EXPERIENCES OF PSYCHIATRIC NURSES OF VIOLENT BEHAVIOUR BY FEMALE PATIENTS WITH MENTAL ILLNESS

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Abstract
As violent behaviour is more often associated with male patients with acute mental illness, little information is available on the experiences of nurses of violent behaviour of female patients. The objective of the study was thus to describe their experiences. A qualitative, descriptive and contextual study was conducted in a tertiary level psychiatric hospital. The target population was registered psychiatric nurses working in wards with patients presenting with acute illness. Purposive sampling was done and data collected through unstructured interviews with 10 nurses. Five themes were identified namely: nurses associate care of acutely ill patients with being exposed to violence, experience emotional turmoil, experience poor relationships with patients, distrusting patients and nursing management and appreciate the learning experiences. Support of nurses by nursing management is required before they are placed in acute wards, after experiencing or witnessing violence and continuously past their confrontation with violence. 

Keywords: Experiences, nurses, violent behaviour, patient with mental illness

Introduction
The occurrence of violent behaviour of mentally ill patients aimed at fellow patients and health care staff (Foster, Bower & Nijman, 2007) poses challenges to staff of psychiatric hospitals (McKinnon & Cross, 2008). More nurses than other members of staff are victims of such violent behaviour due to their 24 hour per day presence in the wards (Moylan & Cullinan, 2011). Exposure of nurses to the violent behaviour of patients directly (when the nurses are victims) and indirectly (when nurses witness violent behaviour aimed at others) could impact negatively on their psychological and emotional health.

Background
Violent behaviour of mentally ill patients is associated with individual and environmental factors (Foster et al., 2007) and occurs more often in wards where patients with acute illnesses are admitted due to their impaired ability to deal with reality (Biancosino et al., 2009). These patients are often admitted to hospital involuntary, causing them to feel helpless and angry (Salerno et al., 2009). Nurses are wrongly perceived to be their enemies (Moylan & Cullinan, 2011) who need to be punished for their hospitalization (Zuzelo et al., 2012).
Potential violent behaviour of patients is identified through screening procedures during admission. A history of aggression is considered to be an indicator of potential violent behaviour (Amore et al., 2008). Patient violence is treated by addressing the illness of the patient (Biancosino et al., 2009) and coercive measures are used as last alternatives (Moylan & Cullinan, 2011).

The types of assault nurses experience include being punched, hit with objects, spat on, slapped, kicked, choked, bitten, thrown onto the floor, twisting of body parts, hair pulling, scratching and sexual harassment (Nguluwe et al., 2014). Physical injuries inflicted on nurses range from bruises, lacerations, fractures, torn ligaments, damaged joints, chronic back aches, loss of teeth, unconsciousness with subsequent cognitive impairment and even death (Moylan & Cullinan, 2011).

After being assaulted, nurses are emotionally upset (Nguluwe et al., 2014), experience post-traumatic stress and often blame their supervisors and hospital management for a lack of support (Ngako et al., 2012). Their inability to have anticipated the possible violent behaviour also caused frustration (Poggenpoel et al., 2011). Experienced nurses tend to cope better with incidents of violent behaviour than their younger colleagues (Jonker et al., 2008), but are still susceptible to compassion fatigue and burn out (Sahraian et al., 2008). When nurses are scared of their patients, they try to avoid them (Ngako et al., 2012) and patient care is therefore compromised (Currid, 2008). Patient violence also often result in nurses taking sick leave to recover from injuries while others resign, leading to severe staff shortages (Nguluwe et al., 2014).

Although violent behaviour of patients with mental illness should be viewed as a priority problem in psychiatric hospitals (McKinnon & Cross, 2008), hospital management and staff consider it to be part of the mental illness of their patients (Chen et al., 2008). Little attention is given to the impact of it on staff, with the result that nurses resign (Salerno et al., 2009) and the care of patients are compromised (Currid, 2008). Violent behaviour is more often associated with male than with female patients (Salerno et al., 2009), however research findings reveal that female patients with mental illness also display violent behaviour (Amore et al., 2008). An extensive literature search identified a lack of research regarding the violent behaviour of female patients with mental illness and the experiences of nurses of such behaviour.

The aim of the research was thus to describe the experiences of psychiatric nurses of violent behaviour of female patients with mental illness.

**Method**

**Design**

In this descriptive qualitative study, an interpretivist paradigm was applied and inductive reasoning was implemented as the researchers used transcriptions of audio-recorded in-depth individual interviews with 10 professional psychiatric nurses regarding a natural situation (experiences of psychiatric nurses of violent behaviour by female patients with...
mental illness) followed by the generation of themes from the interpretation of the raw data (Moule & Goodman, 2014). The participants were full-time employees of a psychiatric hospital; had been working with female patients with acute mental illness for at least 6 months at the time of the study; and had experienced violent behaviour from female patients, either as victims or as witnesses. They were asked to relay what they have experienced when female patients became violent with them and other patients, which were followed by probing questions when necessary to ensure that rich descriptions of the experiences were obtained. Follow-up interviews had to be conducted with five participants as during the initial interviews, they focused predominantly on situations in which they as nurses were the victims of patients’ violence and not much on the patients’ perspective. Field notes were compiled immediately after each interview to describe information such as gestures that could not be captured by audio-recording.

Content analysis was applied. The transcripts and field notes were read and segments in them that seemed significant to the aim of the study were identified, clustered and fitted to descriptive names to form themes.

**Ethical approval**

Written approval of the proposal was obtained from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria (Protocol 400/2015) and permission to conduct the study was obtained from the chief executive officer of the selected hospital. The participants consented voluntarily in writing to partake in the study and that the interviews could be audio-recorded. They were reassured that they could refuse to take part in the study or withdraw at any stage without any negative consequences.

**Trustworthiness of the findings**

The researchers withheld their preconceived ideas about violent female patients with acute mental illness during data collection and analysis to ensure that the findings represent only the views of the participants. The methodology of the study is comprehensively described to enable nurse managers to determine whether the findings of the study are applicable to the circumstances. Excerpts from the transcribed interviews are used in the description of the findings to meet the criteria of confirmability of research results, according to Lincoln and Guba (1985) (Polit & Beck, 2012).

**Findings**

Five themes relevant to the experiences of psychiatric nurses of violent behaviour by female patients with acute mental illness emerged from analysis of the data.

**Theme 1: Nurses associate care of acutely mentally ill patients with exposure to violence**

The participants believed that they remained at risk of assault when they took care of acute mentally ill patients. One of the criteria for admission of patients to acute wards is actual aggressive behaviour and potential for harm to self and others. The participants thus expected the patients to resort to violent behaviour:
“Well I can say, working with patients that have risks of physical aggression, meaning …fighting with staff members most of the time, because of their psychotic level.” (P7)

The acuteness of the patients’ illness was associated with their behaviour. Other reasons for their violent behaviour were observed as inability to cope with the illness, other stressors in their lives, the admission to hospital and needs which were not met. The participants tried to understand that the patients projected their frustration onto the nurses and other patients:

“What we have realised is that you find that some of the patients...is their first episode, first admission, so they do not cope easily. Some don’t have support from their parents, their family members...so they do get frustrated.” (P1)

The participants seemed to know some of the reasons why the patients became aggressive. They expected the patients to possibly become violent when they felt neglected and had some unmet needs. The participants believed that, should they engage with the patients more in order to prevent them becoming violent and also do their best to see to it that the patients’ needs are met at all times, they may not resort to violent behaviour:

“... we can’t always expect incidents. Like we talk to the patients, we give them treatment. So that should minimise the incidents of violence... I think if we engage more with the patients, talk to them, we get to know them better and they feel free (comfortable) with us...” (P2)

Having observed the violent behaviour of the acutely ill patients, the participants ended up accepting it that before stability can be attained, patients would become violent at certain stages and that the more severe the mental illness the greater the chances of the patients displaying violent behaviour. The participants were confronted with incidents of violence so frequently that at some point, they no longer treated the violence of patients with urgency:

“You get so much used to them (incidents of violence) that you think that it’s normal in here. Is no longer an incident when somebody has slapped you... is no longer an incident when somebody has pulled your ear, you know... because we think that this has to happen in here.” (P6)

With their tendencies of disregarding certain extents of violence, the participants would not react when a patient displayed the potential for violence towards other patients or actually violated others in a way that the nurses considered to be not serious. It will only be until the patient had violated several patients or did something the nurses regard to be a major or serious act of violence that they would take action, like removing the perpetrating patient away from fellow patients whom she has already victimised:

“It (the fight) was not that big. It’s just for a moment. Just for a moment and goes to the next (patient) just like that until maybe you isolate that patient, then the problem will be solved.” (P4)
The hospital protocol required, without specification of severity, that all incidents of violence be reported to the management in writing. When the participants considered violence by patients to be the norm within the acute wards, they became inconsistent when reporting the violent incidents as required. The seriousness of violence within the acute wards couldn’t be precisely established if the participants did not report some of the incidents:

“*We have to report all violence...the thing is it happens almost every day, in such a way that sometimes we don’t report...*” (P9)

The participants explained that some of patients became violent towards their fellow patients because they were not impressed with having to share resources within the wards, including the attention of the nurses. Patients were reportedly jealous and felt threatened when new patients were admitted into the ward. They may have felt neglected and as a result became aggressive and violent because of this towards those patients whom they thought were getting more benefits than they (the perpetrators) did:

“... *when the patient who has been around, witnesses that attention is shifted from her to the new patient... she might develop jealousy... and then will poke the other one...*” (P6)

Incidents of violent behaviour of patients increased when fewer nurses were on duty and the care of the patients were compromised. Under such circumstances, the patients had nursing needs that were not attended to and they voiced their dissatisfaction with the nursing care by becoming violent towards the nurses and other patients:

“And if you are short staffed, patients will see it. Those who are disrespectful will see to it that today there is no manpower and they will come and... provoke the staff. And they will be uncooperative to the ward rules and they will start to disrupt the ward.” (P4)

**Theme 2: Experience emotional turmoil**

The participants at times felt emotionally drained, helpless and disillusioned with the challenges that they had to cope with. Although they knew that the violent behaviour that they were exposed to was caused by the acute illness of the patients, they were emotionally upset when it happened:

“You will find like now we have this patient, who will insult you, and because we are only human, we’ll feel... hurt or sad at that moment...” (P8)

The participants felt angry when they realised that sometimes, the patients assaulted them not because they were mentally ill, but just because they had no regard for the nurses:

“Then you realise that this is not only mental illness, but this person has preconceived ideas of why she must look down upon another person. Well that triggers anger.” (P6)
The participants were scared and upset by the thought of what could have happened should a patient manage to go through with some of the assaults. Attempts of assault were also not taken lightly. They seemed to have been experienced as equally terrifying:

“The patient was actually heading for my throat... but I was able to pull myself away...” (P10)

It was reported that witnessing other nurses being assaulted by patients made the observers experience their pain again. When members of the nursing team became terrified of the patients after having been assaulted, the whole team feels threatened and the source of strength for the nurses were weakened:

“If they assault the fellow colleague it’s like they’ve assaulted me still, so it’s really painful.” (P2)

The participants experienced violence between patients as sad. When patients were victimized by fellow patients, it made them feel torn apart as all the women were their patients and they did not want to have to come between them:

“It’s bad... because we nurse them all. We take care of them all. So when they start fighting it’s sad.” (P2)

Verbal abuse was more painful than physical abuse. It caused emotional pain and it took long for the participants to deal with it:

“...then the things that hurt most is the verbal aggression... because then if someone uses vulgar words towards you it takes time to get out of you. When you are alone, relaxing and then you think about it and it comes back that that person did this to you... it hurts too much.” (P1)

How long the emotional pain experienced by the nurses after they were actually assaulted or witnessed violence lasted, depended on the individual participants. Some reported that they would be over the hurt within the same day, whilst others required a longer time to recover. Some participants also reported that it was not easy to get over the emotional pain whilst their perpetrators were still in the ward. Also, the emotional pain encountered in the past was re-lived when they witnessed circumstances similar to that when they were sworn at:

“When you see that person you can remember that she said so many insulting words... and it comes back time and again. Even if you can hear the patient swearing to staff or to another patient it comes back that even me, other patient said... to me. It is not like the physical one, you can have the bruises and it heals.” (P1)

Sometimes the participants were emotionally overwhelmed by the effects of violence by the patients to the extent that they considered quitting work. They ended up enduring the situation by justifying that it was acceptable that the patients were sometimes violent because of the mental illnesses they had and that caring for them would obviously not be an easy job to do:
“At times you will want to… you know this ward is too much, take your bags and leave... It’s work. It’s what I was called to do. It’s... at times being assaulted it comes with the package... Even though it does not but what can you do? You work in a psychiatric hospital!” (P10)

Theme 3: Experience poor relationships with patients
Poor relationships with their patients developed due to the participants’ experiences of being victimised by the patients. Nurses in wards for acute mentally ill patients have to create therapeutic structures and an environment conducive to healing. It is expected from patients to follow the rules of the wards. Not all patients appreciate the arrangements and react to it with violent behaviour aimed at fellow patients and nurses. When the participants tried to instil order, the patients viewed the rules as means to control them and they often then responded with violent behaviour:

“At the end of the day we need to control what happens in the ward. When a patient maybe doesn’t listen to an assistant nurse the assistant nurse will come to us and say ‘this and this is happening’. Obviously you (senior nurses) have to put charge and take over and... and tell it as it is. And we are the ones always... who usually bring the bad news from the team if maybe the patient is not allowed to go to an open ward, or leave. So we are the victims most of the time (of the violent behaviour of the patients).” (P9)

The participants were also of the opinion that, when patients refused to cooperate with them, they did so out of not having respect for them. For them, the violent behaviour of the patients towards them was a sign of disrespect:

“They (patients) are not cooperative; they are so disrespectful... like they (patients) are comparing themselves with the staff... It’s like maybe they are judging, they are gauging, I don’t know how to put it.” (P4)

When the participants experienced patient violence, they became fearful of the patients. Instead of putting the patients and the care of the patients first, they tried to protect themselves from the violent behaviour of the patients. They considered putting their own safety first as of paramount importance before everything and everyone at all times. Assault of nurses by patients seemingly compromised nurse-patient relationships and secondarily nursing care of the same patients:

“You are kind of distant but at the same time you need to nurse that patient as comprehensively as you can.” (P9)

Theme 4: Distrusting nursing management
The participants expected the nursing management, with their experience in nursing, to have an understanding of what they were going through, or to make time to listen to the challenges that nurses were experiencing due to patient violence and how it was affecting them as human beings. This could possibly have enabled the managers to identify the challenges encountered and the support needs of the nurses. There were times when the participants reported to have felt as if the nursing management chose to see and do things
in favour of the patients without considering how the nurses will be affected in such instances:

“And also, if the management can see, can hear our side of the story and listen to us, not take sides and picture themselves being in this ward and try by all means to support us and accommodate us it will be better... So it pains us, it makes us feel like they are not supporting us hundred per cent.” (P1)

The participants felt that a strained relationship existed between them and nursing management. The participants spend more time with the patients than nursing management and they believe that they know best how to take care of them. Instead of supporting the participants, nursing management criticized them. They felt let down when their nurse managers did not support the decisions and interventions that the participants deemed appropriate to prevent patients from becoming violent or assist a patient who was violent already. It made the participants feel that nursing management had no confidence in them and was also putting their lives at risk, as they were the first to get assaulted when the patients become violent:

“At times, you get a response that you don’t want from the management... you will feel that this patient needs to be isolated, this patient needs to be secluded... then they will say 'she is already getting an Ativan orally.” (P10)

**Theme 5: Appreciate learning experiences**

Not all the experiences of the participants were negative. They remained hopeful that the situation could improve through either support from others or their ability to develop ways of coping. Whilst most of the participants did not like working in wards for acutely ill patients, a few felt that the environment offered them the opportunity to nurse patients with complex needs and as a result they embraced the exposure for professional development:

“I’d still work here. I think for experience, ‘cause when you are in female acute wards you’ll have more experience, I will just gain more experience, on how to nurse these psychotic patients, very aggressive patients.” (P2)

The participants hoped that they will discover better ways to manage the anger and violent behaviour of patients. The procedures that they were using did not work well. Some were not applicable to the situation:

“It (the techniques to handle violent patients) does work. Something has to work eventually. ‘Cause we need to manage that patient. Something eventually.” (P9)

The majority of the participants found it crucial to understand the conditions of patients they were dealing with. They also felt empowered when they received training on how to handle the patients when they become violent. Understanding their patients helped the participants to cope better:

“At least we do have in-service training... so we get information that they (the patients) are not doing this because they hate you or they are doing this intentionally.” (P1)
In this study, the participants experienced aggression from patients and also witnessed violence between patients. It seems as if psychiatric nurses are convinced that handling aggressive behaviour of patients is part of their job (Ngako et al., 2012). It therefore becomes expected by them that patients be violent towards them and their fellow patients. According to Stevenson et al. (2015) violence is seen as a result of mental illness and hence deemed acceptable by psychiatric nurses. Incidents of violence thus do not get reported (Zampieron et al., 2010) and the victims do not receive support from their managers. Moylan and Cullinan (2011) found in their study that nurses would not report incidents of violence that they consider not to be serious. Another reason why the participants did not report incidents is because of the lack of prompt reactions to the incidents reported to the nursing management and also the absence of follow up on the incidents, which could possibly create grounds for continued support of the victimised nurses by the management after the violent incidents. Unfortunately, nurses are also often blamed for their own assaults by their management (Sobekwa & Aruchallam 2015). When management does not involve themselves in problem solving and do not offer to nurses the support and guidance they require, the nurses end up losing confidence in their nursing management (Hamdan-Mansour et al., 2011); and experiencing increasing levels of stress (Franz et al., 2010) to the extent that they doubt whether they want to work in mental health nursing (Hazelton et al., 2011).

Regardless of them accepting that the patients are violent due to mental illness, all the participants still became emotionally upset when the patients assaulted them, their fellow nurses and patients. The effects of violence on the emotions of the nurses are negative feelings, as was found by Nguluwe et al. (2014). Psychiatric nurses’ experiences of violence imposed on them by patients, their fellow nurses and patients within acute wards are found to be dominated by negative emotions, such as, amongst others, anger or rage, self-doubt, anxiety, fear and feeling unsafe whilst at work (Franz et al., 2010). The psychological distress observed in those nurses who had been attacked by the patients is reported to be the reason behind negative professional functioning (Yarovitsky & Tabak 2009). The nurses studied in the latter study illustrated their need for support throughout their work and even more meaningfully after they have been confronted by or experienced violence, either as victims or witnesses.

The participants reported that they worked well with fellow nurses and felt supported by them when they were attacked. When nurses are functioning as a team that is emotionally closely knit, they end up feeling like a family and they become angry with the perpetrators when a ‘family member’ is violated. The latter is another reason why nurse-patient relationships are negatively affected, when the angered nurses have to make decisions on how to split their loyalty between their ‘family’ and the patients, which is their core business (Zuzelo et al., 2012). As a result, nurses feel hurt by and angry at the patients when they assault their colleagues. Some participants reported that it felt like they were being assaulted themselves when their fellow nurses were assaulted, and that they found it insulting to be assaulted since they as nurses are there to help the patients. The participants
acknowledged their responsibility towards protecting fellow nursing staff and other patients against harm by other patients. Fear of harm of themselves and others by violent patients is found to be the reason why nurses strengthen their sense of responsibility and support towards ensuring the safety of themselves and other nurses together with the patients in order to limit repercussions (Thupayagale-Tshweneagae & Ganga-Limando 2014). Team members take it upon themselves to make sure that the patients and the environment are as free from violence as possible (Sobekwa & Aruchallam 2015).

Some of the participants reported that they got over the emotional upset within the day the assault had happened or was witnessed, whilst others said they would sometimes still be angry when they reach home. Within the study by Zuzelo et al. (2012), most of the nurses found it impossible or difficult to get over the trauma when there were things that would constantly or sporadically remind them of their encounters with violence, such as being in the same ward where the incident occurred, seeing the perpetrator or witnessing a similar incident. According to Moylan and Cullinan (2011), psychological or emotional trauma negatively affect the victims for much longer than physical trauma would, and that emotional trauma do not receive any recognition or get entertained in most cases as would physical injuries, possibly because the damage isn’t visible until the victim relates it or exhibits the effects or complications of the trauma. In the long run, the nurses who have unresolved psychological and emotional trauma may present with symptoms of altered mental health (Nguluwe et al., 2014).

It became evident that when the participants were feeling exhausted emotionally, their physical functioning was affected and as a result they underperformed due to the inability to cope. A large part of mental health nursing care is executed by the nurses engaging themselves emotionally with the patients and therefor predisposes the nurses to burnout, which according to Kniest and Trigoboff (2009) is commonly experienced by health care professionals who spend the most of their time supporting or treating other people who are troubled psychologically and/or emotionally. If a patient takes longer to recover, it results in the extended involvement of the nurses with the same patient, which some nurses found to be emotionally draining (Zuzelo et al., 2012), increasing the chances of burnout (Stevenson et al., 2015).

The participants acknowledged that they did receive training, which is meant to help them to understand the patients’ conditions and behaviours and also to teach them how to handle the patients when they became aggressive. There were those who found the training helpful and it left them feeling confident that if some of the techniques fail, they would definitely find alternative ways to successfully manage the violence. Franz et al. (2010) found nurses appreciating the in-service training they were receiving, but at the same time verbalising that one will never get to feel absolutely well prepared for the incidents of violence by the patients.

Some participating nurses felt that quitting their jobs due to patients violating them and other patients was not an option for them. They reportedly continued working simply
because they had committed themselves to caring for the patients and have seen their colleagues surviving it, which to them meant that they could also make it. In the study by Itzhaki et al. (2015), it was found that those nurses who made personal decisions and chose to work as mental health nurses, come to the field expecting challenges within the setting and as a result they have positive perceptions of the stress they encounter and that they are able to deal with the stress without negative effects in the end.

In this study, the participants were simultaneously exposed to moments that left them feeling strengthened and positive about their patients and even more willing to continue with nursing the acutely ill patients despite the challenges they met. They were presented with opportunities that pushed them to further their professional development. In the study by Austin et al. (2009), it is illustrated that other than quitting, some nurses are sustained through self-determination to serve and be conscious of the difference they are making in the patients’ lives; and as a result they opt to acquire skills that will help them cope with the challenges of the acute ward environment and to provide care optimally.

Despite all the challenges they experienced within the acute wards, the participants still felt positive about their work environment in that they were determined to maintain their positive attitudes towards the patients and worked to enhance their work experiences. Ngako et al. (2012) saw nurses intending to work further in acute wards despite the challenges, remaining with positive attitudes towards the patients and also willing to improve on their nursing skills for the sake of a healthy nurse-patient relationships and effective nursing care. Some nurses felt that it is imperative that even with a history of violence and other negative behaviour, a patient be given the benefit of doubt. It helped them to remain objective towards the patients prior to their assaultive behaviours (Zuzelo et al., 2012). Other participants indicated that after surviving their exposure to violence, they feel stronger personally and ready for more, even outside their work environment. Itzhaki et al. (2015) reported in their study that with every exposure to incidents of violence, resilience develops in nurses.

**Conclusion**

The study created awareness of the kinds of emotions nurses experience when patients with acute mental illness are violent against them and other patients within psychiatric wards. The majority of the emotional experiences are identified as negative and they have adverse effects on the wellbeing of the nurses. The negative emotional state of the nurses due to encounters of violence also affect the lives of the nurses outside their work environment and the effects can be more detrimental to their health than thought of in certain instances. With the problem of violence by patients with mental illness not likely to be completely eradicated, nurses seemingly could cope better with more support from the nursing management followed by support from other relevant stakeholders, as well as the use of healthy coping strategies.
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