. The Nursing Staff

The majority of the subjects suggested issues related to the nursing staff. One suggested that nurses' salaries and allowances should be increased as an encouragement for them. This was expressed as follows:

"...staff should be encouraged by increasing their wages
and increase risk allowances.. as reward when the staff feel
somebody is taking care of them..."

Another subject suggested that care should be given for the staff as well

as the patient when an incident occurred and the staff got hurt. Another suggested that the nurses who work in the acute wards should be Bahraini, so that they could communicate easily with the patients.

It has also been suggested that nurses who work at the Psychiatric Hospital should come with their own clothes and not wear uniforms.

Some subjects suggested that nurses who worked at the Psychiatric Hospital should have certain characteristics. The following were some comments made:

"The staff should be energetic and good..."

and

"...the staff should be confident because we are dealing with a behaviour of a patient..."

and

".. the staff should be alert, smart and good, especially with mental subnormal. We need more patience with patients..."

Training of the Nursing Staff

Training was another area which was recommended by many subjects. They recommended that there should be more lectures and demonstrations on how to deal with violent patients. When the subjects were asked whether they had had training on how to deal with violent patients, the majority said "No", and requested to have some.

The following were some comments made:

"..all the staff and practicals (enrolled nurses) should be trained in this. How to control and how to manage..."

and

"To have more lectures... it is very good to have demonstrations on how to deal with patients because, sometimes, we are holding patients in an improper way..."

and

"We need training for the staff because we came with diploma in general nursing, but we need to study about psychiatric nursing."

Category 7: Feelings Towards Violent Patients

Under this category, when the subjects were asked how they felt about taking care of violent patients, a few did not answer this question and a few gave irrelevant answers. It could be that they did not understand it, because English was the second language for all of them.

Those who answered the question gave answers, such as "feeling sad", "feeling happy" and "frightened". Others felt that violent patients were uncontrollable, nobody wanted to be hurt and male nurses are needed to manage violent patients.

One subject stated:

"I feel sad, I do pulling, pushing. I do not want to do but I have to do."

Another subject stated:

"Well I was threatened sometimes but it is O.K. I worked here and I should expect these things..."

and another said:

"Of course, when taking care of the patient..risky life ... staff might get hurt. It is a risky job".

A few subjects blamed themselves for the occurrence of a violent incident. The following are comments made by some of the subjects:

"It was my mistake"

and

"May be something wrong with me I catched the patient, or I am not prepared to do so..."

Category 8: The Choice between working with violent and non-violent patients

When the subjects were asked what they would choose when they had the opportunity to choose, the majority reported that they preferred to work with non-violent patients and gave the following reasons:

"Because I do not want to take risk..."

Another subject said:

"Because I am always searching for my safety to be safe I do not want to harm myself and I do not want to make problems for the patient".

and another stated

"...it will be less restrictions, less dangers and less worries."

A few subjects were neutral. They had no preferences and they said that they could work anywhere with violent or non-violent patients.

CHAPTER 5

Discussion

The aim of this study is to explore and describe nurses' perceptions of violence in a psychiatric hospital in the State of Bahrain. It is hoped that the outcome of this study will help in decreasing violent incidents at the psychiatric hospital.

In this chapter, the main findings of the study will be discussed. The data that were found under the fourth category on recommendations and suggestions will be used to support some of the data found elsewhere. The available literature will be utilized to agree or disagree with the findings.

Category 1 : Definition of violence:

Under this category, four sub-categories were identified. These were physical, verbal, aggression and emotion. The majority of the subjects defined a violent patient as one who attacks physically, beats and breaks things.

This definition is consistent with a definition made by Penningroth (1975) who defined violence as: "Any physical behaviour that is destructive of property." (Penningroth, 1975, p. 607). Haber et al (1982) also used a similar definition. They defined violence as "physical force that is used to hurt others".

Many of the subjects defined violence as aggression, or aggressive

behaviour. This is not surprising because many do mix violence and aggression. Sugden et al (1986) indicated that "violence means aggressiveness". Levi-Montalcini (1981) reported that violence and aggression are seen as synonymous. It could be concluded that the definitions which arose from the data were nearly similar to what was found in the literature. This could be due to the subjects' awareness of the topic.

In summary, the following comprehensive definition was formulated, based on the study findings, as well as the literature findings:

Violence is a physical aggression in which physical force is used to inflict physical and/or psychological pain on self, or another person and/or cause damage to property.

Category 2: Causes of violence:

The majority of the subjects indicated that mental illnesses, such as schizophrenia and mania, can cause violence. This is supported by a study of 916 subjects from four in-patient psychiatric services in France. The findings showed that paranoid schizophrenia was associated with crime (Addad et al, 1981).

It has been indicated that the majority of assaultive patients are schizophrenic (Albee, 1950; Fottrell, 1980; Itil, 1981; and Tardiff, 1983). Rada (1981) suggested that patients who suffer from mania or hypo-mania can become "violent and assaultive." (p.104).

Many of the subjects perceived delusion and hallucination as causes for violence. It is interesting to note that most of these subjects worked with

acute and sub-acute patients, in whom symptoms such as hallucinations and delusions were common. Very few were from long-stay wards. This could suggest that their perceptions about the causes came from their clinical experiences with such patients.

Symptoms such as hallucinations and delusions were found to be associated with assaultive behaviour (Kelly, 1982; Kronberg, 1983; and Tardiff, 1983). However, a study of 162 patients from four hospitals showed that violent incidents were common among substance-abuse patients and less common among patients with symptoms such as delusions and hallucinations, (Morrison, 1989).

It could be that when symptoms such as delusions and hallucinations are present, together with other precipitating factors, violent incidents occur more often. This needs further study in order to find out whether these symptoms do cause violence or because the majority of the in-patients suffer from these symptoms, they are the available target.

In this study, nurses who worked in the drug addiction unit were not included. It would be interesting to include such nurses in future research to see whether or not they cite substance-abuse as a cause for violence.

Only one subject indicated that drug or alcohol intoxication could cause violence, although there are many writers who suggest that there is an association between alcohol and violence. For instance, Rada, (1981) and Lyttle, (1986). It has been also indicated that at "least 50% of all violent crimes today are connected with alcohol." (Shaws, 1982, p. 282).

Unmet needs and demands were cited by many subjects as a cause of violence.

Some of them gave the bath as an example. They reported that patients wanted to have a bath but nurses refused to give this, upon their request. This could reflect rigid rules because, in some hospitals, a bath must be given at a specific time. This was further supported by one subject who stated: "No freedom, strict routine" when describing the hospital rules.

It could be argued that rigid rules and no freedom contradict with the existentialism theory which indicates that a person is free to choose. A survey of 115 psychiatrists revealed that "refusing to meet a patient's request" and rigid rules could provoke assaultive behaviour, (Madden, Lion and Penna, 1976, p. 423).

The hospital environment was cited as a cause of violence. Many subjects described the environment as not safe to the patients, overcrowded, lacking some recreational and occupational facilities and noisy.

Kalogerakis (1971) and Tardiff (1983) reported that overcrowding is often associated with violence. This does not indicate that the overcrowding is causing violence but that it could be a precipitating factor for potentially violent patients.

It is important to note that many subjects suggested the need to have a bigger and less congested space. They felt that this was the administration's responsibility. They also suggested the need to have a safe environment, because many of them felt that the environment was not safe, especially in the acute wards. This was expressed as follows:

"... for the violent patient the ward should be suitable like Al Gazali Four, (acute male ward). The ward is full of glasses ..."

Another subject suggested the need to have smoking and non-smoking areas. The reason given for this was that non-smoking patients could be irritated by the smoke and this could provoke violence.

This is an important suggestion that needs consideration as cigarette smoke not only causes major problems such as lung cancer to the non-smoker, but also causes minor problems, such as eye irritation, headaches, nasal irritation and coughs (United States Department of Health, Education and Welfare Office, 1979).

The majority of the subjects felt that some of the patients' characteristics such as attention seeking, demanding, feeling insecure and lack of confidence could cause violent behaviour. Whether these characteristics and behaviours caused violent behaviour, or resulted from violent behaviour needs further investigation. However, one should consider nurses' behaviour and actions towards such characteristics as how they see these patients is important. It has been indicated that "nurses attitudes towards patients were influenced by whether they were seen as being aggressive, unco-operative, demanding, complaining, unpleasant, indifferent, malin-gering or understanding and grateful." (Ritvo, 1963, cited by Davis 1984).

The family and friends were also seen as a cause of violence by half of the subjects. They indicated that some of the families had not visited their patients for long time. This was more often expressed by nurses who worked on the long-stay and mental subnormal ward because the patients were institutionalised for long periods.

In a study conducted in nursing home Care Units in order to find out the

caregivers' perception of aggressive behaviour, twenty two per cent of the caregivers felt that family members could cause aggression. Although aggression and violence are not the same, aggression could lead to violence as it was mentioned earlier (see Figure 1).

The effect of a family on a person is an important issue that needs consideration. The family has an influence on an individual not only as a child but also as an adult. According to the social learning and behaviouristic theory, a child learns from observing significant others and the reinforcement of his/her behaviour. For example, if the father is aggressive, the child might imitate his behaviour and learn aggression. If this behaviour is reinforced there is a great chance of this behaviour being repeated. Also, those who are abusive could have been abused by their parents while they were children (Spinetta and Rigler, 1972, cited by Menuck and Voineskos 1981).

One also should not forget the role of genetic factors, as an individual could inherit certain chromosomes. In some studies, persons with XYY chromosomes were found to be more aggressive than persons with XY chromosomes. According to Goldstein (1974) aggression and disturbed behaviour in monozygotic twins could be higher than in dizygotic twins. Also, one should not ignore cultural values and beliefs which are learnt from the family, and their influence on an individual's behaviour.

A few subjects indicated that physical problems such as hypoglycaemia and epilepsy, etc. could cause violence. This is supported in the literature by Kelly (1982) who indicated that temporal lobe epilepsy could cause violence.

A few subjects indicated that frustration could cause violence. In the literature, Dollards et al (1939) argued that frustration is always followed by aggression and when frustration occurs, aggression results. This was criticised by Bandura (1977) who argued that aggression can result without any previous frustration. Behaviourists, such as Skinner, also argued that aggression can occur when an aggressive behaviour is reinforced. However, frustration as a factor that might lead to, or provoke, violence should not be neglected.

A study of 31 residents in their second and third year residency programme showed that 15 of the 31 were attacked at least once during their second and third years. 14 of the 15 who had been attacked reported that the most common cause for their attack was frustration (Ruben, Wolkon and Yamamoto, 1980). This could suggest that nurses should learn how to reduce frustration when dealing with patients.

In conclusion, it appears that many factors contribute to the causes of violence. These are: mental illnesses and their symptoms, unmet needs, overcrowding, rigid rules and routines, and families and friends. Each factor needs further investigation in order to find out its relationship with the frequency of violent incidents.

Some factors were cited by the majority of the subjects and also supported in the literature, such as, the association between mental illness, i.e. schizophrenia, and violence. Also, rigid rules and routines were cited by many subjects as well as being supported in the literature. Although there are cultural differences between Bahrain and other countries in which other studies have been described in the literature, rigid rules and routines could be expected in hospital settings, especially in a psychiatric

hospital, in which some patients are institutionalised for months or years. This needs further investigation in order to find out whether a psychiatric hospital's environment differs from other hospitals and to compare it with different cultures.

Category 3: Nurses' Role to Prevent Violence

Under this category, the first sub-category that emerged was nurses' qualities. These include communication, attitude, flexibility and knowing the cause of violence. Many subjects stressed that communication and talking with patients were important in preventing violence.

Verbal communication was reported by the subjects. This was carried out through talking with patients and explaining to them and to their relatives. Wilson and Kneisl (1988) maintained that verbal communication is the first step in controlling violence while dealing with "potentially" violent patients. It was also indicated that violence could result from "miscommunication" between patients or staff. (Rada, 1981).

In this study, communication was identified as a problem by one non-Bahraini subject, who indicated that, because of the language barrier, patients were not understood fully. This was expressed as follows:

"Usually in a psychiatric hospital communication is number one. Maybe because we do not understand much Arabic and they (patients) cannot express their real feelings, what they want ... In our place we can talk in our language, but here we cannot, only English, and sometimes patients do not know how to use English ..."

Although the majority of the nursing staff at the Psychiatric Hospital are

non Arabic speakers and half of the subjects were also non Arabic speakers, only one subject identified that communication is a problem for non-Arabic speakers. It could be that either it was not a problem to the others because all the non-Arabic speakers received Arabic classes when they first join the Psychiatric Hospital, or they did not want to admit that it was a problem. This was not investigated, and further study is needed in order to find out whether communication is a problem to non-Arabic speakers or not.

Training for the nursing staff was perceived as an important factor in preventing violence. The need for training was recurrent under many categories. It appeared under the administration's role in preventing violence, the nurses' role in preventing violence and under the recommendations and suggestions.

Many subjects identified training as an important factor and recommended that all the staff who worked at the Psychiatric Hospital should be trained on how to deal with such patients. They saw training as the administration's responsibility. Many of them suggested that clinical demonstrations on how to hold and restrain violent patients should be provided.

This is a good point that needs consideration because a few of the subjects indicated that some nurses were using wrong approaches with violent patients, and this could have resulted from the lack of, or insufficient, training. It was also recommended that enrolled nurses and auxiliaries should receive training on how to deal with violent patients. They suggested that the training could be in Arabic and according to their level of education.

When the subjects were asked about their previous training on how to deal with violent patients, fourteen (66.7%) reported that they had had no training. The rest said that they had had some training which was mainly theory such as lectures, seminars and workshops. When they were asked about their desire to have training on how to deal with violent patients, eighteen of the subjects (86%) indicated that they wanted more training.

In contrast, in the literature, a survey of sixty-seven psychiatric nurses reported that they had had no training in how to deal with disturbed behaviour. Ninety-one per cent felt that further training would be helpful for them (Basque and Merhige, 1980).

A few subjects linked the nurses' roles in preventing violence with giving medication, restraining violent patients and occupying them with some activity. Restraint was recommended to be used when the patients were unmanageable, but they felt it should not be used as the first measure. This has been supported in the literature; for instance Rada (1981) recommended the use of restraint and chemotherapy in emergency situations. Stuart and Sundeen (1991) also recommended the use of restraint, when necessary, and that in order to do so, sufficient staff were needed. Almost half of the subjects indicated that P.R.N injections should be given when patients became violent.

Although psychotropic drugs were used widely with psychiatric patients and also used to calm violent patients, it has been reported that drugs such as "Haloperidol and other Neuroleptics" could "precipitate a violent episode if there is a severe akathitic reaction." (Keckich, 1978, p. 2185). The author described a case in which he developed violent behaviour due to akathisia. Essman (1981) cited Feldman (1962), Guldenpfenning (1973) and

others who reported that Benzodiazepines, such as diazepam and chlorazepam can produce aggressive behaviour in patients given such drugs. This is an important factor that needs consideration when prescribing such drugs. Further research should be conducted on the relationship between such drugs and aggression or violence.

Many of the subjects recommended having more activities in order to occupy and provide recreation for the patients and to divert their minds.

Potentially violent patients cannot tolerate boredom and this can provoke assaultive behaviour (Kalogerakis, 1971). This could support the subjects' recommendations of having more activities in order to reduce boredom. The type of activity should depend on the patients' interests and hobbies, because if a patient is not interested in, or unable to perform, an activity that could cause him to experience boredom and frustration. As many of the acute patients were not allowed to go to the Occupational Therapy Department, some of the subjects suggested having one occupational therapist who would be specialised in dealing with psychiatric patients, to go to the wards and spend some time with the patients.

Category 4: Doctors' role to prevent violence:

The majority of the subjects felt that the doctors' roles were mainly prescribing medications and restraining, or ordering to restrain, a patient. Only one subject felt that the doctors' role included the use of psychological therapy such as "psychotherapy" and "group therapy."

These findings were not surprising as, in general, most people see the doctors' role as mainly prescribing medicine. Although in a psychiatric

hospital communications, such as psychotherapy and counselling, are widely used, in this study, medication and restraint were mostly linked with doctors. It could be that from the subjects' experience, they had come to this conclusion.

Although psychological therapy was not cited as a doctor's role in order to prevent violence, many subjects felt that doctors should talk with patients.

Category 5: Administration's Role to Prevent Violence

A few subjects indicated that there should be proper communication between the administration and the staff, the patients and their families.

A few indicated that nursing staff should be encouraged by increasing their salaries, and allowances, and they should be cared for when they had been physically assaulted by patients.

It has been indicated in the literature that assault victims "need emotional support and reassurance" (Shepherd, 1988, p.1353) This could support the subjects' recommendations of having someone especially from administration to care for them and talk with them. Consideration and further study is needed to find out the current situation and the relationship of the administrative staff with nurses, and nurses' job satisfaction, in order that improvements may be made.

Almost half of the subjects felt that administration could do nothing to prevent violence. They felt that preventing violence was the nurses' responsibility, although the administration staff are the ones who agree on

policies and standards, can recommend staff for training and can make recreational and occupational facilities available in the hospital. However, half of the subjects saw administration's role as being passive in preventing violence. The reasons for this were not investigated in this study and further study in this area is needed. It would be interesting to find out what nurses from different countries and cultures could see as administration's role in preventing violence.

It could be concluded that nurses saw their role as the most important in preventing violence. It could be that they were confident in themselves, but this confidence should not prevent them from realising the importance of others and the need to work as a team in such situations.

Category 6: Feelings Towards Violent Patients

A few of those who answered this question indicated that it was interesting to work with violent patients, a few others indicated that it was a risky job. One felt threatened and a few felt sad, the reason given for their sadness being that they did not want to restrict patients.

In a study of forty staff nurses which was conducted to find out their reactions towards physical assaults by patients. Reactions such as "sadness", "fear of the patient who committed the assaults" and "feeling sorry for the patient" were reported by some of the subjects (Lanza, 1983, p.46).

A few subjects did not answer this question, and a few gave irrelevant answers. It could be that they did not understand its meaning as English was the second language for all of them. Other reasons could be that they did not want to express their real feelings as they felt that, as nurses,

they should accept whatever happened, and should not show their feelings. Another reason could have been that they were frightened that expressing their real feelings might affect their work at the hospital.

In the study by Lanza mentioned above, it was found that 50% of subjects did not answer 65% of the questions on emotional reactions, 55% indicated no response on 80% of the questions on social reactions and 40% reported no response on at least 85% of the questions on biophysiological reaction. The reason given for not responding was "that they had no right to react since being assaulted was part of the job" (Lanza 1983, p. 46).

Experience of Physical Assaults

The majority of the subjects had had experiences of physical assaults by patients at least once. It is interesting to note that the majority of the male subjects had one previous physical assault by patients, while a few had none and one had two physical assaults. All of them had training as psychiatric nurses with the exception of one, who had no previous training and had had two physical assaults by patients.

In contrast the percentage of female subjects, although from similar areas at the Psychiatric Hospital, with nearly equal numbers, was slightly higher (57.2%). They had had assaults ranging from no incidents to ten, 50% had been assaulted more than five times and the majority had been assaulted more than once. No relation was found between training and the number of assaults.

It could be that male nurses attended more workshops and lectures on how to deal with violent patients than female nurses, or because of the physical

build of the male staff that made them able to avoid or control violent attacks. This needs further investigation.

In a study of staff injuries from in-patient violence at a large Forensic State Hospital, it was found that the injury rates were higher among male nursing staff than female nursing staff (Carmel and Hunter 1989). This contradicts the findings found in this study and could be due to the difference in sample size, characteristics and type of injury, as what was considered and reported in one study could be different from another. One should not ignore cultural differences between the two, which limit their comparison.

Many subjects reported that physical assaults by patients occurred while they were being restrained or given P.R.N. injections. Gutheil and Tardiff (1984) reported that half of the assaults which staff encountered occurred while secluding or restraining patients. This could indicate a lack of training of the subjects on how to deal with such patients. This could support the idea that male nurses can hold and better manage violent patients and further study is needed to confirm this.

A few of the subjects blamed themselves for the incidents and one reported:

"Maybe something wrong with me when I catch the patient, or I am not prepared to do so..."

All of those who blamed themselves for the incidents had had in-service training only, such as lectures or workshops and one had not had any training on how to deal with violent patients. All of them recommended the need to have more training.

In a study in a Florida State Hospital, 96 staff participated. 31 had had training in aggression control and 65 had not received any training. From the trained group, only one member of staff was assaulted, compared to the untrained group in which 24 were assaulted (Infantino and Musingo, 1985).

It could be concluded that training is an important factor and prerequisite for dealing with violent patients. The previous findings suggest that training in how to control aggression and violence will not necessarily prevent violence completely, but it can reduce the risk of being assaulted (Infantino and Musingo, 1985).

It was also recommended by some of the subjects that male staff should be available to help in emergency situations in female wards and a few said that female staff were unable to cope in such situations. This point needs consideration and special attention should be given to the cultural and religious backgrounds of the patients as some would not allow male staff to touch them, thus increasing the possibility of violence.

Category 7: The choice between working with violent or non-violent patients.

The majority of the subjects reported that they preferred to work with non-violent patients. The reasons given were that they did not want to take risks and did not want to harm themselves. Although they were seeking their own safety and did not want to be hurt, those who accept working with such patients should expect such things to happen. The risk of getting hurt could be reduced with proper and immediate management of the situation, knowing the cause, if possible, and providing an adequate number of trained staff.

Although a few subjects indicated that they could work anywhere, the views and choices of others should not be ignored because this could influence their job satisfaction and job performance.

All new staff should be informed about the possibility of violent incidents and the possibility of being hurt during the orientation period, so that they can make up their minds when commencing their work at the hospital.

Policy of Restraining

This question was not part of the interview guide. It emerged from the interviews and not all the subjects were questioned on this topic - only those who brought up the point of restraint during the interview were asked. Nearly half of the subjects were questioned.

All of those who were questioned about the policy of restraining indicated that there should be a written order by a doctor to restrain a patient. Most of them also mentioned that they had to inform a supervisor before restraining a patient. This was consistent with the current policy of the psychiatric hospital.

It could be concluded that violence is a job hazard for nurses, as has been shown in this and other studies. All of the subjects had experienced physical assaults by patients at least once. Although female nurses had experienced more assaults by patients than male nurses, many factors could have contributed to this. A comparative study could be conducted in the

future to find out the difference between the two groups.

Although the majority of subjects indicated that they preferred to work with non-violent patients, a few reported that they could work anywhere. Each person's views and choices should be considered when allocating staff into different wards.

CHAPTER 6

Limitations of the Study

1. Questions

a) One question in the interview guide was not answered by all the subjects. As mentioned earlier, it could be that the subjects did not understand the question as English is a second language to all of them. It was not a problem during the pilot study because this was conducted in another country in which English was the first language.

b) One question regarding restraining emerged from the data and was limited to those who talked about restraints.

2. Limitations of the Methodology

a) The sample of the study was small and the subjects were selected from seven out of the nine areas of the Psychiatric Hospital. Nurses from the Drug Addiction Unit, as well as from the Psychogeriatric Unit were not included.

b) The time for data collection was short.

c) Analysing the data was time-consuming

d) Being known to most of the subjects could have biased the data.

e) The presence of a tape recorder while collecting the data may have influenced the subjects' responses.

f) Bias might occur during interpreting the data and identifying themes and sub-categories. Although efforts were made to reduce such bias by inviting two others to assist, as was discussed earlier.

- g) The researcher was unable to go back to the subjects to validate the data with them, and to obtain their agreement on the sub-categories which were identified.

3. Limitations in the Discussion

In discussing the findings, some of the data were not discussed and were not elaborated on further. It would have been time-consuming and lengthy to do so, bearing in mind the time limit for completion of the study.

Recommendations

The recommendations are divided into three sections, one being related to practice, the second to education and the third to research.

1. Clinical practice

- a) There is a need to form a Committee which should have some authority in taking decisions, such as planning workshops, seminars and lectures for all the staff who work with violent patients. Training should include junior as well as senior staff and it should be in theory as well as in demonstrations on how to deal with violent patients.
- b) To increase the number of staff, especially in acute wards.
- c) There is a need to form a team that would be available in emergency, or in case of shortage of staff on a ward in which violence occurred.
- d) An alarm system should be applied in all the wards and kept in the Nurses' stations. This alarm could be connected to the Nursing Officer's office, or to the nurse supervisor who is on call. In case of

emergency, he/she could call for help. The alarm could be installed in more than one place so that it could be heard if the person concerned was not available in his/her office.

e) There is a need for documenting all the violent incidents that take place. The place, time, nature of the incident and people involved should be clearly stated by the nurses. If there are records already in use, these should be reviewed and updated by the Committee.

f) Arabic classes to all non-Arabic speakers should be continued, and the outcome should be evaluated regularly.

g) Occupational and recreational facilities should be available in all the wards, as well as in the Occupational Therapy Department at the Psychiatric Hospital. An occupational therapist, who is specialised, should visit the wards, to assess patients' needs and plan activities accordingly.

h) Counselling services should be provided, together with support sessions for the staff in general and those who had experienced violent incidents in particular.

i) Those members of staff who wear the hejab (headkerchief) should tuck this inside their uniform, to prevent pulling by a violent patient.

j) The cultural aspects of patients should be considered when calling male staff to help with holding and/or restraining a female patient.

k) If there is a need for seclusion, rooms should be kept available and well prepared for use in case of emergency.

l) There should be smoking and non-smoking areas so that non-smoking patients are not irritated by smoke.

2. Education

- a) All the nurses should be specialised in psychiatric nursing. A review of the six months course should take place and methods of managing violent patients should be included, in theory and practice
- b) The post-basic psychiatric nursing programme at the College of Health Sciences should be evaluated and should include theory and demonstrations on taking care of violent patients.

3. Research

- a) This study needs to be repeated by a larger sample and to include nurses from all the nine areas of the Psychiatric Hospital.
- b) Two approaches of research, quantitative and qualitative, could be combined with the use of other methodologies including observation/critical incident, etc. when conducting further research, in order to obtain more data and to reduce bias.
- c) Further study should be conducted to include nurses from a general hospital and comparing them with nurses from the Psychiatric Hospital, and also to find out whether violence is a common problem in general hospitals, or not.
- d) A study should be conducted on patients who have had previous violent episodes.

This study raised a considerable number of interesting issues which need to be explored in further studies, These are:

- The effects of training on violence. Two groups could be compared, one receiving training and the other not and the results compared.
- The association between violence and alcohol, if any.
- To find out what are the factors that made the majority of nurses choose not to work with violent patients.
- Why most of the incidents that were reported by the subjects occurred more among female nurses.

Conclusion

In this study, violence was seen as physical force by the majority of the subjects. Many also indicated that violence meant aggression. There is evidence in the literature also that supports these findings.

Mental illnesses, such as schizophrenia and mania, unmet needs, environmental factors, such as noise and overcrowding, patients' characteristics, such as attention-seeking, demanding, lack of confidence, etc. as well as the patients' friends and relatives were seen as causes of violence.

Many subjects indicated that communication is an important factor in order to prevent violence and suggested that nurses, as well as doctors, should talk with the patients. Many also identified training as an important factor in order to prevent violence and recommended that all nurses who work with violent patients should be trained on how to manage such patients. This also was supported in the literature.

Many significant issues emerged from the data, such as training, flexi-

bility in the hospital rules and routines, communication with patients, as well as that staff should receive support and good communication from the administration. To provide occupational and recreational facilities and a safe place were also recommended.

The majority of the subjects reported having experienced a violent attack by a patient at least once. Most of the frequently attacked targets were female. In a study of staff injuries from in-patient violence in a large Forensic State Hospital, it was found that the injury rates were higher among male nursing staff than female nursing staff (Carmel and Hunter 1989). Difference in the sample size, characteristics, as well as the culture of each should be considered.

Despite the limitations of the study and the inability to generalize the findings, the study achieved its objectives of identifying nurses' perceptions of violence and describing those perceptions. It is hoped that this study will be the first step in initiating research into the area of violence.

A P P E N D I C E S

APPENDIX A.

I) Demographic data:

Sex: Male Female

Age: 20 - 25
 26 - 31
 32 - 37
 38 - 41
 Over 41 years

Education:

Nursing qualification: AD, GN, RN, others.

Additional courses: diplomas, certificates: Yes No.

If 'Yes' please specify:

Number of years in the service:

Less than one year
1 - 5 years
6 - 10 years
Over 10 years,

Number of previous physical assaults (incidents) if any.

None
1 - 4
5 - 10

APPENDIX A (Continued)

II) Interview Guide

1. What does violence mean to you?
- 1.a. If you have experienced a violent attack or violent incident in this hospital, what was it?
2. What do you think the causes of violence for in-patients in this hospital are?
3. What do you think nurses can do to prevent violence?
4. What do you think doctors can do to prevent violence?
5. What do you think the administration such as Senior Nursing Officers, Administrator and the Chairman can do to prevent violence?
6. How do you feel about taking care of violent patients?
7. Have you ever had training on the management of violent patients?

If yes: What was it?

If no: Would you like to have some training in this area?
8. Are there any recommendations or suggestions you would like to make for the management and prevention of violence, in your unit in particular, and in the hospital in general?
9. If you have the opportunity to choose to work with violent or non-violent patients, which would you choose?

Why?

APPENDIX 3:

Codes used for the Categories:

Violence:	Vio.
Definition of violence:	De Vio.
Causes of violence:	Ca. Vio.
Nurses' role to prevent violence:	Nur.pr.vio.
Doctors' role to prevent violence:	Dr.pr.vio.
Administrations's role to prevent violence:	Adm.pr.vio.
Feelings:	Fel.
Recommendations	Rec.
Experience of violence:	Exp. vio.
Choice:	Cho.

APPENDIX C

STATE OF BAHRAIN
MINISTRY OF HEALTH
COLLEGE OF HEALTH SCIENCES

July 2nd 1991

Principal Nursing Officer
Salmaniya Administration
Ministry of Health.

Dear

This is to introduce Ms. Mariam Ali Mulla, Lecturer, Nursing Division, College of Health Sciences, who is at present pursuing a Master's Degree in Nursing at University of Wales, U.K.

Ms. Mulla is currently in Bahrain for data collection (during the months of July and August 1991). The topic of her dissertation is "Nurses' Perceptions of Violence" and she plans to interview a number of nurses at the Psychiatric Hospital.

We would appreciate your support and assistance in facilitating this study.

Best wishes

Yours sincerely.

Dean
College of Health Sciences.

APPENDIX D

STATE OF BAHRAIN
MINISTRY OF HEALTH
SALMANIYA MEDICAL CENTRE
NURSING ADMINISTRATION

July 6th 1991

Dean
College of Health Sciences
Ministry of Health.

Dear.....

Reference to your letter dated July 2nd 1991, regarding permitting Ms. Mariam Ali Mulla the faculty at the College of Health Sciences to conduct her study of "Nurses' Perceptions of Violence".

I would like to inform you that there is no objection to permit her for data collection. She can contact the Senior Nursing Officer at the Psychiatric Hospital to get access to nurses.

Looking forward that the results of the study be shared with us.

Best regards.

Yours sincerely,

Ag. Principal Nursing Officer
Salmaniya Medical Centre.

APPENDIX E:

To The Chairman
Psychiatric Hospital
Ministry of Health.

Dear Sir,

This is to introduce Ms. Mariam Ali Al Mulla, Lecturer, Nursing Division, College of Health Sciences, who is at present pursuing a Master's Degree in Nursing in the University of Wales, Cardiff, U.K.

Ms. Al Mulla is currently in Bahrain for data collection (during the months of July and August 1991). The topic of her dissertation is "Nurses perceptions of violence" and she plans to interview a number of nurses at the Psychiatric Hospital.

We would appreciate your support and assistance in facilitating this study.

Best regards

Yours sincerely,

Dean
College of Health Sciences.

APPENDIX F:

Letter to the Subjects

Dear....

I would like to inform you that you are selected as a participant in my study on nurses' perceptions of violence, which is part of the Master of Nursing degree in which I am currently enrolled.

The interview will be conducted on The interview will be tape recorded. Confidentiality will be maintained and no names will be identified. If you are willing to participate, please call me on....

Your participation will be greatly appreciated.

Yours sincerely,

Mariam Al Mulla.

Appendix G:

Example Interview No. 17

Interviewer: What does violence mean to you?

Subject: It is the aggressive behaviour of the patient verbally and physically.

Interviewer: You said that you experienced a physical attack from patients once, can you explain what it was?

Subject: That time I was in the hospital and one patient was M.D.P. patient. She was on admission; we wanted to restrain the patient to give P.R.N. injection, then she beated with hands my shoulder, because I was bending on her and I think this was my mistake because she was lying on the bed and I was holding her hands and my shoulder was near her mouth so she bit me.

Interviewer: M.D.P. you mean ...

Subject: Manic Depressive Psychosis.

Interviewer: Did you have any incidents here in this ward.

Subject: Here, they are sometimes disturbed, one patient hearing voices; he is murmuring to himself, usually we are restraining him on the chair or bed for 15-20 minutes then he will settle; sometimes we give P.R.N. injection. We are just getting stubborn types. They are asking for paper, and we are giving.

Interviewer: What do you think are the causes for violence for in patients in this hospital?

Subject: (-----) Schizophrenia, they are hearing voices and they are becoming violent. Sometimes these patients, I think due to frustation and boredom, they become violent, boring,

sometimes attention-seeking, then some staff are irritating.
Also I feel, they irritate sometimes then they (patients)
get violent.

Interviewer: Any other causes?

Subject: Epileptic patients sometimes they are getting violent.
Then patients actually they are fighting also.

Interviewer: What do you think nurses can do to prevent violence?

Subject: Prevent violent? (uhm) The approach of the nurse should
be a sympathetic approach and to prevent frustration,
boredom, O.T. (occupational therapy), play, and this what
we are doing here, watching T.V. We do not give them a
chance to be alone. Sometimes taking outside picnics.
Schizophrenic patients we cannot prevent.

Interviewer: What do you think doctors can do to prevent violence?

Subject: They must give proper medicine. Sometimes they (patients)
are becoming frequently violent. They (doctors) will increase
the medicine, sometime P.R.N. injection.

Interviewer: What do you think administration, such as the Administrator,
Chairman, and senior nursing officer, can do to prevent
violence?

Subject: I think they must give classes to their staff in how to
manage violent patients, how to approach violent patients,
especially to practical (enrolled nurses) and auxiliary,
because when we tell them (auxiliary and practical
nurses) not to do like that they will say O.K., I am not
going to touch the patient. They will just neglect the
patient and will not take care, because we just told them
not to do like that. So they are just neglecting sometimes
and if we keep quiet they will sometimes irritate them,

they will say leave him alone like that. That is sometimes happen. Not only practical and auxiliary, but also staff. They need some knowledge, classes.

Interviewer: Practical and auxiliary how do you think you can be sure that they will understand. How to reach their level.

Subject: I think they can take classes in Arabic. It is very necessary that during bath time we have to be after them (auxiliaries and practicals) because maybe they will do something for the patient. Always they will be the cause for these incidents. We will be involved because staff are responsible (-----).

Interviewer: How do you feel about taking care of violent patients?

Subject: (-----) I feel that the patient will be separate in a single room and sometimes the patient is settling. If we keep them in a single room sometimes they will settle and then we call the doctor to give a P.R.N. injection or restrain for some time.

Interviewer: What is the policy for restraint in this hospital?

Subject: We restrain for 5-10 minutes. For P.R.N. injection, we have to take orders from a doctor. We keep the patients away from other patients, so they will not get injury, usually we keep them separate in a single room with one staff. Close observation then we take permission from a doctor (for P.R.N. injection or restrain). Sometimes there is a standing order for injection, with restraining also no use we have to do this. Some patients they need some special things we have to give them unless they get them they will be like this, only disturbed.

Interviewer: If you get the opportunity to choose between working with

violent or non violent patients, which one would you choose?

Subject: Non violent patients.

Interviewer: Non violent patients?

Subject: Yah

Interviewer: Can you tell me why?

Subject: Because this I feel that we are always tense any time they
(patients) are violent and more incidents happen (-----)

Interviewer: Have you had any training in the management of violent
patients?

Subject: They are giving inservice education classes in between, not
always on violence, but we are reading.

Interviewer: Do you think this is enough or would you like to have
more training?

Subject: We want more actually, we want more inservice education.
We are taking books from the library and reading also.

Interviewer: Do you have any suggestions or recommendations on the
management or prevention of violence in your ward in
specific and in the hospital in general? -----

Subject: I feel this glass window is not at all safe, because when
the patient becomes violent he goes towards the window with
sandals or whatever in his hands, he will try to hit the
window. They can put unbreakable glass, this is not at all
safe (----)

Interviewer: Do you have any other suggestions or recommendations?

Subject: Reduce the strength of the wards many patients, 10-12
patients are enough, if more patients overcrowding. If we
have less patients it will be easy also. When one patient
becomes violent, tearing clothes, another patient will see
and imitate him also sometimes (-----)

Interviewer: Do you have any other thing to add?

Subject: (-----) No.

Interviewer: Thank you.

REFERENCES

References

- Addad, M., Benezech, M., Bourgeois, M. and Yesavage, J. (1981) Criminal acts among schizophrenics in French mental hospitals. Journal of Nervous Mental Disorders. Vol 169, No.5.
- Albee, G.W. (1950) Patterns of aggression in psychopathology. Journal of Consulting Psychology, Vol 14.
- Altschul, A and Sinclair, H. (1986) Psychology for Nurses. 6th Ed. Bailliere Tindall, London
- Atkinson et al (1990) Introduction to Psychology. Harcourt Brace Jovanovich, Publishers, San Diego.
- Bandura, A. (1965) Cited by Bernstein, D.A., Roy, E.J., Srull, T.K. and Wickens, C.D. (1991). Psychology, 2nd edition. Houghton Mifflin Co., Boston.
- Bandura, A. (1977) Cited by Tajfel, H. and Fraser, C. eds (1978) Introducing Social Psychology. Penguin Books, Harmondsworth.
- Basque, L.O. and Merhige, J. (1980) Nurses' experiences with dangerous behaviour: implications for training. Journal of Continuing Education in Nursing. Vol 11, No.5.
- Bernstein, D.A., Roy, E.J., Srull, T.K. and Wickens, C.D. (1991) Psychology, 2nd ed. Houghton Mifflin Co., Boston.

Berkowitz, L. (1969) Cited by Kagan, C. (1991) The Effect of Others on Our Behaviour. In: Radford, J. and Govier, E. eds (1991) A Textbook of Psychology. Routledge, London.

Brenner, M., Brown, J. and Canter, D. (1985) The Research Interview: Uses and Approaches. Academic Press, London.

Brink, P.J. and Wood, M.J. (1988) Basic Steps in Planning Nursing Research: From Question to Proposal. 3rd edition. Jones and Barblett Publishers, Boston.

Brown, M. (1988) Dealing with actual or threatened violence. Nursing Vol 3 No 30.

Bryman, A. (1988) Quantity and Quality in Social Research. UNWIN Hyman, London.

Burns, N. and Grove, S.K. (1987) The Practice of Nursing Research Conduct, Critique and Utilization. W.B. Sanders Co., Philadelphia.

Campbell, R.J. (1989) Psychiatric Dictionary. 6th ed, Oxford University Press, New York.

Carmel, H. and Hunter, M. (1989) Staff injuries from in-patient violence. Hospital and Community Psychiatry, Vol 40, No.1.

Davis, B.D. (1984) What is The Nurse's Perception of The Patient? In: Skevington, S. ed (1984) Understanding Nurses: The Social Psychology of Nursing. John Wiley and Sons Ltd., Chichester.

Davis, R.E., Harris, C. and Shelby, J. (1974) Cited by Valzelli, L. (1981) Aggression and Violence: A Biological Essay of the Distinction. In: Valzelli, L. and Morgese, L. (1981) Aggression and Violence: A Psycho/Biological and Clinical Approach. Edizioni - Saint Vincent, Milan.

Dollard, J. et al (1939) Frustration and Aggression. Yale University Press, New Haven.

Edwards, J.G. and Reid, W.H. (1983) Violence in Psychiatric Facilities in Europe and the United States. In: Lion, J.R. and Reid, W.H. (1983) eds. Assualts Within Psychiatric Facilities. Grune and Stratton, Orlando.

Feldman, P.E. (1962) Cited by Essman, W.B. (1981) Drug Effects Upon Aggressive Behaviour. In: Valzelli, L. and Morgese, L. (1981) Aggression and Violence: A Psycho/Biological and Clinical Approach. Edizioni - Saint Vincent, Milan.

Field, P.A. and Morse, J.M. (1985) Nursing Research: The Application of Qualitative Approach. Croom Helm, London.

Fottrell, E. (1980) A Study of Violent Behaviour Among Patients in Psychiatric Hospital. British Journal of Psychiatry. Vol 136.

Freud, S. (1933) New Introductory Lectures on Psycho-Analysis. W.W. Norton and Company, Inc. New York.

Glaser, B.G. and Strauss, A.L. (1967) The Discovery of Grounded Theory. Aldine de Gruyter, New York.

Goldstein, M. (1974) Brain research and violent behaviour. Archive of Neurology Vol 30.

Gorden, R.L. (1987) Interviewing: Strategy, Techniques and Tactics. 4th ed. The Dorsey Press, Chicago.

Guldenpfenning, W.M. (1973) Cited by Essman, W.B. (1981) Drug Effects upon Aggressive Behaviour. In: Valzelli, L. and Morgese, L. (1981) Aggression and Violence: A Psycho/Biological and Clinical Approach. Edizioni - Saint Vincent, Milan.

Gutheil, T.G. and Tardiff, K. (1984) Indications and Contraindications for Seclusion and Restraint. In: Tardiff, K. eds (1984) The Psychiatric Uses of Seclusion and Restraining. American Psychiatric Press, Washington.

Haber, J., Leach, A.M., Schudy, S.M. and Sideleau, B.F. (1982) Comprehensive Psychiatric Nursing. 2nd ed, McGraw Hill Book Co., New York.

Haley, T.J. (1957) Intracerebral injection of Psychotomimetic and Psychotherapeutic drugs into conscious mice. Acta Pharmacologia and Toxicology. Vol 13.

Infantino, J.A. and Musingo, S. (1985) Assaults and injuries among staff with and without training in aggression control techniques. Hospital and Community Psychiatry. Vol 36, No.12.

Ironbar, N.O. and Hooper, A. (1989) Self Instruction in Mental Health Nursing. Bailliere Tindall, London.

Itil, T. (1981) Clinical psychopharmacology of aggression. In: Valzelli, L. and Morgese, L., Aggression and Violence a Psychobiological and Clinical Approach. Edizioni - Saint Vincent, Milan

Johnson, R.C. et al (1985) A cross-ethnic comparison of reasons given for using alcohol, not using alcohol or ceasing to use alcohol. Journal of Studies on Alcohol, Vol 46, No.4.

Kagan, C. (1991) The Effect of Others on Our Behaviour. In: Radford, J. and Govier, E. eds (1991) A Textbook of Psychology. Routledge, London.

Kalogerakis, M.G. (1971) The assaultive psychiatric patient. Psychiatric Quarterly Vol 45.

Keckich, W.A. (1978) Neuroleptics: Violence as a Manifestation of Akathisia. Journal of American Medical Association, Vol 24, No.20. p 21-85.

Kelly, E.M. (1982) Fear of violence. In: Haber, J., Leach, A.M., Schudy, S.M. and Sideleau, B.F., (1988) Comprehensive Psychiatric Nursing. McGraw Hill Book Co., New York.

Kronberg, M.E. (1983) Nursing Interventions in the Management of the Assaultive Patient. In: Lion, J.R. and Reid, W.H. eds (1983) Assaults Within Psychiatric Facilities. Grune and Stratton, Orlando.

Lange, A. (1971) Cited by Tajfel, H and Fraser, C. ed (1978) Introducing Social Psychology. Penguin Books, Harmondsworth.

Lanza, M.L. (1983) The reactions of nursing staff to physical assault by a patient. Hospital and Community Psychiatry. Vol 34, No.1.

Leininger, M.M. ed (1985) Qualitative Research Methods in Nursing. Grune and Stratton, Orlando.

Levi-Montalcini, R. (1981) Views on human aggressive behaviour and on wars. In: Vaizelli, L. and Morgese, L. eds. Aggression and violence a psychological and clinical approach. Etizioni - Saint Vincent, Milan.

Lion, J.R. and Reid, W.H. eds (1983) Assaults within Psychiatric Facilities. Grune and Stratton, Orlando.

Lion, J.R., Snyder, W and Merrill, G.L. (1981) Under reporting of assaults on staff in a state hospital. Hospital and Community Psychiatry. Vol 32, No.7.

Lorenz, K. (1966) On Aggression. Methuen and Co. Limited, London.

Lyttle, J. (1986) Mental disorder: Its Care and Treatment. Bailliere Tindall, London.

Madden, D.J., Lion, J.R. and Penna, M.W. (1976) Assaults on Psychiatrists by Patients. American Journal of Psychiatry. Vol 133, No.4.

Mandel, P. et al (1981) Neurochemistry of Experimental Aggression. In: Valzelli, L. and Morgeses, L. eds (1981) Aggression and Violence A Psychobiological and Clinical Approach. Edizioni - Saint Vincent, Milan.

- Marjot, D.H. (1982) Alcohol, aggression and violence. The Practitioner. Vol.226, No.1364.
- Miller, R. (1991) Hitting back. Nursing Times Vol 87, No.5.
- Morrison, E.F. (1989) Theoretical modeling to predict violence in hospitalized psychiatric patients. Research in Nursing and Health. Vol.12.
- Morton, P.B. (1986) Managing assault. American Journal of Nursing. Vol 86, No.10.
- Murdoch, D., Pihl, R.O. and Ross, D. (1990) Alcohol and crimes of violence: Present issues. International Journal of Addict. Vol. 25, No.9.
- Nye, R.D. (1986) Three Psychologies: Perspectives from Freud, Skinner and Rogers. 3rd Ed. Books/Cole Publishing Co., Monterey.
- Ochitill, H.N. (1983) Violence in a General Hospital. In: Lion, J.R. and Reis, W.H. eds (1983) Assaults Within Psychiatric Facilities. Grune and Stratton, Orlando.
- Penningroth, P.E. (1975) Control of violence in a mental health setting. American Journal of Nursing. Vol 75, No.4.
- Persky, H., Smith, K.D. and Basu, G.K. (1971) Cited by Goldestin, M. (1974) Brain research and violent behaviour. Archive of Neurology. Vol.30.
- Polit, D.F. and Hungler, B.P. (1987) Nursing Research Principles and Methods. 3rd ed. J.B. Lippincott Co., Philadelphia.

Poster, E.C. and Ryan, J.A. (1989) Nurses' attitudes towards physical assaults by patients. Archives of Psychiatric Nursing. Vol 3, No.6.

Powers, R.J. and Kutash, I.L. (1978) Substance Induced Aggression. In: Kutash, I.L., Kutash, S.B. and Schlesinger, L.B. (1978) Violence: Perceptives on Murder and Aggression. Jossey-Bass Publishers, San Francisco.

Poyner, B. and Warne, C. (1986) Violence to Staff: A Basis For Assessment and Prevention: The Tavistock Institute of Human Relations. (HMSO) Her Majesty's Stationery Office, London.

Psychiatric Hospital. Incidents Forms 1989. Psychiatric Hospital, State of Bahrain.

Psychiatric Hospital. Incidents Forms 1990. Psychiatric Hospital, State of Bahrain.

Rada, R.T. (1981) The violent patient: rapid assessment and management. Psychosomatics, Vol 22, No.2.

Radford, J. and Govier, E. (1991) A Text Book of Psychology. Routledge, London.

Ritvo, M. (1963) Cited by Davis, B.D. (1984) What is the Nurse's Perception of the Patient? In: Skevington, S. ed. Understanding Nurses: The Social Psychology of Nursing. John Wiley and Sons Ltd., Chichester.

Roberts, C.A. and Burke, S.O. (1989) Nursing Research: A Quantitative and Qualitative Approach. Jones and Bartlett Publishers, Boston.

Rockwell, D.A. (1972) Can you spot potential violence in a patient? Hospital Physician. Vol 18.

Ruben, I., Wolkon, G. and Yamamoto, J. (1980) Physical attacks on psychiatric residents by patients. Journal of Nervous and Mental disorders. Vol 168, No.4.

Schwartz, B.E., Wakim, K.G., Bickford, R.G. and Lichtenheld, F.R. (1956) Behavioural and electroencephalographic effects of hallucinogenic drugs. Archives of Neurology and Psychiatry. Vol 75.

Seaman, C.H.C. (1987) Research Methods, Principles, Practice and Theory for Nursing. 3rd ed. Appleton and Lange, Norwalk.

Shaws, S.H. (1982) Violence: a personal profile. The Practitioner. Vol 226, No 1364.

Shepherd, J. (1988) Supporting victims of violent crime. British Medical Journal. Vol 297.

Shipley, S.B. and Sylvester, D.C. (1982) Professionals' attitudes towards violence in close relationships. Journal of Emergency Nursing, Vol 8, No.2.

Siann, G. (1985) Accounting for aggression: Perspectives on aggression and violence. Allen and Unwin, Boston.

Slater, E. and Cowie, V. (1971) Cited by Menuck, M. and Voineskos, G. (1981) The etiology of violent behaviour: an overview. General Hospital Psychiatry, Vol.3, No.1.

Spiegelberg, H. (1982) The Phenomenological Movement: A Historical Introduction. 3rd ed. Martinus Nijhoff Publishers, The Hague.

Spinetta, J.J. and Rigler, D. (1972) Cited by menuck, M. and Voineskos, G. (1981) The etiology of violent behaviour: an overview. General Hospital Psychiatry. Vol.3, No.1.

State of Bahrain: Central Statistics Organisation (1989) Statistical Abstract 1988. State of Bahrain.

Stockdale, J. and Phillips, C. (1989) Physical attack and threatening behaviour. Occupational Health. Vol 41, No.8.

Stuart, G.W. and Sundeen, S.J. (1991) Principles and Practice of Psychiatric Nursing. 4th ed. Mosby Year Book, St. Louis.

Sugden, J., Bessant, A., Eastland, M. and Field, R. (1986) A Handbook for Psychiatric Nurses. Harper and Row Publishers, London.

Tardiff, K. (1983) A survey of assault by chronic patients in a State Hospital system. In: Lion, J.R. and Reid, W.H. ed Assaults within Psychiatric Facilities. Grune and Stratton, Orlando.

Terdiman, A.M. and Levy, J.V. (1954) Cited by Goldstein, M. (1974) Brain research and violent behaviour. Archive of Neurology. Vol.30.

Treece, E.W. and Treece, J.W. (1986) Elements of Research in Nursing. The C.V. Mosby Co., St. Louis.

United States Department of Health, Education and Welfare Office (1979) Smoking and Health : A Report of the Surgeon General. Rockville: U.S. Department of Health, Education and Welfare.

Valzelli, L. and Morgese, L.. eds. (1981). Aggression and Violence: A Psycho/Biological and Clinical Approach, Edizioni - Saint Vincent., Milan.

Valzelli, L. (1981) Aggression and Violence: A Biological Essay of the Distinction. In: Valzelli, L. and Morgese, L.. eds. (1981). Aggression and Violence: A Psycho/Biological and Clinical Approach, Edizioni - Saint Vincent, Milan.

Whitman, R.M., Armao, B. and Dent, O. (1976) Assault on the therapist. American Journal of Psychiatry, Vol 133, April.

Wilson, H.S. and Kneisl, C.R. (1988) Psychiatric Nursing. 3rd ed. Addison-Wesley Publishing Co., Melo Park.

Woods, N.F. and Catanzaro, M. (1988) Nursing Research: Theory and Practice. The C.V. Mosby Co., St Louise.