Female patient violence experienced by qualified nurses working in an inpatient psychiatric department in Al Amal Complex for Mental Health (Riyadh) Hospital

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Abstract

Psychiatric nurses are considered the most vulnerable healthcare workers in terms of encountering violence, and this trend is rising. Violence in the workplace poses a threat to the physical, emotional and psychological wellbeing of nursing staff, and in particular those working in mental health settings. This study explores how patient violence is experienced by qualified nurses employed in one inpatient psychiatric unit in the Kingdom of Saudi Arabia, paying attention to the short and long term effects and strategies that could better enable nurses to prevent, minimise and/or address workplace violence. As male and female patients and nurses are segregated in Saudi healthcare settings, this study focuses on female patient violence against female nurses. A qualitative descriptive approach was chosen to provide the philosophical foundation of this work. A purposive sample was used to recruit nine participants working in inpatient settings in one hospital in the KSA. The inclusion criteria required participants to; be a licensed registered nurse, be employed during the past decade in acute psychiatric units for female adult inpatients, and have experience of patient violence in one form or another. Data was collected using semi-structured, face-to-face interviews and participants were asked to complete a short demographic questionnaire. Data were analysed using thematic analysis, with four themes emerging; 1) The Occurrence of Violence; 2) The Determination of Violence; 3) The Impact of Violence; and 4) The Elimination of Violence. In conclusion, participants believed patient violence, such as physical and verbal abuse from patients and their relatives, is an unavoidable part of their work. Despite some positive outcomes of patient

violence, the effects of patient violence were found in the main to be negative, with substantial psychological impacts being noted.

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List of Abbreviations

BVC	Brevet Violence Checklist
BSN	Bachelor of Science in Nursing
CASP	the Critical Appraisal Skills Programme
CATIE	Clinical Antipsychotic Trials of Intervention
CENTRAL	Cochrane Central Register of Controlled Trials
CINAHL	the Cumulative Index to Nursing and Allied Health Literature
CRD	Centre for Reviews and Dissemination
ED	Emergency Departments
EPHPP	Effective Public Health Practice Project tools
EMBASE	ExcerptaMedica Database
KSA	Kingdom of Saudi Arabia
MeSH	Medical Subject Heading
MOH	Ministry of Health
MVRA	MacArthur Violence Risk Assessment
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NIOSH	The National Institute for Occupational Safety and Health
NMC	Nursing and Midwifery Council
OSHA	Occupational Safety and Health Administration
PEO	Population, Exposure and Outcome
POPAS	Perception of Perceived Aggression Scale
PTSD	Post-Traumatic Stress Disorder
RNs	Registered Nurses
SAVE	Scale of Aggressive & Violent Experiences
TA	Thematic Analysis
US	United States
WHO	World Health Organization

Chapter 1 – Background to the Study

1.1 Introduction

It has been suggested that nurses are the most vulnerable healthcare workers in terms of encountering violence, and that this trend is rising, rather than decreasing (Chen *et al.*, 2008; Alkorashy and Al Moalad, 2016).

A number of authors have examined the physical and psychological consequences of workplace violence on nursing staff (Mary *et al.*, 2005; Al-Shiyab and Ababneh, 2018; Najafi *et al.*, 2018). Nurses who have been exposed to violence can exhibit signs of post-traumatic stress, such as anomie, emotional fragility, lack of concentration, absenteeism and the need to leave their job (Gates *et al.* (2011). These findings were reiterated by Laschinger and Grau (2012) who found workplace violence was associated with nurses finding little job satisfaction, deciding to change careers and exhibiting signs of burnout. In addition, a number of psychological problems caused by workplace violence have been identified, including anger, irritation, sadness and depression (Lanctôt and Guay, 2014). In the Kingdom of Saudi Arabia (KSA), healthcare is one of the largest employers in the country, and it has been reported that two-thirds of healthcare workers have been exposed to non-fatal injuries (Algwaiz and Alghanim, 2012). Moreover, it has been found that healthcare workers in the KSA are five times more likely to encounter violence while at work than people employed in any other sector of the economy, with nurses being a

primary target (Hartley *et al.*, 2012). It is clear, from the evidence presented above, that violence in the workplace poses a threat to the physical, emotional and psychological wellbeing of nursing staff. The aim of this study is to explore how female patient violence is experienced by female nurses employed in inpatient psychiatric units in KSA.

1.2 Types of Violence and Definitions

The United States (US) Department of Labour's Occupational Safety and Health Administration (OSHA) states that workplace violence can be defined as a physical assault, threatening behaviour or verbal abuse which takes place in the workplace (OSHA, 2010). The workplace is any place where an employee carries out their work-related tasks, and can be a permanent or temporary setting. Other definitions abound. Gacki-Smith *et al.* (2009) view workplace violence on a sliding scale, starting with abusive language and ending with murder. The National Institute for Occupational Safety and Health (NIOSH) suggests that *"workplace violence ranges from offensive or threatening language to homicide. It is defined as violent actions (including physical assaults and threats of assaults) directed toward persons at work or on duty"* (NIOSH, 2020). The World Health Organisation (WHO) offers a more detailed definition:

"*Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, wellbeing or health*" (WHO, 2020).

The most common form of patient violence against nurses are physical and verbal violence (Speroni *et al.*, 2014).

Physical Violence

One definition by the NIOSH (2020) describes assault as *"attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives."* Further definitions used include the Webster (2020) definition as *"a violent physical … attack,"* or *"a threat or attempt to inflict offensive physical contact or bodily harm on a person (as by lifting a fist in a threatening manner) that puts the person in immediate danger of or in apprehension of such harm or contact." Web page*

Physical harassment, mugging and homicide are other forms of physical violence and are defined separately. Webster (2020) defines physical harassment as "*to create an unpleasant or hostile situation … especially by uninvited and unwelcome … physical conduct.*"

Verbal Violence

Verbal violence encompasses verbal abuse and threats, which are also defined separately. Verbal abuse is defined by Rippon (2000) as the act of swearing, intimidation, yelling, demeaning behaviour and the use of words to scold in public or to badger sexually. Meanwhile, the term *'verbal threat'* is defined by (NIOSH, 2020) as using language to

demonstrate the intention to be violent, and this could be using vocal threats or body language that exhibits harmful behaviour and/or written threatening messages.

1.3 Concepts of 'violence' and 'aggression'

Salin and Hoel (2011) report that *violence* and *aggression* may mean the same thing or be used to indicate different acts. The English use of *aggression* relates to a wider array of acts than *violence*, with the former being a term usually linked to acts in the health service (DeWall *et al.*, 2011). DeWall *et al.* (2011) further describe *violence* as a physical act to demonstrate *aggression*, while Rippon (2000) equates *violence* with *aggression*, indicating that *violence* defines acts that are of greater power, atrocity and shame.

Within the clinical setting, studies have identified different types of aggression and violence (Clark *et al.*, 2011; Dickens *et al.*, 2013; McDonald *et al.*, 2015). Dickens *et al.* (2013) define two types of aggression; instrumental aggression and hostile aggression. Instrumental aggression is intentional and seeks to gain from the situation rather than to necessarily injure the target. Hostile aggression is that which results in injury (Dickens *et al.*, 2013). Roche *et al.* (2010) found that violence can also occur between colleagues in the clinical workplace. They noted that this can be experienced in an array of actions, including; horizontal violence, lateral violence, nurse-to-nurse violence, inter/intra professional violence, incivility and bullying. Violence of this nature can be direct, via acts that are evident and overt, including shouting and hitting, or it may be indirect; acts that

are not evident or are covert, including, chatting about a colleague behind their back or not paying attention to them (Mitchell *et al.,* 2014).

1.4 Proposed definition of workplace violence

For reasons associated with this research, the definition used had to encompass the healthcare setting where nurses are employed, while also taking account of the Saudi legislative structure. Thus, the definition of workplace violence used for this study was:

'Any event where abuse, assault or threats are made towards employees in situations associated with their job and which indicates a direct or indirect danger to their health, welfare and safety. Such an event can be initiated by a patient or a member of a patient's family, visitors or member of staff.'

However, regardless of definition, research to date has been directed towards defining and measuring incidents of violence and the degree to which these have impacted the victim, rather than a comprehensive understanding of why they happened or how to resolve the issue (Anderson *et al.*, 2010; Hutchinson *et al.*, 2013). To address this situation, Anderson *et al.* (2010, p.2529) state: "*the way ahead lies in investigating interventions rather than repeatedly redefining the problem and misdirecting resources into debating semantics or differentiating 'degrees' of violence and aggression*". In exploring interventions between nurses and patients, it is often the effectiveness of the communication between the two parties is often noted as a causative factor.

1.5 Nursing Communication and Nurse-Patient Relationships

First published in 1952, Hildegard Peplau was one of the first nursing theorists to focus attention on interpersonal relations within nursing (Peplau, 1992; Peplau, 1994). Peplau's Theory of Interpersonal Relationships has been described as a revolutionary within the field of nursing, focusing on the reciprocity of interpersonal relationships that exist between nurses and patients (Hariyono, 2016). Whilst this theory was developed almost 70 years ago it is still applicable to contemporary nursing practice. The theory provides a conceptual framework upon which the challenges associated with nursing practice, and particularly communication and relationship issues, can be understood (Peplau et al., 2015).

Nursing is defined within Peplau's theory as an interpersonal process of therapeutic interaction that takes place between a patient and a nurse, the latter being educated and trained to provide the help needed by the patient (Peplau, 1997). Peplau (1997) explains that the common goal of nursing promotes the therapeutic process and motivates nurses and patients to mutually respect each other since both parties learn and grow through the interaction.

Several assumptions underpin Peplau's Interpersonal Relations Theory. The first is that nurses and patients can interact. Secondly, both nurses and patients will benefit and mature through the therapeutic interaction. Thirdly, communication and interpersonal skills are of utmost importance in nursing practice and finally, that nurses must be fully

capable of enabling personal development and avoid situations where patient choice become limited to those preferred by the nurses.

Peplau's Theoretical Model of Interpersonal Relations is based on psychodynamic principles, in which nurses try to understand their own behaviours and the behaviours of others, as well as using human relations principles to identify their own needs (Merritt and Procter, 2010). There are four stages involved in the development of this relationship, starting with orientation. During this stage, a patient seeks help with a perceived problem or need. After this, the identification stage takes place, in which there is a growth in familiarity and respect between patient and nurse. This is primarily achieved by the nurse using their education and skills to address the patient's need (Forchuk, 1994). The next stage is the exploitation phase, where the nurse tries to change the patient's behaviour to solve a problem and address the patient's needs. The objective here is to reach a point when the nurse's assistance is no longer required. Lastly, in the termination stage, the patient is discharged from the nurse's care and the patient progresses with their life using their improve self-reliance skills (Peplau, 1997; Jones, 2014). How a nurse addresses different situations that occur within these stages will be largely determined by their knowledge, values and experiences (Adams, 2017). What is important in deciding how to respond is for the nurse to identify the most suitable options for addressing the specific needs of the patient or situation, rather than a diagnosis (D'Antonio *et al.*, 2014).

Whatever approach is chosen, it is essential that the nurse works to establish an environment that is conducive to developing trust (Jones, 2014; Peplau, 1997). One

example of this might be sharing their knowledge to help educate the patient about their problem and how their needs might or could be addressed (Jones, 2014; Peplau, 1997). In so doing the patient might be helped to better understand (and differentiate) the dependence, interdependence, and independence of factors underlying their mental health problem, thus helping them to take responsibility for their treatment and recovery (Ramesh, 2013).

The nurse's sense of self is also important. Nurses need to acquire a sense of their self and self in relation to others in order to best help others in their therapeutic practice (Adams, 2017). Whilst knowledge of self is a process that is influenced by the nurses education, experience and socialisation, in the therapeutic relationship the process will often start in the orientation stage, where nurses work collaboratively with patients to develop their familiarity with each other (de Brito *et al.*, 2017). This understanding of self (and self in relation to others) peaks as the nurse and patient work towards developing a heightened awareness of what might be required in becoming more self-reliant (Erci, 2011; de Brito *et al.*, 2017). This profound understanding of oneself is fundamental in being able to get to know and help the other person (Snyder, 2014). However, it is also noted that the experience and knowledge a nurse acquires shapes their beliefs and values. For some people this might restrict or limit the opportunities each therapeutic encounter has to offer.

Peplau's theory is predicated on the assumption that the relationship between nurse and patient should be at the heart of the therapeutic process. If nurses are not able to develop

the conditions for a successful therapeutic relationship (perhaps because of unaddressed safety issues or psychological dysfunction caused by previous trauma), then their interactions with patients become more routinised, and lacking in therapeutic impact (Pinho *et al.*, 2017).

The relevance of the selected theory lies in the fact that it results in a major shift in how nurses view their duties, since nurses no longer see patients as passive recipients of nursing actions, but as partners in care (Warne and McAndrew, 2007). This results in the building of relationships between nurses and patients, encouraging patient-centred care which could lead to reduced patient violence. Additionally, the theory provides guidance on effective communication, which will support the nurse-patient relationship, and create a new vision of nursing as a continuous collaboration between staff and patients.

1.6 Workplace violence in nursing research

Workplace violence is a widespread phenomenon and is a cause for concern globally (El-Gilany *et al.*, 2010; Pai and Lee, 2011; Laschinger and Grau, 2012). Hader (2008) conducted an international study regarding workplace violence and concluded that 80% of those whom he had interviewed, in the US, Afghanistan, Taiwan and KSA, had been subjected to violence in the workplace. In 25.8% of cases the violence was physical, and 92.8% of the respondents were female. The findings revealed that 53.2% of the acts of violence were committed by patients against nurses. Overall, 73% of the nurses experienced violence occasionally, 17% experienced violence often, and 1.7% stated that

they always experienced violence at work (Hader, 2008). The findings from Hader's (2008) study were in keeping with an earlier study by Findorff *et al.* (2005), who found that healthcare workers were frequently exposed to violence, with over 50% of those questioned stating they had personally suffered from violence at work. Mayhew and Chappell (2001) estimate that only 20% of violent events among nurses are ever reported, and/or documented. If violence results in an injury to staff members or patients, it is likely to be reported, while the contrary is true where non-physical violence is concerned. Findorff *et al.* (2005) assert that 43% of physical and 61% of non-physical violence is not logged or reported. Looking more closely at this trend, Findorff *et al.* (2005) found that 32% of people in jobs ranging from clinical positions (e.g., nurses, client care assistants, physicians) to clerical and technical positions (e.g., accountants, computer programmers, technicians) had been assaulted. Of those, 8%, dismissed it as something that '*comes with the job'*.

There are many reasons cited for under-reporting workplace violence. Flannery (1996) found that difficulties defining the term violence formed one of the main reasons for underreporting, while Farrell and Cubit (2005), ascribing patient behaviour to the fact that they are ill and hence not responsible for their actions, cite this as another possible reason for not reporting violence. The organisational ethos, which places the onus on the victim to complain, and the idea that it would be too expensive to introduce protective measures to safeguard staff, are also cited as factors for non-reporting (Jackson *et al.*, 2002). Mayhew and Chappell (2001) argue that the recurring notion that violence is part of the

job, a sense of culpability and a perceived lack of a good reason to report violence, since it would result in no personal or organisational change, are other reasons given for limiting the reporting of violence. Other causes presented in the literature include the disgrace of being a victim and the humiliation that comes with it, as well as shame, marginalisation and worry about being belittled and criticised (Jackson et al, 2002). Anxiety about losing their job (Poster, 1996); fear of being blamed for having precipitated the assault or being accused of negligence (Jackson et al, 2002), a sense of culpability, and cumbersome, inefficient and discriminatory reporting mechanisms (Mayhew and Chappell (2001) have all been identified as reasons for not reporting violence.

1.7 Types of patient violence against nurses

Workplace violence is frequently categorised either according to the type of violence or the characteristics of the person who exhibits the violent behaviour. Bowie *et al.* (2012) assert that violent behaviour may be intentional or unintentional, and falls into a number of categories; physical, psychological, sexual, harassment and bullying, and aggression. According to McPhaul and Lipscomb (2004), workplace violence can be divided into three separate categories: physical violence; sexual violence; and psychological violence. Another approach to workplace violence is to categorise it according to the perpetrator (Mayhew & Chappell, 2007), with Forrest *et al.* (2011) suggesting the following subdivisions: someone from outside the workplace; a patient in the workplace; and internal staff members. Shields and Wilkins (2009) note that psychiatric nurses report a

far higher rate of workplace violence than nurses from any other specialism. It has been suggested that this may well be due to patient pathologies, and the nature and ethos of acute psychiatric units (Leeuwen and Harte, 2017) and is something explored further in this thesis.

1.8 The consequences of workplace violence towards nurses

Individual nurses, organisations and the nursing profession per se are all affected by workplace violence. Nurses suffer physical injuries, many of which are minor, but which often result in taking sick leave (Mayhew and Chappell, 2007). It has been reported that on average 3.7 sick days are taken per incident (Nijman *et al.*, 2005). While it is evident that receiving a physical injury affects nurses in a variety of ways, the longer psychological consequences of assault need to be considered (Yang *et al.*, 2012). A number of researchers (Richter and Berger, 2006; Mayhew and Chappell, 2007; Yang *et al.*, 2012) have examined whether nurses suffer from post-traumatic stress disorder (PTSD) after being assaulted. Yang *et al.* (2012) discovered that 17% met the criteria for PTSD immediately after the assault and, six months later, 10% were still exhibiting symptoms of PTSD. Needham (2006) suggests that 78% of nurses in general who had suffered workplace violence showed signs of anger, irritation, sadness and depression, or a combination of these conditions. Phillips (2007) identified how the long-term effects of stress nurses endure, combined with the trauma of being assaulted, can lead to a variety

of reactions, including nightmares, apathy, flashbacks, invasive thoughts and periods of uncontrollable crying.

As a result of the outcomes outlined above, a number of researchers have questioned how exposure to violence impacts patient care. Colligan and Higgins (2006) note how the emotional backlash from a violent incident could result in low morale, a drop-in productivity and a rise in negligence when carrying out duties. Gates *et al.* (2011) suggest that both performance and work-related tasks could be compromised. Laschinger (2014) argues that nurses who have suffered workplace violence may not be able to care for patients in the same way as before the violent episode occurred. Once newly qualified nurses have been exposed to violence, further episodes occurring will be anticipated, and fearfulness and a desire to leave the organisation or setting which has caused them physical or psychological harm might be experienced (Laschinger and Grau, 2012). Likewise, violence can not only have a negative impact on nursing staff's ability to care for patients, but it can also impact on them pursuing their careers (Yıldırım, 2009).

Staff issues inevitably impact on the organisations which employ these staff, as healthcare workers need to be able to communicate and co-operate in order to provide high quality patient care (Arnetz and Arnetz, 2001). Hogh and Mikkelsen (2005) find that hospital employees who have been exposed to workplace violence tend to have a weaker sense of belonging to an organisation than those who have not, reporting that their responses are frequently driven by stress. Violence in the workplace leads to a reduction in job satisfaction, criticism by family members, trauma and a stress-related phenomenon

commonly described as workplace burnout (Danna and Griffin, 1999; Maguire and Ryan, 2007). Kowalski *et al.* (2010) define burnout as the result of high work demands impacting on weak coping resources, resulting in a sense of emotional collapse. In addition, the burnout syndrome often shows itself in a '*pulling back'*, an emotional withdrawal at work, which results in both behavioural and personal distancing (Bianchi *et al.*, 2015). Patient care can suffer as a result of such '*pulling back*' and can impact negatively on the running of the wider organisation.

Workplace violence affects both the individual and the organisation. Peek-Asa *et al.* (2011, p. 166) cite a series of problems which combine to make nurses feel unsafe due to violence. These include: *"lack of support and poor staffing levels which leave them exposed; indifference to issues of safety and concerns which the staff have raised and flagged up; inadequate training; no peer support or administrative help as this may affect the organisation's reputation especially in private hospitals as people could justify violence in the work-place as a bad management."* Taken together, these factors can lead to nursing dissatisfaction (Jaradat *et al.,* 2016).

Hospitals are affected as a result of workplace violence, since absenteeism rates rise, dissatisfaction grows, productivity reduces, and staff levels drop as turnover increases (Walrath *et al.*, 2010). Waters *et al.* (2005) found that the cost of violence and stress in the workplace can amount to 1.0-3.5% of the gross domestic product (GDP) in numerous countries. Links have been made between an individual's well-being, including their mental and physical health, sense of job satisfaction and morale, and their organisation's

costs and productivity (Hatch-Maillette and Scalora, 2002). In 2008, Colonel Murray, President of the American Federal Nurses Association, estimated that workplace violence costs $4.3 million every year, or in the region of $250,000 for every incident, a figure which does not take account of the expenses incurred by the victim and his or her family. Other less visible costs also need to be considered, from legal liability costs, to those of having to recruit and hire replacement staff when turnover is high and unsustainable (Hatch-Maillette and Scalora, 2002). Nursing has problems with recruitment and retention, especially with regard to qualified staff, impacting negatively on organisational budgets (Jones and Gates, 2007). This situation is further complicated by violence in the workplace. For example, Child and Mentes (2010) found that emergency room nurses were unwilling to return to their duties after a violent incident.

1.9 Violence and mental Illness

There is debate within the literature as to whether or not a causal link exists between mental illness and violence. In a review of the literature, Stuart (2003) examines the links between violence and mental illness. She concludes that mental illness is not essential to, nor a reason for, violent behaviour and other factors, such as being male, young and from a low socio-economic background, were likely to lead to violent behaviour. Secondly, she does not agree that the public are at a higher risk of violence from people suffering from mental illness, stating this danger is exaggerated. Thirdly, she argues that substance abuse, whether taking place alongside or apart from mental illness, is a major cause of

violence (Stuart, 2003). Stuart did not provide a search strategy for this research, nor any information on the criteria used to determine which papers were and were not included in her review. In addition, no critical appraisals of the included studies were supplied, and so it is difficult to assess the accuracy of the above conclusions.

Monahan *et al.* (2006) conducted a study and presented similar results, with the authors reporting that people who did not abuse substances, but who had major mental health issues did not differ from a control group of non-substance abusing adults in terms of violent behaviour. In addition, the researchers confirm that the findings of many studies indicate that a substance abuse disorder doubles the risk of violence in patients, something which has already been documented in acute inpatient psychiatry units (Boles and Miotto, 2003). Two studies, those of Mullen (1997) and Rueve and Welton (2008), focus on the connections between patients suffering from mental health issues and violent behaviour, and consider a number of explanations on the subject. They find that the likelihood of violence rises when symptoms of mental illness intervene, drawing a number of conclusions from this. Firstly, they report that the only difference between the psychiatric patients and a non-psychiatric sample within the community was the presence of psychotic symptoms; if a person had psychotic symptoms and they were not being controlled by medication, there was an increased risk of violence, while those whose condition was stable and had been controlled by medication was no different from the community sample. They also acknowledge that there was a slightly greater risk of current and former patients demonstrating violent or illegal behaviour, but state that the link

between mental health and this type of behaviour was less significant than other factors: for example, age, gender and level of education. Mullen (1997) points out that violence needs to be reported and documented for it to become part of data, since it is impossible to measure it directly, and many variables have to be taken into account. In Canada, Arboleda-Florez (1998) carried out a critical literature review on the relationship between mental illness and aggressive behaviour, which included material both from Canada and the USA. The review produced a number of conclusions and statistical connections. Firstly, a history of either violence or criminality is the strongest predictor of violence and criminality, and this is irrespective of the diagnostic group, substance abuse or schizophrenia. Individuals who are suffering from schizophrenia react differently according to whether or not they are having psychotic symptoms. Moreover, those whose schizophrenia is being treated with neuroleptics are less likely to commit violent acts than people who are experiencing psychotic symptoms and not receiving any treatment (Stuart, 2003). These results reiterate the findings of Arboleda-Florez (1998) regarding substance abuse being a significant risk factor for violent and criminal behaviour, and this is true not only of the mentally ill population, but also of the community as a whole and offenders.

Rippon (2000), who undertook a review of the literature, suggests that the absence of clear definitions has made it difficult to tackle the problems of workplace violence, questioning the reliability and objectivity of the reported data. To illustrate his view, Rippon looks at the term violence and aggression and demonstrates how definitions vary

according to whether or not they include emotions and intent. His conclusion is that the two words *violence* and *aggression* has become interchangeable, arguing that the lack of precision and clarity in their definitions makes it virtually impossible to use these terms for scientific research purposes.

These methodological anomalies make it difficult to reach a conclusion about the links between mental illness and violence. Recent research argues that the mentally ill are no more violent than any other section of society (Glied and Frank, 2014); other writers state that they are as violent as or more violent than their non-mentally ill peers (Walters and Crawford, 2014). Some state that there is no consensus on this topic (Bo *et al.*, 2011; Nielssen *et al.*, 2012), while others (Markowitz, 2011; Swanson *et al.*, 2015) are positioned somewhere in the middle of this debate, since they argue that there is a slight link between violence and mental illness with some methodological limitations. Violence, for example, is not easy to measure directly, so studies have used data taken from incidents documented through unverified self-reporting and official documentation. This is problematic, as sampling source (e.g. hospitalised or non-hospitalised sources) has been found to affect the frequency of violence, and statistics can influence the generalisability of results (Van Dorn *et al.*, 2012). In addition, the majority of the samples used have tended to focus on mentally ill individuals who have been hospitalised as inpatients or have been arrested for exhibiting dangerous behaviour, and not the mentally ill in the broader context. Markowitz (2011) notes that study designs often fail to; sift out and remove people who have a prior history of violence (which, as cited above, predisposes

them to violent behaviour), include controls for co-morbid substance abuse, or set out a transparent method for sequencing the study's procedures. As a result, it becomes difficult to argue for or against connections and/or present valid conclusions regarding mental illness and violence.

In a bid to try and bring some degree of clarity to the research in this field, the MacArthur Violence Risk Assessment Study was carried out in the US (Steadman *et al.*, 2015), aiming to give a definitive overview of the complicated and multi-faceted relationship between mental illness and violence. The sequencing in this study was easy to follow, because the authors gathered a great deal of follow-up data for a large group of subjects (N=1,136), indicating a meaningful sample size and a clear timeline. The authors used various measures of violence, which included self-reporting by patients, in order to eradicate the information bias which was evident in earlier studies. In order to avoid confusion and distortion of data which can be created by environmental influences: for example, socio-economic background or other demographics, the authors chose to use a same-neighbour comparison model. This study found no difference between non-substance abusing individuals with a major mental illness and non-substance abusing neighbours in the control group, in terms of their prevalence to violence. However, a coexisting substance abuse disorder doubled the threat and probability of violence. Of the individuals who had a diagnosis of schizophrenia, 14.8% had an occurrence of violence over a 12 month period, and this figure rose to 22% for individuals with bi-polar disorder, and 28.5% for those with major depression. A number of studies have underlined substance abuse as a

major risk factor for violence (Van Dorn *et al.*, 2012; Anderson and West, 2011) and, as a result of robust clinical data, this finding is now accepted as valid in the field. Anderson and West (2011) find that the risk of violence rises sharply if individuals do not take their prescribed medication and continue to abuse substances. Van Dorn *et al.* (2012) harness data taken from the National Epidemiologic Survey on Alcohol and Related Conditions in order to clarify the relationship between mental illness and violence. This US household survey draws on data taken from 32,653 people, who are representative of the national demographic, and reveals that 2.9 % of people suffering from major mental illness annually commit acts of violence, as opposed to 0.8 % of people with no mental illness or substance abuse disorder. This statistic demonstrates a low risk of violence in people with mental health issues, but also highlights a relatively significant difference in risk probability between the general population and individuals with major mental illnesses. Individuals with both a serious mental illness and a coexistent substance abuse disorder had a 10% risk of violence.

Draine *et al.* (2002) are among several researchers who argue that social and economic risk factors have to be considered when assessing the relationship between mental illness and violence. Draine *et al.* (2002) suggest that poverty, crime victimisation, involvement with illegal drugs (whether consuming or selling them), trauma in early life and crime in the local neighbourhood are main reasons for what appears to be a link between mental illness and violence towards other people. These studies suggest that people with serious mental illnesses who live in their communities are frequently socially marginalised during

their lifetime and are exposed to a large number of risk factors for violence (Draine *et al.*, 2002; Van Dorn et al., 2012). Swanson *et al.* (2002) investigated interpersonal violent behaviour across five states, using a sample of n=802 adult psychiatric outpatients. All of the patients were suffering from serious mental illness and were being treated by public behavioural healthcare systems. Swanson *et al.* (2002) found that these individuals had serious and often disabling mental health issues, but at the same time they were also socially disadvantaged. Most of the group were unemployed and hence on low incomes; they lived in poor neighbourhoods; many used illegal drugs and alcohol; and they reported having experienced high levels of trauma and victimisation throughout their lives. These experiences and socio-economic factors were significant correlates of violent behaviour, and thus had to be considered when analysing the link between violence and mental illness. Pertinently, those study participants who had a history of mental illness, but no history of violent victimisation, had not been exposed to neighbourhood violence and did not abuse alcohol or illegal drugs had a 2 % annual rate of violent behaviour, a figure identical to that of people without mental illness in the general population. Criminologists and developmental epidemiologists have shown that people with mental illnesses and the general population share the same risk factors for crime and violence (Silver, 2006; Markowitz, 2011; Swanson *et al.*, 2015), and, according to Loeber and Farrington (2000), exposure to these risks begins very early on in life. This conclusion is partly borne out by the findings of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), the MacArthur Violence Risk Assessment Study (MVRAS) and the five-state study presented above.

Nevertheless, evidence indicates that psychiatric symptoms, and specific combinations of these symptoms, such as delusions, suspiciousness and acute anger, can raise the probability of violent behaviour. Swanson *et al.* (2008) maintain that this is only true of some individuals in certain circumstances, and that if the symptoms are treated, for example through the dispensing of anti-psychotic medication, the symptoms and the concomitant risk of violence will both abate. A large meta-analysis of a range of risk factors for violence in individuals exhibiting psychotic symptoms found that substance abuse and in particular poly-substance abuse, a history of anti-social or criminal behaviour, and refusing or not following treatment protocols were all significant risk factors for the above group of people (Witt *et al.*, 2013). Frances (2011) looked at the findings of the National Institute of Mental Health Clinical Antipsychotic Trials of Intervention (CATIE) to assess possible links between violence and psychosis. The project set up a multi-site, randomised clinical trial and analysed violent outcomes in n=1445 people diagnosed with schizophrenia. Although this group of individuals were all documented as sharing the same diagnosis, the study found they could be subdivided into distinct groups which presented different levels of risk for violence and did not share the same reasons for behaving violently. For example, a third of the sample had shown anti-social behaviour before developing adult psychotic illness, and of this group, 28.2% had engaged in recent violent behaviour, in contrast to those who had no history of anti-social behaviour, of whom 14.6 % had engaged in recent violent behaviour. The violent behaviour differential between the two sets of people was linked more closely to early life victimisation and trauma rather than acute psychotic symptoms such as hallucinations

and delusional thinking. In addition, when they were given and took prescribed anti-psychotic medication, their risk of violence did not reduce to any significant degree. However, some CATIE participants also demonstrated how psychosis can add to the risk of violent behaviour. The study determined that the patients who demonstrated more psychotic symptoms, a mixture of suspiciousness, delusional thought processes and professed persecution, were three times more likely to commit an act of serious violence than people whose symptoms were controlled or who did not exhibit them in the first place (Frances, 2011).

Having looked at the literature, it is clear that there is no evidence of a strong correlation between a tendency to violence and mental illness. Moreover, the research presented above does not confront or cover violence in other hospital departments to compare it with violence in inpatient psychiatric wards, since many of the reviews have looked at both community and inpatient psychiatric settings, in order to establish the link between aggression and patient mental illness. Other writers: for example, Lanza *et al.* (2006), investigate the hospital environment, concluding that it is more strongly linked to violence than psychopathology because of pressures and risk factors such as overcrowding, budget cutbacks and generally poor conditions.

1.10 Prosecution for assault

As noted by Melton *et al.* (2007), there is a myriad of ethical, practical, clinical and occupational health issues involved in deciding how to deal with criminal acts which take

place in a psychiatric hospital. Both patients and members of staff have the right to report a violent act to the police. In addition, staff have a duty to document and report any act of violence against a dependent adult, whether this is perpetrated by a member of staff or another patient. Before a prosecution for assault is set in motion, a number of considerations have to be taken into account; the gravity of the assault, the patient's mental state, the context within which the assault took place, and the therapeutic value of proceeding (Melton *et al.,* 2007).

People in psychiatric settings are often not prosecuted for their violent behaviour, for a wide range of reasons, as their competency to answer for their actions is questionable. Prosecution could also hinder a person's recovery from an assault; however, if a hospital is reluctant to prosecute, the victim could feel a sense of anger and outrage and decide to take out a personal prosecution. If the hospital starts the process of prosecution, the person assaulted could be drawn into a long legal process which could exacerbate the trauma. Melton *et al.* (2007) note that mental health agencies may prefer to avoid prosecution, in favour of transferring the assailant to a more secure facility or effecting changes in their treatment plan. In addition, mental health agencies will try to avoid the negative publicity that comes from prosecution and the concurrent scrutiny of service provision, patient confidentiality and questions on whether staff provoked the assault. However, if criminal acts in hospital are simply ignored, this may validate anti-social behaviour and damage hospital security. Inpatient psychiatric facilities cannot become places where criminal behaviour is overlooked, and hospitals should have transparent and

clear policies on prosecution criteria and procedures, as well as the flexibility to assess individual cases. In addition, if hospitals do not report violence to the police, then there is no public record of it having occurred, whereas prosecution for acts of aggression makes them part of the public record and available to all.

1.11 Psychiatric units

A psychiatric unit is a specialist ward which provides care for those experiencing acute mental health problems. A large number of professionals provide multi-disciplinary care on these units, including psychiatrists, physician specialists, psychiatric nurses, psychiatric social workers and care co-ordinators, occupational therapists, psychologists, and substance abuse teams. Nurses working on psychiatric units are there to provide care to a wide range of people experiencing mental disorders, most common of which are: addictions and substance abuse; Alzheimer's disease; anxiety disorders, including phobias and panic attacks; psychotic disorders, including schizophrenia; and mood disorders, including depression and bi-polar disorders.

1.12 Violence towards psychiatric nurses in inpatient psychiatric settings

In a systematic review of the literature, Lanza *et al.* (2006) undertook a meta-analysis of the available data on violence towards psychiatric nurses, reporting on the prevalence of violent behaviour, the people responsible, and how their violent behaviour affects nurses. They drew three general conclusions from their findings: 1) psychiatric nurses report a far

higher level of violence than nurses who work in any other unit; 2) nurses are the most vulnerable group of health workers when it comes to experiencing violence in the workplace; and 3) taking international data into account, nurses are exposed to more non-fatal violence events compared to other professions.

One reason which has been suggested to account for why patients exhibit violent behaviour towards psychiatric nurses is that the environment they work in precipitates this type of reaction (Spector *et al.*, 2014). Roche *et al.* (2010) suggest it is the nurses who have to intervene and isolate or restrain patients when their symptoms appear to become more acute. This type of physical interaction can increase the risk of violent behaviour on the part of the patients. However, Moylan and Cullinan (2011) note that the solution is not simply to decrease the use of restraint or seclusion, as this has been shown to significantly increase the risk of injuries and assaults suffered by psychiatric nurses. They conclude that management has a duty to support staff and that the current organisational culture should view staff safeguarding as a major concern and goal (Moylan and Cullinan, 2011). Hahn *et al.* (2010) have interpreted the problem in a slightly different way. The authors point out that nurses are first respondents when patients appear to be becoming violent, since they have the knowledge and expertise to handle dangerous situations. Their availability, and the fact that they outnumber all the other disciplines on the unit, may explain the high occurrence of violence towards nurses reflected in the data. Christodoulou *et al.* (2012) carried out a systematic review and meta-analysis to try and discover what set off or preceded incidents of patient violence and found that staff-

patient interactions were an important trigger. They noted that patients reacted badly to limits nurses put on their freedom: most frequently when they were restricted regarding what they could do, or if they were denied a request.

1.13 Epidemiology of violence in psychiatric units

Several studies (Nijman *et al.*, 2005; van Leeuwen and Harte, 2015) note that 76% of nurses have reported incidents of mild aggression, and 16% have reported serious physical aggression. In psychiatric wards, Moylan and Cullinan (2011) found that the probability of incidents of patient violence against nurse is between 34 and 81%. Foster *et al.* (2007) used a cross sectional design for their study conducted in the UK, focusing on analysing the frequency and characteristics of inpatient aggression towards staff, co-patients and themselves, the latter being measured by self-harming. They defined aggression as any type of verbal, non-verbal or physical behaviour which caused actual harm to self, others or property. Psychiatric nurses from 5 different hospitals were asked to document any incidents of violence by using a Staff Observation Aggression Scale, which was amended over the ten months of the study. The results show that staff members were exposed to more than 50% of violence events, and the incident themselves were separated into verbal violence, reported by 60% of the total sample, and feeling threatened, reported by 59%. The authors conclude that nurses who work in psychiatry have a 10% chance, annually, of being injured at work, because of patient violence (Foster et al., 2007). However, cross-sectional studies could provide unreliable

data as they represent a single point in time, although the authors include contextual descriptions to bolster the study's rigour and validity.

Moylan and Cullinan (2011) assert that 80% of psychiatric nurses have been exposed to physical violence at least once during their entire career. Their study set out to produce up to date, in depth material on the nature, incidence and seriousness of assaults and injuries suffered by psychiatric nurses. In addition, the study also looked at whether a nurse's decision to restrain a patient affected the likelihood of assault or injury. The study sample of 110 RNs was drawn from across five institutions in the New York City metropolitan area, comprising two selected psychiatric hospitals, and three general hospitals which had acute psychiatric units. A mixed methods study ensures a degree of precision and insight, but it does not eradicate the possibility of non-response and self-report bias. The sample, too, may not have been representative, given the fact that the authors used convenience sampling approaches.

1.14 Risk Factors for patient violence in a psychiatric setting

In undertaking a literature review on violence against nurses, Lanza *et al.* (2006) confirm the fact that nurses working in psychiatry are at high risk of workplace violence. To carry out the review, they used MedLine to search for English language articles published between 1995 and 2004, using the search terms "nurse" and "nursing ", linked to "violence or assault or aggression or sexual harassment". In addition, they also conducted searches via the lists of references of the publications found in the database. The majority

of studies which were included in the review focussed on developed countries. The authors failed to reveal how many articles were searched, or the criteria which underpinned their decisions to either include or exclude the studies for their review. The review assessed three main themes: the frequency of incidents of physical, verbal and sexual violence; the gap between the number of incidents which are reported and documented and those which occur; and how violence affects nurses. They conclude from their review that, internationally, the frequency of violence towards nursing staff is so common that it has virtually become accepted as the norm. This sobering statement may well go a long way towards explaining why violent incidents are under-reported by nurses who work in acute psychiatric units. The nurses may perceive violence in the workplace as part of their job and become desensitised to violent events as a result. In addition, the authors maintain that nurses tend to only report serious incidents of aggression or physical violence, leaving the majority of violent events undocumented. This might be due to nurses not being sure how to define violence. This review needs to be treated with a degree of caution, since it omits significant key facts, such as the appraisal of the included studies. Moreover, the authors only use one search engine, MedLine, for their material, and restricted their search to English-language publications, which could distort both their findings and their conclusions. Anderson (2002) notes that nurses experience at least one, if not more, violent incidents during their careers, seeing workplace violence as a reality. Many nurses frequently experience both verbal and physical abuse. It is imperative that action be taken to stop patient violence, and in the process ensure that

nurses no longer view exposure to workplace violence as a normal part of the job, and to be expected.

When considering other facets of the mental health environment, it seems that male nurses are more likely to be the victims of violent behaviour than their female counterparts (Early and Williams, 2002). Other research suggests that since women predominate in the nursing profession, female nurses are more liable to be assaulted (Child and Mentes, 2010). Johnson (2004) maintains that there is an implicit suggestion in the literature that both experience and training can be factors in decreasing the risk of violence: however, very little research has been done on this topic. Another risk factor which has been recognised is the amount of personal contact a nurse has with his or her patients. There is evidence to intimate that nurses' communication with patients and their approach to working with a particular set of patients can be a potential risk factor (Balamurugan, 2012). Quintal (2002) has demonstrated that hostility or fear on the part of nurses can increase the risk of a violent event. İş and Deneyimi (2012) identify several factors which could precipitate patients' violent behaviour. These include; the fact that nursing care involves lifting and holding patients, inadequate staffing levels, and a heavy patient workload. Thus, risk factors pertaining to violence against nurses include the nurse, the setting, the patient, and unclear definitions of violence, as well as under-reporting, all of which contribute to the phenomenon of workplace violence being multi-faceted and complex.

1.15 Associated factors for patient aggression in psychiatric care

Researchers have divided the factors which precipitate violent behaviour into three separate levels; the patient level, the staff level and the environmental level, all of which are discussed below.

1.15.1 Patient factors

Patient factors include biological factors, age, gender, social and economic status, and psychopathology. Dack *et al.* (2013) note research into the biological sources of aggression showing that these are linked to heredity, hormonal effects (testosterone), and the function of brain mechanisms (the cerebral cortex and the limbic system). Studies do not agree on whether gender is a determining factor in aggressive behaviour. A number of researchers have not been able to establish a link between gender and violence (Lam *et al.*, 2000; Hojat *et al.*, 2002), while others argue that males are more prone to assault (Hegney *et al.*, 2003; Krakowski and Czobor, 2004; Cornaggia *et al.*, 2011; Dack *et al.*, 2013). As this study focuses on female patients displaying acts of violence towards female staff, it will make an original and important contribution to the existing literature. With regard to age as a risk factor, assaults are more likely to be carried out by younger patients (Cornaggia *et al.*, 2011; Dack *et al.*, 2013). Kwok *et al.* (2006) has narrowed the age range down to adolescent patients, but overall, this area still needs further exploration before a definitive conclusion can be reached. Some researchers have focussed on how culture and economic status impact on violence in society (Springer,

2011). Once again, there is no clear answer to whether or not demographics are linked to physical assaults, but according to Esmaeilpour *et al.* (2011), there appears to be a correlation between physical violence and overcrowding, failed marriages, and poverty.

In addition to the above, there is no conclusive evidence in the literature confirming a link between aggression and psychopathology. Recent research (Gaynes *et al.*, 2017) has produced findings which suggest a link between specific symptoms of mental illness and aggression in certain types of patients. For example, delusions, and in particular those which have a persecutory character, could have a major and explicit influence on aggression (Nolan *et al.*, 2005). Other symptoms may contribute to a lesser degree to precipitating aggressive behaviour. These include thought disorder, raised physiological arousal, disorganised behaviour and substance abuse; although their impact will depend on the phase of the illness in question (Gaynes et al., 2017). Daffern and Howells (2002) argue that people who are experiencing psychosis are most likely to behave in an aggressive manner while they are in the acute phase of the illness. Walsh *et al.* (2002) undertook a review of the literature and provide evidence of schizophrenia and violence being closely related, but that less than 10% of violence in society can be directly attributed to schizophrenia. One social factor which is strongly predictive of violent behaviour during adulthood is child abuse. Elliott *et al.* (2011) and Liu (2011) examine familial and non-familial violence, and conclude that violent individuals reported a higher rate of physical abuse in childhood.

1.15.2 Staff factors

Staff factors include lack of experience, inadequate staff to patient ratios, undefined roles and the fact that most patients do not admit themselves and are forced into admission to hospital (Wax *et al.*, 2016). Guay *et al.* (2016) are among the many researchers who have found that training staff in how to handle aggressive behaviour leads to a reduction in the number and severity of incidents which occur. Ergün and Karadakovan (2005) did not find a rise in the number of incidents of violent behaviour where staff to patient ratios are low. However, another study found that there was an inverse relationship between the ratio of staff to patients and the frequency of assaults on staff (Jackson *et al.*, 2002). Caution needs to be exercised when considering studies regarding the links between staffing levels and incidents of aggression, since high levels of both staff and aggression could result from including patients prone to violence in the study. Unfortunately, no randomised studies have been carried out to date to test these conclusions. (Ng *et al.*, 2001) argued that high numbers of patients on the ward could be a factor in precipitating assaults, while Lorenzo *et al.* (2012) note that wards with clear staff roles, robust psychiatric leadership and regular and expected events resulted in a reduction in the level and frequency of violent events.

1.15.3 Environmental factors

The environment where nurses deliver patient care has been shown to have a significant influence on the incidence of patient violence. A number of researchers (Shields and

Wilkins, 2009; Wilson *et al.*, 2011) have found that emergency department (ED) and psychiatry department staff are at the highest risk of violence. Kindy *et al.* (2005) note that this is exacerbated by a lack of security and surveillance and weak teamwork. Bowers *et al.* (2009) identify additional factors, including a high patient turnover, numerous interruptions and time pressure; while Lin and Liu (2005) cite nursing shortages, inadequate staffing and absenteeism, and the physical stress of the work as possible causes. The risk of violence also depends on the time of day, with risk being highest during evening and night shifts, which coincides with lower staffing levels and support (Lin and Liu, 2005; Shoghi *et al.*, 2008).

Shields and Wilkins (2009) carried out a national study in Canada to explore the risk of workplace violence. The study evaluated four factors: 1) adequacy of staffing/resources; 2) the working relationship between nurses and physicians; 3) support from supervisors; and 4) support from co-workers. In their conclusions, the authors state that all four factors influence the prevalence of physical and emotional abuse in the workplace. Nurses who believed staffing or resources were inadequate were more likely to be assaulted by patients than those who thought they were adequate. Likewise, nurses who felt their relationships with physicians were poor were more likely to report abuse than their counterparts who had a positive view. Similarly, nurses who felt they were unsupported by both supervisors and co-workers were more likely to report violence than those who were satisfied by the levels of support available. The study did not collect data on the frequency or the severity of abuse, which would have been helpful in fleshing out the

overall picture of the predictors and factors which impact on workplace violence. Nevertheless, the findings demonstrate that staff who have a negative perception of their work environment, could be transmitting such negativity to the patients, increasing the risk of them acting violently.

1.16 Statement of the problem

From the evidence presented above, nurses are exposed to patient violence in the healthcare system, and this is particularly pertinent for psychiatric nursing staff (Zeng *et al.*, 2013). To date, most of the studies on patient violence against nurses in the KSA working in psychiatric settings have been carried out using a quantitative approach, offering findings regarding epidemiology, risk factors, causal factors and the consequences of violent incidents in a variety of national and international settings. Moreover, there has been no qualitative study undertaken in the KSA to explore the experience of qualified Saudi nurses working in psychiatric settings who have been exposed to violence. With this in mind, and considering the lack of evidence regarding violence experienced by nurses' in the KSA, a qualitative study is needed in order to comprehend nurses' experiences and perceptions of patient violence, particularly on acute care psychiatric wards. In carrying out this study, an important gap in the literature will be addressed and in doing so will make an important and unique contribution to existing knowledge.

In addition, the scope of the literature reviewed to date and presented in this chapter to provide background information may be limited, due to the dominance of Western literature on the challenges encountered by psychiatric nurses when faced with violence. Violence against psychiatric nurses in the KSA may therefore be under-represented in the existing literature, with different factors potentially impacting Saudi and Western nurses' experiences and perspectives. Thus, the existing literature may fail to reflect the unique and specific challenges involved in psychiatric nursing in the KSA and other developing nations compared to the developed world. This is particularly significant given the social and cultural differences between nursing approaches, with the Western approach differing from the Saudi approach. For instance, nurses working in the KSA face unique issues with regard to nursing regulations, the workplace and traditional customs compared to their Western counterparts (Almalki *et al.*, 2011).

1.17 Personal reflection

I am a Saudi woman who lives with her husband. After I gained my first BSc degree, my family encouraged me to continue my studies abroad and supported me when I pursued my Master's and PhD degrees in nursing. Taking the decision to study overseas was a big decision for me as a Saudi female and I consider myself to be a risk-taker for this reason. As a Saudi woman from the Riyadh region, my choice of PhD topic and methods were very challenging, as there are no Saudi studies about this topic and it is the first time a qualitative study has been undertaken, and initially I felt this might be too great an

obstacle to overcome. Regardless of this fear, the experience of working on this research project has been both extraordinary and a source of great personal development.

The selection of the subject for this PhD was based on my nursing colleagues' experiences of violence from patients. Such cases of patient violence are extremely stressful for my colleagues as female nurses in the KSA, to the extent that the majority of these nursing friends, particularly those who work in psychiatric care, have thought about giving up their chosen career. In addition to suddenly having a great deal of responsibility when they start work as qualified staff, nurses frequently face the problem of violence and abuse within a short space of time. For myself and my colleagues this was problematic, as there is a widespread lack of support and understanding both within the workplace and from family networks. My personal status as a married, Saudi women, undertaking this research has presented both obstacles and challenges, I have relished the opportunity that my PhD study has afforded me to prove myself within the eminently respected higher education environment in the UK.

I strongly believe that people should hear about the experiences of psychiatric nurses in the KSA and understand how incidents of abuse from patients and their families can have a profound effect. Moreover, to deepen their understanding of the issues that nurse's face in the Saudi healthcare context today, it is critical that people comprehend the influence of the cultural factors at play when nurses are exposed to patient violence.

1.18 Aim of the research

This study aims to gain greater insight into qualified nurses' experience of violence when working in acute female inpatient psychiatric wards in the KSA. Additionally, this study also seeks to understand the effects of patient violence in both the short- and long-term context, as perceived by female nurses who have experienced it. It is hoped that the findings of this research will highlight the issue of female patient violence and emphasise the implications, not only for nurses and nurse managers, but also for other hospital staff, hospital management, nursing organisations, and future researchers. In order to avoid and effectively control patient violence in the acute female inpatient psychiatric setting, it is essential that interventions are based on evidence, and particularly that of nurses' own perceptions and experiences. It is also anticipated that the findings presented in this thesis will provide an overall awareness of female-orientated violence in the psychiatry field, and particularly in the developing world.

1.19 Research objectives

- To explore female patient violence as experienced by female qualified nurses working in female acute care in-patient psychiatric units in the KSA
- To identify factors that female nurses' believe increase the likelihood of female patient violence.

- To elicit what implications violence in the workplace has both in the short and long term for female nurses working in female acute care in-patient psychiatric units in the KSA.

1.20 Research questions

To achieve the study's aim and the above objectives, the study will answer several key research questions:

- How do qualified nurses working in Saudi Arabia's female psychiatric units describe their experiences of patient violent behaviour?
- What are the professional and personal implications of patient violence, as described by female psychiatric nurses in the KSA?
- Which approaches do female nurses perceive have a positive impact on the way patient violence is addressed prior to, during and after it occurs?
- What positive and/or negative experiences do female nurses describe on returning to the workplace after they have experienced assault?
- What strategies do female psychiatric nurses believe would prevent, minimise and address workplace violence?

The next chapter will offer a brief overview of the system of healthcare in the KSA, as well as a description of how the nursing profession is organised.

Chapter 2: Overview of the Health Care System and Nursing Profession in the KSA

2.1 Introduction

One of the major goals identified by the management and leadership of Saudi Arabian nursing is to put in place and retain a stable workforce (Almalki *et al.*, 2011). This chapter sets out to describe the state of nursing in the KSA by reviewing available literature in the field. The population of the KSA is growing at the rate of approximately 3.4% every year (Central Department of Statistics and Information, 2012), resulting in ever increasing demands being made on the country's healthcare system. There are a number of health service providers in the KSA, under the general supervision of a health service council, which was set up in 2002 by the Ministry of Health (MOH) (Almalki *et al.*, 2011). The primary function of the health service council is to standardise policies and practices among service providers. The largest of these health care providers is the MOH, which is responsible for more than 250 hospitals, offering 33,277 beds, 2,037 health centres, and accounting for some 60% of health service provision (Aldossary *et al.*, 2008).

The MOH produces and publishes guidelines which are then disseminated to all 20 Regional Health Directorates, who manage MOH services. The MOH has created a system of primary, secondary and tertiary healthcare centres. Primary healthcare centres provide initial assessment and frontline treatment. However, if people need further assessment, they can be referred to public hospitals, the secondary level care providers, for additional investigations and care. Patients with more complex conditions can be moved from the

public hospital to a specialised or central hospital, a number of which have been established by the MOH as medical city complexes. These complexes have often been established in response to local demands for an increase in the number of beds and specialist services, and provide both second and tertiary level healthcare in one place. These medical cities have specific needs and objectives and many, along with certain public hospitals across a range of regions, have been given a degree of independence in their management practices. This is intended to facilitate an increase in efficient working practices and administrative systems, introduce financial flexibility and make it easier to draw up contracts and attract high calibre staff (Almalki *et al.*, 2011).

In 2017, the KSA had a recorded population of 27,019,731. It was established as a nation in 1932 and is therefore young compared to some nations. In 1934, the KSA tapped into its oil reserves, and because of this discovery, it was also the year it took steps to establish its health service. The Ministry of Health (MOH) described the inadequacy of its assets and the limited clinical space in its establishment (Khaliq, 2012; MOH, 2019). Clinics were initially located in the various large cities, subsequently expanding into advanced establishments including, medical centres, clinics and hospitals (Khaliq, 2012; MOH, 2019).

The increased rate of growth of health facilities has recognised a need for psychiatric services to accommodate the greater number of people experiencing mental illness, with one in three people describing themselves as having mental health problems (Almutairi, 2015). The MOH initiated the formation of a structured psychiatric service in response to

the increasing number of people experiencing mental health problems and societies struggling to cope with them. The initial establishment to address these growing problems was formed in 1962; Taif Mental Hospital (MOH, 1980). A second mental hospital would not be established until 1983.

Decentralisation of the system then followed from 1983 through the formation of various psychiatric hospitals that were supported by outpatient clinics throughout the KSA (MOH, 2002). Consequently, this decentralisation led to the majority of the KSA's large cities being served by both main hospitals and outpatient clinics. This was funded by hundreds of millions of dollars, as the state sought to ensure that mentally ill people were able to live in their communities and add to society and the economy of the KSA (MOH, 1980). This data exemplifies the progress made in the KSA from pre-1962 to the present, by enhancing its non-existent psychiatric services to ones dedicated to psychiatric care and the promotion of mental health, and which are distributed across the KSA.

2.2 Culture of Saudi Arabia

Islam is the central focus of the culture in the KSA and is the only religion followed in the KSA (Ezzi *et al.*, 2014). The culture, economic standing and level of education in the KSA are all moulded by Islam (Ezzi *et al.*, 2014). The Arabic name for God is Allah, and it is Allah that Muslims believe dictates good and bad, health and disease and mortality (Rahman *et al.*, 2008). All Saudis speak Arabic as a first language. However, while patients and their relatives for the most part speak Arabic, nurses working within healthcare settings tend

to mainly converse in English, as this workforce is mostly composed of non-Saudis (Almalki *et al.*, 2011). It is this variation between cultures that can form a barrier in the provision of excellent levels of care to patients who are nationals of the KSA and their relatives (Simpson *et al.*, 2006).

Workplace violence is a global problem that can be impacted by the customs and traditions of a culture, and this is the case in the KSA. Despite the extensive transformations and developments in the KSA and the resultant changes, it is still considered a highly religious and tribe-based nation, as dictated by its long-established culture. The KSA is governed by a royal family: the Al Saud family, who are guided by Islamic standards (Ezzi *et al.*, 2014). All elements of life involve Islamic ways and mannerisms, thereby indicating Islam as the sole religious belief in the nation. The aim of the Al Saud family is the elevation of living standards in the KSA. To do this, they have to consider not only religious standards, but also ethical and cultural standards that join the various tribal communities together.

Both the government and society sanction the separation of individuals by gender, thus not permitting men and women to mix. They are not permitted to communicate or work with each other unless there is an obvious need. The provision of male and female dedicated areas ensures this separation is possible. This separation, however, is not applied in medical schools, where mixing is considered a requirement; separating the sexes would mean more funding requirements for separate medical establishments and inadequate provision of female clinicians to Saudi female patients, and this applies to

nursing training as well.

Saudi society is male-controlled: for example, until recently, female adults in the KSA are restricted from travelling or driving distances without the specific permission of a male guardian (Riedy, 2013). This has a direct impact on the work and careers of females and their progression. Lamadah and Sayed (2014) reported that only one in 10 workers were females in the KSA, and Al-Asfour *et al.* (2017) attribute this to the paucity of prospects and lack of appeal for women. The rules and ways of life are less strict in other neighbouring nations, including Lebanon, Iraq and Egypt, compared to the KSA, where the country has maintained powerful management of females regarding their input both politically and economically. Religious beliefs and cultural behaviours are also accused of reinforcing the male-controlled environments in Arab nations. This is evident in regular behaviour towards females and the way in which families deal with their female members. Various studies have indicated these behaviours towards females as the cause of the small number of women in work (Kauser and Tlaiss, 2011).

The money generated from oil has altered life in the KSA significantly, both at the economic and social level. Consequently, the KSA has improved the standard of living and health of Saudis. The provision of education, universities and free healthcare have all contributed to enhancing standards of living. This has been furthered by the absence of taxes. In addition, large funds (about 6.8% of the total Government Budget) have been injected into improving clinical facilities including those in psychiatric hospitals. Services supplied free of charge have also been made available to all those residing in the KSA,

whether nationals or not, as long as they work for the government. Private establishments pay salaries to their workers; even so, the greater proportion of funding of clinical services is provided by the State's budget (Samargandi *et al.*, 2014). From the initial formation of clinical services in the KSA, the majority of the workforce is made up of non-Saudi nurses (MOH, 2018).

2.3 Nursing Education

In 1954, the KSA introduced a year-long training programme for nurses. It took another 22 years for the Bachelor of Science in Nursing (BSN) to be established, and like its predecessor, the course was only open to women. In 2004, men were permitted to join the BSN course (Omer, 2005), and in recent years, both men and women have been allowed to study for the BSN in newer universities. Masters courses in nursing are still not open to men, but the KSA government offers a range of international scholarships, which enable Saudi nursing leaders and educators to go abroad and gain Bachelor, Master and PhD degrees at overseas universities. Nevertheless, the low status and poor image of the nursing profession has led to poor enrolment figures (Gazzaz, 2009). Due to the shortage of both female and male Saudi registered nurses, more than half of the nurses working in public hospitals in the KSA come from overseas, with approximately 51% of all nurses working in 251 public hospitals being expatriates (MOH, 2018).

At present, the nursing profession in the KSA is in a transitional period and is tackling issues created by the country's rapid economic development, and the social changes this brought

in its wake, as well as a fast-expanding pool of local nurses who are joining the workforce. Tumulty (2001) points out that, unlike in western countries, nursing is not a long-established profession in Saudi Arabia. From the time the Saudi health service was first set up, the vast majority of nurses it employed were expatriates, drawn from 40 different countries (Aboul-Enein, 2002). There was virtually no literature on nursing published before 1960, and it was not until twenty years later that studies of nursing began to be written (Mufti, 2000; Tumulty, 2001; Aboul-Enein, 2002). Mufti (2000) points out that until 1960, Saudi healthcare was based on traditional approaches to treatment and there were no nursing or medical schools in the country, and thus no Saudi nursing professionals. Tumulty (2001) states that the first public nursing school was founded in Riyadh in 1959, and although many others followed, and both nursing education and health services are established in the KSA, most nurses continue to come from abroad. Almalki *et al.* (2011) note that this trend means that the nursing workforce do not share Saudi cultural values. The very fact that nurses in Saudi Arabia come from different cultural and ethnic backgrounds, and do not share a common religion or tradition, has made it difficult to standardise and ensure high-quality nursing care. Al-Mahmoud *et al.* (2012) assert that various barriers can easily spring up between nurses and patients, on the basis of religious, cultural and language differences. The complexity of the social and cultural backdrop also impacts on new nurses since, as noted by Tumulty (2001), the Saudi nursing profession has become used to working with expatriate nurses within a western frame of reference and under western guidelines. For many decades, nursing has assumed a western identity in Saudi Arabia, and it is only recently that this has been challenged and modified. KSA has

now begun to promote local professionals and encourage them to assume the roles of expatriates, in management, policy making and healthcare legislation in general.

2.4 The nursing shortage in the KSA

There is a chronic shortage of nurses in the KSA, with the ratio of nurses to patients being 52 per 10,000 (Almalki *et al.*, 2011). In comparison, Kuwait has 63 nurses for every 10,000 patients, Japan 112, Canada 97 and the UK 84 for every 10,000 patients (WHO, 2019). This situation may be the result of the sudden departure of many expatriate nurses during the Second Gulf War of 1990, leaving Saudi hospitals facing a staff crisis and leading to a policy of "Saudization", in order to guard against a repetition of this occurring. At present, only 50% of the nursing workforce is made up of Saudi citizens, so the policy will take a number of years to improve staffing levels (MOH, 2018).

The shortage of nurses is further exacerbated by the rapid growth in new health provision and the general expansion of health services, with the parallel rise in beds available and a shortfall in staff who can undertake a nursing role. According to Al-Mahmoud *et al.* (2012) a number of issues have been identified when evaluating staffing levels. These include: (1) insufficient numbers of qualified Saudi doctors and nurses in the healthcare sector; (2) the fact that education within the health sector has not expanded to produce and train the number of professionals required by health services, particularly in the field of nursing; and (3) the fact that the MOH does not provide a broad range of training and scholarships.

Saudi culture does not consider nursing as a suitable job for women; indeed, the job itself is viewed negatively (Aldossary *et al.*, 2008). Working conditions reflect the low status of nursing, since little attention is paid to ensuring a work-life balance, with night shifts remaining a bone of contention as they are considered to contradict traditional values (Al-Mahmoud *et al.*, 2012). For example, for Saudi females, it is more challenging to select a medical career, due to its demanding nature, with societal expectations of females being very different to those of males (Mebrouk, 2008). In a traditional society like that of the KSA, there are more expectations in terms of females and their role within the family and domestic responsibilities, leaving little time for them to practise and/or prepare for being a member of the medical profession. Women who might wish to go into an occupation with such a poor image as that of nursing could face family tensions and opposition.

In KSA, all social spheres are dominated by male individuals. Females are still subject to tight control in terms of how they behave and what they can do (Kucinskas, 2010). It is usually a male family member who exerts this control and females are forced to comply and/or are reticent to oppose the restrictions (Al-Asfour *et al.*, 2017). By contrast, the social behaviour of Saudi male individuals is largely free of limitations (Al Alhareth *et al.*, 2015). Wife and mother are the main roles that Saudi females have been traditionally expected to fulfil. Prior to 1960, there were no public institutions of education for girls in KSA and only domestic employment was available to female individuals (Al Rawaf and Simmons, 2011). Nevertheless, more recently, there has been a broadening of

employment opportunities for females in KSA (Alghamdi *et al.*, 2019). For instance, females can work in the retail industry as shop assistants in stores exclusively for women, although this industry continues to be monopolised by men.

There are numerous hurdles, especially related to religious and social conventions, that females have to deal with if they want to become nurses in KSA (Azim and Islam, 2018). The perception of nursing in Saudi society is negative, being viewed as an occupation that "maids" or women without education do (Azim and Islam, 2018).

2.5 Professional Regulation

While all nurses must register with the Saudi Commission for Health Specialties, there is an issue as to who can in fact be termed a nurse. Graduates from secondary institutions (high schools), those who have studied at health institutes and health colleges, and university graduates (who form a small percentage of the nursing profession) can all apply to register. In addition, although university enrolment remains low, increasing numbers of students are choosing to attend private nursing institutions and community colleges, but these are not accredited by the MOH. There is no psychiatric nurse speciality in the KSA: however, those general nurses who choose to work in psychiatric wards are referred to as psychiatric nurses by the hospital and MOH.

2.6 Expatriate nurses

The KSA attracts expatriate nurses from different countries. Expatriate nurses are invariably women drawn by financial, professional or personal reasons: the latter could include Muslim women who wish to perform the Hajj while in the KSA. Contracts are valid for up to 12 months and may or may not be renewed; expatriate nurses are not offered contracts covering whole families, but only the nurse, who may find herself alone and missing her family. In addition, if a qualified Saudi national applies for a nursing post, the expatriate nurse can find her contract being terminated early and be unable to claim compensation (Almalki *et al.*, 2011). In general, western expatriate nurses secure better pay and conditions than women from other countries such as those coming from the Philippines and Sri Lanka. This results in those nurses coming from these countries applying for posts in the USA, Canada and the UK, to improve their remuneration and work environment rather than staying in the KSA.

2.7 Government policies and legislation in the KSA regarding workplace violence

Generally, the Middle East region is aiming to have zero tolerance towards workplace violence against healthcare staff across its institutions and has passed legislation and introduced policies to make this a reality. However, this has not occurred to date. In Kuwait, the law states that anyone who attacks a public servant, working in a ministry or medical staff, including nurses working in a hospital, can be fined or imprisoned and will be charged with assault (Adib *et al.*, 2002). In Qatar, Article 167 of the country's Penal

Code specifies that anyone who attacks a public official or an individual carrying out a public service, prevents an official from carrying out work duties, resists him or her with violence because of, or while they are performing their job, can be imprisoned for up to three years and fined up to ten thousand Riyals (Al-meezan, 2004). In the KSA, the Penal Code is based on Saudi Law 187 of the 1960 Act 16, paragraph 1, and states that anyone who *"hits, assaults, uses a weapon against or to threaten an individual while they are carrying out their job or because of their job, will serve a minimum of six months' imprisonment."* In 2007, penal code 49 modified the period of imprisonment from six months to one to two years. In 2011, amended Article 33 (no.8, paragraph 2) specified that *"anyone who hits or assaults an employee who is executing their job, or because of their job, will serve a minimum sentence of six months' imprisonment"*, adding (paragraph 1b) *"the term employee would include any faculty member at a private university; teacher at a private school or college; and doctors and nurses at private hospitals."* The KSA approach to dealing with workplace violence has been undermined by the decision to reduce the term of imprisonment served by individuals who attack healthcare professionals to six months, from one to two years. In addition, in the KSA, many assaults on healthcare staff are viewed as disputes between individuals, and thus not covered by workplace policies. In 2010, this topic was discussed by the MOH and the Director of Public Security, with the regional management and the police being subsequently ordered to view all assaults on staff in the work environment as specified under Article 187 of the Penal Code not as disputes between individuals. Nevertheless, attacks on healthcare staff

persist and continue to be poorly dealt with by the authorities (Alkorashy and Al Moalad, 2016).

2.8 Violence in the workplace in the KSA and the Middle East

Recent studies conducted throughout the Middle East have universally concluded that workplace violence in healthcare settings is a common phenomenon in the region. The studies were undertaken in Jordan (Ahmed, 2012), Iraq (AbuAlRub *et al.*, 2007), Kuwait (Adib *et al.*, 2002), Morocco (Belayachi *et al.*, 2010), Egypt (Samir *et al.*, 2012), and the KSA (Alyaemni and Alhudaithi (2016). The studies cited many reasons for the prevalence of workplace violence. These included a lack of specific policies formulated to counteract violence (AbuAlRub and Al-Asmar, 2011), lack of good communication between staff and patients, relatives and close friends (Adib *et al.*, 2002), high stress levels affecting both patients and staff (Belayachi *et al.*, 2010) and a lack of professional skills on the part of nurses (Samir *et al.*, 2012). When exploring the source of violence towards health care professionals, it has also been suggested that the largest number of incidents are caused by patients' relatives (Ahmed, 2012; Samir *et al.*, 2012), as well as the patients themselves, peers and employers (O'Brien-Pallas *et al.*, 2008). Other researchers (Ahmed, 2012; Samir *et al.*, 2012) suggested there are a number of additional factors; substance abuse, access to firearms, inadequate security and a flawed system for checking people's whereabouts and movements in the health care sector. Finally, one study identified young newly qualified nurses, and those who were working in the emergency and

intensive care departments, were particularly vulnerable to experiencing violent incidents (Ahmed, 2012).

In a study undertaken in Iraq, AbuAlRub *et al.* (2007) found 49 out of a total of 116 health care workers had been subjected to physical violence at work. Adib *et al.* (2002) noted that 48% of health care workers questioned in Kuwait asserted that they had been subjected to verbal aggression during a six-month period. In Morocco, Belayachi *et al.* (2010) identified that 70% of the workplace violence was directed at the doctors who worked in emergency departments. Öztunç (2006) discovered that over a one-year period, 80.3% of nurses, from 290 hospitals in Turkey, had been the subject of verbal abuse. Samir *et al.* (2012) focussed their study on eight hospitals in Cairo, Egypt, and found that 86.1% of the 461 obstetrics and gynaecology nurses had been the victims of workplace violence. AbuAlRub and Al-Asmar (2011) studied physical workplace violence in Jordan, reporting that 22.5% of the 420 nurses participating in the study had been attacked at work and were critical of the manner in which this had been handled by management. Ahmed (2012) analysed the experiences of 447 nurses in Jordan, who had worked in a number of departments in three hospitals located in Amman. Some 37.1% of the nurses revealed they had been verbally abused, and 18.3% had been physically abused. According to Ahmed (2012), few of the affected nurses reported these incidents, since they had no faith in the system punishing offenders. Despite there being limited data on violence against psychiatric nurses, a common conclusion in all of the above

studies was that health care workers needed to be protected, whether through hospitals introducing policies to this end or through improving the judicial system.

In the KSA, Alyaemni and Alhudaithi (2016) distributed questionnaires to 150 workers in three Riyadh hospitals. The response rate was high, with 121 completed questionnaires being returned, a rate of 80.6%. Of those completed and returned, 100 came from women (82.6%), with 71 (58.7%) having worked as a nurse for five years or less. The study findings demonstrate that the majority of respondents had been a victim of violence over the last year (n=108, 89.3%). Of the 108 participants, 80 (74.1%) individuals who had experienced violence described it as verbal abuse, while 20 of the 108 (18.5%) had experienced both verbal and physical violence. Patients were responsible for 82.4% of the violent incidents (89/108), while relatives accounted for 64.8% (70/108) of the violent incidents. Alyaemni and Alhudaithi (2016) found that the most important factors which precipitated violent incidents were three-fold; language barriers, communication breakdown and a lack of awareness of the rights of patients. The above data regarding evidence of workplace violence in the KSA is in keeping with studies from other countries. For example, in Turkey, Pinar and Ucmak (2011) report that 91.4% of those questioned had experienced verbal aggression over a one year period. Similarly, Ergün and Karadakovan (2005) note that while incidents of verbal violence were widespread in Turkey, being reported by 98.5% of respondents, physical violence was rare, with 19.7% attesting to having experienced physical violence. Using questionnaires, Algwaiz and Alghanim (2012) surveyed 600 doctors and nurses working in the KSA. Their findings suggest that nurses are more

frequently subjected to violence compared to doctors, the difference being statistically significant (P<0.001), and with abuse being more verbal than physical. Similarly, Alkorashy and Al Moalad (2016) conducted a survey of 370 nurses and determined that over 50% had been exposed to violence, for the most part verbal aggression, in the preceding 12 months.

Alyaemni and Alhudaithi (2016) explored why nurses did not report workplace incidents of violence and found that 47.2% of nurses questioned did not wish to take matters further, with 15% believing it was a pointless exercise, and 6% refraining because of a sense of shame. These findings are in keeping with similar studies across the region. For example, in Iran, Esmaeilpour *et al.* (2011) revealed similar feelings of '*pointlessness*', a conclusion reinforced by Erickson and Williams-Evans (2000) in their American research study. AbuAlRub *et al.* (2007) analysed Iraqi nurses' attitudes to complaining about workplace violence and discovered that most nurses felt it was a pointless exercise which would lead nowhere. Overall, it would appear from the evidence presented above that nurses and health care workers in many countries tend not to report or respond to workplace aggression unless it leads to actual physical harm (Kamchuchat *et al.*, 2008). One of the reasons why incidents of workplace violence are not reported might be the lack of staff training on what to do in these circumstances. Alyaemni and Alhudaithi (2016) study revealed that 82.6% of respondents had not been given any training on how to respond to violence, and this could be the result of a general lack of policies and strategies for dealing with violence in the workplace.

Alzahrani *et al.* (2015) carried out a quantitative study between June and October 2015 at three public hospital ED in Tabuk city, KSA, one of which is a military hospital, the other two being run by the MOH, examining the causes of ED violence and how it impacts on care standards. The sample consisted of 129 healthcare workers, including nurses, doctors and paramedics, with ages ranging from 21-62 years. Of the male respondents, who made up 64.3 % of the group, 48.8% were physicians, and 34.1% were nurses. Violence during working hours was reported by 90.7% of participants, with a significant rise in reporting among: older workers (>35 years) (p=0.027); individuals working in MOH EDs (p=0.044) physicians (96.8%) and nurses (90.9%).The respondents reported that 58.9% of the aggressive behaviour took place during night shifts; 79% of incidents involved the use of fists and hands and 17.3% involved weapons or instruments. Insults were reported in 38.5% of the cases, and 65.3% of those questioned had previously reported violence, but believed no action had been taken. According to Alzahrani et al. (2015), respondents believed that a lack of punishment led to a rise in the frequency of violent attacks and verbal abuse in EDs. In addition, they cited the following contributory factors: staff shortages (88.4%); overcrowding (87.6%) and inadequate security (87.6%). When questioned as to what improvements could be introduced, 91.5% of respondents wanted to see a system for reporting violent incidents introduced, and 91.5% stated that there should be a clear punishment system put in place, which staff, patients and their relatives could refer to and follow.

Mohamed (2002) examined whether nurses in several hospitals in Riyadh were subjected to workplace violence. To do so, he produced a self-administered questionnaire and distributed it to 500 randomly chosen nurses, of whom 434 responded. The questionnaire asked demographic questions, as well as asking for information regarding which hospital and department each nurse was working in when they were subjected to violence, why they thought such incidents occurred and what traits they could identify about their assailant. Of those who completed the questionnaires, 78.6% (n=341) were females and 21.4% (n=93) were male; overall, their mean age was 36.1 years. The results were as follows: 54.3% (N=235) of nurses had experienced workplace violence. Of these respondents, 93.2% had been on the receiving end of verbal abuse, 32.8% were subjected to verbal threats, and 28.1% were exposed to attempts of physical violence, 17.4% sexual harassment and 16.2% to actual physical assaults. The nurses who worked in the ER and psychiatry departments were exposed to the highest rates of violence; 62.1% and 84.3% respectively. When asked why they believed that they were being exposed to workplace violence, nurses cited a number of reasons, including a lack of security guards (82%), inadequate numbers of nursing staff (63%), language barriers (36.3%), and the fact that people were allowed to move freely and without supervision around the hospital (21.5%).

Mohamed's (2002) study underlines the fact that nurses who work in ERs and psychiatric departments are at the greatest risk of workplace violence, a finding in keeping with a number of global studies (Cornaggia *et al.*, 2011; Moylan and Cullinan, 2011). Mohamed (2002) found that most violent incidents took place in psychiatric hospitals (87.1%), with

50.9% occurring in general hospitals and 45.1% in private hospitals. These results are reiterated by Spector *et al.* (2014), who discovered that there is a far lower assault rate in general hospitals than mental health hospitals.

2.9 Stigma and mental illness within the Saudi context

The term 'stigma' originates from a Greek word used to describe marks burned into individuals' skin to show that there was something bad, strange or immoral about them; and to indicate to others that they should be avoided (Link and Phelan, 2001). It is a visible symbol that differentiates them from others, reducing their status of wholeness, and portraying them as a tainted individual (Goffman, 1997). In more contemporary use, stigma has been defined by Pescosolido *et al.* (2008, p. 431) as "a mark that differentiates a person from others according to socially developed judgments that some individuals or groups are worth less than others."

Hinshaw (2009, p. 3) defines stigma as a "devaluation of a person based on a feature or trait that they possess which is associated with membership of a group considered unfavourable by the wider society". When used in the context to mental illness, stigma is often related to social judgments and devaluations made about people who suffer from mental illnesses (Bharadwaj *et al.*, 2017).

Labelling theory is commonly associated with stigma (Scheff, 1974), but there are conflicting opinions regarding the labelling of mental health problems. The labelling of such problems usually refers to defining or identifying the problem. Clinicians have

suggested that labelling is important, as it can help both patients and their relatives by removing uncertainty and providing them with a better understanding of their illness (Angermeyer and Matschinger, 2003; Angermeyer *et al.*, 2014). Such an approach can help individuals to know who might help them and what might be done to address their problems. Another benefit of labelling is identified within Sociological Role Theory (Biddle (1986). In this theory, it is believed that a person's daily activities are performed in line with socially defined roles and expectations. If a person with mental health problems is considered to have an illness, then they will be treated as a patient and not held responsible for their actions that result from the illness. This has the potential to generate an attitude of acceptance towards people struggling with mental health problems (Parsons, 1969).

In contrast, the labelling of mental health problems can have a negative impact, triggering negative stereotypes and causing discrimination (Scheff, 1974). Moreover, Link and Phelan (2013) put forward an adapted approach to exploring the outcomes of labelling as an extension to Scheff's theory. In the former's approach, it is suggested that labelling mental illness can cause social rejection, which can ultimately lead to the stigmatised person withdrawing. The negative outcomes of such behaviours include; feeling ashamed, reduced self-esteem and fewer work opportunities (Link *et al*., 2013). A later study carried out by Link and Phelan (2014) also found that stigmatising attitudes can deter individuals from seeking help and thus increases their psychological illness.

Singh *et al.* (2016) point out that there is widespread stigma attached to mental illness. It has been found that negative attitudes can impact many aspects of life, such as employment, education, housing, family relationships and friendships (Fitzpatrick, 2015). Stigmatisation is influenced by several factors including; the labelling of mental illness, perceived causal factors, and lack of mental health awareness. Nonetheless, most existing research has focused on the western world. There is thus a possibility that such research has been biased by western social values and perceptions of psychology.

There are identifiable differences between western and non-western cultures in term of individualism versus collectivism (Obeidat *et al.*, 2012). Research by Markus and Kitayama (2010) showed that culture can impact on an individual's sense of self. In cultures that place high emphasis on independence and autonomy (i.e. western cultures), a person is expected to be independent, autonomous and self-contained. However, other cultures emphasise relatedness and interdependence (i.e. non-western cultures like that of Saudi Arabia) and, in such cultures, the self is considered to be connected to external society and relatedness is promoted (Markus and Kitayama, 2003). Such cultural variations undoubtedly impact how a person feels and behaves (Markus and Kitayama, 2010).

2.9.1 Culture and Stigma

Culture is described by (Shin *et al.,* 2013) as being created through an individual's interaction with the world around them. It refers to the beliefs, values and attributes that are shared by a social group which impact their norms, customs, practices, social

institutions and psychological processes. When used in the present research context, the word 'culture' refers to the norms, beliefs and values shared by a specific racial or ethnic group.

Papadopoulos *et al.* (2013) explain that the constructs of individualism and collectivism have drawn a great deal of attention in cross-cultural psychology. It is possible that mental illness is considered in collectivistic cultures to be non-conforming to group norms and thus other group members may wish to avoid them or eliminate them as part of the group. This causes people who experience mental health problems to form out-groups who are treated poorly. In contrast, the self is considered to be independent in individualistic cultures and thus those with mental health issues may be regarded as separate and thus not be stigmatised to such a great extent (Papadopoulos *et al.,* 2013). However, it has also been suggested that members of collectivist cultures may have a more profound sense of duty towards their group and feel more connected to the other group members, which may make them more accepting and supportive of people with mental health problems (Shea and Yeh, 2008; Han and Pong, 2015). As this phenomenon has not been satisfactorily addressed further research into the stigmatisation of mental illness in collectivist cultures is required.

2.9.2 Cultural Considerations

The majority of research into stigma is based on an assumption that stigma works the same way for everybody (Boyd *et al.*, 2014). Nonetheless, it is well-known that

stigmatisation varies between cultures. For example, Rao *et al.* (2007) explain that diagnoses of mental illness are usually made according to signs of deviation from socio-cultural and behavioural norms. This indicates that stigma related to mental illness can often be associated with culture. Important differences between groups in terms of their tendencies for stigmatisation may thus be missed if we simply treat everybody through the same cultural lens.

Research that has explored cross-cultural stigma has shown that stigmatising attitudes regarding mental health are largely related to cultural differences (Abdullah and Brown, 2011). Stigmatisation can lead to racial and ethnic disparities in the use of mental health services (Dobalian and Rivers, 2008). Nonetheless, it is unlikely that the differing stigmatizing attitudes and service use are caused by membership of a specific ethnic or racial group. Primm *et al.* (2010) suggest ethnicity is seldom a demographic indicator that causes difference, but is used instead as a proxy to determine unmeasured cultural and contextual factors which cause inter-group variations.

2.9.3 Types of Stigma

Public stigma and self-stigma are the two key types of stigma associated with mental illness. These types of stigmas carry equal importance and often co-exist (Corrigan *et al.*, 2013). Social stigma is usually caused by the perceptions members of society have of individuals with mental health issues; while self-stigma is caused by the internalisation of how a person believes their mental health problems are perceived (Corrigan and Rao,

2012). An individual's perception of their mental health problems frequently reflects how others view them. Those suffering from mental illness often believe that others do not want to communicate with them. They often report feelings of shyness, shame, regret, and self-loathing, which plays a fundamental part in their self and social stigma (Crocker, 1999; Corrigan, 2004). As well as having a direct impact on how people with mental health problems interact with others, professional stigmatization can also have an indirect impact in the form of prejudice and discrimination (Stuart, 2008).

2.9.3.1 Public Stigma

Corrigan *et al.* (2014) describe public stigma as primarily concerning the public's response to those with mental illness Moreover, those who experience mental illness, as well as their friends, relatives and mental health professionals, can be adversely impacted by public stigma (Corrigan *et al.,* 2014). For example, in some instances, an individual's chance of securing a house or job can be reduced due to public stigma.

The families of people diagnosed with mental illness are also impacted by public stigma. For example, relatives may find that their social status is decreased within their communities or parents are frequently held responsible for causing mental illness in their children (Parcesepe and Cabassa, 2013). Siblings and spouses are often blamed if those who experience mental illness do not adhere to their designated treatment plans. Research evidence also indicates that children with parents who have mental health

issues are often regarded as being less worthy due to their parents' illnesses (Corrigan and Kleinlein, 2010).

2.9.3.2 Self-Stigma

Several researchers have defined self-stigma as the internalization of public stigma about mental illness (Vogel *et al.*, 2013). Corrigan (2007: p.32) asserts that "self-stigma can cause an individual to have negative thoughts and emotional responses including feelings of shame, lowered self-efficacy and low self-esteem." Those who experience mental illness may consider themselves to be less important due to their illness, which ultimately causes them to doubt their self-worth and self-efficacy (Corrigan and Kleinlein, 2010).

2.9.4 How Cultural Norms, Values and Socialisation Impact Stigmatisation

Many cultural influences can affect public and self-stigmatisation. Such factors include culture-specific beliefs about mental health and its aetiology, historical injustices, values, norms, socialisation and mistreatment on the part of the government and healthcare systems (Abdullah and Brown, 2011). Cultural norms probably play a significant role in initiating the stigmatisation process. It is such norms that guide our sense of which behaviours are normal, strange or symbolic of mental illness (Yang *et al.*, 2007). For instance, in some Middle Eastern countries, hearing voices and seeing visions may be considered normal. However, this is considered abnormal in Western cultures and thus may be seen as indicative of underlying mental health problems (Mohamed, 2011).

The extent to which a stereotype is endorsed is largely determined by socialisation, cultural background, history and culture-specific attitudes regarding mental illness (Dupree *et al.*, 2015). Through media representations of mental illness, an individual may be socialised throughout their upbringing to believe that people with mental illnesses are dangerous. This conforms with the stereotype, making it easy for the stereotype to be accepted. The same process occurs in cases of self-stigma, with individuals being more susceptible to internalising stereotypes about themselves that fit their socialised beliefs about mental illness (Sadler *et al.*, 2015).

Nonetheless, it is not always the case that agreement with the stereotype causes discrimination. The extent to which an individual will stigmatise a person experiencing mental illness is very much influenced by a combination of factors including their cultural beliefs and their opinions regarding how acceptable it is to stigmatise mentally ill individuals (Abdullah and Brown, 2011). For examples, an individual with African origins who has a very spiritualistic nature may believe that those with mental health issues are cursed and stigmatise them due to this. However, it is also possible that, despite still believing that mentally ill people are cursed, they may believe that it is not right to discriminate.

In Saudi cultures, family honour, patriarchy, hospitality, respect for authority and hiding emotions are highly valued (Stephenson and Ali, 2018). However, when seeking help for mental illness, being open to discussing feelings is typically advised. These contradictory messages play a significant role in exacerbating stigmatisation in KSA. Moreover, family

honour is very important in Saudi cultures, meaning that people are expected to behave in ways that will present their family favourably at all times (Hamdan-Mansour and Wardam, 2009). Additionally, in such cultures it is commonly believed that people who experience mental illness are dangerous, unclean, pessimistic and immature, resulting in family shame from admitting to, or seeking help for mental illness (Hamdan-Mansour *et al.* (2011). Moreover, therapy for mental health problems requires a level of openness and honesty that may completely oppose the societal value of hiding emotions, as well as demeaning the family honour.

Furthermore, there is a tendency within the general public in KSA to assume that individuals with mental illness will be uncontrollable or disrespectful due to the common belief that such people are immature and dangerous (Alamri, 2016; AlAteeq *et al.*, 2018). This attitude could lead to a stigmatisation of those with mental health problems even if their actions are not disrespectful or dishonourable (AlAteeq *et al.*, 2018). To address this, respect for authority could be employed in schemes to promote anti-stigmatisation by raising awareness that those who experience mental illness can be respectful individuals. Mohamed (2011) explains that hospitality is very important in Saudi culture since it demonstrates honour and reputation. Although it is unlikely that valuing hospitality could exacerbate stigmatisation, it highlights the possibility that hospitality could be used to reduce stigmatisation by displaying warmness and generosity to those struggling with mental health problems.

2.10 Study setting

The Saudi healthcare system was the research setting for the current study, and particularly the Al Amal Complex. Hospital care can vary on a territorial or provincial level depending on the respective government in control of the given jurisdiction (Almalki *et al.*, 2011). Although the Saudi healthcare system consists of specialised psychiatric hospitals, acute care hospitals and acute inpatient mental health facilities, there is no definitive classification system for psychiatric hospitals in the KSA. Acute psychiatry facilities in this hospital typically serve the adult population, dealing with various conditions including addictions, personality disorders, depression, bipolar disorder, and schizophrenia. The aim of hospital admission is to ensure that patients are provided with a safe and secure space to heal and become stable, to continue with courses of treatment, and be connected with relevant support and services in the local community. According to Almalki *et al.* (2011), this psychiatric unit, as with other acute psychiatry units in the KSA, is typically operated by multidisciplinary teams consisting of nurses and doctors, as well as pharmacists, vocational rehabilitation specialists, recreational therapists, occupational therapists, social works, psychiatrists, and psychologists.

In 2002, Al-Amal Complex for Mental Health was formed with the aim of opening up access to rigorous therapies for mentally ill patients and those suffering from addictions who reside in Riyadh in the KSA. The objectives defined for the hospital were: (a) the provision of a safe health setting for treatment of mentally ill patients and those suffering addiction; (b) to promote teamwork to fulfil the focus and aim of advancing staff abilities

which would result in enhancing the quality of the work in the hospital; (c) add to the intensive programmes for the rehabilitation of patients aimed at aiding them in advancing their personal abilities, to enable them to once again live a fulfilled life, reintegrate with society and contribute to it through their individual aims and hopes; and (d) have efficient input into global, national and local studies associated with issues of addiction and mental illness, which could result in better therapies being offered for these conditions.

The subdivisions of the hospital include: (a) Admissions, where outpatient clinic patients and critical cases referred from the emergency department are registered. Ongoing management of patients is available prior to ascertaining a diagnosis and prescribing suitable treatment. Following stabilisation, a person is then referred to the Recovery subdivision. (b) The recovery subdivision is made up of units where people who are stabilised are registered following a period of stay in the Admissions unit. Here, patients are expected to continue their treatment for longer periods of time. Those working in recovery seek to ascertain progress in patients, by registering changes in behaviour and any improvement in their psychological health. It is during their stay in recovery that the patient care management plan is examined and finalised by the medical team, with a view to enabling the person to reintegrate into society. (c) Rehabilitation is the next subdivision. Patients' stay in rehabilitation is governed by how long they need to build their skills and confidence, and recover from their illness before progressing to the Day Care Centre. (d) The Day Care Centre offers patients support while reintegrating into the community.

2.11 Conclusion

This chapter has provided an overview of the health care system and nursing profession in the KSA and focused on violence in the workplace in the KSA and Middle Eastern countries that have the same working environment and share a similar culture and tradition. The next chapter will provide an integrative review of the studies that explore the perceptions and experiences of nurses toward patient violence in a psychiatric setting. This review helped in clarifying the topic of interest, as well as informing me about the best methodological approach and study design.

Chapter 3: Literature review

This chapter will examine current literature related to patient violence towards psychiatric nurses. It will initially offer a description and justification of the search strategy employed, and sources and criteria used in the selection of research papers for this review. In addition, a data extraction table summarising the reviewed literature is presented. A critical assessment of the articles included in the review has been undertaken, creating an evidence base through employing appropriate critical appraisal tools. Following this, the key outcomes from the studies will be examined, before finally discussing what the literature offers in relation to my research.

3.1 Introduction

Polit and Beck (2010) state that nursing research is a continuous investigation aimed at creating knowledge regarding crucial matters related to the nursing profession, such as nursing practice, training, governance and information technology. A literature review *''aims to help with the creation of the research's intended methodology''* (Nieswiadomy *et al.*, 2012, p. 71). A literature review has been described as *"the pinpointing and investigation of literature and information already available, which is tied to the topic of research"* (Kazdin, 2011, p. 480), while an integrative review is able to carry more weight with regard to evidence based practice for nursing research (Whittemore and Knafl, 2005). Whittemore and Knafl (2005) suggest integrative reviews are beneficial to the pinpointing, evaluation and applicability of findings in an independent study, and are

critical when it comes to building the basis of subject knowledge. This type of review can affect the quality of care patients receive, ensuring it is in line with scientific guidelines by assessing levels of evidence of nursing practice. An integrative review is seen as a critical component of health care, and it has the potential to guide practice through scientific knowledge (Gawronski and Bodenhausen, 2006). Using an integrative review facilitates the use of a number of different methodologies, and the binding together of subsequent results: for example experimental and non-experimental research (Whittemore and Knafl, 2005). As a result, adopting an integrative review can play a central role in evidence-based practice, particularly in the contemporary era of nursing (Gawronski and Bodenhausen, 2006).

The integrative review is in keeping with the principles of completing a systematic review, that is, the methods employed must be reliable, detailed and clear throughout the research study (Higgins and Green, 2008). A crucial part of achieving this is to provide descriptions with sufficient detail in order for others to make the same search with the same results, establishing greater trust in the review, as well as limiting questions surrounding process reliability (Mays *et al.*, 2001). The procedures used to choose studies for inclusion in the review need to engender a wide range of results, involving all related materials, instead of only covering unique specifications of the research design (Arksey and O'Malley, 2005). All studies included in this review went through identical evaluation markers, involving an in-depth assessment and a critical evaluation of the data and findings presented. To best address this, the integrative review below was completed in

line with five key stages, defined by the Centre for Reviews and Dissemination (CRD, 2009). The first stage is to create a research question; the second stage involves a database search and choosing suitable studies for inclusion; thirdly, the results must be plotted; fourthly, the quality of the studies retrieved for review should be evaluated; and the last stage involves organising, summarising and sharing the material.

3.2 Stage 1: Formulating the research question

In this review, the research question was closely tied to the wider aims of the proposed research study, which were to examine, define and understand the experiences of female psychiatric nurses who had been exposed to female patient violence. Population, Exposure and Outcome (PEO) was used as a way of organising the review question and to ensure there were no misunderstandings, and that there was a clear focus, while supporting an expansive review (Bettany-Saltikov, 2012). Table 1 shows the main PEO elements involved. The current integrative review used the PEO procedure in order to structure the research question (Bettany-Saltikov, 2012). PEO is thought to be a beneficial way of defining queries in reviews, since it does not limit population size to a single category or restrict choice of related material tied to the main research (Doody and Bailey, 2016).

Table 1: The main PEO elements involved in this review

PEO framework	Details	Application to this search
The Population (P)	Linked with the general target population	Mental (psychiatric) nurses
Exposure (E)	Describes the events under investigation in the research	Exposed to patient violence
The Outcomes (O)	Results and subsequent effects following the event	The perceptions of female Saudi mental (psychiatric) nurses regarding the effects of being exposed to patient violence had on them.

Through using the PEO framework, I was able to establish the following research question:

'How do female Saudi mental (psychiatric) nurses (P) experience, perceive and interpret (O) patient violence (E)?'

The majority of studies undertaken in a KSA context examined the prevalence and the impact of patient violence on nurses, as presented in Chapter 1 of this study. Therefore, as there is little work investigating this topic in the specific context of Saudi Arabia, or Arab nurses in general, a wider view looking at the subject globally was adopted.

3.3 Stage 2: Database search

This integrative literature review was aimed at covering a wider range of literature than initially planned, to absorb more global research to answer the research question rather than limiting it to the KSA context. In order to implement this efficiently, several approaches were used to identify related material. These included; use of online databases, manually examining leading journals focusing on the topic area, and hand searching reference lists of relevant papers. Initially, important key terms needed to be established, and this was completed through using the PEO framework. The key terms used for the search can be seen in Table 2.

Table 2: Key words used for database search

PEO	**PEO for this review**	**Key words**
Population	Mental (psychiatric) Saudi nurses.	'mental nurs*' or 'psychiatric nurse' or 'nurse'.
Exposure	Exposed to patient violence.	violence, assault, abuse, aggression, workplace physical violence.
Outcomes	Experiences and perceptions.	'Experience' or 'perception' or 'feeling' or 'thought' or effect, impact, result, outcome, repercussion, consequence, absenteeism, sickness absence, sick leave, productivity, psychological distress, posttraumatic stress disorder, and quality of life (as this could reflect the experience among nurses).

Using thesaurus terms as well as free text allowed the search to have superior results, and every keyword/term was searched for independently, as well as in combination with other concepts. The medical subject heading (MeSH) term option was employed to make sure all related keywords came up in the results and were filtered through Boolean operators AND or to combine keywords and synonyms, and achieve truncation (Lipscomb, 2000). In order to gather articles which included two or more terms, the AND operator was employed, while OR allowed articles to be found with either/or any of two or more terms. Using Boolean operators to establish control and reach in the research findings is considered beneficial (Smyth and Craig, 2011). Additionally, the level of ability to detect related literature (sensitivity) and the overall number of articles gathered (precision) are crucial to search results from keywords (Brownson, 2011). Once the research question and key terms were established via the PEO framework, certain databases were examined for related research papers. It is recommended that initially, a limited search should be carried out using the MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases, as these provide an overview of most nursing research studies (Aveyard, 2014). The findings from this initial search (abstracts, titles and tables of contents) can be employed to provide a more varied set of search terms to complete a wider search of databases. Lastly, bibliographies and reference lists of the papers identified were examined in order to uncover more potential material.

Databases used in this review were the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline EBSCO, Medline Ovid, PubMed NCBI and the

ExcerptaMedica Database (EMBASE). Also, further searches were conducted on the Cochrane Central Register of Controlled Trials (CENTRAL) and Science Direct, to maximise the amount of related literature available. In addition, in-depth examinations of reference lists within the identified studies allowed the author to make sure the search was sufficiently detailed and all pertinent papers for the review were identified. Employing these strategies to complete the search provided a detailed investigation of the topic, identifying a number of research papers related to this study (Facchiano and Snyder, 2012; Creswell, 2013). Further sources included the British Journal of Nursing, Ethos, and the British Nursing Index, which were manually examined across a number of volumes, in order to pinpoint papers related to the topic which otherwise could have been excluded from databases. Examples of this include editorial discussions linked with research outcomes or abstracts from conference proceedings, as well as papers that had invalid indexing. While looking for papers manually is time consuming and mundane, it is a necessary process when it comes to finding material which could have been overlooked during the keyword search. Regardless, this can be an onerous task as, according to Taylor (1998), roughly 45% of journal references and citations have a minimum of one mistake, meaning that the benefit of this additional search process could be compromised.

3.4 Stage 3: Selection of appropriate studies to be included in the review

From the initial findings, it was clear that the wider search had generated relevant as well as irrelevant results. This meant that the unrelated findings needed to be filtered out.

Integrative reviews allow for restrictions on the materials identified through inclusion and exclusion criteria linked to the research topic (Randolph, 2009). Initially, search criteria restricted results to papers involving mental health nurses (male and female), who had experienced patient violence, violent episodes initiated by adults aged 19 or over (since psychiatric units in Saudi hospitals are restricted to adults over the age of 19), and studies written in English or Arabic, due to these being the two languages spoken by the researcher. Such criteria were implemented at the start of this research, alongside an analogous method being used for the integrative review across every source, even though these criteria were established after the primary stages of the research, since as the researcher I needed to develop my knowledge regarding the range of studies available.

In addition to the above, studies to be included in this review also needed to focus on mental health/psychiatric nurses experiences, perceptions, level of support and emotions related to exposure to violent events in the clinical setting. Studies which explored the perceptions and experiences of nurses working in several areas of the hospital, including the psychiatric setting, were also included. However, only findings related to psychiatric setting are reported in this review.

The categories of studies included in this review were original research papers and systematic reviews. Exclusion criteria in relation to the study population included studies involving only non-psychiatric nurses, and those who were not qualified mental health nurses. With regard to the nature of the studies, articles focusing entirely on violence prevention programmes were not included, and excluded outcomes were anything

outside the feelings, perceptions and experiences of nurses in the inpatient mental health setting context. Lastly, conference papers, opinion-based papers, letters, editorials and comments were also excluded. Furthermore, there was a requirement to set limitations regarding the timeliness of the studies. Thus, the timeframe for included papers was between January 2000 and October 2019. January 2000 was chosen as this was when nurse training changed from an associate degree to a full degree course (McHugh and Lake, 2010) and there is evidence to suggest education might be a mediating factor for violence in the workplace (Magnavita and Heponiemi, 2011). October 2019 is when I started writing my draft thesis and agreed with my supervisors to stop looking for literature. This was a pragmatic decision, but as a researcher I do accept important data could have been excluded as a result.

3.5 Results of the search

The initial search resulted in 320 papers being identified. After duplicated papers were discarded, 312 were left and the titles and abstracts of these were screened using the inclusion and exclusion criteria. Of the 312 articles screened, 145 were removed as they did not meet the inclusion criteria; 80 papers focused on violence against non-psychiatric nurses, and 32 made comparisons of violence across various healthcare setting. Further, research not used in this review were studies that focused on the effect of a programme to limit patient violence or took account of problems outside patient violence (n=37). Certain studies were rejected (n=10) because of language reasons, as they were published

in a language other than Arabic or English. Some studies had English abstracts, but the main body of the paper was written in a different language, including Chinese, Danish, Spanish and Italian. Of the 312 studies found, eight remained after the filtering process (See Figure 1). Of the eight studies, three were quantitative studies (Nolan *et al.*, 2000; Maguire and Ryan, 2007; Jonker *et al.*, 2008), and five were qualitative (Ilkiw-lavalle and Grenyer, 2004; Kindy *et al.*, 2005; Chapman *et al.*, 2010; Baby *et al.*, 2014; Stevenson *et al.*, 2015).

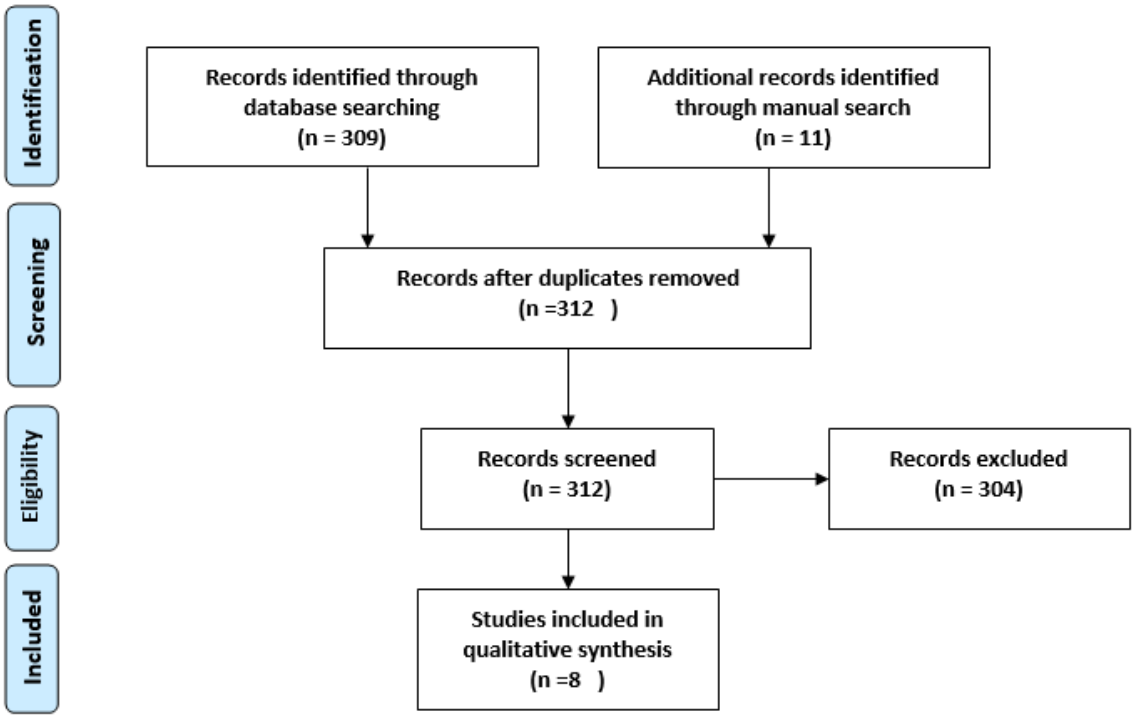

Figure 1: PRISMA chart

3.6 Stage 4: Charting the findings

At this point, key data was charted from the eight studies included in this review. The term *charting* is used by Webster and Watson (2002) to describe the action of pooling and examining data after being filtered and organized by areas of concern. Charting is sometimes referred to as data extraction in systematic reviews, and can include statistical analyses, subsequently used to undertake a meta-analysis. To ensure there is uniformity in the research, a data extraction sheet was used (see Table 3), which is in line with the actions defined in CRD (2009) for systematic review purposes. In this instance the data extraction sheet is made up of author(s), year of publication, location, aim of the study, research design, details of the population and sample size, method of data collection, and data analysis.

Table 3: Data extraction sheet

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
Chapman *et al.* (2010) Australia	Find the number of nurses in different settings who are experienced in workplace violence and comprehend their feelings on receiving this abuse.	Explorative qualitative study.	Convenience sample 35 nurses who had experienced workplace violence. Demographics: Primarily female, in their early 40s, who had worked, mostly part time, in the industry for a mean of 17.8 years.	Semi-structured interviews.	Transcripts were coded & findings clustered; identifying patterns and meaning.	Certain nurses are capable of dealing with and cognitively processing violent behaviour and the stresses it involves this could involve three approaches: 1) comparing themselves positively with their colleagues; 2) judging themselves positively; 3) finding a positive outcome, either for themselves or others or the hospital in the event itself.

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
Jonker *et al.* (2008) Netherlands	Understand the conditions surrounding nurses' ideas regarding commonplace aggression, their feelings about patient violence and the determining factors related to coercive methods.	Descriptive cross-sectional quantitative study.	Convenience sample of 113 nurses working across six closed and semi-closed inpatient wards in one mental health institution. 85 completed the survey (75% response).	Two questionnaires were used: (1) Attitude Toward Aggression Scale; and (2) Perception of perceived aggression scale (POPAS). Variables derived from the Theory of Planned Behaviour were also measured. Cronbach's alpha was set at 0.70	Descriptive analyses and Independent t-tests.	Some 69% of nurses reported encountering non-threatening verbal aggression; 31.8% reported passive-aggressive behaviour; 29.5% reported splitting aggressive behaviour (behaviour that divides a group in two opposite poles;) 23.5% reported being threatened with physical aggression and 9.4% reported physical violence. Findings on the ATAS scale showed the highest score was for 'patient aggression is destructive and offensive', and the lowest score for 'patient aggression is communicative and protective'. The use of validated tools ensured rigour in the study's findings on attitudes and perceptions.

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
Maguire and Ryan (2007) Ireland	Pinpoint the categories of violent or aggressive events which nursing staff had to deal with across a 1 month timeframe.	Descriptive cross-sectional quantitative design.	Convenience sample, nurses employed in Mental Health Services in Ireland. 280 questionnaires were given, and 87 returned (31% response) Just 37% of the sample were less than 39 years of age, with 20% aged between 40 and 44 years, and 43% aged 45 or over. Roughly 27% of the demographic were male, and 73% female. Permanent employees of the employing agency accounted for 74% of the total, while 26% operated on temporary contracts.	Questionnaire survey (Scale of Aggressive & Violent Experiences (SAVE) -adaptation of an existing instrument which categorizes and defines a range of aggressive and violent incidents. Also, POPAS (Oud, 2001),	Descriptive & inferential statistics. Data subjected to a series of one-way anovas and chi-squared analysis.	Nursing staff in this Mental Health Service experienced high levels of verbal aggression, with distinctions obvious between threatening and non-threatening aggression.
Baby *et al.* (2014) New Zealand	Examine and define psychiatric mental health nurses' history of patient violence.	interpretive and descriptive qualitative study.	A purposeful sample of 13 registered mental nurse nurses at one centre.	semi-structured interviews.	Analysed using (Boyatzis, 1998) three stages of theme development.	Perpetrator risk factors for patient violence include mental health disorders, alcohol and drug use and the inability to deal with situational crises.

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
Nolan *et al.* (2000) England	Establish the level of violence and the nature of these events against mental health nurses, and investigate the support provided after these incidents.	Descriptive cross - sectional quantitative design.	Convenience sample1 - 25 psychiatrists and 670 psychiatric nurses in 5 centres. Response rate was 47% overall, with 60% psychiatrist response rate (n=75) and 45% for mental health nurses (n=301).	Postal questionnaire 20 items - previously validated by (Arnetz *et al.*, 1996).	Descriptive &inferential statistics using Pearson's chi-square statistical test (v2). Statistical signifcance was assumed at $P < 0.05$.	Large proportion of nurses did not receive any support after violence event.
Stevenson *et al.* (2015) Canada	Define patient violence incidents in acute psychiatric hospital environments, their professional and personal outcomes of these incidents, and what approaches do nurses feel affect current practices of patient violence.	Interpretive descriptive qualitative study design.	Purposeful sample, 12 Canadian registered nurses who self-reported experiencing patient violence within acute care inpatient wards. The 12 nurses shared 33 experiences of work-related patient violence.	Semi-structured interviews.	Thematic analysis and constant comparison techniques.	Patient violence was considered part of the job among mental nurses.

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
Kindy *et al.* (2005) Canada	Allow registered nurses to describe their experiences in environments where they could be assaulted, and how they deal with ongoing threats.	Phenomenological Qualitative design.	Purposive sample, 10 registered nurses in psychiatric or psychiatric/forensic facilities.	semi-structured interviews.	phenomenological analysis (Colaizzi, 1978), exemplifying Spielberg's Elements.	• Catalysts for violence: low staffing levels, lack of promised changes to the working environment, professional elitism and slow reactions to emergencies. • 'Perplexing: extreme vigilance, fear, and indecision on whether or not to return to work. • 'pervasive invasive sequelia' efers to the emotional price of being exposed to patient violence: nurses questioned their own value to the organisation and often changed the way they acted outside work, invariably taking on negative traits.

Author/s	Aim	Design	Population and Sample	Data Collection	Data Analysis	Main Conclusion
(Ilkiw-lavalle and Grenyer, 2004) Australia	Look into patient and staff outlooks regarding violent incidents in order to comprehend the emotions felt, the reasons behind these occurrences, and provide suggestions on how to limit these events.	Descriptive cross - sectional qualitative design.	A sample of 29 staff and 29 patients across 4 psychiatric inpatient units. 47 WPV events across a four month timeframe, interviewed close to the event time.	Semi structured face-to face interviews.	The two researchers separately determined the meaning of each significant statement, comparing their interpretations Significant statements were organized into themes To check the validity & meanings of themes, they were discussed with some of the participants.	Mental nurse believed that patient's illness as the cause of the aggression.

3.7 Stage 5: Evaluating study quality

Before study appraisals are used in a systematised integrative review, it is important to ensure that the content is valid, provides adequate evidence of the findings, and suggests reasonable causes for discrepancies (i.e. not coincidence alone) (Meade and Richardson, 1997). In addition, enough data should be provided in order to evaluate the integrative review outcomes, with regard to relationships with clinical practice. Numerous researchers (Lohr and Carey, 1999; Sanderson *et al.*, 2007) suggest that the aim of an appraisal is to establish which studies have sufficient quality with regard to treatment outcome, and are aimed at feasible targets, thus offering a detailed description of potential proposals which can establish a deeper comprehension of the review results.

The eight studies reviewed in relation to this research were qualitative or quantitative, with differing study designs, ways of collecting data and analyses. Using the Critical Appraisal Skills Programme (CASP) for qualitative studies and the Effective Public Health Practice Project tools (EPHPP) for quantitative studies, the papers included in this review were graded as strong, moderate or weak.

The CASP tool, having gone through revisions and appraisals, is able to establish how rigorous qualitative studies are through using screening questions in ten different aspects of the research process (Katrak *et al.,* 2004). Walsh and Downe (2006) describe these areas as being; the research goal, how suitable the recruitment approach is, if the design facilitates the intended research aim, data gathering methods, the nature of the

participant-researcher link, ethical matters, data analysis, results (statement of findings), and research value. The EPHPP tool is employed to evaluate quantitative studies because of its demonstrable reliability throughout individual domains and high-class correlation coefficient value (Armijo-Olivo *et al.,* 2012). The EPHPP tool evaluates selection bias, study design, confounders, blinding, data collection methods, withdrawal and drop-out rates, and analysis. In addition, when a research paper is interventionist, the tool is able to evaluate intervention integrity (Thomas *et al.,* 2004). Crucially, the CASP and EPHPP tools are not aimed at ranking the standalone value of every study's results compared to the rest of the studies, but instead, they are a way of measuring the quality and validity of each study through rating its rigour and use of suitable methodology. As a result, the tools provide a robust critique of the research, indicating the level of confidence a researcher should have in the findings of those studies. The next section examines the studies and the methodological steps taken in the papers reviewed.

3.8 Analysis of included studies

3.8.1 Geographic distribution of the studies

The countries of origin for the studies are shown in the data extraction sheet, with all papers coming from developed countries across four continents. All the studies were conducted at universities or public medical facilities. It is important to note that there was no study originating in the KSA or any nearby nations, where nurses would be operating

in similar conditions to those in Saudi Arabia. As a result, my study examining the effects of violence towards nurses within this context is pioneering.

A total of three articles (Nolan *et al.*, 2000; Ilkiw-lavalle and Grenyer, 2004; Kindy *et al.*, 2005) were multi-centre studies, involving participants working in a number of hospitals or health care centres across various regions in Australia, Canada and England respectively. Multi-centre studies make generalising results to a wider population more feasible. The other studies (n=5) involved participants from a single health care facility, which limits generalisation of the finding to other hospitals or areas.

3.8.2 Study Objectives

The aim/s and objectives of the chosen studies are defined in detail, and in order to examine the experiences and feelings of psychiatric nurses involved in patient violence, certain papers (Nolan *et al.*, 2000; Maguire and Ryan, 2007; Jonker *et al.*, 2008) look at categories of patient violence and how much support was offered to nurses after such experiences. For more detail of the aim/s of each of the studies included in this review, please see the data extraction sheet (Table 3)

3.8.3 Research Design

Quantitative methodology was seen in three of the studies (Nolan *et al.*, 2000; Maguire and Ryan, 2007; Jonker *et al.*, 2008), which is a type of research that is employed to quantify a topic through the production of numerical data or data which can be

statistically presented (Creswell, 2013; Choy, 2014). Certain variables existing in a study's structure are identified by the quantitative researcher, and relationships across these are then investigated and established (Punch, 2013). In the three studies included in this review, quantitative methodologies offered a way to identify the links that connect certain personal or social elements likely to be related to patient violence, offering insight into the topic area.

While quantitative research provides statistical evidence of relationships between one object and another, it is not able to examine subjects in their natural environment, or interpret the value certain findings have for participants in the way that qualitative research does (Malina *et al.*, 2011; Yilmaz, 2013). For example, regarding this study, the occurrence of patient violence has been established through evidence provided by quantitative studies, but the experience of being on the receiving end of such violence can only be acknowledged through qualitative research. However, quantitative studies require a large sample size, with the accuracy of results being correlated with the amount of people involved (Östlund *et al.*, 2011). Sample size is discussed in more detail in Section 3.8.5.

Each of the three quantitative studies used a descriptive cross-sectional strategy, the benefit of this research design being its descriptions of the incidents of patient violence against psychiatric nurses (Badke-Schaub *et al.*, 2011). Also, for topics that have limited previous study, such as perceptions of patient violence in psychiatric ward setting, this design allows for a basic knowledge to be generated effectively. However, Reiners (2012)

warns that participants might not offer accurate enough information in answering questionnaires, especially with questions related to emotional status. Similarly, if the participant does not feel comfortable answering a question, this might have implications for the study findings, in so much as incomplete questionnaires may be discarded. In addition, the researcher might overlook or be selective with data tied to the study's hypothesis (Greenhalgh, 2014), raising the possibility of researcher bias, compromising the study's ability to generalise the results across the wider study population (Brink and Wood, 1997).

Of the five qualitative studies reviewed, two used interpretive/descriptive methods (Chapman *et al.*, 2010; Baby *et al.*, 2014), but all focused on describing nurse perceptions of patient violence. Regardless of chosen methodology, qualitative research is said to be all-encompassing, process focused, and comprehensive in its methodology (Baxter and Jack, 2008). This allows for a deeper comprehension and more detailed theory development for an event or situation, offering a systematic and subjective way of defining occurrences and finding meaning behind them (Noor, 2008). However, qualitative approaches are unable to generate data which can be applied to a wider population, as study sample sizes in the reviewed papers ranged from 10 (Kindy *et al.*, 2005) to 35 (Chapman *et al.*, 2010).

3.8.4 Data collection and measures

In the main, data collected in the quantitative studies included in this review was by self-completed questionnaire. Likewise, all the qualitative studies included in this review used semi-structured, face to face interviews to collect data. For more detail, please see the data extraction sheet (Table 3). The quantitative studies may have used self-completed questionnaires as they are said to be *''very flexible and can provide wide coverage''* (Groves *et al.*, 2011, p. 8). As information is limited regarding the topic at hand, and there is little existing research on psychiatric nurses' perceptions and experiences of patient violence, a questionnaire can allow for the production of the topic's fundamental comprehension, as it can encompass a large proportion of the target population (Östlund *et al.*, 2011). However, methods that involve participants completing the task alone can restrict the validity of the study, this may in part be due to poorly structured questions or poor interpretation of the questions (Polit and Beck, 2010). As a result, conclusions reached are not fully reliable, especially for responses based on opinions and emotions (Polit and Beck, 2010; Greenhalgh, 2014).

All quantitative papers in this review employed questionnaires that had previously been validated. Thus, the reliability and validity of the questionnaire had been tested, increasing robustness in comparison to a newly devised questionnaire being used (Saris and Gallhofer, 2014). In addition, in order to evaluate the reliability of the data collection tools, all studies should undergo a pilot phase prior to the main study being initiated, this having a clear benefit in ensuring consistency of the instruments used (Saris and

Gallhofer, 2014). Moreover, in one study, (Jonker *et al.*, 2008), the Cronbach's alpha method was used to evaluate the internal consistency of the tools. In general, all quantitative studies included in this review offered a detailed description of the tools employed and their content.

The qualitative studies included in this review utilised face-to-face, semi-structured interviews with participants, a flexible method that allows the researcher to investigate a range of subjects and clarify or adjust them as required. According to Simons (2009), interviews are particularly effective in identifying participants' diverse experiences, while one-to-one interviews are a particularly appropriate medium for assuring participants that their answers will remain confidential. This sense of trust also enables participants to share sensitive information that they may have been reluctant to divulge in a group context. In the studies reviewed, conducting interviews facilitated an in-depth investigation of participants' subjective interpretations. However, caution needs to be taken as interviews can be exposed to researcher and/or interviewer bias (Lloyd *et al.*, 2006).

3.8.5 Sampling Strategy and Population Cohort

A review of sampling approaches used in other studies allowed me, as a novice researcher, to find the most appropriate strategy for the current study. The studies in this literature review collected data from a sample of 783 psychiatric nurses collectively. The sample sizes used in the quantitative studies were between 113 and 795, while the

sample size of the qualitative studies ranged between 10 and 35, with none presenting a justification for their sample size. Sample sizes used in all quantitative studies (Nolan *et al.*, 2000; Maguire and Ryan, 2007; Jonker *et al.*, 2008) were thought to be suitable for the fundamental statistical tests used. Inclusion and exclusion criteria were described in all studies except one (Stevenson *et al.,* 2015). Response ratios were shown in all three quantitative studies (Nolan *et al.*, 2000; Maguire and Ryan, 2007; Jonker *et al.*, 2008), and were between 31% and 75%. Nonresponse bias could be present in the studies with low response rate (Nolan *et al.*, 2000; Maguire and Ryan, 2007). All studies include male and female participants.

Sample selection methodologies were presented in all research papers, with a convenience sample being used in five of the studies (Nolan *et al.*, 2000; Ilkiw-lavalle and Grenyer, 2004; Maguire and Ryan, 2007; Jonker *et al.*, 2008; Chapman *et al.*, 2010) and purposeful sampling being used in three of the studies (Kindy *et al.*, 2005; Baby *et al.*, 2014; Stevenson *et al.*, 2015). Convenience sampling, which is sometimes referred to as availability sampling, is a unique category of non-probability sampling which is based on data being collected from conveniently available participants for the study (Farrokhi and Mahmoudi-Hamidabad, 2012). In some specific environments, convenience sampling might be the only available choice, and most of the studies using this approach justified its use due to ease of accessing sample participants (Emerson, 2015; Etikan *et al.*, 2016). The benefits of convenience sampling include being: a simple method for recruiting participants (Emerson, 2015); usefulness for pilot studies and the production of

hypotheses; data collection which is achievable in short time periods (Bujang *et al.*, 2012; Emerson, 2015); and the low cost of implementation (Emerson, 2015). The negative aspects of using convenience sampling include; greater vulnerability to selection bias and other factors outside the researcher's control (Goodman, 2011); a prominence of sampling errors; and the lack of reliability associated with convenience sampling (Bujang et al., 2012).

Purposeful sampling is sometimes referred to as 'judgment', 'selective' or 'subjective' sampling, and entails a researcher using their own judgment to select the study's population (Etikan *et al.*, 2016). Purposive sampling is a non-probability sampling approach which happens when the researcher uses their own judgment to make sample choices, believing that they can achieve this effectively without investing a lot of time or expense in a more complex recruitment process (Barratt *et al.*, 2015; Emerson, 2015). The benefits of purposive sampling include; low costs incurred in terms of time and money, its appropriateness when there are few primary data sources in the study and its effectiveness when examining anthropological circumstances requiring intuition to uncover meaning (Acharya *et al.*, 2013; Suen *et al.*, 2014). The disadvantages include; potential for researcher judgment error, poor reliability and high bias, and the fact that research findings cannot be generalised (Acharya *et al.*, 2013; Ritchie *et al.*, 2013). The sample's demographic data was evident in four studies (Kindy *et al.*, 2005; Maguire and Ryan, 2007; Jonker *et al.*, 2008; Stevenson *et al.*, 2015), while no such data was available

in the other papers. The latter could have sample bias if certain members are underrepresented or overrepresented relative to others in the population.

3.8.6 Results Analysis Strategy

With regard to the qualitative research papers used in this literature review, the data collected was examined through two key analytic approaches; namely thematic analysis (Stevenson *et al.*, 2015) and content analysis (Kindy *et al.*, 2005; Chapman *et al.*, 2010; Baby *et al.*, 2014).

The quantitative studies involved in the review employed descriptive and inferential statistical analyses in order to identify the level of significance. The latter allows for the important variables related to patient violence in psychiatric settings to be identified and accounted for. All studies involved in this review gave sufficient detail of their data analysis approaches, meaning that the analytic process can be replicated. Ethical approval was made apparent in all papers.

3.8.7 Summary of Methodological Quality Assessment

Using the Critical Appraisal Evaluation tools for critically analysing the studies included in this review uncovered a number of positive aspects. The authors had all made their research goals clear, offering a clear description of their aims, which is crucial for all scientific papers. The highest quality research will present a very clear description of its research questions and goals (Hulley *et al.*, 2013). The studies were unanimously

representative of mental health nurses, with three out of the eight studies collecting data from multiple sites (Nolan et al., 2000; Ilkiw-lavalle and Grenyer, 2004; Kindy et al., 2005).

The CASP and EPHPP tools for quality assessment of qualitative studies was employed to evaluate the included studies, and it showed all were of moderate to good quality (table 4). Each of the studies presented clear aims, employed reliable sampling methods (allowing the research objectives to be reached), with justified and robust data extraction methods. Interviews were conducted in all five studies, after consent had been taken from the participants, and verbatim extracts were used to demonstrate findings in order to avoid misunderstandings of any kind. Thematic (Ilkiw-lavalle and Grenyer, 2004; Stevenson *et al.*, 2015;) and content analysis (Kindy *et al.*, 2005; Chapman *et al.*, 2010; Baby *et al.*, 2014) was employed to analyse data to ensure findings were trustworthy when being reported.

However, all studies included in this review (quantitative and qualitative) were undertaken in developed countries, and while they do show trends, because of the differing cultures and health systems it would be difficult to transpose findings to the Saudi situation. In light of this, the usefulness of the studies for the Saudi context is compromised (Williams, 2011). In addition, in all studies included in this review, no standard definition of patient violence was used, and therefore the reliability of results may be compromised. Since the included papers did not offer clear descriptions of what was meant by patient violence, the reported rates of patient violence could be higher or lower than they actually were, because of poor classification (Binns et al., 2009). Samples

across these papers were primarily chosen with a non-probability sampling method, but with no justification as to the reasons for these choices, or why or how the number of participants' had been chosen. All quantitative studies stated their inclusion and exclusion criteria, but most did not provide a complete picture of the participant demographics. Without exception, the three quantitative studies employed a self-report questionnaire. As a result, the reliability of the responses could be impacted due to misunderstandings or misinterpretation of the questions. Also, respondents could have significantly different ways of comprehending the questions presented to them (Austin *et al.*, 1998).

Lastly, none of the studies included in this review examined or explored the link between psychiatric nurses' perceptions of patient violence and social and cultural impact in any detail. A qualitative approach that explored the effect of social and cultural factors would have been useful, as it would have allowed for a more in-depth comprehension of nurses' perceptions of patient violence and its impact on various personal, professional, and cultural elements of nurses' lives.

Table 4: Methodological assessment of the included studies

	Author(s)/ Year	Methodological Quality	Conceptual Quality	Reporting Quality	Overall Quality of Study
1	(Chapman et al. (2010)	An explorative qualitative method suitable for accomplishing the research goal was employed. To ensure the representativeness of the research sample, participants were recruited through non-random, convenience sampling. Data were collected through semi-structured interviews and thematic analysis techniques compatible with the research question were used to examine the data. An explanation was provided about the method and reasons for participant selection to obtain the necessary research data.	A clear picture was given about nurses' experience of workplace violence and their attitudes towards such abuse. The research did not focus on assessment of patient violence in a single context (e.g. hospital, healthcare system, region). Therefore, several approaches were deliberately used to recruit participants and ensure as much sample diversity as possible.	Raw data extracts with in-depth information about the participants were used to back up the findings. Several insightful conclusions could be formulated based on the rich detailed data produced by the employed qualitative approach.	The evidence was of moderate quality.
2	Baby et al. (2014)	The study was based on an interpretive descriptive qualitative design coupled with a grounded theory approach. Data were	A clear picture was created about the history of patient	In the context of data analysis and selection for presentation, the authors	The evidence was of

		collected through semi-structured one-to-one interviews and analysed through thematic analysis techniques suitable to the research question. The research sample was small (n = 14) and the study was conducted in a single centre.	violence experienced by psychiatric mental health nurses.	demonstrated critical scrutiny of the impact of their role and possible bias. The findings were clearly stated and addressed in connection to the initial research question.	moderate quality.
3	Stevenson et al. (2015)	The study was based on an interpretive descriptive qualitative approach, with 12 participants recruited through purposeful sampling. Data were collected through semi-structured interviews and analysed through techniques of thematic analysis and constant comparison that were suitable for the research question. The results might not be fully reliable because the research sample was not large enough. Saturation could have been achieved in relation to additional thematic patterns if a bigger sample had been used. Another issue is whether the sample was representative of the RNs who had experienced serious violence, since they may have quit their position, institution or field. The sample may be affected by volunteer bias because individuals with an interest in the topic might have been more	A comprehensive picture was provided about incidents of patient violence in the context of acute psychiatric institutions, the nurses' professional and personal outcomes regarding such incidents, as well as the strategies identified by nurses as having an impact on existing practices related to patient violence. The research was made more rigorous	The research aim was achieved, and a large volume of data was gathered. However, the separate themes could be analysed further. Despite the small size of the research sample, several events were investigated, indicating how diverse the experiences were. The experiences presented by the RNs were varied and covered different nursing roles in various hospitals and regions.	The evidence was of good quality

		open to participation or by recall bias, as participants might have had problems remembering incidents.	through the application of a number of approaches, such as the Thoughtful Clinician Test. Certain aspects of the findings could have been improved through triangulation of the results against organisational policies and incident reports.		
4	Kindy et al. (2005)	The study was based on a qualitative exploratory phenomenological approach, with participants recruited through non-random sampling. Data were collected through semi-structured interviews and analysed through techniques suitable for the research question. The procedure of participant recruitment was presented and justified as being appropriate to obtain the necessary research data. The research sample was small in terms of the nurses recruited and the settings covered,	The main themes were comprehensively examined, with good description of the experiences of violence and the settings in which they happened, and strategies of managing threats. There was good presentation of the	The selection of data for presentation was explained and the process of analysis was outlined. The findings were backed up by ample data, while contradictory data were addressed as well. The participants were asked to confirm the accuracy of the transcripts and data interpretation, thus making	The evidence was of moderate quality

		thus reducing the representativeness of results and increasing the risk of sampling bias and recall bias.	findings and direct citations were used to reinforce them. The findings were further supported by the theory of nursing interpersonal relations proposed by Peplau (1952). Meetings and practicing interview strategies, comparison and synthesis of separate theme analyses, and formulation of general theoretical categories and subcategories all helped to increase interrater reliability. The research was established to be credible and reliable based on comprehensive paper trails, journalising and	the findings and conclusions more valid and credible. The volume of gathered data was high and every separate theme justifies additional investigation. The findings were clearly presented and addressed with respect to the initial research question.	

			bracketing exercises, as well as participant and peer review.		
5	Ilkiw-lavalle and Grenyer, (2004)	The study was based on a qualitative, exploratory, descriptive, cross-sectional approach, with a total of 58 participants (29 personnel and 29 patients) from four psychiatric inpatient institutions recruited through non-random sampling. Data were collected through semi-structured interviews and analysed through techniques suitable for the research question. The procedure of participant recruitment was explained and justified as being appropriate to obtain the necessary research data. There was a risk of sampling and recall bias.	The main themes were extensively investigated, with consideration given to the participants' perspectives about the incidents of violence and related causes, as well as ways of reducing the occurrence of such incidents. Open-ended interview questions were asked, meaning that more data were obtained from the participants who could express themselves better.	The selection of the data for presentation was explained and the process of analysis was outlined. The findings were backed up by extensive data, while contradictory data were also addressed. Raw data extracts were used to back up the findings and the impact of contradictory data was taken into consideration. The findings were clearly stated and addressed in connection to the initial research question.	The evidence was of moderate quality
6	Jonker et al. (2008)	The study was based on a research design compatible with the research question. Convenience sampling was applied to recruit 113 nurses from six closed and semi-closed inpatient wards in the same mental health	A clear picture was provided about the factors influencing nurses' perceptions of prevalent aggression,	Sample overview was obtained from basic descriptive and inferential analysis, including absent data and outliers. Analysis	The evidence was of moderate quality

		institution. Data were collected and analysed through suitable methods. The items in the survey instrument were related to earlier studies carried out by the institution and a panel of experts reviewed the survey validity. The internal reliability and consistency of the satisfaction items were backed up by the nursing research conducted by Shaver and Lacey (2003). All the gathered data were self-reported data. Consequently, the results might be affected by recall bias and inclination to give socially acceptable answers, due to being based on the nurses' self-reported histories of violence. No longitudinal data were collected.	their attitudes toward patient violence, and the aspects associated with strategies of coercion.	results were considered statistically significant if the p-value was .05 or lower according to v2 analysis. Due to dissimilarities between institutions and potentially cultures, the results are not applicable to other mental health institutions.	
7	Maguire and Ryan (2007)	The study was based on a descriptive, cross-sectional design and conducted in multiple centres. The eligibility criteria were clearly outlined and data were collected through a dependable method. A careful approach should be applied to result interpretation due to low response rate (280 questionnaires were given, and 87	The study indicated the types of incidents of violence or aggression that the nursing staff were exposed to over a period of one month.	Descriptive and inferential statistics were used. One-way ANOVA and chi squared analysis were conducted on the data. The methods used were appropriate for accomplishing the research goal.	The evidence was of moderate quality

		returned (31% response) obtained through a non-probability method and the use of mean substitution for absent data.			
8	Nolan et al. (2000)	The study was based on a descriptive, cross-sectional design. Convenience sampling was performed to recruit 795 participants (125 psychiatrists and 670 psychiatric nurses) from five centres. A 20-item survey questionnaire distributed via post was used to collect data about the participants' experiences. A 47% response rate was achieved, with 75 psychiatrists (60%) and 301 nurses (45%) completing the questionnaire. The validity of the questionnaire had been confirmed earlier by Arnetz et al. (1996). The results are not generalisable due to questionnaire response rate (47%). The study may not be applicable outside the region it focused on, but the findings and suggestions could be useful for other mental health workplace environments.	Investigation of the extent and types of violence that mental health nurses were exposed to, as well as the available support.	Descriptive and inferential statistics were used based on Pearson's chi-square statistical test (v2). A p-value of less than 0.05 was considered to indicate statistical significance.	The evidence was of moderate quality.

3.9 Stage 6: Ordering, condensing and presenting the material.

The final step of this integrative review involves the organization and delivery of the findings of the eight studies reviewed, and any subsequent contrasting evidence. When undertaking such a review, the main investigators need to examine and assess numerous articles, with a small selection of these being included in the end publication. Thus, the possibility of important conclusions and results from papers that are not as highly rated can be overlooked (Beelmann, 2006). However, this review aimed to present a map of all known data and where it came from. As a result, the section below provides a thematic analysis of the eight studies included in this review.

3.10 Thematic analysis of the included studies

The research technique whereby results from multiple studies are methodically reviewed and integrated based mainly on textual and linguistic summarising is known as thematic synthesis (Javadi and Zarea, 2016). This technique is textual in nature, despite incorporating statistical analysis, and aims to formulate a narration regarding the results of various studies by merging together existing sources. Besides integrating evidence related to a range of research questions, thematic synthesis also includes a component of a broader review approach, which assesses the quality of research-based evidence via systematic methods (Castleberry and Nolen, 2018). Nevertheless, there are no recommendations as to how the other relevant components can be addressed.

This section will provide a thematic synthesis of the findings of the eight studies included in this review. From the eight studies, six overarching themes were identified: (1) impact of patient violence; (2) factors related to patient violence against psychiatric nurses; (3) types of patient violence; (4) interventions used to reduce patient violence in psychiatric settings; (5) sources of support after exposure to patient violence in psychiatric settings; and finally (6) feelings of nurses who were exposed to patient violence.

3.10.1. Impact of patient violence

The impact of patient violence appears to affect a person's life in a number of ways. The affects include damage to the emotional lives of individuals, resulting in many negative emotions, such as fear for self, panic, frustration, feeling unsafe, depression, sadness,

distress and anger (Baby *et al.*, 2014). Baby *et al.* (2014) identified the emotional impacts as the most obvious consequences, suggesting these can lead to more fundamental and long-lasting personal and professional struggles. Also, the negative effects of violence in the workplace could bring about loss of self-esteem, low self-confidence and mental burnout (Baby *et al.* (2014). Within their study the effects of workplace violence outside the workplace were also evident, with family and social relationships worsening as a result (Baby *et al.* (2014). In the study carried out by Stevenson *et al.* (2015) nurses believed that being exposed to various types of violence (such as verbal or physical abuse) impacted their professional lives, as well as their personal wellbeing. Study participants stated that the emotional and physical stress after being involved in violent scenarios impacted their capacity to continue successfully undertaking their jobs. Nurses experienced several different emotions after being subjected to physical violence. At the time of the incident itself, certain nurses felt that they were scared, shocked, or even numb, as well as some reporting that they did not feel anything, including pain, during the physical attack (Stevenson *et al.*, 2015). One specific nurse in the study stated that she did not know what she was feeling, and that '*adrenaline took over'*, without feeling anything specific, even though she knew she had been beaten up and had a swollen arm and bruises (Stevenson *et al.*, 2015, p. 6).

Based on Stevenson *et al.'s* (2015) findings, physical violence has caused injuries and a number of negative physical health problems to the psychiatric nurses in their study, including; bites, bruises, cuts, torn hair, along with musculoskeletal shoulder and knee

damage (Stevenson *et al.*, 2015). In addition, there were less direct, but still harmful effects suffered, such as being spat on, being doused in water, headaches, muscle stiffness, sleep problems and disturbing thoughts. Certain nurses taking part in the study felt they made worse choices in their everyday lives after being exposed to violence, such as using alcohol and smoking as a coping strategy. The physical damage of being exposed to physical violence was reiterated in Baby et al.'s (2014) study, with consequences ranging from more mild injuries, such as bruises, grazes, pain and swellings, to more grave injuries, including head trauma, suffocation and sensory problems.

In Stevenson *et al.'s* (2015) study it was evident that in the period following the event, most psychiatric nurses were still required to offer care to their patients, even though they had experienced an act of aggression. This was usually the case when participants stayed at work after the event or worked shifts soon after it. To try to ensure personal safety, the nurses tried to stay away from the patient who had harmed them, even in situations where they were assigned to that patient. Sometimes, the nurses did not agree to work with these individuals during the shifts that followed an incident, in order to protect themselves, as they believed they needed to slowly build their confidence back and establish a reconnection with the patient. A participating nurse that had to continue working with the aggressive patient stated that *''I feel like I kind of went more automatic. I did what I felt was ethically and legally appropriate for care, but I can tell you for sure I did nothing that was extra for this person. I did not want to spend time with this person. I*

feared for my own safety and I was upset about what had happened" (Stevenson *et al.*, 2015, p. 4).

One specific aspect Stevenson *et al.* (2015) investigated was whether or not the experience impacted the psychiatric nurses' capacity to act as a professional nurse, and this was shown to be based on the perceived seriousness of the event. Some of the nurses in Stevenson *et al.'s* (2015) study believed they had trouble focusing on their responsibilities, were dazed after the event, had difficulty in establishing trust between self and the troublesome patient, and they tried to keep a safe distance. Thus, the nurse's capacity to deal with the patient's emotional difficulties could have been impacted, and subsequently their capacity to pre-empt any violent incidents was inhibited (Stevenson *et al.*, 2015, p. 5). Nurses in the study were shown to feel differently towards the patient, specifically having less empathy, with one participant stating how they felt they were *"less professional and emotionally invested with them after an incident."(p.5)* a number of nurses felt that they had less confidence in predicting and dealing with patient violence after being exposed to these events. However, a minority of participants stated violent episodes were valuable experiences, increasing their self confidence in handling violent patient incidents in the future, with one participant stating they *"had more confidence in their abilities to handle these situations, but before these events they were unsure and naive about such incidents"* (Stevenson *et al.*, 2015, p. 6).

As is the case with physical abuse, verbal violence appeared to initiate feelings of fear and anxiety in psychiatric nurses (Stevenson *et al.*, 2015). Participants' stated that they felt

less safe after these events and were not in a position to handle this abuse, with fears of further violence at a later time. Participants' also felt angry and in emotional pain after this type of verbal abuse, and it was perceived as a personal attack, either against their personality or their body, as well as their position and capability as a nurse. As with incidents of physical violence, participants felt that they were more anxious and fearful after verbally violent incidents, particularly when around the aggressive patient in question (Stevenson *et al.*, 2015). In an earlier study, Kindy *et al.* (2005) suggested that following violent events, participants reported having less trust in those around them, more fear, and tried to be on their guard more often, resulting in lower morale. Kindy *et al.* (2005) also reported few cases of post-incident debriefing and support, and often there was blame and punishment placed on nurses by their superiors following a violent event.

It was also reported that nurses had difficulty dealing with their position as health care providers, needing to care for their patients and protect them, while also taking their own safety into account (Stevenson *et al.*, 2015). In Stevenson *et al.'s* (2015) study, participants' were found to have trouble dealing with the idea of being harmed while upholding their professional responsibilities. This meant that while psychiatric nurses could take action to protect themselves, in turn this caused them stress. During these physical confrontations where fear and poor self-confidence affected their capacity to handle patient violence, the participating nurses stated that they protected themselves first and their patient second. In cases of verbal violence, involving constant threats or

personal attacks, the psychiatric nurses acted to protect themselves as their top priority. In instances where patient violence was shown to be related to patient illness, nurses would place the patient needs above their own. This was also found to be the case for staff who believed in the recovery model. However, not all participating nurses were this selfless, and they all had limits to when they would prioritise themselves above the patient (Kindy *et al.*, 2005).

3.10.2 Factors related to patient violence against psychiatric nurses

From the evidence reviewed the rise in violent incidents could be attributed to a number of different factors, including personality, professional skill, clinical positions, as well as other static and dynamic elements (Baby *et al.*, 2014). Nolan *et al.* (2000) reported a substantially higher level of patient violence was directed towards nurses under the age of 39, compared to nurses over this age. The majority of participating nurses who had to deal with violence were reported as having had under 10 years of mental health nursing experience. However, a much higher percentage of those exposed to violence (more than one in five) had worked for 6-10 years in mental health care, compared to the non-victim group (one in eight).

Ilkiw-lavalle and Grenyer (2004) explored the reasons behind the aggressive events they investigated through interviewing patients and staff (45 and 46 incidents respectively), and it was seen that there were three main reasons for these events. Firstly, there were violent events based on the patient's illness (e.g. delusions). Secondly, there were

incidents due to interpersonal clashes, including communication problems between patients and staff. Thirdly, there were violent episodes due to limitations within the clinical setting, including not being allowed to leave the hospital. The way that patients and staff viewed these events was significantly different. Patients saw illness as being the main reason for aggressive events to a greater degree than staff did, and the same variance applied for interpersonal conflicts (Ilkiw-lavalle and Grenyer, 2004). Stevenson *et al.* (2015) also identified a number of patient-nurse and environmental aspects which were seen as factors influencing patient violence. From the patient perspective, types of psychiatric diagnosis, patient's history of violent behaviour, and substance misuse were considered influencing factors. From the perspective of the nurses, communication between nursing staff, debriefing after violent incidents and quality of patient assessment, were thought to be important factors. Lastly, aspects related to the unit itself played a role in patient violence, including availability of nursing staff, lack of physical space and lack of available activities for patients.

Chapman *et al.* (2010) suggested the major external reason for workplace violence was physical and/or psychological illness, while the leading internal cause was lack of experienced staff. These findings are similar to those seen in the study undertaken by Jonker *et al.* (2008), who found that older and more experienced nurses were seen to experience fewer incidents of violence. In Kindy *et al.* (2005) study, it was seen that a number of elements happening at the same time was the major reason for violent incidents, all with concurrent negative impacts. The psychiatric nurses in the study stated

that they shared a feeling of being abandoned by their superiors, through poor scheduling on days with unsafe levels of staff coverage, poor staff retention, enforced overtime, a number of nebulous promises regarding safety, ignoring dangerous signs, unsuitable policies, too much paperwork, and poor understanding of their patients. Additionally, shortages of medicine, poor adherence to a treatment plan, poor cooperation on the part of staff, sluggish reactions to emergencies, elitism, poor availability, and lack of respect for all ethnicities, races and genders were referred to (Kindy *et al.*, 2005). Participating psychiatric nurses stated physicians and ancillary personnel were despondent towards issues regarding patient interaction. In the study by Kindy *et al.* (2005), staff were shown to exacerbate the lack of safety in an environment by having limited education or training and being tired and/or burnt out. Conversely, some psychiatric nurses felt they had a commitment towards their colleagues, even though they were operating in unsafe environments, believing they should maintain group safety above addressing their own personal needs.

The design of the facility was also identified as having the potential to impact negatively on security in psychiatric units. One of the psychiatric nurse participants stated that *"the tension was high, and in combination with the lack of space and privacy, everyone in that environment feels agitated"* (Kindy *et al.*, 2005). Ilkiw-lavalle and Grenyer (2004) showed that lowering aggression could be achieved in three ways. Firstly, the patient could be controlled through medication. Secondly, interpersonal clashes could be dealt with more effectively, through communication becoming more efficient and meaningful. Thirdly,

flexible limit setting could help, including a greater number of ward activities. Roughly half of the patients and staff put forward ideas to help limit violence, but even after being prompted, the views from the two groups differed greatly, with regards to the three main factors identified above. A greater number of staff compared to patients put forward ideas regarding medical management to limit violence, whereas more patients put forward ideas to deal with interpersonal conflicts.

Those taking part in the Stevenson *et al.* (2015) study felt that the culture of nursing inherently involved patient violence and needed to be dealt with as a fundamental part of the sector, especially in the case of verbal violence. The psychiatric nurses taking part in the study suggested the frequency of violence made it an integral part of their job and because of this they did not feel the need to constantly report it. However, they also refused to tolerate such violence, and the incidents had a negative effect on the ways the psychiatric nurses viewed nursing.

3.10.3 Types of patient violence in the psychiatric setting

Of the types of violence that nurses reported they had to deal with every day, it was found that verbal abuse was most frequently encountered (Baby *et al.*, 2014). In Baby et al.'s (2014) study, psychiatric nurses felt this type of violence was inherent to their daily routine, and could be an opportunity for therapeutic engagement, by modelling more suitable ways of acting to their patients. The work of Maguire and Ryan (2007) demonstrated similar findings, where non-threatening verbal violence had the greatest

mean score, showing that it was the most widely encountered type of incident. Ranked second was physical violence, while sexual assault/rape were not shown to have occurred amongst the participants. In the study by Stevenson *et al.* (2015), incidents of verbal violence, involving abuse, emotional and psychological violence, were not as easily described by the majority of psychiatric nurses, who simply stated that these were extremely common incidents, involving bad language, threats, bullying, gestures, verbal sexual abuse, confrontational acts and demeaning behaviour. Amongst the participating psychiatric nurses, threats, intimidation or gestures (n = 7 incidents) were the most commonly encountered type of verbal abuse. Stevenson *et al.* (2015) showed that categories of physical violence encountered by participants included; being chased, being physically assaulted, punched and kicked, spat on, choked, or being assaulted with a weapon, as well as acts intended to bring about further violence (i.e. vandalism).

3.10.4 Interventions to reduce patient violence in psychiatric settings

From the incidents examined, different information and interventions were reported by staff (Ilkiw-lavalle and Grenyer, 2004). Of the interventions used, oral medication was used in 32% of incidents, secluding the patient was used in 27% of events, isolating a patient with 'time out' accounted for 14%, and intramuscular injections were used in 11% of incidents. Patient restraint was used in 9% of incidents, and simply talking to a patient was an intervention used in 7% of incidents (Nolan *et al*., 2000).

In Stevenson *et al.'s* (2015) study, patient violence was shown to bring about different nurse behaviours, with participants being more likely to use medication or coercion to pre-empt and prevent violence. Some of the psychiatric nurses stated that they felt more wary around patients and attempted not to get involved personally in incidents of verbal violence. The approaches appeared to be based on how serious the threat was considered to be, and if any other incidents were going on with the patient. Implementing interventions as a way of preventing violence can be both a secondary, as well as a primary strategy, where the focus moves from a single nurse's efforts to a team-based solution to control and pre-empt patient violence. However, even with a move towards nurse-centred approaches, participants believed that they were acting in the patient's best interests. While most approaches were described and actually used by nurses, the majority of participants believed these strategies were only useful when needed, or when used at an appropriate time. Most participants were not able to articulate a plan which would be ideal for dealing with workplace violence (Stevenson *et al.*, 2015).

The study by Jonker *et al.* (2008) highlighted an ideology of trying not to use forcible methods when dealing with violent incidents. Chapman *et al.* (2010) demonstrated nurses were able to manage violent incidents better through using methods such as counselling, physical and chemical restraints, and not being involved in this type of event when their confidence was low. In Chapman *et al.* (2010) study one psychiatric nurse suggested they avoided risky or volatile patients for a few weeks until they had regained their confidence.

3.10.5 Sources of support after exposure to patient violence in psychiatric settings

After an event involving verbal or physical violence, participants in Stevenson *et al.'s* (2015) study looked for support through informal as well as formal avenues. It was noted that management primarily offered formal support after such an event, but the participants continued to look for informal support, through their co-workers, family and friends. In Nolan *et al.'s* (2000) study, one in two nurses, and more than one in four psychiatrists, who had been exposed to verbal or physical violence, were given support following such an incident. Just under one in three psychiatrists did not believe they required support, whereas 17% of nurses did. Results showed it was co-workers who were the primary supporters for the two groups. In the study undertaken by Stevenson *et al.* (2015), '*support management'* was seen as key in offering formal support when a violent incident occurred. Where a staff member was injured the law was involved, or the person involved had to take a break from work. Participants in the study stated they had a positive relationship with their superiors and used them as a major support after a violent event. The nurses in the study also noted that when their manager did not make light of or overlook the event, and having the incident recognised as important was helpful. One of the participants stated that just recognising the event as being painful and not having it minimised was important, as well as conveying the message that it was not acceptable. However, some of the nurses said that they felt angry, alone and were blamed by their managers for the incident occurring. Some participants had no contact with managers following a violent incident, whereas others reported receiving a phone call or had a short

conversation, which were perceived as compassionate, but not offering enough support (Stevenson *et al.,* 2015).

Jonker *et al.* (2008) showed that the general mean score for social support nurses perceived they received from their co-workers when dealing with patient aggression was 4.39 (mean), with a standard deviation of 0.50. Using a 5-point scale, findings demonstrated that the nurses felt there was sufficient support from their co-workers when they needed to deal with patient aggression. More experienced professionals and nurses operating in a long stay ward felt a great deal of social support from their colleagues. In the study by Baby *et al.* (2014), peer support was shown to be the most widely used approach for a number of reasons; two of these being closeness and timeliness. Management support was seen to have improved compared to what had been offered in the past, but the psychiatric nurses participating in the study felt there was too little input from management.

3.10.6 Feelings of nurses who have been exposed to patient violence:

Stevenson et al. (2015) reported when violent incidents occurred involving other staff or patients, some participants described focusing their emotions and energy on protecting others. Shortly after the event, nurses reported that they were often able to reflect on their feelings and their immediate emotional response to the incident (Stevenson *et al.*, 2015). It was at this point that participants expressed fear, as exemplified by such statements as, *"we were terrified"*, *"it scared me"*, or *"that guy scared the living bejeezus*

out of me" (Stevenson *et al*., 2015, P. 6). Not only were participants afraid for their immediate safety, but they feared what could have happened if the situation had ended differently

After physically violent incidents, there can be feelings of anger towards the patient, and this was most evident when psychiatric nurses believed patients were in control of their actions. Stevenson *et al.* (2015) showed anger could be aimed at the psychiatric nurse's co-workers, as they felt that these individuals did not act as a team and could have exacerbated the incident. As soon as physical violence happened, participants reported there was a greater level of awareness and alertness in the following days and weeks by those involved in the incident. These emotions would spill over from the working environment into their home environment, and feelings of anxiety were reported to be prevalent in the psychiatric nurse's everyday lives (Baby *et al.*, 2014). One participant stated that they did not realise they were *"so much more aware than usual, and they formed habits of examining a room with a different view with regards to danger"* (Baby *et al.*, 2014, p. 6).

It was noted that a number of the female participants felt that they were belittled through verbal violence, for example by the use of sexually explicit comments about what they looked like (Nolan *et al.*, 2000). It was often the case that the nurse-patient relationship would change as a result of verbal violence, where the severity of the verbal abuse correlated with how much the psychiatric nurse took a step back from the aggressor,

trying where possible not to work with them, and sometimes even asking to be moved away from that particular ward (Nolan *et al.*, 2000).

While incident reports should be written very close to the event, this was not a consistent practice amongst nurses. It was noted that psychiatric nurses usually felt that they should complete reports on incidents which resulted in physical injury, but did not give the same attention to physically violent events that did not bring about serious injury (Baby *et al.*, 2014). Similarly, nurses did not feel the need to report verbal abuse, even though they have a responsibility to do so (Chapman *et al.*, 2010). Thus, it could be suggested that certain levels of violence might become the norm for some psychiatric nurses, who no longer comprehend the results of these events since they are so common, and the impact on their own health is overlooked. The emotions and worries of the psychiatric nurses did not change, irrespective of whether the individual involved had decided to take additional time off after the event, was coming back after a planned break or was simply returning the following day. They were concerned at what their colleagues' reaction to the situation might be, were troubled at the thought the patient could still be on the unit and constantly returned to the subject of their safety (Kindy *et al.*, 2005). These feelings of vulnerability continued for several days following these incidents. In Stevenson *et al.'s* (2015) study, a number of psychiatric nurses involved the law, and pressed charges against patients, or instigated restraining orders. This was usually found in situations where significant injuries or emotional damage were experienced, and the nurse felt that the patient was conscious of their actions and did not control their aggression. Certain

participants stated that the police or co-workers advised them to pursue legal action against patients, whereas clinical supervisors and hospital administration were found to be less supportive of these actions. Also, the time and effort needed to follow the legal path was a discouraging aspect.

In Stevenson *et al.* (2015) and Kindy *et al.'s* (2005) studies, psychiatric nurses shared a variety of approaches that could be of use to them in managing situations of violence, with different levels of success. The main areas that psychiatric nurses felt needed to be improved were the clinical environment itself (both the physical environment and collaboration amongst colleagues), and establishing best practice guidelines to deal with patient violence, in order to solve the role conflict problems brought about through duty to self in combination with duty to care (Stevenson *et al.*, 2015). Extra training was seen as an important area that can help limit healthcare worker stigma in relation to their patients, and boost their understanding of evidence-based risk evaluations, prevention and management options, together with practically handling patient violence (Kindy *et al.*, 2005; Stevenson *et al.*, 2015). In addition, psychiatric nurses showed that organizations must allow for these acts of violence to be discussed and examined, in a safe and blame-free workspace for staff involved, who would then feel secure when reporting violent incidents (Kindy *et al.*, 2005; Stevenson *et al.*, 2015). Thus, there must be collaborations with managers and staff to set up practices which can limit violent incidents and maintain patient care.

3.11 Discussion

This integrative review shows that mental health nurses experience patient aggression as both damaging and insulting. It has previously been suggested that patient aggression can sometimes be used for protective or communicative purposes (Jansen *et al.*, 2006): however, this was not considered as a viable possibility in the eight studies reviewed.

The wider belief among nurses included in the studies related to patient aggression being primarily destructive and offensive, having a negative effect on patient-nurse relationships, resulting in a generally more negative outlook on violent patient incidents. Most often, mental health nurses taking part in the studies included in this review stated that they could reasonably handle the widely encountered types of aggression, such as non-threatening verbal aggression, but they had less success when dealing with physical aggression. When nurses lack experience, they are more exposed to the negative effects of patient aggression (Nolan *et al.,* 2000).

Based on the previous findings, it could be suggested that restrictions, taking away services, and overloading the senses through too much activity within a confined space (ward) can all act as a precursor to initiating workplace violence (Chou *et al.*, 2002; Kontio *et al.*, 2010). The findings of the review presented in this chapter and other previous studies (Brewin *et al.*, 2000; Elbogen and Johnson, 2009) show that the characteristics of patients who have a tendency towards violence include personality disorders, previous history of aggression, stress, mental illness, lack of confidence, feelings of being trapped,

limited self-control, poor communication, being scared and feeling oppressed. These characteristics can inhibit the individual's capacity to understand what is going on around them, leading to a greater chance of violence (Buchanan, 2008).

The outcomes of the studies in this review show that verbal abuse is the most widely encountered type of incident (Nolan *et al.*, 2000; Maguire and Ryan, 2007). However, within the included papers there was no agreed clear definition of verbal violence, with the majority of nurses believing it to be simply part of their work (Kindy *et al.*, 2005; Stevenson *et al.*, 2015). In addition, verbal, as well as physical violence, often occur repeatedly (Gudjonsson *et al.*, 2004; Baby *et al.*, 2014).

Christodoulou *et al.* (2012) carried out a systematic review and meta-analysis of the included data to try and discover what set off or preceded incidents of patient violence. They found that poor staff-patient interactions were an important trigger. They noted that patients reacted badly to any limits which nurses put on their freedom. This was echoed in a number of studies included in this review (Ilkiw-lavalle and Grenyer, 2004; Kindy *et al.*, 2005; Baby *et al.*, 2014; Stevenson *et al.*, 2015), and it was seen that patient aggression is more widely encountered by individuals with less nursing experience and who perhaps have less ability to deal with patient aggression compared to their more experienced co-workers (Nolan *et al.*, 2000). When nurses have both greater experience and a higher level of education, they are more able to effectively deal with patient aggression, and do not use coercive means as early as their less experienced counterparts (Jonker *et al.*, 2008). It is suggested that these experienced individuals have greater

effectiveness in pinpointing early signs of aggressive behaviour and can implement suitable solutions as necessary (Jonker *et al.*, 2008).

Based on the findings of this review, the type of relationship, power and behaviour are considered the three main aspects relating to workplace violence (Ilkiw-lavalle and Grenyer, 2004); Stevenson *et al.* (2015), supporting the previous findings of Daffern *et al.* (2006). These three elements are connected and, if experienced negatively, can result in violent outbursts. The key basis for the nurse-patient relationship is to address the requirements of the patient in a mutually agreed way through therapeutic means (McCarthy *et al.*, 2019). However, this relationship can become violent as a result of the power imbalance and personality traits of the aggressor and the person on the receiving end (Chen *et al.,* 2008). Power can be taken away from a person in order to force a beneficial reaction, or uphold the perceived balance, and this can sometimes be enacted through an abuse (or simply misuse) of power (Duxbury and Whittington, 2005). Once a patient is disempowered, workplace violence increases significantly (Kindy *et al.* (2005). There must be confidence, the ability to make decisions, and cooperation, in order for the relationship to be therapeutic. With change to any of these elements, the potential for violence can increase and cause significant damage (Gillies and O'Brien, 2006).

In undertaking a literature review on violence against nurses, Lanza *et al.* (2006) confirmed the fact that nurses working in psychiatry are at high risk of workplace violence. In Stevenson *et al.*'s (2015) study, participants perceived violence in the workplace as part of their job and became desensitised to violent events as a result. In addition, nurses tend

to only report serious incidents of aggression or physical violence, so the majority of violent events are not documented (Lanza *et al.*, 2006; Stevenson *et al.*, 2015). This might be due to nurses not being sure how to define violence.

This review shows that workplace violence is usually seen through continued, unwarranted, unwanted and aggressive actions, with substantial damage to the person receiving these violent acts, and with limited support from management (Baby et al. (2014). For the nurse experiencing violence there are individual ramifications, as well as the wider workplace and community being affected (Gates *et al.*, 2011). The damage and embarrassment arising from workplace violence brings about lower motivation, a lack of confidence and low self-esteem. The findings of this review show that these acts of violence have instant, and usually long-lasting effects on interpersonal relations, work dynamics and the work environment at large, bringing about a negative impact to the quality of service offered (Ünsal Atan *et al.*, 2013; Baby *et al.*, 2014). Despite this important finding, all studies included in this review (quantitative and qualitative) were undertaken in developed countries with well organised healthcare systems, making it difficult to transpose findings to less developed healthcare systems, including the Saudi context. Moreover, the studies included in this review did not examine the link between psychiatric nurses' perceptions of patient violence and its social and cultural impact in any detail. A qualitative approach that explored the effect of social and cultural factors would have been useful, as it would have allowed for a more in-depth comprehension of nurses'

perceptions of patient violence and its impact on personal, professional, and cultural aspects of a person's life.

3.12 Conclusion

How nurses experience patient violence has been the subject of both qualitative and quantitative studies. Researchers have shown that nurses who work in psychiatric settings are at high risk of experiencing violent behaviour, and this has a significant negative impact upon them and possibly the care they deliver. Nurses can feel vulnerable and anxious, with their working environment often contributing to their sense of exposure and helplessness. The majority of studies relating to this topic have come from Europe, Australia and the USA, with very few studies being conducted in the Middle East and more specifically in the KSA. Therefore, there is a pressing need to undertake further studies based on qualitative methodology, to explore the perceptions of mental health nurses regarding patient violence in inpatient settings in specific local contexts, such as those of the Middle East.

Chapter 4: Methodology and Research design

4.1 Introduction

The methodology underpinning any research study represents the overall approach taken to conduct the research (Holden and Lynch, 2004). It entails consideration of the specific research strategies, procedures and stages involved in data collection and analysis (Berg *et al.*, 2004). The methods used in a research study also provide an in-depth account of how the research has been carried out in terms of the research design, context, sample characteristics, data collection methods, data analysis tools, and the limitations associated with any of the adopted methods (Burns and Grove, 2010). Given this, the research methodology also reflects the researcher's understanding of which strategies and methods to use in order to present valid and meaningful research findings.

Burns and Grove (2010) define the research design and methodology as a '*map*' that determines the way in which the study is conducted, with Marczyk *et al.* (2005) noting that both aspects guide the researcher towards the overall goal of the research. This study uses a qualitative approach to consider violence regarding the experiences of individual Saudi female nurses and the wider social and cultural context of nursing in the KSA. This is the first study on this topic that has taken a qualitative approach in the KSA, facilitating an in-depth understanding of the experiences of psychiatric nurses. I firmly believe that the findings of this research will make a unique contribution to existent knowledge concerning inpatient psychiatric patient violence against nurses per se, and in particular

of female patient violence towards female psychiatric nurses. This research principally uses semi-structured interviews with nurses to collect data, using the method of thematic analysis described by Braun and Clarke (2006) to make sense of the data.

The research methodology and design I adopted for the current study will be outlined later in this chapter. Sampling technique, data collection methods and data analysis will be described, and a critical evaluation of the qualitative-descriptive research design in addressing the research questions presented in this study will also be discussed.

4.2 Research Questions

This study seeks to answer the following research questions:

- How do qualified nurses working in Saudi Arabia's female psychiatric units describe their experiences of patient violent behaviour?
- What are the professional and personal implications of patient violence, as described by female psychiatric nurses in the KSA?
- Which approaches do female nurses perceive have a positive impact on the way patient violence is addressed prior to, during and after it occurs?
- What positive and /or negative experiences do female nurses describe on returning to the workplace after they have experienced violence?
- What strategies do female psychiatric nurses believe would prevent, minimise and address workplace violence?

4.3 Philosophical Framework

This study's key objectives were to identify, investigate and describe the experiences of patient violence among female nurses in the KSA context. This approach meant that it was critical to explore their personal perceptions of violence in their working environments, so as a researcher, I chose methods that would both answer the research question and meet the wider needs of the study.

Social interactions have a significant influence on the meaning that people apply to their own experiences (Jackson *et al.*, 2007). Therefore, in this study, it was necessary to understand participants' subjective perceptions in order to fully understand and express the meanings that female psychiatric nurses apply to their experiences and perceptions of workplace violence in psychiatric settings. Research suggests that the best way to gain insight into social reality is to explore the meaning that individuals apply to the things they experience, as well as the meaning they apply to the actions they take as a result of those experiences (Elo *et al.*, 2014). The reason for this is that both time and culture impact the way in which we understand the world around us (Seale, 2004). Therefore, in the context of this research, an understanding of the meanings female psychiatric nurses attribute to their experiences of violence in the workplace, and their own and others' actions need to be explored within the context of their values and beliefs (Sandelowski, 2010). In doing this, insight into the way in which time and culture shape participants' experiences will be gained. Although participants in research studies tend to have experienced a similar situation, in this case patient violence, it is normal for participants

to provide details of their unique and differing perceptions of these experiences. This reflects each participant's individual interpretation of an experience based on their own subjective reality (Luck *et al.*, 2007). The qualitative research methodology chosen for this study was carefully selected to ensure that the subjective meanings ascribed by each participant would be upheld (Quick and Hall, 2015). This qualitative approach is compatible with the belief that individual behaviour and feelings are impacted by the meaning individuals associate with their experiences. Within the literature, subjective knowledge is emphasised as a key source of knowledge as it provides major insight into participants' experiences and the meanings they ascribe to them (Ingham-Broomfield, 2015).

4.4 Quantitative vs Qualitative approaches

For several years, research has been classified into two paradigms; qualitative research that considers a holistic world view of no single reality, and empirical, analytical quantitative research. These quantitative and qualitative paradigms differ in terms of philosophic premises, epistemological roots, and purposes (Yilmaz, 2013). The philosophic premise is underpinned by theoretical frameworks aiding research practice that is founded on explicit values and assumptions (Cody, 2013).

Yilmaz (2013) outlines three major differences between quantitative and qualitative research. First, quantitative research focuses on randomly selected sets of variables and experimental controls, while ignoring other variables that can impact the outcome, thus

not taking context into consideration. Qualitative methods include contextual knowledge. Second, quantitative methods do not consider purpose and meaning, whereas qualitative research recognises the importance of acknowledging purpose and meaning in understanding human behaviour. Third, quantitative methods follow the etic theory regarding an outsider who is not involved, and is detached from his study objects, whereas qualitative methods explore insider or emic views. There are also differences in the data obtained in each of the two paradigms. Quantitative data, for example, is numeric, whereas qualitative data tends to be collected through text or language, providing more in-depth descriptive experiences that are directly attained from individuals experiencing the research subject (Polit and Beck, 2010). Research approaches are sometimes referred to as positivism, post-positivism and post-modernism.

4.5 Positivism, Post-positivism and Post-modernism

According to Polifroni (2011), Comte (1788-1857) is commonly regarded as the founder of positivism. Positivism is an authoritative perspective that highlights generalisability and validity of findings as the measured properties. Yilmaz (2013) states that positivism provides ideas of accurate, value-free, and clear knowledge of the world, claiming to be 'scientific' as it does not involve speculation and emphasises what is posited, similar to the term 'given' or 'datum' in Latin, or data in plural. According to positive science, reality can be established with certainty and it aims to establish facts scientifically by experiment,

comparison, and observation, with worldly objects having meaning independent of and before consciousness (Butts *et al.*, 2012).

The precision of positivism has been opposed by the introduction of post-positivism. Houghton *et al.* (2012) states that this is a probability position and does not concern certainty. Moreover, with post-positivism, knowledge is not restricted to only that which is affirmed empirically, rather it states that it is only possible to approximate reality (McGregor and Murnane, 2010). Positivism differs significantly from post-positivism, in that positivism highlights verification of theory and post-positivism focuses on falsification of theory (Ponterotto, 2005). However, the two concepts also have a common aim of prioritising the cause and effect connection of the phenomena which can be examined and measured, and the researcher must remain detached from the study topic and objective in both positions (Ponterotto, 2005). Further, the frameworks of both positivism and post-positivism form the basis of quantitative research.

Post-modernist positions reject not only positivism, but post-positivism as they consider the latter as a type of science which 'silences too many voices' (McGregor and Murnane, 2010). Post-modernists contend that it is important to focus on the significant features of existence such as gender issues, individual beliefs, power differentials, class and economic influences, and cultural and social contexts, all of which must be examined with an approach that questions what is being taken for granted (Aranda, 2006). As noted by Ponterotto (2005), post-modernism is based on constructivism that includes a relativist position according to which multiple valid realities are assumed. Bryman (2008) observed

that this notion states that findings indicate external reality. More importantly, it recognises that the research participant forms the reality and that it includes the researcher's involvement which can affect the interaction, as well as the research (Ponterotto, 2005). The researcher's interaction with participants is crucial for meaning-making, as together they will co-construct the study's findings based on their combined interactions (Ponterotto, 2005). Thus, this position acknowledges diversity and uniqueness. This position recognises that everyone experiences reality differently, that it can change with time, and that what is known by individuals holds meaning in particular contexts (Aranda, 2006). Therefore, the focus for post-modernism is on narrative traditions, hermeneutics, discourse, and critical social theory (Butts *et al.*, 2012). It can thus be stated that post modernism is pluralist and has resulted in non-empirical methods of inquiry and qualitative methodologies which can provide the researcher with tools to better understand unique realities.

To understand the fundamental basis and philosophical framework of this research, it is important to further examine its epistemological and ontological position, as well as the resulting research design and methodology. According to Creswell (2003) for efficiently exploring the research questions including the 'why' and 'how', the best suited philosophical approach must be taken into account because it offers a definitive insight into the reality of the researcher, as well as how much others are able to understand it.

As noted by Cresswell (1998), all researchers tend to have a worldview which informs their inquiries. Ontological problems are related to the nature of reality as well as being,

thus enabling how a phenomenon is understood (Crotty, 1998). There has been a long-standing debate on whether people inform the development of the social world or whether its existence is independent of them. According to positivists, there is only one reality which is discoverable, identifiable, as well as measurable, and this is referred to as naive realism (Ponterotto, 2005). Ponterotto (2005) states that post-positivists also believe in only one reality, while also believing that it cannot be truly captured or measured and is called critical realism. The constructivist/interpretivist position is opposed to these two positions, believing in multiple realities, and referred to as the relativist stance.

Sartre (1943) believed subjectivity to be the ontological foundation of knowledge. Patient experience has been noted as an important contribution to knowledge, specifically in health and social care (Warne and McAndrew, 2007). Knowledge is often referred to as epistemology. Epistemology refers to what knowing means, as well as its creation, acquisition, categorisation, and dissemination. In terms of research it also includes how the research participant, the knower, and the one-who-wants to know, the researcher, are related (Ponterotto, 2005; Butts and Rich, 2011). Ceci (2000) argue that knowledge is related to the knower. Ponterotto (2005) also noted that, in positivism, the researcher and participant do not depend on one another and the researcher does not influence the emerging data, thus making it an objectivist position in which findings are regarded as true. Post-positivism does recognise the researcher's influence on the process while maintaining its objective stance and considering the researcher and participant as being

independent of one another. Further, the constructivist/interpretivist approach is subjective and regards reality as socially constructed, and while both the researcher and participant can be changed because of their dialogue and interaction, they remain dependent on one another (Ponterotto, 2005).

4.6 The Chosen Paradigm

In this study, a constructionist paradigm is used. The reason for implementing a constructivist approach is that it promotes understanding what individual events mean and offers insight regarding individual realities (Appleton and King, 1997). The constructivist approach enables the researcher to determine a phenomenon's reality, as well as understanding potential solutions for a problem (Denzin and Lincoln (2011).

In this qualitative paradigm, the ontological assumptions are that reality is subjective, socially constructed, as well as being embedded in age, gender ideology, class, sexual orientation, and race. Thus, women are not only expected to understand their behaviour differently, but their understandings will also differ from that of women belonging to other cultures and historical eras. Hence, this study will provide an understanding that is based in culture, as well as history.

In terms of the constructionist perspective, findings of the study will also take account of the relationship developed through the researcher's interaction and collaboration with the participant. Hence, the interviews were organised in such a way that a conversation

could be held with the women participating, involving give and take, rather than one person asking the questions while the other answers (Aranda, 2006).

4.7 Approaches to Qualitative Research

Qualitative research is not limited to one approach and can involve various strategies concerning diverse data sources and methods to; investigate life, describe a group's cultural behaviour, or develop theory (Sandelowski, 2010; MacDonald, 2012).

Qualitative research methods focus on individual behaviours and experiences in the social setting, by focusing on describing and interpreting the social environment (Fossey *et al.*, 2002). It is argued that human behaviour is shaped by individuals' own interpretations of social experiences and interactions, through which a sense of self develops (Khan, 2014). Individuals then choose to take certain actions as their interpretations of the world develop and change (Ulin *et al.*, 2005). Given that the current study focuses specifically on female psychiatric nurses' experiences and perceptions of violence in the workplace, I chose a qualitative methodology with the intention of understanding the processes and interpretations the participants' attribute to this phenomenon. This approach is considered to be particularly suitable given that these interpretations are connected with the development of nurses' self-identity (Khan, 2014).

Societal and context-specific phenomena, such as patient violence, are argued to be best understood using a qualitative research design (Lambert and Lambert, 2012). According

to Thorne *et al.* (1997), the main benefit of using a qualitative methodology is that it uses the language obtained through data collection as a representation of meaning. In this way, qualitative research can be valuable in gaining insight into the way a person interprets a situation and the meaning they apply to it (Lambert and Lambert, 2012).

4.7.1 The Qualitative Research Design

The qualitative research design was developed through the explorations of researchers and practitioners in the fields of academia, social psychology, ethnography and history, with the approach having no single point of formation (Hammersley, 2007). It is argued that research is conducted to add richness and depth to our experience of the world, rather than to fully capture and model it (Patton, 2005). Qualitative research focuses on developing theory, providing insight, describing and interpreting situations, events or contexts through the use of methods that are process-focused, subjective, holistic, inductive and emic in nature (Malagon-Maldonado, 2014). The qualitative approach emphasises understanding individuals, their interactions with the world around them, and the way in which they interact with themselves (Ormston *et al.*, 2014). It is also defined as focusing on understanding the gestalt; contextual and specific attributes of events through the observation, documentation, analysis and interpretation of patterns, trends and characteristics (Speziale *et al.*, 2011). Qualitative research essentially aims to highlight the human experience of social reality through a deep exploration of individuals' lives (Arghode, 2012), requiring qualitative researchers to pay attention to the uncovering of the complex dynamics often evident in the chosen phenomena (Jones *et al.*, 2006).

Qualitative studies adopt a holistic approach, emphasising both personal experience and the wider context in which it occurs. It seeks to provide insight into individuals' perceptions of their own experiences and those of other people (Hammersley, 2007). As a result, qualitative research can provide a detailed view of participants' reality (Arghode, 2012), but to achieve this, researchers need to be non-judgemental, open-minded, flexible, have the ability to develop rapport and be a good listener (Mouton and Marais, 1992).

Whilst there are numerous advantages to qualitative research, as noted above, there are also limitations. Firstly, qualitative research is more challenging to carry out compared to quantitative research, the former typically taking months or years to conduct (Neergaard *et al.*, 2009; Turner III, 2010). Qualitative research depends on rich information, leading to the data collection process requiring more time and effort for filtering and classification. Qualitative data analysis is also more time-consuming, with quantitative data typically being undertaken with the aid of computer software, whereas qualitative data is often analysed manually, by sorting through responses and observations in order to determine key themes or patterns. Additionally, qualitative research is unique and impossible to repeat in an identical manner, since its flexibility allows the researcher to intuitively adjust the research process as it is carried out (Burns and Grove, 2005).

The primary aim of the current study is to gain insight into female psychiatric nurses' experience of patient violence, and the meanings they attribute to it. No previous studies have explored this topic in the KSA, nor in the Arab region. Thus, there is a gap in the

existing literature regarding factors influencing nurses' experiences of patient violence and the extent to which it impacts their lives in the short and longer term. Nurses' own accounts of patient violence are greatly under-represented in the qualitative literature, therefore providing a rationale for this study and using a descriptive qualitative design.

However, it can be challenging to ascertain which specific research philosophies and methods equate to qualitative research given the lack of universal criteria (Creswell *et al.*, 2006). Consequently, there is some conflict regarding the use of one individual research philosophy in qualitative research, whilst the adoption of multiple philosophies is also questioned (Creswell *et al.*, 2006). It is asserted that specific research philosophies should be adopted only with compliance to relevant criteria (Crossan, 2003). Glaser (2002) argues that the validity of the chosen research method can be reduced if the criteria are not upheld. Rolfe (2006) echoes this point, suggesting this can have a negative impact on the credibility of the research findings. Others argue that multiple research methods can be used in conjunction, favouring a more flexible approach in order to seek deeper insight (Holden and Lynch, 2004). Hammersley and Atkinson (2007) assert that whilst social research can be supported by philosophical perspectives, it is more important for the research to remain true to the research phenomena than to a specific set of methodological criteria.

In addition to the above, discourse engendered by positivists questioning the scientific merit of the qualitative approach, has also led to conflict in terms of how best to define qualitative research with regard to methods, methodologies and philosophies.

Consequently, it has been common practice for qualitative researchers to attempt to gain greater credibility by defining their work as narrative, ethnographic, phenomenological or grounded theory (Sandelowski, 2000). However, it is argued that this approach goes no further in developing a credible definition of qualitative research, instead appearing somewhat defensive (Sandelowski, 2000; Wolcott, 1992). Smith and Wolverton (2010) promote the adoption of a qualitative research approach without the need to focus specifically on grounded theory, ethnography, or any other philosophical approach; suggesting it is not necessary to support qualitative methods with one specific philosophical framework. This is in accordance with my beliefs and, for this reason, the current study is described simply as a qualitative-descriptive research study. A great many researchers have adopted the same methodological approach, with recognition of the specific benefits and challenges associated with it as a standalone method (Ilkiw-lavalle and Grenyer, 2004; Kindy *et al.*, 2005; Chapman *et al.*, 2010; Baby *et al.*, 2014; Stevenson *et al.*, 2015). Thus, it is suggested that research based on grounded theory or other research philosophies is no more credible or meaningful than qualitative-descriptive research (Colorafi and Evans, 2016).

4.7.2 Qualitative Descriptive Research: An Acceptable Design

Based on the above discussion, my chosen methodology is a descriptive, qualitative approach. Qualitative descriptive studies aim to comprehensively describe, in simple terms, particular events that individuals or groups of individuals experience.

Qualitative descriptive studies can thus be regarded as the least 'theoretical' among all qualitative research approaches (Willis *et al.*, 2016). Moreover, it has been noted that qualitative descriptive studies are said to be the least encumbered among other qualitative approaches in terms of an existing philosophical or theoretical commitment (Bryman, 2017). Phenomenology, ethnographic approaches and grounded theory, for example, are founded on particular methodological frameworks based on particular disciplinary traditions (Lambert and Lambert, 2012). In contrast, qualitative descriptive studies often are based on naturalistic inquiry that includes conducting an examination in the object's natural state as far as possible in terms of the research context. Hence, pre-selecting study variables, manipulating variables, and prior commitment to a theoretical perspective of a phenomenon is not required. Further, despite qualitative descriptive studies differing from other qualitative research designs, it is possible to use certain aspects of other approaches (Colorafi and Evans, 2016). For example, a qualitative descriptive study can include aspects of grounded theory if using comparative analysis while assessing data. However, a qualitative descriptive study cannot be considered grounded theory as it does not develop a theory from the generated data. Further, almost any purposeful sampling technique can be used in a qualitative descriptive design.

In qualitative descriptive studies, data collection tends to determine the nature of the particular events being studied. Similar to other qualitative approaches, data collection includes interviews and/or focus groups that are minimal to moderate, open-ended, or structured. Additionally, it is also possible to collect data via observations and through

assessments of reports, records, documents, and photographs (Colorafi and Evans, 2016). However, in contrast to other qualitative approaches, when analysing data qualitative descriptive research does not implement a pre-existing set of rules which are developed from an epistemological or philosophical standpoint integral to that particular research approach. Instead, qualitative descriptive research tends to be driven by data, as codes are also developed from the participants' accounts and meaning of the phenomenon being explored. Like other qualitative research approaches, qualitative descriptive studies include simultaneous data collection and analysis.

In a qualitative descriptive study, data is presented through a straightforward descriptive summary concerning the data's informational contents which is logically arranged. The data's organisation is based on the researcher, as well as the way in which the data was given. For example, data presentation can be organised in terms of time of occurrence; actual or reverse chronological order of events; categories/subcategories; the most prevalent to least prevalent themes; presenting an event from the multiple participant's perspectives; or moving from an event's wider context to a narrow context such as particular specific cases (Colorafi and Evans, 2016).

Hence, the outcome involves a descriptive summary concerning the chosen event(s) arranged so that the findings are presented to the intended audience in a relevant manner. Therefore, a qualitative descriptive approach is selected for ensuring a phenomenon's straightforward description is provided.

4.8 Ethics

The University of Salford's Post-Graduate Research Ethics Panel approved the study prior to the research being conducted (Appendix 1). The research was carried out with full consideration of respect, equality, fair treatment, and participants' wellbeing at all times. Participants were also assured of confidentiality, with informed consent forms provided (Appendix 2). In addition, permission for the study was granted by the Director of Health Affairs from the KSA MOH and the Al-Amal complex hospital in KSA (Appendix 3). Researchers must prioritise the pursuit and maintenance of ethical standards. This research followed the Declaration of Helsinki (World Medical Association, 2013) guidance, which states that the ethical requirements of research must be respected, including avoiding being dishonest and respecting participants' rights.

4.8.1 Autonomy and Informed Consent

All research directly involving participants must be carried out with informed consent as a fundamental ethical principle (Koivisto *et al.*, 2001). Therefore, all potential participants involved in the current study were provided with a written letter of invitation to take part in the study, along with a participant information sheet describing the nature of participation, the purpose of the study, their right as participants, and the approach to data handling (see Appendix 4 and 5 respectively). Participants were reassured that their personal information and responses would remain confidential and anonymous. Participants were also informed of their right to withdraw from the study without having

to give a reason, with the researcher's contact details provided if they wished to do this, or indeed if they had any other queries about the research. Participants were assured that their involvement in the study would be completely voluntary, and that they were under no obligation to participate in the research. Participants were asked to respond to the participant information sheet within 14 days if they wished to participate, at which time an agreed venue and time would be arranged for the interview. Interviews were conducted after the participant signed a consent form (see Appendix 2).

4.8.2 Confidentiality

Researchers must ensure that participants' responses are kept anonymous and private at all times in order to ensure confidentiality (Orb *et al.*, 2009). In the current study, the researcher therefore ensured that confidentiality was upheld throughout participant recruitment, data collection data analysis and during the write-up of the research thesis. The names and identifying details of all participants were removed from the raw data, including the audio recordings and transcripts of interviews, in order to uphold confidentiality. Each participant was therefore assigned a pseudonym for analysis and write up purposes. Furthermore, the transcripts were created only by the researcher, meaning that participants' interview responses were not heard by any other individual. However, anonymised transcripts were shared with my supervisors in order to enhance the analytic process by sharing and discussing our thoughts on the interviews. Participants' personal characteristics and information were concealed by ensuring that no information was taken from the transcripts that could identify any of the participants.

4.8.3 Minimisation of Harm

No counselling support is provided to Saudi psychiatric nurses or other healthcare professionals working at Al Amal Complex in Riyadh, nor is there a GP referral system in place at present. Recalling times when they have experienced patient violence had the potential to cause distress to the participants. This was therefore raised as a potential ethical concern, with respect to the wellbeing of participants in this research. To minimise any potential risk, participants were reminded at the start of the interview that they could stop and take a break when they felt the need and/or they could terminate the interview. As a mental health nurse, at the end of the interview, I turned the recorder off and gave each participant the opportunity to talk about any distress they might be experiencing. However, it must be highlighted that none of the participants reported any feelings of distress during the data collection process.

Participant confidentiality and privacy were upheld throughout the research period in order to ensure that participants felt safe to be open and truthful when discussing their experiences and perceptions of patient violence. Interviews were held in a private room within the acute care psychiatry department of the Al Amal Complex in Riyadh and participants were able to select an interview time that best suited them to avoid any inconvenience. Again, reassuring participants of the voluntary nature of their participation, and providing them with the option to withdraw from the research at any time, also helped to ensure that the research was conducted in an ethical way.

4.8.4 Justice

Keith-Spiegel *et al.* (2006) define justice as the researcher's commitment to the equal and fair treatment of all participants. Justice most often arises as a concern in the areas of participant selection and researcher-participant inequity (Fassinger and Morrow, 2013). In order to address this risk, no potential participants were excluded from the sample chosen for this research study unless they failed to meet the pre-determined inclusion criteria. In other words, all those who volunteered and met the inclusion criteria were included.

4.9 Setting and sampling approaches

4.9.1 Setting and study context

The Saudi healthcare system was the research setting for the current study, and particularly, the Al Amal Complex. The Al-Amal Complex for Mental Health consists of Psychiatric, Addiction, and Emergency units, Clinics, a Laboratory, Pharmacy, and a Rehabilitation unit. The Psychiatry Division is specifically for the treatment of mentally ill people.

There are 25 beds in the acute psychiatric unit where the study took place. There is an intensive care area specifically for patients who are regarded as more ill and at greater risk of absenting themselves or harming themselves or others. Room layouts also varied, with one private room and other rooms accommodating up to four patients. The staff

consisted of various combinations of RNs and registered practical nurses (RPNs). The ratio of RNs to RPNs varied from 100% RN, to perhaps three RPNs to one RN, and the ratio varied depending upon the particular shift.

In addition, the workload varied from one nurse to four patients to one nurse for six patients according to shift, staff availability and nurse capacity. Nurses on the day shift have more capacity as they are higher in number compared to the number of nurses on night shift. The unit had a broad range of diagnosed illnesses, such as behavioural problems, substance abuse, mood disorders, personality disorders, psychotic disorders, co-morbidity disorders (developmental disorder accompanied by a psychiatric disorder), as well as patients lacking a formal diagnosis.

This study regarding patient violence was narrowed down to the female acute care inpatient psychiatry setting within the Saudi healthcare system, in order to address the anecdotal issues related to violence in this specific area. Additionally, despite the known risks of this setting, little qualitative evidence relating to this topic has been provided in the literature to date. Furthermore, the researcher's familiarity with the setting was also beneficial in gaining access to the hospital and the nurse participants.

4.9.2 Al Amal Complex for Mental Health (Riyadh) Accessibility

The accessibility of the research setting is a key factor to consider in designing any research study (Seidman, 2013). Since I had attended training at the Al Amal Complex before the study began, the issue of accessibility was not a problem. However, despite

my previous experience with the hospital, communication via official channels still needed to be maintained. Therefore, an overview of the research proposal, along with the ethical approval obtained from the University of Salford's Ethics Panel, was forwarded to the Al Amal Complex, Office of the Advisor for Academic Affairs, with the Al Amal Complex Advisor then providing written consent (Appendix 3) for the research to take place at the hospital.

4.9.3 Sample

As the current research focuses on patient violence in the female acute care psychiatry setting from the nurse perspective, a purposeful sample was used. Purposeful, or purposive sampling refers to the sampling approach wherein participants are chosen because they can offer in-depth insight into the issue being investigated (Creswell, 2007). For the purpose of this study female nurses working in the female acute psychiatric setting, who had experienced patient violence in the workplace, were recruited. The inclusion criteria for participation in this study were as follows: (1) the nurse must be a licensed registered nurse (RN) within their local area; (2) the nurse must have worked as a nurse in the inpatient psychiatric unit within the last decade; and (3) the nurse must have encountered at least one form of patient violence in the workplace. Participants involved in legal proceedings regarding patient violence were unable to discuss these cases and, therefore, were excluded from the research.

Purposeful sampling can involve heterogeneous or homogeneous sampling, with the latter representing the selection of participants sharing common characteristics (Palinkas *et al.*, 2015). As Patton (2002) notes, this sampling approach is beneficial in research where there is a need to perform a detailed study of an event experienced by a homogenous group. Thus, homogenous sampling was adopted in the current study. Homogenous sampling allows the researcher to select groups that have experienced the given phenomenon at different levels of severity (Patton, 2002). In addition, intensity sampling was conducted in order to gain the greatest insight into the topic. Intensity sampling involves the selection of participants that are likely to be able to describe intense, though not extreme, cases of the phenomenon in question (Patton, 2002). Here, intensity was taken as the experience of physical attack, with or without injury; verbal/emotional abuse, such as harassment; and threatening or intimidating behaviour. The reason for choosing to perform intensity sampling was primarily that it could have been more difficult to access nurses who had experienced extreme cases of patient violence. The reason for this is that nurses who had experienced this level of violence were more likely to have been deceased, suffering from long-term disability, or to have left the healthcare system. Intensity sampling can be more beneficial than extreme sampling as it may allow the researcher to gain a broader and more accurate picture of the phenomenon at different levels of intensity, whilst also providing richer information than standard cases (Patton, 2002).

4.9.4 Sample Size

The size of the sample in qualitative research need not apply any specific criteria: the most important point to consider when determining the sample size is the ability to address the research question(s) (Sandelowski, 1995; Russell and Gregory, 2003). In the current study, the sample size was chosen based on two main considerations. Firstly, a sample of the chosen size was considered appropriate to provide an adequate range of perspectives and deep enough insight with regards to experiences of patient violence amongst female nurses working in the acute female psychiatric settings; secondly, the chosen number of participants was considered feasible in terms of the time available for data collection, transcription and analysis (6-12 months). Since patient violence in the psychiatric inpatient setting occurs relatively frequently, the sample size for qualitative research cannot easily be decided *a priori*. However, it was determined that a sample size of approximately 8 to 10 nurses would be sufficient for the study to reach data saturation.

With regard to the size of a qualitative research sample, it has been suggested that it should be sufficiently large so that the investigated topic is understood in a new light, yet sufficiently small to allow detailed, case-based analysis of qualitative data (Marshall *et al.*, 2013). Furthermore, the sample size can be restricted provided that the acquired data have high usability (Malterud *et al.*, 2016). Several variables must be considered in determining sample size, including research scope, how complex and accessible the topic is, data quality, and research design. Moreover, the structuring of qualitative interview questions should also be considered, as there is evidence that this determines the

richness of data. For example, data of greater richness can be derived from open questions that are posed at a later interview stage (Marshall *et al.*, 2013).

When determining saturation, it is important to determine the degree to which it is perceived as an event or process. Many authors label saturation as a 'point', which implies that it is a separate event that the analyst can distinguish as such (Mason, 2010; Liang *et al.*, 2013; Saunders *et al.*, 2018). Conversely, given the possibility that the 'new' can always arise, saturation has been defined as a 'matter of degree', and therefore the focus of saturation should be to reach the point where it would be 'counter-productive' to acquire more data, and the general narration is no longer enhanced by the 'new' (Strauss and Corbin 1998). Likewise, Mason (2010) referred to the point where additional collection of data produces 'diminishing returns'. Indeed, such an incremental method to achieve saturation has been adopted by several authors. For instance, in their interview-based investigation of unplanned pregnancy, Walker (2012) expressed confidence in reaching or coming close to thematic saturation. Meanwhile, drawing on the perspective posited by Nelson (2017) the actual notion of 'saturation' implied a fixed point and the impression of 'completeness', which was what made it contentious. 'Conceptual depth', representing the researcher's perception that an adequately deep theoretical comprehension has been attained, was proposed as a more suitable notion, especially in terms of grounded theory.

In the context of such an incremental interpretation of saturation, a further interview does not immediately enhance the richness and insight of analysis, although it is surmised

that analysis does become richer or more insightful. Thus, the question to be answered is not about whether saturation has been achieved, but about the amount of saturation considered to be sufficient (Fusch and Ness, 2015). Although this question is not as direct, it is more appropriate to emphasise that it is up to the analyst to determine when saturation has been attained. Therefore, instead of referring to a particular point, saturation involves continuous and progressive decision-making that may never have an end point.

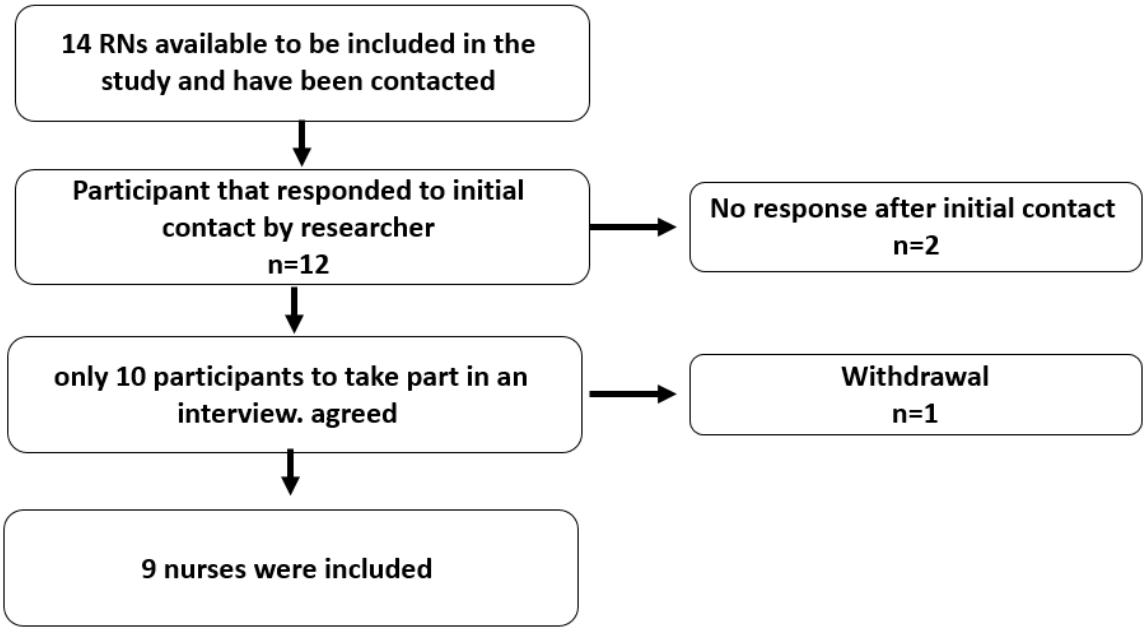

Figure 2: Participant recruitment process

4.9.5 Participant Recruitment

Participant (n=10) recruitment was carried out through two meetings with the Al Amal Complex nursing administration department, the first being held with nursing managers and head nurses, and the second with psychiatric nurses. At these meetings, I provided a brief overview of the purpose and aims of the study, with written invitations (Appendix 4) and participant information sheets (Appendix 5) provided for nurses who might be interested in taking part. I was able to develop rapport and trust with the prospective participants as a result of the interactions during these meetings. This also allowed the potential participants to ask questions regarding the study and the nature of their participation, whilst also enabling me, as the researcher, to determine which of the potential participants would fulfil the inclusion criteria. Interviews were then arranged with those who volunteered to participate and who met the aforementioned criteria for the study.

4.9.6 Interview Preparation

Since research must begin with an extensive review of relevant literature, the interview preparation stage essentially begins prior to the participants being selected. It is important for researchers to gain some level of understanding into the lives and experiences of the chosen population before commencing with interviews (Knox and Burkard, 2009). This knowledge is gained through reviewing existing literature. Thus, in the current research, a review of the qualitative and quantitative literature on patient

violence in the nursing setting was conducted in order to enable me to gain insight into nurses' experiences with the given issue.

4.9.7 Building Trust and Rapport

Agreeing to take part in a research interview can cause interviewees to feel anxious, preventing them from feeling comfortable and being able to share their experiences openly. In order to overcome this, the researcher must take care to put the interviewees at ease. Participants will evaluate the interviewer from the moment of meeting, and it is therefore important for the interviewer to present a friendly, welcoming image that helps to build trust. Participants are more likely to feel comfortable taking part in research when they feel fully informed about the nature of the study, the researcher's details, and what will be asked of them as a participant in the study (Rubin and Rubin, 2011). In the current study, the two meetings held prior to the interviews were conducted for this purpose, allowing the researcher to connect with potential participants, explain the purpose of the research, and answer any questions the potential participants may have had. The researcher also met with the participants while consent was being taken before the interviews took place, and further build rapport with the interviewees. Additionally, all interviewees were informed ahead of time that the interviews would be audio recorded, conducted in Arabic, with the recordings later being translated into English to create interview transcripts of their responses which would be analysed.

4.10 Data Collection Method

Interviews can involve structured or unstructured dialogue between the interviewer and interviewee, with participants encouraged to share their thoughts and experiences relating to the research questions (Gill *et al.* (2008). Individual semi-structured interviews were carried out as the primary data collection method in this study. In order to gain consistency, as the researcher I was also the only interviewer. The semi-structured interview approach was used, as it is frequently adopted by qualitative researchers allowing for an in-depth study of personal and social events, whilst also gaining insight into participants' experiences, interpretations and meanings (Fylan, 2005; DiCiccio-Bloom and Crabtree, 2006). Morse and Field (1996) note that the benefit of the semi-structured interview approach is the flexibility it offers to participants in terms of elaborating on their responses, whilst also enabling the researcher to address the key topics of interest. Semi-structured interviews start by asking the participant a number of pre-designed questions, and then encouraging them to expand upon their responses (Whiting, 2008). As noted earlier, the interviews were held in a private room at the hospital, for the participants' convenience and each lasted for approximately 60 to 90 minutes.

In addition to the interview, participants were provided with a brief questionnaire to collect demographic data before the interviews began. This enabled me to gather relevant information to give context to my subsequent analysis. Information such as the participants' age, position, nursing experience, and shift pattern was collected (see Appendix 6). The semi-structured interviews were then conducted, focusing specifically

on the participants' personal experiences of patient violence in the hospital setting and their perspectives on what might be done to reduce violence.

The interviews were audio recorded, with consent to do this being provided by each participant beforehand. Written notes were also taken with regards to any behaviours that may not have been captured in the recordings, such as motions, gestures, facial expressions and intonation of speech (Crist and Tanner, 2003). Prior to the analysis stage, verbatim transcriptions of the audio recordings were created with the observational comments included. The transcriptions were then encrypted, and password protected, being accessible only to myself, the researcher, and the supervisory team. Any comments that could identify any of the participants were removed from the transcriptions in order to maintain anonymity.

Confidentiality can be maintained most effectively when using one-to-one interviews, and this can also help participants to feel safe in sharing opinions or accounts that they may not wish to share with peers or colleagues. Thus, it is asserted in this research that the use of the one to one interview as the main method of data collection enabled the researcher to explore participants' feelings and experiences, as well as the ways in which they interpreted these experiences. An interview guide based on the research questions was created before the interviews were carried out (see Appendix 7). This helps the researcher to remain on topic whilst also allowing for flexibility and deeper exploration of key themes based on the participants' responses (Bloch, 2004). During the interviews,

the researcher also invited the participants to ask any questions they may have, as well as to share any information they believed could be of interest (Doody and Noonan, 2013).

Whilst the interview method has many benefits, as outlined above, the interview process does have its challenges. For instance, in the current study, it became difficult to find a suitable time for the interviews to be held, since the participants were on duty as nurses in acute psychiatric units. In many cases the participants were unable to attend their interview at the agreed time, as they were too busy on their shifts to participate. Initially, most of the participants stated that they would prefer the interviews to be held during their shift, since they would find it difficult to get home if they stayed after their shift had ended. Because of the issues encountered, the interviews were held in a private room on the ward to make it easier for the nurses to participate in the interview. The Arabic language was also used during the interviews for the nurses' convenience, and to maximise participation. Whilst the primary language spoken at the Al Amal Complex is English, and the participants were trained in the English language, Arabic remains the native language of the KSA. Therefore, Arabic is the language in which participants can communicate most easily.

The interviews for the present study all took place while the participants were employed in the same Psychiatric Hospital. On occasion this presented a challenge, since the participants' colleagues were aware of who was being interviewed and when the interview was taking place. Nevertheless, as the researcher I sensed empathy and respect from the nurses in response to their inclusion in the study. With one exception, the

interviews took place in the wards where the participants worked. The interview venue was easy for the participant to access and participation would not be a drain on the individual's time. Interruptions occurred during two of the interviews, but in each case the interruption was dealt with and it was possible to continue.

4.10.1 Disadvantages of the Interview Method

As with all research methods, the interview method is associated with certain advantages and disadvantages. One of the main limitations of the interview approach is that it is less cost-effective to conduct compared to questionnaires, taking a longer time to carry out (Lloyd *et al.*, 2006; Opdenakker, 2006). Consequently, the interview method typically involves a smaller sample than the questionnaire method. Additionally, the data collected through interviews are more extensive and, therefore requires more time and effort to filter and analyse. In the case of semi-structured interviews, ideally the researcher does not delegate the interview sessions to other individuals and carries out the interviews him/herself to ensure that the participants' responses remain on topic (Johnson and Turner, 2003).

4.10.2 Conducting the Interviews

Most interviews begin with a general question to help the interviewee feel at ease. The interviewer can help participants to share information freely using active listening and good communication skills, such as nodding, demonstrating that they are paying attention, and maintaining eye contact. Researchers can explore themes in greater detail

by using conversational probes, prompting the participant to share more about their experiences related to the topic (Doody and Noonan, 2013). It is also important for interviewers to know how to properly use cues that help to obtain authentic information of participants' experiences and the meanings they ascribe to them (Ryan *et al.*, 2009). It was important for me, as a novice researcher, to control how the interviews progressed and the topics discussed, while allowing participants the freedom to express their experiences and perceptions in their own words.

4.11 Reflexivity

Reflexivity refers to the researcher's intentional and constant re-evaluation of thoughts and perceptions as the research progresses (Pillow, 2003). This is based on the assumption that the researcher will begin the research with a number of pre-existing beliefs and expectations. The benefit of reflexivity is that it allows the researcher to consider how their own perceptions might influence the collection and interpretation of data, as well as the analysis (Berger, 2015).

It is argued that qualitative studies can be more at risk of being impacted by researcher bias compared to quantitative studies, with the interests and preferences of the researcher having a greater potential to influence the way that the research is carried out, as well as the findings of the research (Bryman, 2006). The influence of the researcher's subjectivities on all aspects of the research is readily acknowledged in relation to qualitative research (Dixon-Woods, 2010).

Whilst the researcher's familiarity with the Al Amal Complex was advantageous in terms of accessibility, the disadvantage in having this knowledge was that many of the staff found it difficult to shift from their perception of me as a visiting mentor from the university, to a researcher conducting a study within the hospital. Reflexivity was therefore important during the course of the research in order to minimise researcher bias. One of the ways in which this was achieved was to ensure that the purpose and aims of the research were clearly shared with key individuals and participants throughout the research period. Furthermore, the participant information sheet also clearly stated that the research was being conducted as a PhD study, and I also ensured that I positioned myself as a student at the University of Salford by wearing my student ID badge and wearing informal clothing whilst present at the hospital. Moreover, as the researcher I considered my part in the process in order to uphold ethical standards and permit the data to uncover the authentic experiences of the participants without prejudice or assumption.

4.12 Demonstration of Reliability

In the following analysis, the reliability of the data is inherent in the narrative, first-hand source. No alterations to the study approach were made during the research process and a detailed transcript is provided in order to give voice to the lived experiences of female RNs who have experienced violence while on duty in the acute female psychiatric unit at the hospital. The data analysis with supporting statements from the participants clearly

demonstrates the authenticity and trustworthiness of the study findings; each of the nine participants voicing their unique, as well as revealing some shared, experiences.

4.12.1 Methodological Rigour and Trustworthiness

There is much debate over how best to determine the quality of qualitative research. Whilst researchers such as Tobin and Begley (2004) assert that quality assessment should be carried out in the same way for both quantitative and qualitative research, others (Tudor *et al.*, 2013) suggest that different evaluation techniques should be used since the two approaches differ significantly. The trustworthiness of the research has been suggested as the key measure of the quality of qualitative research (Hadi and Closs, 2016).

As a novice researcher I communicated with my supervisors throughout the study process in order to ensure that the trustworthiness of the research was supported by more experienced researchers. My supervisors reviewed the interview questions before the interviews were carried out in order to ensure that they were open-ended, clear and relevant. Following transcription, I then analysed each interview, with excerpts from a large portion of the transcripts forwarded to my supervisors for cross-analysis. The analysis undertaken by each supervisor was then discussed at my supervisory sessions, with ideas and perceptions being shared, collated and considered together with my own analysis. This promoted further thinking on my part and I believe gave me a more rounded view when developing my final analysis.

Methodological rigour is greatly influenced by the trustworthiness and quality of the transcriptions as the key source of data for analysis (Ritchie and Spencer, 2002). As noted, audio recordings were taken of each of the interviews, with the researcher both carrying out the interviews and creating the interview transcripts. An in-depth account of the data collection and analytic methods adopted in this study was also created in order to further support the trustworthiness of the research (Chan *et al.*, 2013). The analysis of the data is accompanied with a clear description of the data analysis process, as rigour relies upon systematic data analysis and the transparent reporting of the processes involved (Cope, 2014).

The belief that the quality of qualitative and quantitative research should be evaluated using different criteria is held by myself in regard to the current study, as they are different both on a methodological and theoretical level. As mentioned earlier in this section, it is proposed that trustworthiness is the most appropriate measure for assessing the quality of qualitative research. Trustworthiness refers to the reader's belief that the research findings are meaningful and valuable (Shenton, 2004). This differs from validity and reliability, which refer to the degree to which the findings represent participants' true experiences, as well as the likelihood that the same results could be replicated if the research were to be repeated (Krefting, 1991). Krefting also notes that qualitative studies can differ greatly in terms of their purpose and methodologies, suggesting that trustworthiness itself must also be measured in different ways. Trustworthiness can be

measured specifically in terms of credibility, transferability, dependability and confirmability, each of which will now be discussed in greater detail (Shenton, 2004).

4.12.2 Credibility

Tobin and Begley (2004) define research credibility as the belief that the research findings are valuable and interesting. Measures were taken to ensure that the findings of the current study were credible. For instance, whilst data were collected by myself alone, the transcripts were also analysed by my supervisors to promote further analytical thinking.

My analysis was discussed and considered with that of my supervisors in order to ensure numerous descriptions could be considered and there was some process checking regarding codes and themes I had initially ascribed. This comparison was carried out both at the start of the data analysis phase and halfway through the data analysis process (Krefting, 1991). This strengthened the confirmability, dependability and credibility of the research. The credibility of the research was also supported through regular communication between myself and my supervisors, which also enabled insights and findings to develop as the research process continued. Moreover, I shared a summary of points from several participants with my supervisors to help ensure the findings accurately represent participants' experiences.

My prior experience in the acute care inpatient psychiatric nursing field lends additional credibility to the research, with further support given by having personally conducted all of the interviews. This ensured that the data collected was consistent, and that my

experience in the field could be utilised to the best extent possible, allowing participants to feel comfortable sharing their experiences openly. Some participants were happy to continue their interviews beyond the allocated time, with all other interviews being carried out for the full agreed time. This indicates that the interviewees felt safe to share their experiences, with a good level of rapport and trust built between myself and the participants.

4.12.3 Transferability

Transferability represents how well the findings apply to individuals outside the sample population, or how well the findings reflect the experiences and opinions of the chosen population. The inclusion criteria were set to include only female nurses who had experienced patient violence while working in the acute female psychiatric unit, ensuring that the findings would be richer and more transferable, supporting further research and providing greater insight into the experience of this specific group. The rigour of the study was also supported by acknowledging that the participants may have a unique understanding of patient violence not shared with myself. Also, I tried hard to avoid analytical errors, such as premature closure, wherein the findings are developed too early during the research process (Thorne et al., 2004). I achieved the latter through using open coding for the key themes, with narrower and more specific coding subsequently carried out. In addition, researchers are required to present a full description of the research population and setting to allow readers to form their own judgement as to how transferable the findings are (Krefting, 1991; Tobin and Begley, 2004). Therefore, this

approach was also adopted in this research (more detail will be presented in Section 4.14).

4.12.4 Dependability

Dependability refers to the degree to which the quality of data, collection and analysis, are consistent (Gunawan, 2015; Connelly, 2016). Since coding was only performed by myself, inter-coder reliability was not relevant. However, in order to ensure agreement over the coding system used, as well as the key themes generated, samples of the transcripts with the coding were cross-checked with my supervisors at numerous points.

4.12.5 Confirmability

Cope (2014) defines confirmability, which is also referred to as neutrality, as the extent to which bias has been avoided during the research being conducted. For this study, I kept a record of meetings from all supervisory sessions, allowing the processes undertaken to be developed and documented. This ensures that the research findings can be confirmed and audited, allowing the research quality to be more easily evaluated (Thorne *et al.*, 2004). Furthermore, this also enables the study to be repeated by other researchers using the same processes (Tobin and Begley, 2004; Gunawan, 2015; Connelly, 2016).

4.12.6 Participant Wellbeing

The participants were not considered to be placed in any physical danger as a result of their involvement in this research. However, due to the nature of the research topic, it

was acknowledged that the participants may find discussing patient violence upsetting or distressing. Therefore, I took great care to be sensitive towards the verbal and non-verbal cues of the interviewees to ensure that participants were as comfortable as possible. No emotional or psychological distress was reported or observed amongst any of the interviewees during their engagement in the research.

4.13 Interview transcript translation

The first step towards analysing the interviews was to transcribe them verbatim. The transcript must remain true to what each participant said. This means that transcriptions must include pauses, mis-hearings and speech dynamics (Biggerstaff and Thompson, 2008). In the present study, interviews were carried out in Arabic. For this reason, I translated them into English, since it enabled my English-speaking supervisors to understand the given data. This was crucial since it allowed me to check my own data interpretation. Transcribing the interviews in Arabic prior to translating them into English was a viable option, which would enable frequent referral to the original data throughout the process of analysis and presentation.

It is difficult to ensure trustworthiness in qualitative research where the need for language translation occurs. It is critical that the translator is observant, conducts back-translations and accounts for culture and language differences. These are key issues that must be addressed when conducting the research (Chen and Boore, 2009). The researcher/translator's capacity to comprehend the cultural background of interviewees

is at the heart of successfully overcoming translation dilemmas. Attempting to understand the real-life experiences means that the researcher must constantly make crucial decisions and interpret cultural meaning, as well as just translating literal meaning (Tsai *et al.*, 2004; Chen and Boore, 2009). For this reason, it is vital that the interpreter possesses a similar cultural background to the research participants (McCormack, 2000). In the present research, I personally translated the interviews, since I have the same cultural history as the participants.

4.14 Data analysis

As stated by Hesse-Biber (2010), qualitative research approaches are varied and diverse and offer a nuanced evaluation. In conducting a qualitative analysis, thematic analysis (TA) is often considered the most fundamental method and one that should be adopted by all researchers as it is not only flexible, but also provides the foundational skills required for several other qualitative analytic methods (Vaismoradi *et al.*, 2013). 'Thematizing meanings' is, in fact, considered a generic skill for all qualitative analyses (Braun and Clarke, 2014). Moreover, Gibbs (2007) suggested thematic coding, not as an independent approach, but one that is conducted as part of the major analytic traditions of qualitative research.

Qualitative analysis can be classified into those that stem from an epistemological or theoretical position and those that do not depend on theory or epistemology (Caelli *et al.*, 2003). As a research method, TA is flexible as it has theoretical freedom while

providing a complex and detailed data account. Not only is TA a flexible and accessible method, it is also popular as a qualitative method for data analysis (Vaismoradi *et al.*, 2013; Braun and Clarke, 2014). In the following sections, I will provide a detailed explanation of how I undertook TA and the six-step process (Braun and Clarke, 2006) I used in conducting my analysis.

4.14.1 Thematic analysis

Developed by Braun and Clarke (2006), TA is described as '*sophisticated'* and *'systematic'* by Cramer and Howitt (2004, p. 341). TA is an analytical method that is used to methodically identify, organise, and evaluate the patterns or themes in a dataset (Braun and Clarke, 2014). Researchers can better identify and understand the cumulative and shared experiences and meanings as TA pays attention to the meaning of patterns. Thus, it determines the common elements present regarding a subject and examines them (Vaismoradi *et al.*, 2013). The patterns that are identified using TA should be relevant and pertinent to the specific research topic that is being studied. An analysis has to determine a question's answer even if the question itself may not become clear until the analysis is done (Vaismoradi *et al.*, 2013). In a dataset, a large number of patterns can be identified, and an analytic method has to discern those patterns that answer specific research questions (Braun and Clarke, 2006).

TA can be adopted not only as a realist or essentialist method to observe participants' experiences, reality, and meanings, but also as a constructionist method to study how

experiences, realities, meanings, and events affect society's various discourses (Braun and Clarke, 2014). Moreover, TA can also be applied as a contextualist method that is between essentialist and constructionist methods. TA can, therefore, be applied to mirror reality as well as to examine reality (Braun and Clarke, 2006). Often, TA is classified as a realist account and thus its theoretical position must be established. There exist several assumptions within a theoretical framework, such as the type of data that is present or their real-world implications and relevance. It is important to clarify this when undertaking thematic analysis.

4.14.2 Why I choose to use thematic analysis.

There are two major reasons for choosing to use TA; firstly accessibility and flexibility (Holloway and Todres, 2003). TA offers easy access for those who are unfamiliar with qualitative research to conduct an analysis that may appear overly complicated, vague, or conceptually challenging. It familiarizes the researcher to the mechanics of coding and to systematically analysing qualitative data (Braun and Clarke, 2014).

TA's flexibility is evident in the various ways in which this method can be conducted. Analysis and coding data uses a 'bottom up' approach, which is an inductive approach. This is determined by the content of the data (Joffe and Yardley, 2004; Braun and Clarke, 2006). This means that the content of the data forms the basis of the codes and themes such that the researcher's analysis of the data correlates closely to that provided by participants. In contrast, the 'top down' approach to analysis and coding of data is a

deductive approach (Braun and Clarke, 2006). In this, various subjects, ideas, and concepts are brought to the data by the researcher to interpret and code the data such that these ideas and concepts form the basis of the codes and themes and the mapped analysis by the researcher does not closely correlate to the content of the original data (Castleberry and Nolen, 2018).

4.14.3 Themes

Themes have been defined as something that captures the important aspects of the data pertaining to the research question and which represents a pattern or meaning present in the dataset (Braun and Clarke, 2006; Braun *et al.*, 2012). This is carried out in the reviewing phase when themes are interpreted (Braun and Clarke, 2006).

TA takes account of the implied level of data, such as latent concepts or underlying ideas, requiring interpretative work at the theme development level (Boyatzis, 1998; Braun and Clarke, 2014). Several other studies, such as those by Joffe (2012) and Pollio and Ursiak (2006) have also noted that TA is more suited to determine implicit or latent meanings. This is especially true for data-driven or inductive TA using a bottom up approach for developing themes, as was the case in the present study. McLeod (2011, p145) uses music as an analogy for a theme. He uses *'theme'* to refer to a *'melody or some emotional resonance'* that is present throughout the musical piece. Thus, a *'musical theme indicates the composition of musical cues that hold unique meaning for the listener'*. In the current study, these segments of '*melody'* are the segments of text that formed the initial themes,

that is, McLeod's '*musical cues'*. McLeod's concept of the composition of musical cues corresponds with this study's analysis of themes present in various texts, as well as the significance given to interrelationships among themes during analysis.

A researcher's subjectivity is important for analysis so that appropriate judgements regarding what aspects are important, noteworthy, and related can be made. This adds to the analytic process. Moreover, as themes are related to what holds specific meaning for the listener, in this case is the researcher, the analysis must determine the rationale behind, and the creation of, that meaning (Castleberry and Nolen, 2018). Expressing how difficult it is to articulate the precise meaning of a 'theme', McLeod (2011, p145) states that *"a theme is more than what is being said, that there is more to be understood by the listener or reader if they allow themselves to reflect upon what is said."* He states that *"a theme is a pattern that repeats in an attempt to convey the significance of how a person perceives the world."* McLeod emphasises that to identify themes, as well as their interrelationships, the researcher must take an associate and sensing approach in understanding themes. It requires ample time and effort to reflect upon a theme to identify and understand its significance. I considered it essential to completely immerse myself into the text in order to generate themes that accurately represented the data, similar too how one would immerse themselves into music.

4.14.4 Doing thematic analysis: a step-by-step guide

Braun and Clarke's (2006) six steps framework was helpful in managing and analysing the data logically and was thus effective in my study. However, it should be noted that such step-by-step guidelines are not rules and some flexibility should be applied when analysing data (Patton, 1990).

Phase 1: Familiarising myself with my data

As in all qualitative analytic methods, in this phase, I immersed myself in the data by reading the textual data and listening to the audio-recordings multiple times. In this phase I made notes about the data while reading or listening to it, writing comments in my notebook to focus on what I believed to be potentially important aspects of the data. At this stage, the notes I made helped me read the data as data. Reading data as data involves an active, critical, and analytical reading of the words, as opposed to a surface reading like I would read a novel or magazine (Alhojailan, 2012). It involves thinking about what the data means by asking questions such as 'How does this participant interpret their experiences?', 'What are their assumptions when interpreting these experiences?', 'What is the type of world that their interpretation reveals?' My notes generally resembled a stream of consciousness and ideas jotted down for my benefit. These notes worked as memory triggers or aids that were useful during the coding phase of the analysis. This phase was intended to make me intimately familiar with the content of my dataset and to begin noticing things that may apply to my research questions. I read my

dataset thoroughly at least twice to ensure that I knew every aspect of the data.

Although transcription may be considered tedious and time-consuming (as mentioned in 4.13 Interview transcript translation), it was an effective way to familiarise myself with the data (Alhojailan, 2012). Moreover, Oliver *et al.* (2005) has argued that transcription can be considered an important phase in analysing data within descriptive qualitative methodology. Data analysis was dependent on my familiarity with the data. However, rather than considering it as a linear process, I treated it as an iterative process by repeating every step multiple times until I reached the insights that I have presented in the finding chapters.

Phase 2: Developing initial codes

Once I had familiarised myself with the content of the data and identified what I believed were its interesting aspects, Phase 2 began. In this phase, initial codes were used to identify those features present in the data that held my interest. Fereday and Muir-Cochrane (2006) refer to codes as the fundamental element of raw data that can assess the relevant phenomenon in a meaningful way. Coding involves the data being organized into meaningful groups and, as such, is part of the analytic process (Tuckett, 2005). The coded data, however, differs from the analytical units or themes which have a broader concept. The data is analysed interpretatively in the next phase where themes are developed and the concerned phenomenon is analysed (Boyatzis, 1998).

I followed Charmaz and Mitchell's (2001) process to develop a manual coding index in which I reviewed the transcripts and labelled those aspects that seemed potentially important. Using this, I developed codes which were a pattern of statements or words related to a significant meaning (Vaismoradi *et al.*, 2016). These codes descriptively denoted the meanings of the data. (Coyne and Cowley, 2006) have described similar methods and have argued that it is not possible to analyse each data piece as described. Table 5 present one example of the coding mechanism.

Table 5: Example of coding of transcription

Transcript	**coding**
I was subjected to many incidents, including verbal and physical and I used to verbal violence from patient and family, but one incident I was hit by a patient and affected me. Some family shout on us and blame us for anything happened to patient and also abuse us for not allow food or smoking and other thing related to policy.	Many (Frequency) Source (patient and family) Verbal is part of the job Shout ,blame Hospital policy

I began the analysis by evaluating the interviews of four participants. The same code was assigned when participants identified similar meanings or situations in the transcript. I placed these codes in the text's margin (Vaismoradi *et al.* (2016). Initially, however, multiple codes were assigned to certain sections. I identified 65 codes through initial manual coding, along with which I also wrote memos, following the suggestions of Strauss and Corbin (1998). These memos indicated the initial stages of my analytical process and were used for explaining the codes. Writing memos helped in articulating the recurring

themes that were observed in the data. Memos worked as both reflective and analytical tools by continuously challenging my earlier conceptions and descriptions of the data and ensuring that alternative interpretations were examined. This technique adhered to the iterative process of analysing data in the framework approach (Smith and Firth (2011).

Phase 3: Determining themes

When the initial coding and collation of all data had been accomplished and various codes identified, Phase 3 began. In this phase, the focus is diverted from codes to themes by classifying the various codes into themes and assembling the relevant coded data within the themes that have been identified. I began analysing my codes and examined how these different codes could potentially form an overarching theme. I wrote down each code with a brief description on different pieces of paper and shuffled the pieces around to organise them according to the relevant themes. While some codes became major themes, others were more suited as sub-themes or were discarded.

Phase 4: Examining themes

Once a set of potential themes are established, Phase 4 begins. This phase involves refining the potential themes. During this process, some of the potential themes are revealed as not being themes at all, particularly when the data is too varied or there is not enough to support such themes. Similarly, some themes may combine to form one theme, and other themes may have to be separated into multiple themes. This is where the dual criteria of internal homogeneity and external heterogeneity for judging

categories comes into play (Patton, 1990). The themes should be clearly distinguishable and the data within them should come together comprehensively.

There are two levels involved in refining themes. The first level requires the researcher to review the coded data, and to do this I had to examine each theme's collated data extracts and determine whether they formed a cohesive pattern. Once I had achieved this I could progress to the next level. Where themes did not form a coherent pattern, I evaluated whether the problem was within the theme or only certain aspects of the data that may not have fitted with the theme. If it was the latter, I worked on my theme again and created a new one for those data extracts that did not fit in the existing themes or discarded those extracts from my analysis. I was only able to move on to the second level of this phase after I was satisfied that the potential themes were reflective of the coded data.

A similar process was employed in the second level, except that it was undertaken with the complete dataset. In this level I determined whether the individual themes were valid in terms of the dataset and whether my potential themes reflected the meanings present in the dataset. To an extent, the researcher's analytical and theoretical approach indicates what an accurate representation would mean. At this level, I re-read the entire data, not only to determine whether the themes were applicable to the dataset, but also to ensure that no data was left out during the coding stages. As coding is an organic and ongoing process, recoding is expected. After making sure that the thematic map is valid, I

progressed to the next phase. If it was not valid, I reviewed and refined my coding until I was satisfied with the themes that I developed.

During this process, if I identified more interesting themes that I believed were applicable, I began coding these too. It is important to remember, however, that coding and developing themes can go on indefinitely and that one should not become over-enthusiastic with re-coding ad infinitum as there are no clear guidelines when to stop this process (Gibbs, 2007). Once I saw that my revised codes were not contributing anything of value, I stopped this process. As this phase ended, I had a better understanding of the different themes and how they relate to each other, as well as what they suggest about female patient violence against female psychiatric nurses.

Phase 5: Defining and refining themes

Once I was satisfied with my thematic map of the dataset, I started with Phase 5. In this phase, I defined the themes and refined them. Here, 'defining and refining' refers to determining the 'essence' of each theme and of all the themes together, and identifying the aspects of the dataset to which each theme applies (Braun and Clarke, 2006). Each individual theme required me to analyse them in detail. Apart from determining what each theme is conveying, it was crucial to contemplate how each themes' 'story' fits into the overall 'narrative' told by the data as a whole and as it pertains to my research questions. This also ensures that the themes do not overlap excessively. Therefore, I considered the themes individually, as well as how they relate to each other. I further

determined whether there were sub-themes within a theme, that is, whether there were themes existing within themes. Sub-themes can help in structuring complex and large themes and in establishing the data's hierarchy of meaning (Braun and Clarke, 2006). Toward this end of this phase, I was able to determine my themes clearly. A suggested test is to ascertain whether the content and scope of each theme can be conveyed in a couple of sentences. If this cannot be done, the theme may need to be further refined.

Phase 6: producing the report

Once the themes were established, Phase 6 began. In this phase, the final analysis and report write-up is presented. A TA write-up should be able to convey the complex data such that the reader is convinced that the analysis is valid and has merit. The analysis, and its write-up, which includes data extracts, should provide a coherent, concise, non-repetitive, interesting, and logical account of the data and the story that it tells within, as well as across, the various themes. The write-up must also include sufficient evidence, or data extracts, that establish the existence of the themes that are present in the findings (Zhang and Wildemuth, 2009).

4.15 Chapter Summary

This chapter has presented a detailed account of the descriptive qualitative methodology adopted in this study. Additionally, this chapter has justified the use of the methods and approaches outlined, whilst also describing the research design, participant selection and

sampling processes, and the data collection and data analysis methods used. This chapter has also presented a discussion of all relevant ethical considerations made when I undertook this research.

Chapter 5: Findings

This chapter will commence with a presentation of demographic information relating to the nine registered female nurses who took part in the research. Following this, a detailed description and interpretation of the nurses' experiences of patient assaults will be provided. The latter will be presented as themes emerging from the study.

5.1 Demographic Profiles

Nine registered female nurses working on a psychiatric female inpatient unit in Riyadh formed the sample in this study. All nine women had undertaken generic training to become a registered nurse. The women had an average of 12.5 years' experience working as a registered nurse, with 8.5 years being the average length of service working in a psychiatric setting. Of those participating, seven were from the KSA and two were non-Saudi nationals. All worked eight hour shifts and had a bachelor's qualification in nursing. (Please see Table 6 below).

Table 6: Demographic characteristics of participants

Criteria	Number
Gender	All were female
Age	Range 26-40 years mean: 31.5 years
Education College University Master's degree PhD	 3 5 1 0
Experience as nurse	Range 3-17 years mean: 6.8 years
Experience as mental nurse	Range 2-8 years mean: 3.8 years
Nationality Saudi Non Saudi	 7 2
Fulltime Part time	9 0
Marital status Single Married Divorced	 1 5 3

5.2 Themes

Following analysis of all nine interviews, four overarching themes were identified, with each of these having a number of sub-themes. The overarching themes are; (1) The occurrence of violence, (2) The determination of violence, (3) The impact of violence, and (4) The elimination of violence. Each of these themes together with their sub-themes are presented in Table 7 below.

In order to provide evidence to support the findings, direct quotations from the transcripts have been used, as this enriches the transparency of the research. To safeguard participants' anonymity, any personal information has been excluded from participants' direct quotations. In addition, each participant was given a number, one to nine, and will be referred to by their number when their personal quotations are used to clearly demonstrate the research findings.

Table 7: The themes and subthemes of this study

Themes	Subthemes
1. The Occurrence of Violence	Defining violence Type of violence Accepting the inevitable Time of occurrence
2. The Determination of Violence	Personal factors Workplace factors Socio-cultural factors
3. The Impact of Violence	Immediate consequences Individual experiences of violence Longer-term consequences Feeling abandoned
4. The Elimination of Violence	Achieving the prevention of violence; Reporting the incident Achieving control

5.3 Theme 1: The Occurrence of Violence

Within this overarching theme, participants described what happened to them with respect to violence in the workplace. As shown in Table 6 above, this theme has been broken down into four sub-themes: (i) Defining violence; (ii) Types of violence; (iii) Accepting the inevitable; and (iv) Time of occurrence.

5.3.1 Defining violence

At the start of each interview, participants were asked to define violence in psychiatric units. The answers participants gave included descriptions of both physical and verbal violence.

''it is understood by the "patient violence" term that it is referring to a patient's negative thoughts about the hospital and healthcare team and their desire to express it using words or body parts to attack nurse." (RN1, p1).

Violence was defined by several participants as something that included physical contact, such as hitting, with intent to harm. However, others also included nonphysical violence, for example '*flailing*' (RN6, p1), *'spitting',* (RN4. p1) *'squaring up in your face'* (RN4. p1) and verbal assault within their definition.

Nonetheless, RNs often focused on describing the violent act deemed to be the most threatening to their personal well-being, rather than those that were viewed as less threatening, such as swearing or cursing. For example, three of the participants initially

stated that verbal abuse happened frequently and therefore was not always regarded as violence (this will be further explained in Section 5.3.4). However, more detail from participants showed that they consider it as part of their job as it occurred frequently and they did not to report it.

All participants talked about experiencing violence from the family or relatives of patients within their definition of patient violence.

''This includes the patient's family as well'' (RN3, p1),

''Some family shout at us and blame us for anything that happened to the patient and also abuse us for not allowing food or smoking and other things related to policy" (RN6, p1).

Three of the participants associated patient violence with being integral to their mental illness:

''Patient's violence stands for physical violence or speech from the patient due to her/his illness'' (RN5, p1).

"It is meant by patient violence, the hitting, fighting and speaking aloud toward nurses. Mostly due to mental illness'' (RN7, p1).

The above evidence demonstrates the wider context in which participants define patient violence. Such contexts include; adopting a hierarchy of violence, with verbal attacks

often not being regarded as abuse, violence from the patient's family, and attributing it to the patient's illness.

5.3.2 Type of violence

The RNs who took part in the study outlined various incidents of patient violence at work, which included both verbal and physical assault. During the interviews, nurses outlined various violent events that they regarded as physical violence on the part of a patient or their family members towards nurses. The physical violence that was reported took several forms, including being ''trapped, being struck, seized, thumped, throttled or being spat upon''. Furthermore, the use of a weapon was also reported, in addition to the destruction of the immediate surrounding environment such as smashing windows. Four participants reported incidents that included a mixture of violence; for example, being hit and kicked at the same time. Hitting was the most commonly described act of physical violence, followed by grabbing, often by the hair, and kicking. Such incidents did not just involve physical violence, some of them involved simultaneous verbal assaults such as swearing, threats and offensive comments.

'' I was caught by the patient, who spoke to me, sat me down, put her hand on my shoulder and threw me on the ground, and she kicked my back badly with her leg with all her strength and she said, 'I will kill you'' (RN2.p1).

''She suddenly attacked me and held my Hijab against my neck. She was very strong, and I felt dizzy and [experienced] *loss of consciousness. It was a really bad experience''* (RN1, P1).

For most participants, incidents of violence, which included verbal, emotional and psychological abuse, appeared to be more difficult to describe. A lot of the participants could only give a general description of verbal violence since it was agreed that being subjected to it happened very frequently (this will be discussed in more detail in the next section 'Accepting the inevitable'). Eight acts of verbal violence were reported by the participants in this study. These varied from swearing, being threatened, rude gestures, intimidation, sexually inappropriate comments, nasty comments or confrontations. The most frequently reported experience was threatening behaviour and intimidation.

"I was subjected to many incidents, including verbal and spitting, squaring up in your face' or I have been threatened many times during the work" (RN4, p1).

''The patient held me until I couldn't defend myself from the speed of the kicking and beating me. She used a smashed window to attack me" (RN3, P1).

"The situation, however, ended after a time of hitting …….with the help of others" (RN3, P1).

5.3.4 Accepting the inevitable

The study participants stated that nurses working in the psychiatric department fully expect to be assaulted, as it is inevitable and considered part of their job as a mental health nurse.

''I have been subjected to many incidents, including hitting and using words, but this always happens to us as mental health nurses'' (RN3, p1).

These expectations were described by the nurses in such a way that they appeared to be normalising violence. Consequently, only one participant had bothered to report the violence. One participant stated:

"I used to accept verbal violence as it occurred frequently" (RN5, p1).

Similarly, participant 4 considered verbal violence as an inherent part of a nurse's role when working in the psychiatric unit;

''I'm used to verbal violence from patients and their family'' (RN4, p1).

This is further confirmed by participant 7, who expected to be a victim of violence any time during her shift;

''I had faced many [verbal violence] and I expect this to occur anytime'' (RN7, p1).

This tendency for nurses to normalise violence in the working environment could result in inadequate remedial action and may be a significant hindrance to limiting the risk of further violence.

5.3.5 Time of occurrence

Six nurses reported that most violence occurs during the evening shift. Only two nurses claimed that the greatest level of violence occurred across all shifts, but peaked in the afternoon when families visit the patients.

''Regarding timing, the violence can occur in all shifts especially in the evening when there are visitors'' (RN5, p3).

However, one participant claimed that the nurses working on the morning shift were exposed to most of the violence.

In summary, ‘’The Occurrence of Violence’’ theme identified ways in which the participants defined violence and the types of violent acts they had been exposed to, including those from patient’s relatives. In addition, participants also voiced how the experience of patient violence was a normal aspect of their role as a nurse when working on the psychiatric unit, with what appeared to be passive acceptance of this situation. The risk of violence in relation to time was also discussed. However, there was some discrepancy as to which shifts were most problematic in terms of violence occurring. In the next theme, participants’ perspectives on what can trigger violence will be presented.

5.4 Theme 2: The Determination of Violence

Factors contributing to violence in the workplace are encompassed in the second theme. This theme has three sub-themes; (i) personal factors; (ii) workplace (hospital) factors; and (iii) socio-cultural factors. Each of these sub-themes can be further sub-divided into specific vulnerabilities in the workplace which might increase the risk of violence. Hence, personal factors can be sub-divided into (a) factors relating to the nurses, and (b) factors relating to the patients. Workplace factors can be sub-divided into: (a) managerial factors; (b) environmental factors; and (c) doctor patient communication. For example, managerial factors may include the extent to which violence is reported and what steps are taken to reduce the risk of future violence. This will depend upon whether the hospital management is proactive, reactive or complacent. Environmental factors may influence the frequency and seriousness of the violence, while doctor-patient communication was clearly perceived to have an influential role.

5.4.1 Personal Factors

Personal factors that were perceived to trigger violence can be divided into those related to nurses working in psychiatric wards and those related to the patient's

a) Factors related to Nurses

The participants in the present study described themselves as care providers, responsible for assisting patients with treatment and recovery. They also stated that they had to take

responsibility for the safety and welfare of patients, their relatives and colleagues on the ward, and there were many approaches needed to accomplish this.

"I love the psychological ward, so I always read about mental illness and how to deal with patients, and I have always participated in workshops on awareness of mental illness, I like to give those patients the care they needed.'' (RN5, p4).

The necessity of having rules in place to limit risk and maintain safety was reported by participants. More frequently than in other disciplines, however, it was the nurses themselves who were responsible for enforcing the rules.

''Hospital policy such as sleeping hours and no smoking, patients think it is from the nurses not the hospital.'' (RN2, p2).

These rules are initiated and implemented through hospital policy, particularly for those who are admitted involuntarily. However, the nurses in this study reported being frequently made responsible for enforcing those rules. This created a power differential that might be heightened due to nurse having to enforce organisational rules. The rules frequently reduced patients' freedom: for example, the nurse having to refuse a patient permission to leave the hospital. One participant talked of patients' referring to the ward as *"a prison*" (RN4, p4). According to the nurses in this study, patients demanding or attempting to leave the hospital before being discharged appeared to be a major factor contributing to patient violence. Other hospital rules also appeared to be a precursor to violent behaviour.

''Patients do not accept the hospital system, including sleeping and waking hours and the no smoking policy'' (RN3, p3).

''A woman asked for a drink of coffee after dinner. The nurse refuses to give it to her because the patient has to sleep earlier and also because they have early morning sessions with the psychologist in the next morning. Patients do not accept this system and blame the nurses and start hating her and may hurt her anytime." (RN3, p3).

The loss of power arising from the RN withholding something from the patient or "*placing boundaries up on her''* (RN2, p2) was the most strongly recognised trigger for physical and verbal violence. According to RN8 (p2),

"Patient asks for a smoke and according to the rules and hospital policy, the nurse should say no."

This was supported by RN09's statement '*the denial of a request was the most frequent trigger for patient violence*' (p1). Similarly, a frequent precursor to patient violence was the patients' perception that their rights were being ignored, especially when they were involuntarily hospitalised. RN1 stated:

''I think, I spot a certain cause which led to the event; I asked the patient what had caused her to do this, and she told me that she liked me, but when I prevented her from escaping she began to hate me. She told me other nurses deal with her as a prisoner and she did not like to be on the ward.'' (RN1, p2).

Based on the findings of this research the denial of something appeared to be a common factor triggering patient violence. Likewise, if patients thought they were being deprived of their rights, i.e. being admitted involuntarily to hospital, this often acted as an antecedent to subsequent violence. RN9 outlined an example of this:

''The patient was prevented from doing something they want to do (*smoking or drinking) this led to the violent attack."* (RN9, p1).

"When distributing meals containing no sugar, a patient felt unhappy even though she is diabetic, and she told me to switch the meal with a patient next to her. However, I refused to do so since it was her own meal. She got upset and tried to throw everything into my face.'' (RN8, p2).

Some of the study participants also believed they had a responsibility to ensure the safety of their colleagues. One patient who the nurse was delivering care to, threatened another member of staff with physical violence. The participant believed that the interaction between the patient and various members of staff resulted in further violence. According to RN02:

"Upon the doctor's request, the nurses and I tried to give her the needle, and we asked for help from the men, who helped us to hold the patient. Then the patient became aggressive with me and my colleagues too who tied her. She was trying to take any opportunity to express this anger by shouting at us, every time we did something to her, she told us that we allowed a man to come to tie her up while she was uncovered.'' (RN2, p1).

When considering this incident within the context of Saudi culture whereby the genders are segregated, and as a female patient it is not acceptable to be seen by male security, the action of calling for help to hold the patient down would be likely to incite aggression. Furthermore, in this study, ineffective communication between nurses and patients was also found to be a nurse-related factor contributing to patient violence. A number of participants made comment on this;

''Sometimes the nurses make patients aggressive by using some word or shouting at patients.'' (RN2, p2).

“That's to say, the patient was treated in an inappropriate manner, such as the patient spoke to the nurse, but the latter refused to respond.” (RN8, p1).

Nurses have a responsibility to protect patients from misunderstanding the nature of the relationship they have with the nurse. Within the therapeutic relationship a nurse should always be professional and respectful; it cannot be personal. One participant, who believed she was having a positive interaction with patients was surprised when she was attacked;

''I had faced many and I expected this to occur at any time, but one case affected me so much. It happened while I was sitting with the patients in the sitting room, where patients used to sit, and was playing cards with them, two patients surprisingly caught me, one grabbed my hands and the second grabbed my legs.'' (RN7, P1).

In order to de-escalate potential incidents, nurses need to think about the consequences of their own behaviour. To do this, they must assess their own feelings and remain vigilant and aware of what they are saying and how they are acting. This requires constant self-discipline, as well as a high degree of self-confidence on the part of the nurses' own judgement and understanding.

In conclusion, participants perceived that it was the nurses' responsibility to enforce the hospital rules and policy. Not respecting the patient's privacy, their human rights and the prevailing socio-cultural context of their lives were all considered possible triggers that could lead to violence. The rules, hospital policy and boundaries which are established should mirror the service's mission and vision, support personal responsibility and provide patients with the help they need, while ensuring the environment is safe for everybody.

b) Factors related to the patient's mental illness

From the participants' perspective, patient-related factors contributing towards violence were often considered to be their mental illness/cognitive impairment. Participants believed the patient's mental illness compromised their ability to interact appropriately with the nurses, resulting in unpredictable behaviour that appeared to catch the nurse unaware.

''As the patient was suffering from hallucinations, I expected the reason [for violence] *was among those symptoms.''* (RN3, p2).

When analysing the nine participants' interviews, it became evident that as far as physical violence is concerned, all believed that individuals with psychosis displayed some form of violence, and this was caused by the symptoms associated with such conditions, including impulsivity, hallucinations and delusions. Participant 4 stated:

''This is related to their mental illness; some patients have delusions about all other people." (RN4, p2).

Participants also suggested it was the mental illness affecting patient behaviour that led to acts of violence. An example of this was given by participant 6:

''The result of a hallucination that a patient might have, heard or seen something, So the patient's verbal or physical violence is a result of delusions, part of her mental illness' (RN6, p2).

A similar view was reported by participants 7 and 9:

''Thus, there are several specific factors that might have triggered the incident: for example, changing mood and patient behaviour attributed to their psychiatric ailment.'' (RN7, p1).

''Also, there are factors that might have triggered the incident such as (a) delusion; she felt I hit her or talked about her" (RN9, p1).

Mental disorders including schizophrenia and bipolar affective disorder were identified by the participants as associated with patient violence. However, one participant avoided attaching violence to a diagnosis, but rather to the individual's personality. The participants perceived patients' ability to manage stress and anxiety, as well as their illness, often caused them to lose control and this ultimately influenced their violent tendencies, irrespective of their psychiatric diagnosis. As this participant explained:

''This is a personal thing not related to her mental disease." (RN1, p3).

Some of the participants in this study highlighted how changing the patient's treatment, for example by prescribing a new drug or altering the dose, may trigger unexpected aggressive behaviour among the patients. Participants 9 and 5 offered examples of this;

''Due to changing the dose [of medication]*, was the cause of the incident''* (RN9, p1).

''In a case where the doctor changes the medication for the patient or lower the dose, this could affect the patient's mood and behaviour.'' (RN5, p3).

Participants also stated that a history of violence and/or substance abuse also correlated with tendencies for violence. When patients are admitted to the ward due to violence in the community, participants also regarded this as an increased risk for violent actions within in the hospital setting. One participant commented;

''the patient had aggressive history particularly with family''. (RN8, P2).

One participant (RN3, P1) described substance misuse as being a direct contributing factor to violent behaviour in hospital *"I think addiction plays a significant role in violence attack in some patients''*. History of substance abuse was highlighted by another participant as risk of patient violence:

''She wanted to run away as this patient had a long history of substance abuse, therefore she was unable to manage stress'' (RN6, P1).

The study participants believed delusions and hallucinations that is related to patient mental illness could trigger aggression outbursts and such factors may be described as intrapersonal, patient-related antecedents. In addition, they also acknowledged that a history of violence and substance misuse also had the potential to trigger violent events within the hospital setting.

5.4.2 Workplace (Hospital) Factors

Workplace-related factors are the conditions within the hospital which can promote patient violence, and which are the hospital's responsibility to manage. These factors can be further sub-divided into: (a) managerial factors; (b) environmental factors; and (c) factors related to doctor-patient communication.

a) Managerial Factors

The participants consider that patient violence in the workplace is aggravated by the heavy workloads set by the management. The effects of these workloads are; a reduction

in the amount of time the nurses can give to individual patient care, a reduction in the number of experienced staff available, an increase in levels of frustration among nurses, and the provision of conflicting information. The study participants all concurred that heavy workloads influence the level of violence, as patients become increasingly frustrated and aggressive when they receive less care and attention from the nurses.

"I remember there were six nurses for the first time and five for the second with me (nurse to patient ratio 1:6, 1:5). And this is one of the reasons that such an incident occurs, there is a shortage of mental health nurses and even some of the nurses are not mental health nurses, but working in psychiatric wards due to a mental health nurse shortage." (RN5, p4).

As well as influencing the levels of patient frustration and aggression, an increased workload also affects the nurses in various ways; by raising levels of tiredness and impatience, increasing the amount of stress on senior staff, reducing the time available to provide individual patient care and allowing insufficient time to finish tasks. During the interviews, it became apparent that the availability of staff on the ward was significant in terms of influencing the potential for patient violence. The nurse patient ratio in the study setting ranged from 6:25 to 4:25. The majority of participants who were exposed to violent events were those on the night shift, when there is a lower ratio of nurses to patients (nurse to patient ratio 4:25) compared to the day shift (nurse to patient ratio 6:25).

The findings of this study also demonstrated insufficient education amongst staff regarding workplace violence also impacts on the escalation of violent behaviour. The participants highlighted the importance of further education regarding how to approach, calm and physically intervene with patients who may be violent. Several participants stated that mental health nurses '*must be trained in self-defence*' and must have '*physical training'* (RN7, p4). They reported that training should cover various activities of how to deal with aggressive behaviour and improve their communication skills with patients.

B-Environmental factors

Some participants identified hospital environment-related factors that they thought impacted on the potential for patient violence. Such factors included the lack of activities for patients to engage in while they were on the ward. Two participants (RN 4 and 1) believed boredom, due to an absence of patient-focused activities, served as a factor impacting patient violence:

'' *Patients feel bored as there is no activity to do''* (RN4, p2).

''There are no activities or programme for patients' and this made them feel bored'' (RN1, p2).

Insufficient physical space and overcrowding was a further related factor seen as influencing violence. Participants outlined a lack of space as often causing interpersonal friction between patients.

“The patients do not like each other and there are some problems between the patients themselves, especially with different psychiatric conditions and personality disorders being all together in limited space” (RN1, p2).

They also indicated that space and over-crowding can trigger violence. Participant 2 stated:

''Crowded wards with limited space and no activity for the patient may trigger violence'' (RN7, p2).

Patient-patient interactions can also spark off episodes of violence. Patients in psychiatric inpatient units have many opportunities to meet up with others, whether this is during recreational or therapy-based sessions, group activities or simply by socialising in common spaces. One participant in the study described conflicts between patients on the ward as having a direct impact on aggressive behaviour towards the RN. For instance, participant 7 explained:

''Patients have problems with each other. This irritates them and then they get angry at the nurses'' (RN7, p1).

''The patients themselves are continually fighting and bullying, they tried to hit each other, this puts them in an angry state all the time'' (RN7, p2).

C. Factors relating to doctor-patient communications

Communication between the patient and doctor should be a two-way process. It is not only the patient's right, but also their responsibility to obtain correct medical information, with the doctor being in a position to expedite this process. Communication via the doctor to the patient is important in Saudi culture, as patients are more likely to trust a doctor than a nurse. However, this communication needs to be effective as the patient needs to understand the information and be satisfied with their treatment during admission to the hospital. Effective communication will help ensure patients have more knowledge about their illness, better understand the way in which the hospital delivers care, including policy, and have more reasonable expectations regarding how mental health professionals can help them. Raising patients' awareness and understanding of hospital policies will also lead to greater compliance with what they are permitted or not permitted to do while in hospital and the reasons why such rules need to be implemented.

"Some doctors do not explain the rules to the patient and leave us to explain everything, this puts us in direct contact with patients and they do not accept instruction from nurses. They always ask us if they can talk to the doctor." (RN3, p2).

Hence, the study participants asserted that the doctor must take time to consider those factors which may promote violence in the psychiatric ward. According to RN5:

''I think the doctor is very important to calm down and explain everything to the patient. They [patients] *do not accept our advice. The doctor is the key person in preventing violence*." (RN5, p1).

The above example may reflect the power differential between doctor and nurse, and the status afforded to doctors within the Saudi culture.

5.4.3 Socio-cultural Factors

Socio-cultural factors contribute to violence within the workplace, but these are beyond the hospital's capacity to manage or control. In the present study, participants suggested that the stigma surrounding mental illness in the KSA is one of the key socio-cultural factors contributing to increased violence and aggression among people who are mentally ill. This stigma arises from a tendency for Saudi society to ascribe mental illness to a combination of biological, spiritual, and environmental factors. Some Saudi families believe mental illnesses are an inherited disease, whilst others associate it with evil, or relate it to low social status and social or family problems. These beliefs cause concern for the families of those who have a mental illness, often compromising their reputation, and may also adversely affect family cohesion in Saudi society (Alamri, 2016). Hence, those who experience mental illness may find themselves being perceived as a burden by their family, as well as being rejected by the wider community. Fear of public rejection often leads relatives to hide the fact that a member of their family has a mental illness. Furthermore, in light of the investment Muslim Arab society ascribes to family reputation

and cohesion, the diagnosis of mental illness may incur an even greater degree of stigma in this particular community (Elbur *et al.*, 2014; Alamri, 2016).

All the above factors have a negative impact upon people diagnosed with a mental illness, with those receiving inpatient care generally receiving fewer visits and less support from their families in comparison with other patients. The study participants indicated that this can make patients more aggressive and can result in patient violence being focused on nurses who are present on the ward and therefore an easy target. According to participant 5:

''A few factors triggered the incident, such as those that irritate the patients, they had no visit from the family, especially when she sees another patient has a visit, the patient starts screaming and beating ……. the low level of family support and visits to those patients makes them aggressive toward the health care team'' (RN5, p2).

The impact of insufficient family support upon the patient was described by another participant:

“When the patient did not receive a visit from the family, her condition is reversed and she starts crying, beating and screaming. This is why she did not take medicines.'' (RN7, p1).

Participant 4 expressed a similar experience:

''Well, the patient had to leave the hospital according to the doctor (discharge), but her

son hasn't come to take her. So she was very angry and irritated and found a way to express this anger by attacking me. Yes we are face to face with patients, they blame us for everything'' (RN4, p1).

Another participant ascribed a violent incident to the segregation of genders in the traditionalist Saudi community:

''You know the Saudi culture and the sensitivity in the issue related to men and women relationship. It is not allowed for men to look at a woman or touch her, so in her case, we asked a man to help us and this was a very sensitive issue in this patient." (RN2, p1).

In summary, the theme of ''The Determination of Violence'' presented the findings in relation to triggers and contributory factors for violence that occurs within the hospital setting. These were divided into personal factors on the part of patients and nurses, organisational factors and factors related to Saudi culture. Participants highlighted how a patient's mental illness and their role in enforcing hospital rules and policies could trigger a violent event. Heavy workload was considered to be one of the hospital factors that prevented nurses from developing more effective therapeutic relationships with their patient's thus increasing the prevalence of violence. This was accompanied by insufficient education amongst staff regarding workplace violence. Participants suggested more ward activities for patients could reduce violent events. The next theme will present the impact of a violent event on the nurse and patients.

5.5 Theme 3: The impact of patient violence

Most of the study participants agreed that physical and verbal violence in the workplace has various effects upon those experiencing it. The participants described a broad range of impacts including personal physical and emotional effects, personal and professional dissatisfaction, reduced productivity and ultimately resignation from the nursing profession. The emotional impacts included feelings of fear, insecurity, stress, desensitisation, intolerance, suspicion and hyper-vigilance. This third theme examines the impact of violence in the workplace, with evidence being presented under the following four sub-themes: (i) Immediate consequences; (ii) Longer-term consequences; iii) Feeling abandoned; and (iv)Positive impacts. These sub-themes are further divided into an additional six subthemes as presented in Figure 3 below.

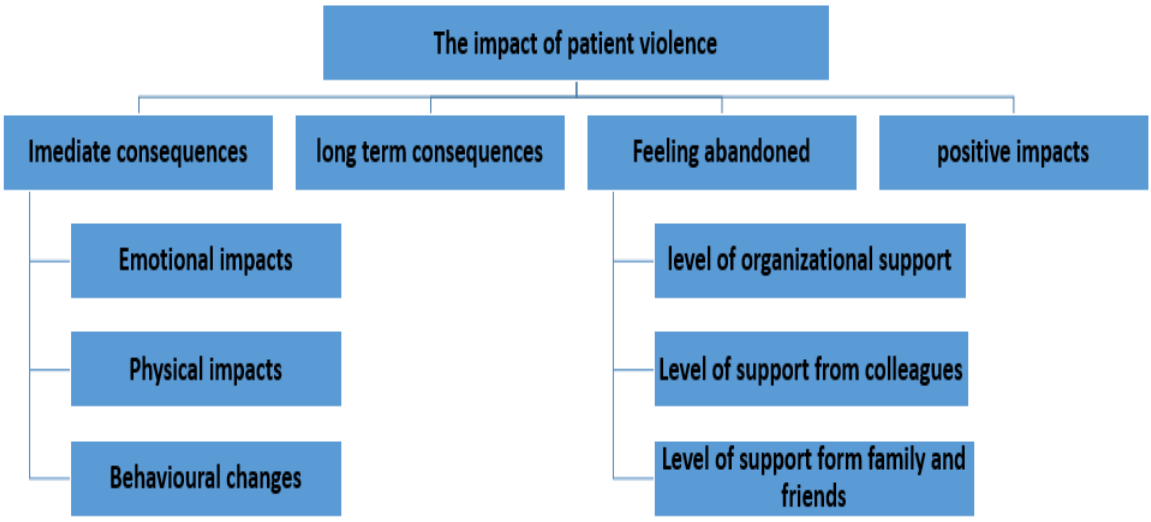

Figure 3: The subthemes included in this theme

5.5.1 Immediate consequences

Each of the nine study participants admitted to having experienced numerous negative emotional, physical and behavioural impacts when exposed to violence. This subtheme explores some of the participants' views of how patient violence events affect them.

a) Emotional Impacts

The emotions perceived by the participants during incidents of patient violence included fear, shock and/or numbness. Reflecting on an episode of physical violence, one participant said:

''I felt terrible, I cried all night from fear that I was about to die of being suffocated by the patient. '' (RN7, p2).

Many participants reflect and describe their feelings after the incident had taken place. It was then that the participants generally reported having felt fear, demonstrated in statements such as: *"I was extremely anxious and scared"* (RN6, p2)*, or "I constantly felt scared and unsafe all the time"* (RN1, p3). The participants were not only concerned for their immediate safety; they also tended to worry over what the final outcome might have been under different circumstances, or what might happen in future incidents. For example, two participants explained: *''I still feel scared, unsafe, and stressed all the time''* (RN2, p2). *''I stayed for some time in fear and thinking that such an incident may be repeated* (RN6, p3). Concerns over what might have happened if the event had played out

differently appeared to occupy their thoughts, irrespective of whether or not the nurses suffered physical injury during the actual incident*:*

"I was too afraid for myself and my fear turned into panic." (RN2, p2).

Two participants emphasised feelings of fear that they might be personally blamed for the incident, either by the hospital administrators or the nursing team*:*

''I was worry about being blamed by my team.'' (RN6, p3).

''They will blame me as I was sitting with them and playing, the hospital administration will find any mistake and put the responsibility on me.'' (RN7, p3).

Another two participants worried about what their colleagues might be feeling about them personally: *''Also I feel shyness of the people who attended the situation and my colleagues at work* (RN3, p2)*. ''The nurses here will start laughing and blame me for this case''* (RN1, p4). In addition, some of the participants did blame themselves, or at least felt partly to blame for the incident. For example, one participant said*:*

''Once I was affected and asked myself, what did I do to the patient? I felt that I have to explain more about hospital regulation to the patient or ask the doctor to explain the policy to the patient.'' (RN5, p2).

B) Physical Impacts

Visible and non-visible physical injuries were described as a result of experiencing patient violence. Visible injuries included bruises, bites, hair loss, lacerations and musculoskeletal injuries affecting the shoulder or knee. In addition, non-visible injuries such as headaches, muscular tension, insomnia and nightmares were reported following patient violence. Some participants also reported poor diet and feelings of stress after their exposure to patient violence. For example, one participant said:

"I felt stressed, anxious and could not eat anything because I had had a bad day on the unit" (RN8, p2).

The extent to which physical violence affected the nurse's ability to function professionally depended upon the perceived severity of the occurrence. Some participants found it difficult to focus on nursing tasks or to think clearly following a violent incident. Moreover, one participant reported a feeling of diminished trust towards the aggressor, which led to her keeping *"a little more distance"* (RN7, p3). These effects may in turn reduce the nurse's capacity to recognise future symptoms of patient anguish or tension, thereby diminishing their ability to actively avert violence. Some participants described a sense of decreased empathy towards the patient. For example, two participants suggested:

'' I was very careful when dealing with the patient later on, I am always ready for any attack.'' (RN8, p2).

''I spend less time with patients, it really affected carrying out my nursing role.'' (RN1, p1).

C) Behavioural changes

Following patient violence, study participants reported changes in their own behaviour. For example, a nurse may more readily resort to medication or coercive measures in order to suppress violence and uphold her own safety. Conversely, in an attempt to avoid violence, the nurse may become increasingly cautious towards patients, as described by RN1 above, and less liable to engage and spend time with the patient. In dealing with verbal violence, one participant stated;

''I felt working there has changed my behaviour and the way I used to deal with people.'' (RN7, p3).

Due to patient violence she had been exposed to, one participant started examining her options to change shift in the hope of avoiding the night shift, during which she felt most vulnerable. She explained;

"I started trying to find a day shift and swap, because I did not wish to work nights any longer." (RN1, p4).

In addition, verbal and physical violence in the workplace resulted in numerous perceived effects not only on the RNs, but also on the patients themselves. While the nurses perceived physical and emotional effects along with the impact on their ability to function professionally, they also reported signs of physical and emotional effects upon the patient

who had initiated the violence. Nevertheless, patients were observed to calm down after incidents of violence and, in some cases, the participants said they observed signs of remorse on the part of the patient. Patients were sometimes reported as apologising for their behaviour: *''she calmed down and came apologising to me''* (RN4, p2). The effects of patient violence upon the patient appeared dependent upon the emotional experience and the relationship between nurse and patient. The study participants often considered a violent incident adversely affected the nurse's relationship with the patient who had initiated the violence. This in turn, would negatively impact upon the quality of healthcare received by that patient. Some of the reasons why the nurse-patient relationship and patient care were adversely impacted are emphasised in the following two statements:

''I currently spend less time with the patient and try to be careful all the time, it affects my relationship with all other patients negatively.'' (RN9, p3).

''Because I'm not going to focus on a therapeutic relationship after this event." (RN4, p3).

Therefore, workplace violence can have a negative impact on patients, as nurses may withdraw from interacting with them, become less caring and compassionate, and their desire to build therapeutic relationships may be compromised. Nurses may become overly cautious and more restricted when they interact with patients and visitors.

"I'm not likely to have a nurse-client relationship with that individual, just because I do not trust them" (RN4, p2).

5.5.2 Longer-term consequences

Serious and long-lasting professional and personal consequences were reported by participants who had been subjected to violence in the workplace. Their personal lives were, and often still are, affected by feelings of emotional hurt, insecurity, vulnerability and lack of means for self-defence against aggressive patients and visitors. Nurses who are threatened or experience moments of fear react in various ways, such as becoming stressed, exhausted, mistrustful, intolerant, hyper-vigilant, desensitised and sensitive to insult or criticism.

‘’*I constantly felt scared and unsafe all the time.’’* (RN1, P3).

‘’I felt scared and angry.’’ (RN6, P2).

''I think I will retire early, I feel exhausted by the workload, not respected and the violent attacks on this ward are very stressful and scary.” (RN1, p5).

The study participants did not readily divulge the long-term impacts of the violence they had experienced. When these were mentioned, they focused only upon the self. The lasting effects of violent events were related to the participant’s emotional self and to their professional decision-making.

''I was thinking of leaving the job.'' (RN6, p3).

Many participants recognised feelings of desensitisation towards patient violence, a response which was perceived as both a negative consequence of the experience and a positive mechanism for coping with it. Three of the participants claimed to have become more '*hardened'* and *'downbeat'* due to the cumulative effects of repeated verbal violence. Following physical and verbal violence in the acute psychiatric ward, two RNs described feeling *"emotional exhaustion"* (RN1, p1) and "*every time I decide to quit the job*" (RN4, p2), leading to a lack of empathy towards their patients. These participants also considered patient violence could lead to their resignation from acute inpatient psychiatry in favour of other work:

''I said to myself I have to switch to another section.'' (RN4, p3).

''I'm thinking to move to another department because I need to change my work with patients and revive my activity.'' (RN8, p4).

Several of the study participants considered that the high frequency of verbal violence in their workplace led to them being more tolerant of it. These participants initially believed that the overall effects of verbal violence were less significant than those of physical violence. However, after verbalising and becoming aware of their own responses in the present study, a number of participants revised their views on the cumulative and lasting impact workplace violence was exerting on them. One participant commented:

''I will leave this job early if there is no improvement in the situation.'' (RN2, p2).

This study has illustrated that nurses regard violence seriously, to a point where they feel the need to make a choice of whether or not to continue in the nursing profession. As exemplified in the following quotations, nurses may elect to leave the profession specifically because of violence in the workplace:

''It is a very bad experience and every day I have the idea to quit the job and stay safe in my home.'' (RN3, p2).

"Also, in the long term, I will change my mental health field to another, because it is possible to have a stronger or severe injury as a result of patient violence." (RN9, p3).

Despite this experience, a sense of altruism made one participant decide to continue to work in psychiatric settings:

''Every time I decide to quit the job, but when I think about other patients' I change my mind.'' (RN4, p2).

5.5.3 Feeling abandoned

This subtheme deals with the perceived lack of support provided at an organisational level, as well as the limited support from colleagues and family after violent events. This subtheme is further divided into: 1) level of organisational support, 2) level of support from colleagues, and 3) level of family support.

a) Level of organisational support

Many participants perceive violence in the psychiatric unit as just part of the job; an attitude that could lead to an environment in which violent behaviour is tolerated (Section 5.3.4, accepting the inevitable). The study findings have revealed a significant lack of managerial and administrative support for psychiatric nurses faced with patient violence. Study participants reported minimal support or acceptance from the hospital administration when violence had been reported. For instance, the participants reported incidents in which the hospital failed to react in support of a nurse who was assaulted. One participant remarked:

"There is a lack of sense of safety and also no appreciation or support from the medical administration." (RN9, p3).

Participants in this study reported that they go back to work immediately after a violent incident, unless they have been physically injured. This is due to the hospital policy of not giving sick leave or time out following such patient violence. Those exposed to violence are rarely offered any two-way verbal support, in either a formal or informal context, following the incident. The lack of attention offered to those who have been violated could contribute to the detrimental impact of the experience. Moreover, some participants felt extremely angry as they believed they were either unsupported or blamed by their managers for the incident.

“The hospital administration offers us no support and tends to blame nurses for whatever issues may arise.” (RN2, p2).

Most of the participants received no verbal contact from their managers after a violent incident, while others reported minimal support from the nursing office. Some individuals expressed concern that their managers might place the blame on them when questioning them about the incident.

''I did not get any support from the hospital administration and all my colleagues told me not to report the event as they will blame me'' (RN4, p3).

These observations suggest that the administration does not acknowledge the importance of providing the necessary support to nurses who have been threatened or assaulted. The participants assert that managers and administrators must prioritise various forms of support if violence in the workplace is to be combatted. Most participants felt saddened and disappointed by their managers’ lack of support and continued to experience issues and concerns regarding their return to work after the incident. As one participant commented:

''I went to the head nurse, expressing my fear of what the patient had already done to me. She was very supportive, but she told me that nothing will be changed as we work in this ward with a risky group.'' (RN7, p4).

Although the study participants generally expected support from nurse leaders (managers, administrators, or senior staff who provide training), this expectation falls somewhat short of reality. This resulted in enhanced levels of stress along with feelings of suspicion, frustration and generally having been let down on the part of the participants. Repeated examination of the data clarified that every participant experienced a recurrent lack of support from senior staff and managers during incidents of violence. Moreover, this inadequate support was repeatedly described in similar terms; that the nurse leaders were failing, either as individuals or as representatives of the organisation, to provide support for nurses who were victims of violent events or in need of care.

''There is no support from the hospital administration and there is a nursing blame culture in the hospital. Management are neglectful of us, they are not interested, they're ignorant.'' (RN9, P3).

This failure of nurse leaders to provide support was perceived by the nurse participants' as a *'let-down'* with significant impact upon the nurse's actual experience of violence and subsequently work-life quality. The participants regarded this '*let-down'* as contributing more to their emotional trauma than the actual assault.

'' I was affected very badly, particularly with regards to the lack of psychological or financial support from the hospital administration.'' (RN5, P5).

Many nurses described the lack of managerial support as promoting feelings of being criticised in the work setting. The managers can, themselves, appear aggressive as they continually scold staff or threaten them with performance assessments or disciplinary action. The nurses repeatedly spoke of feeling despair in the working environment because the management appeared to be criticising them. One participant stated:

"Management pay us no attention and disregard us completely; they are indifferent and inconsiderate." (RN6, p3).

Another participant suggested:

''There is a lack of a sense of safety and also no appreciation or support from the medical administration'' (RN 9, p3).

Possible solutions put forward by one of the participants included compulsory training courses for managers to enhance their management skills, along with robust policies for defending staff against workplace violence.

''The nurse office and management need to learn and be educated about how to support nurses after violent attack or bullying incidence." (RN7, p4).

b) Level of support from colleagues

Study participants discussed the response of colleagues during a violent incident in order to help manage it. Colleagues would often provide first-aid for the injured RN and

sometimes even assume charge of care for the aggressive patient. Nevertheless, only two participants received informal emotional support from colleagues after an incident:

'' My colleagues support me and everyone shares their bad experience with me'' (RN3, p3).

"The other staff support and encourage me and this help me to relax." (RN4, P1).

Most participants reported having no support from their colleagues after an incident, irrespective of the nature of the incident or the feelings they experienced. For some participants, this was also due to a reluctance on their part to talk about the incident, as they feared they might be blamed for what had happened. For example, participant 1 stated:

"I do not like to talk with my colleagues as I feel this may make the situation worse. The nurse will start laughing and blame me for this case." (RN1, p4).

Similarly, Participant 5 explained:

''I don't like to talk about my problems nor about things that displease me. A lack of support is the main reason for this.'' (RN5, p3).

Blame is often perceived as being endemic within the work environment, such that the study participants felt inhibited from talking about their feelings or reporting an incident for fear of being blamed. Non-Saudi studies suggest that people are reluctant to be forthcoming and truthful in reporting violence as there is an inherent presumption that

they will be blamed as an individual and possibly even reprimanded for the incident (Gifford and Anderson, 2010; Cooke, 2016). This fear of blame and punishment therefore creates a significant psychological hindrance to reporting incidents or sharing personal experiences with colleagues. The general environment of blame in the workplace was again emphasised in the following statement:

''My colleague was not very supportive and blamed me for this case" (RN2, p3).

Participants in this study highlighted the importance of discussing their feelings with colleagues in order to receive a degree of emotional support. Such support is vital in replacing feelings of isolation with those of comradeship. The importance of support from colleagues is paramount, as the working relationships between RNs and their colleagues directly influence their perceptions of the working environment (Baby *et al.*, 2014; Lantta *et al.*, 2016).

b) Level of support from family or friends

For Saudi individuals, going to work in a mixed-gender setting such as a hospital continues to be a controversial issue, despite the fact that the majority of hospital specialties are gender segregated, including the psychiatric unit where this study was undertaken. Conservative and religious Saudis generally regard this kind of work as 'haraam' (forbidden), except during national crises. In contrast, more liberal-minded Saudis may regard such work as being down to personal choice, particularly in view of the significant number of jobs available within the health care profession. Within this context, most of

the study participants noted that their friends, relatives, families and the public at large tend to regard nursing as inappropriate for Saudi females and, hence, provide little support for RNs subjected to patient violence. Participants' 2, 3 and 7 reported similar family experiences:

"My husband tries to convince me to change my job and he is still doing that now" (RN2, p3).

"*My family advise me to leave the job."* (RN3, p3).

"I have been through, talked to my sisters just to get relaxed and secure. Because she is the only one who understands my work and encourages me. Other family members or friends did not support me. They think that it is my fault to choose to become a nurse. No one likes nursing jobs in the KSA." (RN7, p3).

The study participants also felt challenged by the social and cultural attitudes towards nursing being an inappropriate role for Saudi women. Saudi culture regards it as unacceptable for females to undertake long shift work and, particularly, to be away from their homes overnight, even if this is a requirement of their work:

"The family will blame me as I choose nursing; nursing in Saudi culture is not a good choice for family as you know" (RN4, p3).

In addition, many families are opposed to their female relatives being employed in a mixed-gender hospital setting. Regardless of the effects of globalisation and the push for

more Saudis in employment in health care, Saudi parents are frequently opposed to young Saudi girls taking up work in such settings or from experiencing any contact with men. Hence, the general attitude within Saudi society is that it is wrong for Saudi females to take up nursing. One of the study participants found this particularly frustrating:

"I think you need to explore this issue in your future studies, we are blamed by family and by all other people for being a nurse. They consider nursing is not for Saudis." (RN4, p3).

Such socio-cultural attitudes arise from the traditional view that Saudi women should stay at home and look after their families. The traditions of gender-segregation and the veiling of women result in intense public and government opposition to the involvement of Saudi women in the nurse-aide training programmes in health care. Because of these traditions, which are believed to arise from religious obligations to protect women and uphold family honour, nurses feel unable to talk to their family members about the frequency or severity of violence in the workplace:

"To be honest they blame me as I chose to be a mental health nurse to work with this group of people." (RN6, p3).

"I did not mention this [violence] *to my family as they will prevent me from my work. They did not like nursing."* (RN9, p3).

Study participants indicated that Saudi culture generally regards nursing as an inappropriate career for women. Moreover, the participants agreed that this public

perception had significant impact upon the degree of support they received or should expect; all participants concurred that people regard nursing as socially inappropriate.

5.5.4 Positive impact of violent incidents

While few participants perceived positive outcomes of workplace patient violence, some became more aware of these after a significant time lapse since its occurrence. Moreover, the perceived positive effects occasionally contrasted with the more immediate effects of the experience (short-term). The reported positive impacts included; an enhanced awareness of risk, improved focus on the patient, heightened awareness of the nurse's duty of care, and an increased sense of self-regard. Moreover, positive outcomes were perceived when the participants examined the effects of patient violence upon their feelings about nursing either in a defined context, such as mental health, or generally.

''As they are mental patients, I started to give them more time to talk and this helps me to avoid any attack, made them relax most of the time'' (RN8, p4).

Following their experiences of patient violence, a few of the study participants described an enhanced awareness of safety and/or risk which resulted in increased vigilance along with more timely intervention and an enhanced focus on the patient. Furthermore, the nurses tended to take on more responsibility for their own personal safety. As participants 4 and 6 remarked:

"I always think of risk." (RN4, p3).

''I learned that every patient has a key and [if] *I know this patient is irritated, then I try to keep her calm, but the negative effect of the job is that I became a tense and nervous person especially with my children, husband and in my relations with people.''* (RN6, p3).

In summary, 'The Impact of Violence'' theme described the effect of violent events on participants, as well as the lack of support provided to participant after violent events. According to participants, this lack of support was at organizational level, with limited support from colleagues and family, the latter being due to cultural issues. However, participants also identified some positive impacts of patient violence, including enhanced awareness of risk during their rostered duty. The next theme will focus on the participants' perceptions of how violence on psychiatric wards might be reduced.

5.6 Theme 4: The Elimination of Violence

The fourth overarching theme of the present study examines potential strategies for reducing or reporting violence in the workplace. This theme has been further divided into the following three sub-themes: (i) Achieving the prevention of violence; (ii) Reporting the incident; (iii) Achieving control.

5.6.1 Achieving the prevention of violence

In examining this sub-theme, the study participants focused primarily on what is needed for the prevention of violence. This was further divided into: a) what the individual nurse needs; b) what the unit and team need; and c) what the organisation needs.

a) Needs of the individual nurse

The most frequently identified need for the prevention of violence was that of relevant further education. As the participants had not specialised in the field of mental illness, they expressed a need for further educational courses along with workshops dealing with a broad range of topics such as: diagnosis of mental illness; symptoms and treatment; defining what we mean by violence (including verbal violence); developing strategies for preventing violence; recognising the triggers of violence; building self-awareness in relationships; developing skills for better therapeutic relationships; and recognising the power differential between patients and nurses. The desire for more education by the participants is evidenced in the following statements:

"I do recommend intensive courses for nurses to be instructed to deal with the aggressive patient perfectly." (RN3, p4).

''There must be an intensive training course for nurses on how to deal with irritable patients and strategies to deal with aggressive and irritated patients.'' (RN4, p3).

''To minimise the violence, there is the suggestion to do a workshop for dealing with mental patients.'' (RN5, p4).

''Nurses need more training to be confident in dealing with the patients'' (RN1, p5).

''Psychiatric medicine is very difficult, and nurses need more training to be confident in dealing with the patients.'' (RN1, p3).

The participants also identified the need for nurses and their colleagues to have a better understanding of the roles and approaches of team members.

''To minimise the violence.....We have to work as a team not individually.'' (RN5, P4).

b) Needs of the psychiatric unit and the team

At unit level, the study participants recognised a range of needs for avoiding patient violence, such as more physical space for patients (including appropriately equipped and stocked therapeutic spaces, e.g. quiet rooms or comfortable rooms), along with an increased programme of activities:

''Making fun and activities for patients, as this removes the bored feeling and builds a good relationship between the patients themselves and between patient and mental health nurse; these activities must be always there in the department'' (RN7, p4).

The study participants expressed a desire for increased staffing levels in order to alleviate the low staff-to-patient ratios. They also felt the need for a safe ratio of experienced to inexperienced nurses:

''Doubling the number of nurses and improving their skills to deal with patients with mental illness, especially with patients who stay long in the hospital'' (RN9, p3).

The participants believed that increasing the nurse-patient ratio would help prevent violence by giving the nurses enough time to better develop a relationship with their

patients and colleagues; However, an increased number of nurses may not be sufficient in preventing patient violence: what is important is the level of understanding as to how to use interpersonal dynamics to deal with violence or prevent it occurring in the first place (Schafer and Peternelj-Taylor, 2003). Effective therapeutic relationships and being able to spend appropriate periods of time with a patient (with the right level of skills and knowledge) is likely to play a central role in preventing patient violence.

‘’Nurses should spend the time they need to get to know their patients, to have a clear picture of what is happening to them, what brings them comfort and what triggers their aggression - these kind of things. If that occurred, we would be able to pool our knowledge and really work as a team, and to run the unit with a team outlook." (RN8, p.4).

The participants in the study emphasised the importance of upgrading communication between team members and making sure they cooperated with and helped each other, in order to minimise the risk of violence. Currently, each ward where the participants worked differed in its levels of teamwork and collaboration, but everyone agreed that it was essential to continuously monitor and encourage teamwork. Several of the participants emphasised the need to improve the way in which teams worked.

''We have to work as a team not individually'' (RN5, p4).

''We need to work as a team to help each other.'' (RN2, p4).

c) Needs of the Organisation (Hospital)

A relatively small number of the study participants favoured increasing the numbers of security personnel and upping surveillance practices, both on the unit and across the hospital. It was believed that this would facilitate improved patient monitoring, provide a sense of security for nurses and patients, and enhance the relationship between nurses and security providers:

''Improving the hospital safety procedures is very important.'' (RN1, p5).

''Increase the number of nurses and safety guards, especially male guards to help in such cases.'' (RN3, p2).

However, introducing these types of security measures could be counterproductive, and simply raise the patients' anxiety levels while they are living through a psychological emergency, and lead to higher levels of violence (Muir-Cochrane *et al.*, 2012).

A number of participants agreed on the need for improved hospital policies regarding the management of patient violence, along with well-defined requirements for patient behaviour. Most of the participants were not aware of hospital policies in regard to managing violence, and the current policies relating to patient violence were viewed as poorly designed.

"Some change to hospital policy [is needed] *as sometimes the patient is irritated and needs isolation, but the hospital refuses to put them in the isolation room and says the situation is stable and this is very dangerous."* (RN3, p3).

5.6.2 Reporting the incident

The findings of the present study indicate that rather than being encouraged to report incidents, nurses are often discouraged from doing this. Moreover, the nurses often assume that reporting will have no effect and therefore regard it as a time-consuming activity. When violence is reported, the management is perceived as either unresponsive or a source of negative consequences.

''The incident reports or complaint is useless and was not taken seriously in our hospital. You will use your time and effort for nothing.'' (RN5, p4).

''I made a complaint about the case and asked to switch her to another section, but nothing was done.'' (RN8, p3).

''The hospital administration always blame us for such incidents, they worry if the Ministry of Health hear about this." (RN5, p3).

The perceptions of participants about reporting incidents of violence were that it is pointless, as there would be an absence of support for the nurse. The present study has also highlighted a lack of professional assurance, with the participants expressing concern that a request for support might be seen as an admission of failure:

''I just made a verbal complaint to the head nurse and she advised me to relax. She did not like the idea of making a complaint as this may badly affect the ward. So they will blame the head nurse.'' (RN7, p4).

Hence, among the multiple reasons why incidents go unreported, the fear of blame for precipitating the assault, of accusations of negligence and/or lack of skill as a nurse are significant factors. Nurses are concerned that they may be regarded as incapable or, if there was no physical injury involved, as troublemakers:

"I did not complain about the patient, because nothing will be changed, all the hospital do is blame the nurse in the end. I have previously submitted a written complaint about a patient and the hospital and doctor put the blame on me. I was blamed and I did not have a response to my complaint for three years, because those are mental illness patients, and they did not consider them responsible for their behaviour. Another thing is mostly they blame the nurse in order not to affect the hospital and the hospital's reputation." (RN3, p4).

The findings in the present study indicate that nurses who reported violent events in the workplace were, on most occasions, offered no form of official or social support, counselling or managerial protection. Furthermore, the nurses were instructed not to inform the authorities and, hence, the events were not investigated. The nurses were frequently made to feel that they were doing wrong by reporting the event. Having

reported a violent incident, the nurses felt unfairly treated by both the management and their colleagues.

The study participants put forward a number of possible solutions for encouraging the reporting violence in the workplace. These included establishing an easy reporting protocol.

''The reporting procedure is time and effort consuming, it is better to have an easy way to report the events.''(RN9, p2).

Another suggestion was to establish a telephone reporting protocol via which the nurse could contact a member of staff in charge of complaints. This member of staff would then request verbal information from the nurse in order to fill in the complaints form.

“It takes a long time for this procedure, it is better to report this by phone and get updated easily, but this system is not available here and you have to do paperwork which takes too much time to get any response.” (RN4, p2).

The study participants also put forward possible protocols for general management and incident management, such as intervention during and after violent events. It was agreed that clear policies on violence in the workplace must be implemented.

''There is no policy to deal with an attack or after the attack, we manage based on the doctor’s opinion, no clear rule, it should be a clear policy.'' (RN6, p3).

5.7 Achieving control

When considering the key strategies for achieving control of patient aggressiveness and preventing patient violence, the study participants listed the following: knowledge of the use and effects of medicines on aggressive patients; knowledge of the legal aspects of patient care; how to recognise agitation and evaluate risk; and knowledge of de-escalation strategies. It was also seen as important to avoid placing inexperienced and less-knowledgeable nurses in potentially aggressive situations alone. The study participants reported having used medication to calm patients down, defending this approach for its potential to contain or prevent violence which might otherwise harm the patient and/or staff. Hence, it was regarded as being in the patient's best interests*:*

''They use medication to control the patient.'' (RN1, p5).

"They took the patient to the room and gave her medicine to calm her down." (RN4, p1).

Medication was therefore being employed not only to treat the patient's illness, but also to keep them calm and reduce the chance of violence. Medication was also employed as a chemical restraint in some cases where the patient's aggressive behaviour was getting worse and the staff felt the need to respond before a more severe incident occurred. According to study participant 4:

"The patient was given a needle to calm down." (RN3, P1).

Physical restraint was most frequently resorted to in cases of physical violence. Participants suggested this was to avoid and manage additional violence, while safeguarding staff and other patients.

At that instant, and in those particular circumstances, these interventions were considered the least risky options. One participant stated, *"Nurses have to protect themselves, and protect the patient from harming them selves, and possibly other patients. So in such a situation, physical restraints are the best option to ensure everyone is safe. It is not ideal, but it is only used as a last resort."* (RN1, p.3).

In summary, the fourth overarching theme ''The Elimination of Violence'' offers insights into the participants' perceptions of potential strategies for reducing and reporting patient violence. For a nurse to achieve the prevention of violence there is a need for further education, as the participants were general nurses working in an acute psychiatric ward with no specialist training in psychiatry. Therefore, participants expressed their need for further educational courses along with workshops dealing with a broad range of topics. Moreover, participants reported that there is a need for more therapeutic spaces for patients, along with an increased programme of activities, increased security staff and surveillance on the unit. There was discouragement from reporting violent events and participants regarded it as a time-consuming activity, as no action is taken on the part of management. Finally, this theme considered strategies for achieving the control of patient aggression, including using medication to calm patients down.

5.8 Chapter Summary

Saudi nurses working in mental health units in a regional public hospital in the KSA and taking part in the present study indicated that they faced physical and verbal violence at work on a frequent basis. The nature of this violence was varied and included biting, kicking, punching and scratching, as well as verbal violence. Violence against nurses has become commonplace, to the point where nurses in this study seemed to regard it as a necessary part of their job. Moreover, they have come to expect no active response from the hospital management, so they are reluctant to report the incidents.

The general findings of this study demonstrate that many forms of violence are experienced by nurses in the workplace, ranging from verbal to physical violence. Under-reporting of violent incidents had several contributing factors, with participants believing that reporting is unnecessary when there is no physical injury. Nevertheless, verbal abuse was found to be the most frequent type of violence experienced at work by participants, while physical violence was less common, but still only reported by a small proportion of nurses.

Data presented in this chapter demonstrate how violence in the workplace impacts nurses both personally and professionally. As well as affecting their personal lives and working relationships with their colleagues, violence affects their professional lives by influencing how they relate to patients, as well as reducing job satisfaction and, in some cases, leading to resignation. While some of the participants believed that colleagues had

abandoned the profession specifically because of violent experiences, no evidence was presented to suggest that nurses who had experienced more severe forms of violence were no longer in the profession. However, this phenomenon is worthy of further research.

The participants provided practical suggestions for potentially solving or limiting the problem of violence in the workplace. These included various general management protocols, improvements to established strategies during and following violent incidents, appropriate implementation of established policy, and improved practical and emotional support for those exposed to violence. While most of the support provided to participants after violent incidents came from their colleagues rather than managers, they believed the general public had a lack of awareness of violence towards nurses in the workplace. The participants considered their own friends and family to be unaware of the seriousness and regularity of the violence they experienced professionally.

The present study provides an insight into the level of violence experienced by participants in the workplace, along with an appreciation of the forms of violence involved. The quality and forms of support received by nurses following incidents of violence have also been explored. These findings could inform nurses and managers alike regarding consequences of violence, contributing factors and reluctance to report. It could also be useful in helping to established support protocols for nurses who have been exposed to violence at work.

In addition, support is essential once a violent act against a nurse has taken place. The study findings indicate that participants felt isolated following a violent event and frequently experienced numerous emotional difficulties. Appropriate support, including one-to-one verbal interactions, has the potential to limit the impact of trauma caused by a violent incident on a mental nurse. The findings from this study clearly indicate that participants generally felt a lack of support from their managers and colleagues, which further contributed to the issue of under-reporting. Despite the negative impact of patient violence, some participants perceived positive outcomes of workplace patient violence; some became more aware of the impact of patient violence and developed appropriate coping strategies through increasing their awareness of risk and improving their therapeutic relationships with patients.

Chapter Six: Discussion

6.1 Introduction

Patient violence against nurses has been identified for many years and despite some progress being made in addressing the issue, it remains largely unresolved (Roche *et al.*, 2010; Yang *et al.*, 2018). Violence in the workplace is an important public health issue (Mitchell *et al.*, 2014). For nurses, their health and quality of work life is adversely affected by being exposed to aggressive or violent behaviour on the part of patients (Roche *et al.*, 2010; Esmaeilpour *et al.*, 2011; Gates *et al.*, 2011; Pai and Lee, 2011). One of the challenges of investigating and addressing patient violence within a mental health context is that it is a sensitive issue; this emotive topic having the potential to lead to participants' being re-traumatised when having to remember their previous distressing experiences. When exploring the topic, account needs to be taken of the wellbeing of participants, in this instance nurses and patients, as blame cannot be attributed to either group; rather the focus needs to be on resolving this contentious, emotionally driven issue for the safety of nurses and patients alike (Khatri *et al.*, 2009)

The aim of conducting this study was to gather in-depth qualitative data that would illuminate how nurses working in an acute female psychiatric unit in the KSA experience and perceive patient violence. In this chapter, I discuss the findings of this study, including; nurses' experiences and perceptions of patient violence, the background and factors that contribute to patient violence, how violence and aggression is managed and

prevention strategies. Within this chapter, an initial discussion aligned with each of the four themes identified in the previous chapter will be presented. This will be followed by a summary of the discussion in Section 6.6.

6.2 Theme 1: The Occurrence of Violence

Participants' views differed regarding the definition of patient violence and the forms of violence to be considered, as revealed in the first theme presented in the previous chapter. For instance, verbal abuse was considered 'normal behaviour' by many participants, whereas some participants thought it was a form of violence. Regardless of this, violence was predominantly identified as physical acts, which is consistent with the findings of some of the studies reviewed in Chapter 3 (e.g. Maguire and Ryan, 2007; Baby *et al.*, 2014).

If workplace violence to be stamped out, changes to professional and workplace culture must be fostered by nurses, other healthcare professionals, and employers alike, so that it is not condoned in any shape or form (Cleary *et al.*, 2009). It has been found that incidents of workplace violence often go unreported because of the lack of clarity about what constitutes workplace violence. The absence of a clear accepted definition might compromise the reporting of violent incidents, with staff and organisational managers having little or no common ground for acknowledging their responsibilities regarding patient violence. Such issues can be avoided by imposing a zero-tolerance policy so that every incident of workplace violence gets reported (Oram *et al.*, 2013). Nurses and

employers must make such changes in order to take effective measures to minimise and eventually fully extirpate workplace violence.

Therefore, the absence of a standard definition of workplace violence is a significant issue, as highlighted by both the findings of this and previous studies (Dillon, 2012; Sharma and Sharma, 2016). Whereas some definitions of workplace violence are narrow and refer just to actual or attempted physical assault (Campbell *et al.*, 2015; Kraus *et al.*, 2015), other definitions are broader and consider that any type of intentional harmful behaviour towards past or present colleagues and the organisation constitutes workplace violence (Campbell *et al.*, 2015). A comprehensive definition of workplace violence is more appropriate than a narrower one with regard to its scope and implications. The International Council of Nurses (2018) has issued a suitable definition of workplace violence, describing it as incidents where individuals are subjected to abuse, threats or assault within their workplace, compromise of their safety, and well-being or health being directly or indirectly jeopardised The WHO also aptly defined workplace violence as actual or potential harm suffered by individuals in their workplace as a result of deliberate exercise of power, threatened or real (WHO, 2020).

This study also revealed variation in the definition of patient violence, with participants individually applying their own beliefs to this concept. This variation may impact the actions that a nurse may adopt in managing patient violence. If a nurse does not perceive a patient's behaviour as aggressive (for example verbal aggression is considered by some as 'acceptable') then this type of violence may not be reported. The under-reporting

might be due to the lack of definition and because of this, nurses may lack confidence as to whether or not to report violence. This reinforces the notion that it is important to have a universal definition of patient violence, not only for reporting, but for having reliable data relating to the topic in order that appropriate guidance and policies can be established (Vessey *et al.*, 2010).

The findings reported by Iozzino *et al.* (2015) reinforce the variability of nurses' definitions of patient violence. According to Iozzino *et al.* (2015), all nurses are likely to have their own personal definition of violence. This personal variation in perceptions of violence compounds the challenge of devising a universal standard definition of patient violence. This in turn, makes it difficult to reliably evaluate the extent of the problem and to understand fully the experiences of nurses (Hallett *et al.*, 2014; Iozzino *et al.*, 2015).

Furthermore, developing a reliable database of the size and nature of the problem is difficult because there is no consistent definition of patient violence across different organisations or professions (Farrell and Mann, 2014). This makes it particularly challenging to compare studies from different sources, and consequentially affects how the issue is seen to be addressed (Anderson and West, 2011). Staff and patients alike can become confused by this uncertainty and inconsistency; behaviours that are tolerated in one location or situation might be penalised in another (Farrell and Mann, 2014).

The evidence collected in this study indicates that often nurses working in a psychiatric unit in the KSA have been exposed to different forms of aggressive and violent behaviour. The participants' experiences of such violence reported in this study are comparable to

those reported in other studies. In a study by Llor-Esteban *et al.* (2017) abuse or violence was reported by 64% of nurses. Among the manifestations of verbal abuse reported in Llor-Esteban *et al.'s* (2017) study, were sarcasm, shouting and swearing; examples of physical abuse included being scratched, spat at and being hit with a hand, fist or elbow (Llor-Esteban *et al.*, 2017). Similar violent actions have been reported in a number of other studies, with physical violence being seen as potentially more harmful than verbal violence (Pinar and Ucmak, 2011; Aksakal *et al.*, 2015; Al-Omari, 2015).

Physical violence came to the fore in the present work, as it has done in other studies. By contrast, investigations of verbal or emotional abuse are now also being reported in earnest (Al-Omari, 2015; Al-Azzam *et al.*, 2017). Verbal violence cannot be automatically assumed to be less important than physical violence, because nurses have been more inclined to report the latter (Spector *et al.*, 2014). The modelling of a correlation between physical and verbal violence can be undertaken in a number of ways. The hierarchical theory of aggression is one approach (Morrison, 1992). Patients tend to manifest physical violence after first engaging in non-physical or verbal violence (Morrison, 1992). This observation has led to the formulation of a so-called 'hierarchy of violence' model, with the probability of physical violence being preceded by non-physical violence. In light of this, Lanza *et al.* (2006) suggests verbal violence directed at psychiatric nurses must be properly recorded and prevented. Generalisation of this model to the entire workplace gives rise to the hypothesis that physical violence in an organisation is harboured by verbal or non-physical violence, regardless of whether the same or different perpetrators

are responsible for aggravated types of violence. In addition to the close correlation between incidents of non-physical and physical violence, there was a seven-fold increase for employees who were the target of non-physical violence to be exposed to physical violence, compared to those without experience of non-physical violence. In fact, physical and non-physical violence were inextricably linked in most cases, so that it can be deduced that non-physical violence constitutes a risk factor for physical violence (Lanza *et al.,* 2006). Thus, even though the perpetrators are not the same, physical violence is more likely to occur in circumstances where there is a high incidence of non-physical violence (Magnavita and Heponiemi, 2012) .

The hierarchical theory of patient aggression has been criticised. Lanza (1985) and Whittington and Patterson (1996) suggest this theory portrays physical violence as the culmination of a mounting sequence of patient actions, starting with an excess of emotion and/or verbal violence, violence against property, and eventually, physical violence against a person. Verbal violence rarely degenerates into actual physical violence against a person, but it always precedes patient physical violence when it does occur (Morrison, 1992; Duxbury, 2003). This prompted Spector *et al.* (2014) to suggest that the management of verbal abuse could be a strategy for reducing the probability of physical violence against psychiatric nurses. This is of relevance to the situation in the KSA as verbal abuse seemed to be accepted by the majority of research participants as part and parcel of their position as mental health nurses.

The correlation between verbal and physical violence was reinforced by a qualitative study undertaken by Shahzad and Malik (2014), who found that verbal violence had nearly always been experienced by nurses who experienced physical violence at the hands of patients. However, (Çelik *et al.*, 2007) and Shahzad and Malik (2014) suggested that nurses could experience verbal violence not just from patients, but also from co-workers, thus potentially fostering a culture of violence nurtured by verbal violence from both patients and co-workers. Whether verbal or emotional, non-physical violence can precipitate patient physical violence. In the present study, the majority of participants had experienced violence from patients, whilst some also experienced violence from relatives. This is consistent with the findings of other studies, which reported that patients were the chief perpetrators of physical and verbal violence, followed by visitors and relatives, and other healthcare practitioners, such as doctors (Phillips, 2016; Llor-Esteban *et al.*, 2017). Unless violence in all its various forms is recorded it will be impossible to develop prevention strategies that will appropriately serve patients, nurses and organisations alike.

The elucidation for this correlation requires additional scrutiny. It is possible that a culture of disrespect is promoted by the acceptance of non-physical violence in healthcare contexts, which in turn promotes physical violence, regardless of whether the perpetrators are the same (Spector *et al.*, 2007). Such a relational or systemic view of violence is in keeping with an expanded hierarchical theory of aggression (Morrison, 1992), and applicable to the overall healthcare system rather than just to individual

patients. The outcomes of behavioural modelling studies reinforce this perspective by revealing that graver types of violence enacted by both the initial perpetrators and by observers are preceded by milder types of violence, if they are condoned (Spector *et al.*, 2007).

Tackling non-physical violence perpetrated by both patients and employees is a viable starting point for minimising or preventing physical violence in healthcare contexts. In other words, physical violence can be diminished by curtailing non-physical violence and thus causing a shift in policy on workplace violence (Aksakal *et al.*, 2015). The aim of minimising non-physical and physical violence reflects the principles of occupational and environmental health nursing to manage environmental risks, including workplace violence and other psychosocial risks, and to create a work environment where health and safety norms are upheld (McPhaul and Lipscomb, 2005; Aksakal *et al.*, 2015). However, diminishing non-physical violence is a goal in itself. Non-physical violence was experienced not only by employees coming in direct contact with patients, but by all categories of employees (Franz *et al.*, 2010). This type of violence causes disruption to both an individual's personal and work life (Sun *et al.*, 2017) and even mild forms can have a marked effect through recurrent exposure (Hills and Joyce, 2013).

In a systematic meta-analysis, the incidence of patient violence against mental health nurses is well recognised in acute mental health settings (Iozzino *et al.*, 2015). In particular, papers included in this review reported that by working in these areas they were vulnerable to repeated exposure to violence because either there were patients

who were being treated for a lengthy duration, or because the nurses were working in an area of care where large numbers of patients were prone to aggression or violence. These findings are in keeping with those of Spector *et al.* (2014), who describe in their systematic review how globally, nurses working in emergency, geriatric and psychiatric departments were exposed to the most frequent episodes of violent behaviour. Similar behaviour has been found in Saudi studies (El-Gilany *et al.*, 2010; Basfr *et al.*, 2019)

Of the nine nurses participating in this study, six report that most violence occurs on the night shift. Only two nurses claimed that the greatest level of violence occurred across all shifts, peaking in the afternoon when families visited patients. Only one nurse claimed that those working on the morning shift were exposed to most of the violence. These results are consistent with those of Ahmad *et al.* (2015), who undertook a review of the literature which included 13 papers exploring the time occurrence of patient violence. Ahmad *et al.* (2015) found that most patient violence occurred during the night shift. However, the results of these two studies are inconclusive and further research is needed to explore time and its relationship to violence before conclusions can be made.

Nurse participants in this study attributed the violence to the patient experiencing delusions and hallucinations. This appeared to compromise the nurse's perception of the extent of the threat, which also meant they categorised the behaviour as being something other than violence. In contrast, Truman *et al.* (2013) noted that nurses did not attribute violence with having a communicative or protective role, rather it was perceived as destructive or offensive.

Algwaiz and Alghanim (2012) highlight nurse' gender as being one of the variables that predicts violence. The risk of violence is greater for females, and in the KSA where the majority of nurses are female; this in turn promotes the perception that violence is part of the nursing role. To tackle patient violence more effectively, nurses need to change their acceptance of violence being a normal part of their work (Baby *et al.*, 2014).

Saudi society is deeply patriarchal and female individuals are under the control of male individuals (Ismail, 2012). The Saudi family is rooted in numerous cultural taboos, with the perception that it is a woman's duty to act as family nurturer and maintain family cohesion at any cost, including their own happiness (Mobaraki and Soderfeldt, 2010).

In theory, aspects of the female social status can be linked with violence against women in several ways. First of all, given that Saudi family, political, economic, and social structures are monopolised by men, there is a likelihood that the implemented policies and norms reflect and reinforce the notion that females are subservient to males (Vyas and Heise, 2016). Secondly, violence can be exploited by men in institutions they dominate to retain their authority by preventing female advancement or autonomy (Al Alhareth *et al.*, 2015). Violence prevention or sanctions are unlikely in such institutions, since the implemented policies and norms are formulated by men. In fact, violence may even be promoted, either directly or indirectly (Dobash and Dobash, 1979).

This process is greatly abetted by female fear. The so-called "fear-victimisation paradox" has generated considerable consternation among criminologists, with women being more afraid than men, despite the fact that they are less likely to experience violent crime

(Derksen, 2012). This female fear has been labelled as unjustified by some and legitimised by others. According to the "shadow theory", what women are afraid of is being subject to a type of violent crime that rarely affects men, namely, sexual violence (Ferraro, 1996). Likewise, the female fear of men can be attributed to experience of intimate violence and the women's perception that they are vulnerable (Culbertson *et al.*, 2011). As Killias and Clerici (2010) suggest, women's fear is likely to be greater if they think that they cannot avoid violence. Alvi *et al.* (2011) suggested that female fear was connected to specific social contexts and the immediate environment.

Feminist theory maintains that men use fear to retain their dominance over social institutions by controlling how women behave or preventing women from engaging in various societal spheres (Yodanis, 2004). Furthermore, women's behaviour can be controlled by violence even if they have not experienced violence at the hands of men (Stanley, 2013).

Awareness that horrendous violence does happen to other women is sufficient for women to regulate how they behave and how they navigate their way in society. Thus, the male status takes precedence over the female status owing to the existence of a culture of fear (Riger *et al.*, 1981). Findings from this study showed that female nurses accept some form of violence in their work; and their worry and fear is more about the response of their family blaming them to choose nursing as a career.

6.3 Theme 2: Determination of Violence

According to the findings within this theme, patient violence was usually triggered by interpersonal interactions and influenced by patient-related precursors such as psychosis. In this study, the nurse-patient interactions that led to violent incidents often involved the nurses having to limit the patients' freedoms in some way, either by denying a request or by placing restrictions on them. Dack *et al.* (2013) support this viewpoint, while Demir and Rodwell (2012) and Papadopoulos *et al.* (2012) further this by indicating that these incidents tend to be triggered by the patient's resentment of staff member's power over them. The results from these previous studies mirror those of the current study, whereby participants described the intrinsic power struggle between staff and patients as one of the causes of patient violence.

Analysis of nursing relationships have often led to the consideration of power dynamics (Lamadah and Sayed, 2014), despite the fact that the profession of nursing is not typically ascribed significant power (Katriina *et al.*, 2013). These power dynamics are particularly evident within the context of mental health, where professionals are authorised to apprehend individuals considered to be ill and requiring assessment and/or treatment.

The concepts of empowerment, service user participation and rehabilitation are becoming increasingly popular within the nursing literature, and mental health policy in particular, as they are contrary to the notion of coercion and control in the psychiatric field (Caldwell *et al.*, 2010; Holmström and Röing, 2010). Nevertheless, no consensus has

been reached as to the viability of empowerment and how it affects patient autonomy and consent in a system advocating detention and conformity (Grant, 2009). Hence, empowerment should be considered within a setting where unequal power relationships prevail, such as in the field of mental health. Christens (2012) suggests the lack of clarity within the nursing literature about what constitutes empowerment, and what related strategies there are to address this, stems from the fact that nurses promote empowerment with no thorough consideration of the notion of power.

Foucault, an authority on the matter of power in the mental health field, deemed that power was inherently a positive force pervading every aspect of society (Foucault and Howard, 1967; Foucault, 1973). Foucault believed individuals both yielded and submitted to it constantly, so that power was not the prerogative of particular people or groups or exclusively associated with deliberate action. From this perspective, knowledge specifying what constitutes truth or "discourse" serves to legitimise power (Shiner, 1982). Discourses function as normalising frameworks, directing individuals on how to behave and how to perceive the world, thus acting as a disciplinary tool (Foucault and Sheridan, 1979). McNay (1994) argued that the way power was defined by Foucault lacked specificity, depriving it of analytic force. Nevertheless, Foucault's stance promotes different approaches to comprehending power whilst steering clear of reductionism and specificity.

Mental health nursing is often declared to be rooted in the "therapeutic relationship", which is why the impact of power on relationships has relevance for the role of mental

health nurses (Peplau, 1997; Pazargadi *et al.*, 2015; Peplau *et al.*, 2015). Peplau (1997, p. 16) discussed therapeutic relationships extensively in the context of nursing, defining the profession as 'a significant, therapeutic, interpersonal process.' Subsequent authors have established therapeutic relationships as the central concern of nursing in the field of mental health (Hewitt and Coffey; 2005; McAndrew *et al.,* 2014). A therapeutic relationship within the context of mental health nursing aims to give the patient the sense that he/she is a worthy individual and can convey their thoughts openly, with no fear of being dismissed (Sucala *et al.*, 2012; Theodoridou *et al.*, 2012). Furthermore, a therapeutic relationship should promote communication that affords the nurse insight into what the patient needs and thinks, and equips the patient with the ability to understand and deal with their environment (Sucala *et al.*, 2012). However, the environment in which this study took place was marred, the nurses' being powerless in terms of being told what to do by doctors and management, and in doing so they had to exert power over the patients. This situation would have the potential to compromise the development of therapeutic relationships.

A study by Ventura-Madangeng and Wilson (2009) systematically reviewed literature exploring nurses' experiences of violent incidents and found nurses perceived a number of elements in the psychiatric clinical environment contributed to patient violence. These included; hospital rules and polices such as visiting hours and restrictions on the number of visitors, triage times, and no-smoking regulations. Such restrictions, which often interfere with the familiar, could lead to a sense of powerlessness among patients and

their families, resulting in stress and frustration. Meanwhile, staff are expected to impose such policies and regulations in addition to providing clinical care, adding a sense of tension to the nurse-patient interaction. In the literature, other, broader factors also came into play within institutional health care systems, including; heavy workloads, long waiting times, casual labour, unclear admission policies and the high acuity of patients (Ventura-Madangeng and Wilson, 2009). In the current study, most participants reiterated these broader factors, although indicating that they felt they were outside their control.

Exercising influence over a person or group is dependent on power. In the specific context of nursing, power is a prerequisite for nurses to influence not only patients, but also doctors, other healthcare practitioners, as well as other nurses. Nurses cannot perform their tasks successfully if they do not have power (Katriina *et al.*, 2013). Furthermore, nurses lacking power have a lower level of job satisfaction, and are more likely to suffer burnout and depersonalisation (Laschinger *et al.*, 2012). Another implication of powerlessness among nurses is that patient outcomes are less than ideal (Manojlovich, 2007). These considerations call for the effective empowerment of nurses.

However, to move towards empowerment nurses' need to feel secure and safe in the work they do. To achieve this hospital rules and policies need to be effectively implemented. Relationships between staff and patients should be professional, therapeutic, safe and effective with mutually agreed boundaries (Buhari, 2013). Nurses can evaluate their interaction with patients based on the continuum of professional

behaviours. The ‘zone of helpfulness’ is in the centre of this continuum and confirms that nurses are behaving safely and professionally toward patients. On each side of this zone, boundaries can be transgressed due to either insufficient involvement (left-hand side) or excessive involvement (right-hand side), both of which can have negative implications for the nurses and patients (Buhari, 2013).

Insufficient involvement can be perceived as deprivation and segregation, with patients experiencing suboptimal involvement on the part of nurses. Patients do not receive the care they need when nurses ignore them, which can have significant adverse repercussions not only for patient health, but also for the nurses themselves. Excessive involvement is associated with breach of boundaries, which can be damaging to the patients and it occasionally engenders the prioritisation of the needs of the nurses rather than those of the patients (Baca, 2011). For instance, a breach of boundaries can happen when; a nurse shares private information with a patient, expresses feelings towards a patient, accepts gifts from patients or has sexual intercourse with a patient (Audet and Everall, 2010). As they are vulnerable, highly reliant on nursing, and mentally or emotionally unstable, patients have a greater susceptibility to breach of boundaries than nurses (Drum and Littleton, 2014).

Nurses can resort to a range of approaches to ensure that professional boundaries are maintained within clinical practice (Powell and Davies, 2012). Among the strategies that nurses can adopt to uphold boundaries when dealing with vulnerable patients are acting and speaking amiably and professionally, as well as clearly delineating the professional

relationship and their own duties in relation to the patient (Doel *et al.*, 2010). The nurse-patient relationship is especially at risk of being transgressed based on the tone of voice used by nurses, as this can be subject to interpretation (Valente, 2017). For example, excessive nurse involvement can be implied by a highly amicable and inviting tone. It is crucial for nurses to prioritise patients' best interests and show awareness, not only of their feelings and attitude, but also of their cultural background. An unprofessional relationship can be precipitated by the perception of an action by a patient in Saudi Arabia differently from a patient in a Western country, due to cultural dissimilarities (Karout *et al.*, 2013). Hence, nurses should not diverge from the zone of helpfulness and should never lose sight of the professional nature of their relationship with patients or of their specific role. In this way, nurses can avoid breaching professional boundaries with vulnerable patients.

The relationship between nurse and patient is dependent on professional boundaries in all settings, but more so in the context of mental health care (Valente, 2017). This is because of the vulnerability of individuals requiring clinical assistance for mental health issues (Jones *et al.*, 2016) and such issues can make some individuals especially prone to breach boundaries (Gutheil and Brodsky, 2011). Mental health nursing depends primarily on the therapeutic use of self by nurses, which requires them to draw on their personal attributes and use their skills to ensure professional boundaries are kept (Stuart, 2013). These boundaries should allow staff to say 'No' when boundaries are tested and ensure staff are able to maintain their professional integrity. Boundaries also function as the

foundations of safe and effective therapeutic relationships with patients. Whilst boundaries should be maintained at all times, recognising and identifying which limits are negotiable and which are not is important, so that patients and staff are fully aware of what these boundaries mean.

One example of a non-negotiable boundary is an interpersonal one. In this instance, it is unacceptable for nurses to allow patients to swear or to discuss a nurse's personal life. If nursing staff provide care to a patient over a long period of time, it is understandable that boundaries may become blurred, particularly if patients become dependent and/or over familiar. No matter what the role of the nursing staff, however, contact between patients and staff must stay within professional boundaries. It is the job of the nurse to protect patients from any misunderstandings the patient may have about their relationship with the nursing staff. Therapeutic relationships are thus bound by professionalism and mutual respect, and to be effective, these boundaries need to be maintained (Adshead, 2012).

Although maintaining non-negotiable boundaries and limitations within a psychiatric ward is important, there is room for flexibility and negotiation where necessary. For example, a nurse taking a highly distressed patient to the quiet room to calm down and talk after 10pm when the ward rules state patients should be in their rooms. Discipline on the ward is essential to maintain peace, but when nurses are too emotionally distant from their patients or controlling without remembering about the need for care, this can create resentment and affect both sides' ability to achieve equal, respectful relationships (Moreno-Poyato *et al.*, 2016).

Therapeutic relationships between patients and healthcare practitioners must be based on suitable professional boundaries (Stuart, 2013). Treatment outcomes can either be positive or negative, depending on whether such boundaries are managed effectively or not (Buhari, 2013; Subotsky, 2013). Besides potentially causing new trauma for the patient (Gutheil and Brodsky, 2011), inadequate boundaries can also lead to practitioners feeling exhausted and fatigued (Skovholt and Trotter-Mathison, 2016).

Nursing in any setting relies greatly on the patient-nurse relationship, but more so in the field of mental health (Bridges *et al.*, 2013), as it forms the basis for psychiatric treatment (Jones *et al.*, 2016). Thus, the main task of mental health nurses is to create a therapeutic relationship with the patients (Gallop, 1998). The purpose of this relationship is to facilitate objective fulfilment and equip patients with the tools needed to avoid, resolve or make sense of their mental health problems (Travelbee, 1971). Furthermore, since patients require help and nurses have a responsibility to deliver care, the nurse-patient relationship is unequal, with both parties able to learn from it (Bridges et al. 2013; Stuart, 2013).

However, the results of this research and other recent studies have indicated that therapeutic relationships are not accorded the importance in clinical contexts that the nursing literature stresses they deserve (Cutcliffe *et al.*, 2015; Cutcliffe and McKenna, 2018). For instance, Cutcliffe *et al.* (2015) reviewed the assessments of inpatients in several countries (UK, Portugal, Canada, Switzerland, Germany, and Australia) and found cordial therapeutic relationships were not a part of the care provided. To the contrary,

inpatients experienced coercion and cruelty; they were not shown any interest, they were strictly controlled by the professionals, and were excessively administered pharmacological 'treatments' (Cutcliffe *et al.*, 2015). Other studies have reported how mental health patients felt constricted by the relationship with healthcare practitioners and that they received low quality treatment, feeling like they were something to be repaired, with no effort made to understand what they were saying, which caused the patients to feel constantly irritated and frustrated (Ljungberg *et al.*, 2016).

No standard definition of a 'therapeutic relationship' has been formulated to date (Bhatia and Gelso, 2018). Welch (2005) reported that related concepts, such as ''empathy and self-disclosure, needed to be delineated better as they were initially devised for psychotherapy purposes and were not exclusively applicable to the nurse-patient relationship'' (Welch, 2005, p. 161). However, there is no doubt that the therapeutic relationship is highly significant within mental health care, even though defining it within in this context is challenging.

Participants in this study wanted to be in control of the ward, yet situations where staff were too controlling over seemingly trivial issues increased tension on the ward. For example, the television should be turned off at 10pm in the common room. But if special circumstances mean a programme runs over 10pm for ten minutes or so, such as a football match, the nurse should not insist on turning off the TV. It does not suggest that psychiatric nurses are inconsistent or disobeying ward rules, but demonstrates flexibility in clinical decision making. Consistency in terms of boundary management is essential,

but it does not automatically equate to making the same decision in every case (O'Keeffe *et al.*, 2015). Because of the nature of psychiatric wards, nurses often make judgements one day which could be different the following day depending on the circumstances (Alexander and Bowers, 2004).

Whether fixed or flexible, ward rules should never be retaliatory and should be handled with respect. If staff apply rules without regard to the patient, this can result in unnecessary confusion and in a worst-case scenario, conflict, which in turn creates a hostile, stressful environment where nurses will find it difficult to provide patients with the appropriate care (Priebe and McCabe, 2006). This is in addition to a stressful work environment for nurses that includes heavy workloads for staff and a low nurse-to-patient ratio.

Similarly, a study by Jaradat *et al.* (2016) concluded that violent incidents have a stronger relationship to the circumstances on the ward rather than to the client population. Moreover, the ward environment may become unstable as a result of factors including increased workload, fewer registered nurses or sudden changes in patient needs, thus increasing the risk of violence (Roche *et al.*, 2010). This is similar to the findings of this research where nurse shortages were perceived as a cause of patient violence by the participants.

Dickens *et al.* (2013) reveal that aggressive behaviour from patients was more likely to occur at certain points in the ward routine, especially those that occupied staff to the extent that they were less able to respond directly to patient demands. Such times

included handover, treatment times, dispensing medication and meal periods. In contrast, the current study identified night shifts as a time when violence is more likely to occur, while staff are not faced with as many tasks, there are fewer staff on duty and there is an expectation on the part of patients that they will conform to the hospital rules of bedtime and other restrictions.

Participants in the current study reported that specific diagnoses and symptoms of illness were associated with patient violence. Cornaggia *et al.* (2011) agree with this analysis and add that the mental illness, as well as the diseased condition of a patient, are internal factors which play a significant part in patient violence. Nederlof *et al.* (2011) found that patient characteristics in the context of mental illness are associated with the potential for violence, including symptoms such as delusions, hallucinations and paranoia. These can be compounded by personality disorder, the use of alcohol and other substances and demographic features, particularly being young and male (Nederlof *et al.*, 2011). However, regarding the latter, all participants in this study were referring to patient violence they had experienced from females.

Justifying violent events as being directly related to mental illness was an important part of the experience for participants in this study, a fact that is consistent with other studies (Colasanti *et al.*, 2010; Lane *et al.*, 2011). Both studies (Colasanti *et al.*, 2010; Lane *et al.*, 2011) found that violence towards nurses in psychiatric settings is often related to the patient's mental illness impairing their judgement. Dack *et al.* (2013) highlight the role stress and pain play in contributing to patient violence in psychiatric settings, as well as

identifying substance abuse and mental confusion in the elderly as being important factors. It is notable that the participants in this study did not emphasise the internal factors relating to their own behaviour, which Renwick *et al.* (2016) suggest has the potential to create conflict with patients, as behaviour in patients may be escalated by a staff member's inability to regulate or control their own frustration and anxiety in response to such behaviour.

The perception of participants in the current study regarding psychotic symptoms possibly contributing to patient violence is supported in the existent literature. Cornaggia *et al.* (2011), in a review of the literature, identified mental illness and substance misuse as increasing the risk of violence. In addition, participants in the present study suggested that patients who had a history of violence were more likely to exhibit aggressive behaviour towards staff and patients while in hospital, again a factor reiterated in the literature (Iozzino *et al.,* 2015). In the current study, participants suggested that substance abuse among patients might also contribute to aggressive tendencies and could also indicate that the patient may not be able to cope with stress effectively. The perceptions of the nurses in the present study about substance abuse are echoed by a number of researchers (Cornaggia *et al.*, 2011; Hsu *et al.*, 2014). As well as disinhibition associated with substance abuse, it can also trigger and increase violence among patients as a result of symptoms such as anxiety and agitation, common when withdrawing from substances (Sariaslan *et al.*, 2016). Other studies have also suggested a history of substance use may

increase the probability of violence in patients (Stone *et al.*, 2011; van Leeuwen and Harte, 2017).

Countries within the Arabian Gulf have seen a large increase in the prevalence of addiction in the past ten years (Alahmari *et al.*, 2019). Several studies have sought to establish the extent of the problem to ensure that addicts can access the services they need. In response to this problem, treatment centres for drug and alcohol abuse (e.g. "Al-Amal" hospitals) have started to proliferate in the KSA (Alahmari *et al.*, 2019). A number of studies have discussed the factors that have led to an increase in the prevalence of substance abuse in Saudi Arabia in the recent two decades (Almarhabi *et al.*, 2018; Alahmari *et al.*, 2019; Saquib *et al.*, 2020).

Participants in the current study also perceived poor communication between patients and doctors as a factor that contributes to patient violence, a finding similar to that of Ha and Longnecker (2010) which links rising violence to a lack of effective communication. In contrast, when patient-doctor communication is deemed effective, patients state that they are more satisfied with health care services (Ha and Longnecker, 2010; Nagpal, 2017). Cousin *et al.* (2012) advise that good patient-doctor communication comprises elements such as the likely duration of treatment, hospital rules and the acceptance of policies. It is therefore essential that health care professionals are trained to communicate effectively with patients, but this is given scant attention in the KSA, especially within the government sector, due to heavy patient loads, low number of staff and lack of resources. Kourkouta and Papathanasiou (2014) also explored communication

between patients and healthcare teams, demonstrating that nurses believed physicians and other allied health professionals failed to provide adequate information to patients about their treatment and hospital rules, an issue that participants in the current study also identified.

In the present study, participants regarded themselves as powerless, subjugated victims, in need of help from those around them. This may be akin to the drama triangle (Karpman, 1968), whereby this dynamic model of conflict and social interaction identifies how individuals instinctively either take on, or attempt to manoeuvre others into taking on, the role of victim, rescuer or persecutor. As with those taking on the role of a 'victim', the present study participants disowned all responsibility for the unfavourable situation in which they found themselves, believing they were completely powerless to change it. Meanwhile, the doctor is regarded by the participants as the 'rescuer'who will save them and make every effort to assist them in circumventing the violence. The participants may even neglect or deny responsibility for addressing their own needs, instead expecting the doctor to enhance their feelings of self-worth as caregivers. In the present study, participants regard the patients as angry, hostile persecutors who are disparaging and holding them as victims, responsible for the undesirable policies and rules of the hospital that they, the patients, have to abide by.

The importance and potential of the drama triangle model lies in the realisation that individuals can move between each of the three roles while remaining trapped within the triangle. The three roles are mutually dependent upon one another; the victim needs a

rescuer; the rescuer longs for a fully dependent, helpless person to rescue; the persecutor needs someone to blame for all their woes. Unable to view the entire situation from a position of outside observer, the study participants perform these roles in order to satisfy personal needs (of which they may not even be aware) and appeared unable to acknowledge their own contribution to maintaining the triangle.

An individual who is trapped in the triangle needs to become fully conscious of the part s/he is adopting within a given situation. When one person breaks out of a role, this can accelerate the escape of others from their respective parts and actions. A particularly beneficial development is when the victim begins to develop a more mature outlook, to accept personal accountability for emancipation and to actively provide for her own personal needs. Thus, in order to break the drama triangle, the sole escape route from the triangle is to behave as a mature individual and not take part in the game (Karpman, 1968). Rather than seeking a rescuer, participants in this research who regard themselves as victims must take on accountability for their own needs and begin to look after themselves. They can only escape the triangle by contesting their deep-seated belief in their inability to look after themselves. Rather than continuing to think of themselves as disempowered, they must recognise their own abilities to solve problems and to lead others. The only possible escape route is the acceptance of full accountability for one's own thoughts, emotions and responses.

The key factor was described as the development of robust, calming nurse-patient relationships; the nurse could potentially escape from the triangle by ensuring they

communicate effectively with the patient (Feo *et al.*, 2017). Hence, effective communication may be counted as one of the most valuable therapeutic tools. Previous investigations by Olsson and Schön (2016) also demonstrated the significance of the staff-patient relationship as a basic resource, enabling the patient to feel secure and confident in the ward. Moreno-Poyato *et al.* (2016) presented a literature review describing a healing relationship in psychiatric care as comprising a two-way interaction between patient and nurse, founded upon trust and centred upon the provision of remedial aid. The review concluded that present-day staff frequently spend less time interacting with patients than they spend in the office. This was cited as an obstructing influence on the therapeutic relationship, such that patients frequently view mental health nurses as condescending, paternalistic, authoritarian, or intimidating. Such negative feelings on the part of patients are likely to be associated with subsequent violence (Brunero and Lamont, 2010). However, Pelto-Piri *et al.,* (2013) assert that nursing staff are completely capable of setting up meetings with patients in a form that enables the patient to communicate without recourse to violence.

Effective communication with the patient is regarded as one of the most valuable tools in psychiatric care, both in terms of avoiding physical and verbal violence by inviting the patient to express how s/he wishes to interact with the nurse, and in terms of arriving at a shared understanding of the circumstances during a violent event (Hahn *et al.*, 2012). Gillespie *et al.*, (2010) assert that many situations could be defused simply by remaining calm, confident and attentive during interactions with patients.

The above discussion showed that violence is simply attributed to internal factors within the victim or perpetrator, this may exclude other salient factors which will not be addressed unless they are first recognised (Cutcliffe and Riahi, 2013). In addition, when these internal causes are attributed to nurses or other healthcare staff, the organisation may feel that these can be solved by training, thereby shifting the focus from the organisation to the individual (Whittington and Richter, 2006; Woods and Ashley, 2007). Continued emphasis on psychopathology merely serves to reinforce the existing stigma and stereotypes about mental illness (Jansen *et al.*, 2005; Whittington and Richter, 2006). It is suggested that it is preferable to switch the focus from a violent 'individual' to a violent 'incident' as the latter approach acknowledges that a range of internal and external factors are involved when an incident occurs (Jansen *et al.*, 2005; Whittington and Richter, 2006). This study reaffirms this finding, as participants identified that problems with environmental and managerial aspects of psychiatric healthcare led to an increased level of violent incidents with patients. For example, as presented in section 5.4.2) participants perceived workplace (Hospital) factors such as increased workloads for nurses led to a rise in the level of violent incidents. Participants believed that due to this staff spent less time with patients. The fact that nurses were less available to meet the needs of patients led to frustration among patients and thus to more incidents of violence (Staggs, 2013). Najafi *et al.'s* (2018) qualitative study supports this, suggesting nurses participating in their study believed increased levels of abuse from patients occurred because they were unable to provide the expected level of care as a result of increased workload and pressure.

While this study and that of Papadopoulos *et al.* (2012) found there was believed to be an increase in the number of violent incidents when staffing levels are low, this finding is at odds with other studies (Bowers and Crowder, 2012; Slemon *et al.*, 2017). Nurses who participated in the current study also attributed increased levels of violence to other nurses not being specifically educated in mental health nursing. While all these factors may contribute to what nurses perceive are increasingly frequent and severe levels of violence, it is also likely that increasing workloads also affect their perceptions, as mental health nurses have been identified as being vulnerable to exhaustion and burnout (Kowalski *et al.*, 2010; Van Bogaert *et al.*, 2013; Alenezi *et al.*, 2019). As well as potentially leading to a lack of patience, nurses have less time to complete their work or care for patients, both of which may increase the violence that is directed toward them by patients. It was clear that nurses participating in this study perceived a lacked confidence in their ability, and a perceived unwillingness on the part of hospital managers to address these workload issues.

With regard to the specific attributes of inpatient psychiatric units, within this study two factors were seen to contribute to patient violence, namely lack of activities and physical space. In the present study, participants believed lack of activities on the unit led to boredom and hence to violence, a finding in keeping with other studies (Newbill *et al.*, 2010; Parnell, 2012; Cutcliffe and Riahi, 2013). Once a patient is admitted onto a ward, this becomes their temporary home, so it should be a place where they feel safe and secure enough to interact with other people. Although patients need to have a personal

space, they also benefit from mixing with others. The common areas of the unit should facilitate this socialising and offer patients a comfortable and stress-free environment. Overcrowding and noisy environments can cause patients to become tense, which then can create additional feelings of fear and anger (Angland *et al.*, 2014). Often maintaining safety and security is not about staff watching patients, but interacting and engaging with them. To be able to do this, staff require good lines of sight where they can observe patients, but also areas where they can engage with patients either individually or in groups (Magnavita, 2011).

Physical space and overcrowding are identified extensively in both qualitative and quantitative literature as making a notable contribution to levels of violence (Virtanen *et al.*, 2011; Cutcliffe and Riahi, 2013; Angland *et al.*, 2014). Cutcliffe and Riahi (2013) state that environments which create the right balance between density, privacy and control are most effective in minimising violence, adding that straightforward practices such as assigning individual rooms and avoiding overcrowding can be used to meet this aim. Participants in this study also identified a number of these strategies when discussing how best to guard against and minimise violent behaviour which is the result of overcrowding. Some of the strategies proposed included providing more activities for patient to engage in, and making sure the room and the ward are spacious and not constricting.

A large number of research studies into aggressive behaviour in psychiatric wards have focused on overcrowding, when considering contributory environmental factors for violence (Cornaggia *et al.*, 2011; Virtanen *et al.*, 2011; Ulrich *et al.*, 2012). Ulrich *et al.*

(2012) and Cornaggia *et al.* (2011) note that certain researchers suggest that crowded wards raise levels of aggression, as patients find themselves experiencing unconstructive or traumatic situations, such as a lack of privacy, a rise in stimulation levels or mayhem, and confusion. However, few studies have explored overcrowding in psychiatric facilities by specifically examining environmental factors, and the studies which do exist tend not to describe the physical setting of the wards. In the discipline of environmental psychology, spatial density refers to the amount of space which each person has in a physical environment (measured in square feet or metres) and social density is defined as the number of people in a room (Ulrich *et al.*, 2012). Studies of other environments, such as prisons and flats, have determined that social density is key to predicting the likelihood of crowding stress and aggressive behaviour (Ireland, 2012). In contrast, spatial density is far less significant, unless the personal space of each person has become highly restricted (Baum and Paulus, 1987; Novelli, 2010). Various studies examining aggression in psychiatry settings have characterised crowding as a simple matter of high bed occupancy rates on wards to the acuity of the patient (Virtanen *et al.*, 2011). Ulrich *et al.* (2012) suggest other studies have taken a wider view and combined a range of terms, including downsizing, crowding, ward space, patient density and ward density. The frequently used term "density" (along with many others) is rarely given a clear definition and this, along with the absence of descriptions of the physical environment, makes it challenging for healthcare architects and researchers in related fields to shed light on findings relating to overcrowding and aggressive behaviour on psychiatric wards. Available studies have not established a clear link between overcrowding, defined in

terms of high bed occupancy and aggression or violence in psychiatric facilities. A number of these studies have found a positive connection with aggressive behaviour (Virtanen *et al.*, 2011; Algwaiz and Alghanim, 2012), whereas other studies found no evidence of any link (Pich *et al.*, 2010; Ulrich *et al.*, 2012). In this qualitative study participants argue that overcrowding and lack of activity increases tension for patients and this manifests in more aggressive behaviour and violence towards nurses.

It may be useful to examine crowding theory and research in environmental psychology to clarify the link between ward occupancy rates and aggressive behaviour, since no correlation has yet been established on this issue. Historically, Baum and Paulus (1987) noted that there was a large body of evidence to show that the stress which comes from crowding, and the aggression which follows, are connected to flaws in the physical environment, preventing people from finding privacy, taking controlling over their relationships with other people and avoiding stress factors, such as disputes and noise. Unlike psychiatry, research in environmental psychology has drawn a distinction between spatial density and social density (Baum and Paulus 1987), indicating psychiatric facilities need to be designed in a way which reduces stress and aggression, by including additional environmental features. These features would allow patients to enjoy privacy, control their relationships with others, avoid sources of stress, and call upon helpful and effective distractions, such as nature, to help them reduce their own stress levels (Baum and Paulus, 1987; Ulrich *et al.*, 2012). To date this has not been the case in psychiatric services in the KSA and was identified as a present-day problem by the participants in this study.

This research revealed that aggression among psychiatric patients was exacerbated by the fact that Saudi families tend to keep psychiatric illness a secret, which led to some patients receiving limited support and visits from their family members. Participants contended that this lack of support from family and receiving fewer visits had a negative effect on patient's mood and thus increased the threat of violence, adding that the stigma and shame associated with mental illness in Saudi society made patients feel anxious and stressed.

The nurses in this study also believed families appeared to prefer their relatives to be hospitalised, a finding supported by Alshowkan *et al.* (2015), who suggest that the shame of having a relative diagnosed with schizophrenia in Saudi families has far-reaching effects on the lives of the entire family. The family shame associated with people with mental illness in Arab countries is the subject of a limited number of studies, with Alshowkan *et al.* (2015) advancing the view that family members who have mental illness are kept hidden due to concerns that the family will suffer a poor reputation if people know about the illness. Not only is this finding supported by participants in the current study, it is also articulated by Dalky (2012), who reports that the shame associated with psychiatric illness in the KSA negatively affects the level of support and care given to family members who experience mental illness. The public attitude towards people with mental illness has been studied in the Yemen and Qatar, among health professionals in Jordan and Palestine and in non-health providers working at mental health units in both Kuwait and Egypt;

results from all of these studies confirmed a negative perception of psychiatric illness and those who experience it (Dalky, 2012; Alshowkan *et al.*, 2015).

Stigma has been identified as a significant obstacle hindering individuals with mental health problems from seeking help and getting treatment (Thornicroft, 2008). Through stigma, individuals who do not comply with the established norms are ostracised and isolated from society. Thus, they become victims of discrimination, due to inaccurate perceptions, causing them to be feared, rejected or avoided by others (Mukolo *et al.*, 2010). At a global level, the mentally ill experience more difficulties due to being stigmatised, leading to psychiatric morbidity, relationship issues, social isolation, and restricted opportunities for education and work (Dockery *et al.*, 2015). Therefore, in their desire not to attract such stigma, individuals may choose not to seek help, which can result in further deterioration in their mental health and a possibility of them becoming aggressive.

There is a perception among Muslims that “good” Muslims do not develop mental health problems; with somatic metaphors (e.g. “having a dark life,” the “heart falling down”, “oppression in the chest”) often being cited by patients in the Arabian Gulf when describing how their depression feels. In a UK study, (Cinnirella and Loewenthal, 1999) the impact of different types of religious faiths (i.e. Christianity, Islam, Hinduism, and Judaism) on perceptions of mental health problems was explored. Results showed those who practiced Islam considered that conditions such as depression and schizophrenia could be managed through religious faith and were comforted by the thought that praying

to God would get them the help they needed. Similarly, Ciftci *et al.* (2013) and Sayed (2015) reported that Muslim Americans were more likely to turn to religious leaders than mental health practitioners for help.

Studies on the impact of Arab culture on mental illness were reviewed by Fakhr El-Islam (2008), who reported that the way in which Arabs perceived and dealt with mental health problems was heavily influenced by cultural beliefs and customs. Moreover, the use and perception of mental health services depended on the Arab socio-cultural setting. The stigma of mental illness is a major factor preventing Arab people from seeking professional help (Gearing *et al.*, 2011). Likewise, the literature review conducted by Ciftci *et al.* (2013) revealed that there was a tendency among Arab individuals with mental health problems towards somatisation of their symptoms so as not to be stigmatised for their condition.

There is a strong belief among Arab Muslims in supernatural forces, including Jinn, black magic (Sehr), and the evil eye (Hasad), which are often invoked to explain symptoms of mental illness. For instance, individuals suffering from mental health problems are believed to be possessed by evil spirits (Jinn) (Aloud, 2004; Weatherhead and Daiches, 2010). In addition, physical and psychological ailments, as well as unsuccessful relationships or businesses, are attributed to the evil eye, which can be described as strong envy for others' success (Fakhr El-Islam, 2008; El-Islam, 2015).

Preceding a compliment with 'Ma sha' Allah' ('whatever God wills') is considered a way to prevent the evil eye. Meanwhile, magic or witchcraft (Sehr) is considered a series of practices influencing a person physically or mentally without direct contact through knots (oqad), incantations and words expressed in writing or orally. Another common perception of mental illness among Arabs is that it is a trial or punishment for sinful behaviour from God, or that it is God's will (Youssef and Deane, 2006).

It is crucial that the stigma surrounding mental illness in developing countries, including the majority of Arab countries, be dismantled. In such countries, the pervasive customs, values, and beliefs are in stark contrast to those in Western countries. Furthermore, there are scant resources available for mental healthcare and individuals with mental health problems are affected, not only by the stigma associated with their condition, but also by economic deprivation often associated with the illness (Ciftci *et al.*, 2013).

The above discussion emphasises that the formulation and application of mental health management strategies and theories in Arab countries must take account of the social, cultural, religious and political characteristics of those countries. Contextual analysis of concepts helps to clarify not only the scope of those concepts, but also the settings in which they are applicable (Rodgers and Knafl, 2000). Knowledge derived in this way can be harnessed to identify avenues of future development. Considering the singular social and cultural customs and practices pervasive in Arab countries, it is important to examine stigma associated with mental illness in relation to those customs and practices in order to develop and implement effective nursing approaches. This will facilitate mental health

problems among Arab people being diagnosed and treated successfully and may, as a consequence, reduce patient violence.

6.4 Theme 3: The Impact of Violence

The findings of this research identified a number of personal impacts resulting from violence in the workplace, one of these being participant's mental wellbeing. Negative effects on mental wellbeing can impact on nurses' relationships with people both inside and outside the workplace, with feelings of stress, hypervigilance and exhaustion being reported by the participants in the current study. In addition, participants also reported negative psychological effects, describing emotions such as humiliation, embarrassment and guilt, as well as fear and anger. These findings are supported by Van de Sande *et al.* (2011), who detailed the emotional confusion caused by patient violence. Such emotional confusion is intensified when senior staff and colleagues respond in a non-supportive manner (Gates *et al.*, 2011). Meanwhile, Hahn *et al.* (2012) contend that emotional wellbeing and motivation are gradually eroded by persistent and repeated exposure to violence from patients. Camuccio *et al.* (2012) investigated the emotions and feelings of 33 Italian nurses who were working within a mental health setting. The findings revealed that the principal emotion that they felt when caring for an aggressive patient was fear. Although a sense of fear was individual, it was also found to be evident for the wider team, and comprised both fear of being harmed and of doing harm. According to Ball (2017) when nurses feel fear, they are likely to withdraw, leading to a deterioration in

therapeutic relationships. In turn, this leads to the nurse adopting a de-personalised approach to the patient and substituting individualised interventions for more generalised ones, which may lead to increased levels of aggression, thus generating a vicious circle of negative relationships (Ball, 2017).

Depersonalisation is a facet of burnout. Burnout comprises three main categories; depersonalisation, emotional exhaustion and personal accomplishment (Maslach and Jackson, 1984; Schaufeli and Maslach, 2017). In the current study, participants suggested that their anger toward patients built up and caused them to withdraw and feel less compassionate. Maslach *et al.* (1986) refer to the development of these cynical, negative attitudes as depersonalisation, which is a pivotal aspect of burnout. Kumar (2007) argues that nurses who work with particular patient groups, including those who are suicidal and aggressive, have an increased risk of burnout and advise that this is aggravated by the level of contact with such patients, especially if they are aggressive. Melchior *et al.* (1997) suggest nurses who relentlessly focus on the negative aspects of patients develop a more cynical view of human nature overall, which might make them less compassionate.

Participants in this study also reported the physical effects of assaults from patients, including '*facial bruising'* and the sense of feeling '*shaken'* or *'exhausted'* by the violence. The reported injuries were considered '*minor*' and did not warrant medical attention, which could be a reason for non-reporting. However, the psychological effects appeared to be considerable and often lasted for weeks after the event itself, which was evidenced by the participants' sharp recall of the details of the violent events long after it had

happened. Participants suggested their self-esteem had been adversely affected and they felt stressed and angry as a result of the assault. They reported being less engaged, not only with the patient who was responsible for the assault, but also with patients more broadly. Many participants questioned their choice of career and the values, attitudes and beliefs that they had about the profession prior to the assault (Gates *et al.*, 2011). These findings are in keeping with the notion of burnout, and are echoed in many studies regarding the impact of patient violence against RNs, and its psychological impact (Hahn *et al.*, 2012; Kitaneh and Hamdan, 2012). Such findings suggest timely action by hospital management is necessary in order to address increased workplace violence, as this is likely to have a negative effect across the health care system if it continues. A business case could be developed to encourage hospital managers in the KSA to address this issue if the direct and indirect costs of workplace violence were quantified.

Spector *et al.* (2014) found nurses' abilities to interact with patients are negatively impacted by verbal and physical violence. The findings of this study demonstrate that participants found it difficult to carry out their work, as they were hypervigilant and avoided certain patients who were assessed as being high-risk for violence, meaning their care would be restricted. The restriction would result from depersonalisation, a form of high anxiety, which might stop the nurse from delivering compassionate care to potentially violent patients (Spector et al. 2014). Bigwood and Crowe (2008) found that nurses also felt that violent patients were time-consuming, and thus reduced the time available to care for other patients. Diminished quality of care following exposure to

workplace violence is evident in the existent literature (Gates *et al.*, 2011; Yang *et al.*, 2012). Other studies (Hutchinson *et al.*, 2006; Gacki-Smith *et al.*, 2009; McNamara, 2010) all reported not only that nurses were less able to provide effective care, but they were also more likely to make errors. In addition, Catanesi *et al.* (2010) revealed that nurses stopped enjoying working with patients when they had been exposed to violent incidents.

Violence by patients can disrupt nursing care in many ways. An individual nurse's reluctance to engage in care with an aggressive patient tends to place a higher burden on others within the health care team (Roche *et al.*, 2010; Jacob and Holmes, 2011). The long-term effects of patient violence are also evident in organisational terms, particularly with regard to recruitment and retention. In the present study, many of the participants declared that they were looking for new work opportunities, with their search frequently being motivated by their experiences of patient violence. Similarly, Ros *et al.'s* (2013) study found that a large number of participants were considering changing their careers, after having weighed up the risks and benefits of nursing and come to the conclusion that little was likely to change in the short-term. Nurses who have felt at risk of being assaulted by a patient are far more likely to decide to leave nursing (Gates *et al.*, 2011). Roche *et al.* (2010) discovered that nurses' intention to find new employment was strongly linked to the perception of emotional violence, rather than to actual assault or threat of violence. Lanctôt and Guay (2014) contend that workplace violence results in nurses feeling less committed to the organisation and specifically leads to a lack of confidence in the ability of the organisation to effectively manage the issue. The rate of

attrition as a result of perceptions of violence should not only be of interest to employers, but also to the wider community, as this could result in a loss of skilled nursing staff to care for patients (Magnavita and Heponiemi, 2011).

The quality of care offered in the KSA is adversely impacted by the insufficient number of qualified nurses (Alghamdi and Urden, 2016) and the high rate of turnover among nurses (AL-Dossary *et al.*, 2016; Hibbert *et al.*, 2017). Alongside the intensive proliferation of both state and private healthcare centres, this matter has led to the country being highly reliant on nurses from other countries, who make up over 60% of nurses in Saudi hospitals. The US, Australia, the Philippines and India are just some of the 40 countries plus, where expatriate nurses originate from (Al-Dossary *et al*., 2016).

In this study, some participants advised that workplace violence had led them to consider leaving the profession entirely, which has significant implications both for the individual and for the health care system more broadly. The health care system devotes considerable time and resources to training nurses, so to lose them is costly on a number of levels (Booker, 2011). In addition, when experienced nurses elect to leave the profession, the loss of their expertise directly affects the hospital they work for, as well as having an indirect effect on the nursing profession as a whole. Previous research (Chapman *et al.*, 2010; Pich *et al.*, 2010; Hahn *et al.*, 2012) also found that violence towards nurses may influence their decision to resign, with not only experienced nurses being lost from the workforce, but also that it is then extremely challenging to attract nurses back to the profession. While similar findings can be drawn from the current study,

the findings of this study do not capture the full picture, as it does not include nurses who have already left their positions (or the profession) as a result of patient violence. However, this has been reported in the literature (Chang and Cho, 2016). In the present study, data regarding workplace violence are not detailed enough to establish the cost either to individual nurses or the healthcare system; for example, in terms of injuries, sick days due to stress or resignations. Nonetheless, the data are robust enough to determine that further research is needed to ascertain the emotional cost to nurses and to estimate the financial effects for nurses, hospitals and the wider health care system. If the direct and indirect cost of workplace violence could be quantified, this might prompt more attention to this vital issue, as well as contributing to a business case that would encourage hospital management and the government of the KSA to take positive action to reduce violence against nurses in the workplace.

When nurses did experience workplace violence in the current study, they frequently did not receive the right level of support, whether formally from management and colleagues, or informally from friends or family. All the participants in this study called for a greater level of support from hospital management during and after incidents. This call was prompted by their perceptions of the hospital management being unwilling or unable to protect them from threats of physical or verbal violence. When violent events occurred, the follow-up afterwards from both formal and informal channels varied considerably. Kvas and Seljak (2014) described a similar finding regarding how the level of support that nurses experience can profoundly affect their ability to carry on and deal

with further incidents of violence. The perception of support is regarded by nurses as crucial throughout the existing literature, as it decreases the negative attitude toward the workplace per se, as well as having a beneficial effect on the adverse physical and psychological symptoms following violent events (Moumtzoglou, 2010; Taylor and Rew, 2011).

In a study undertaken by Lanza *et al.* (2011), it was reported that nurses who believe they are being blamed or punished by managers and colleagues feel unsupported and therefore fail to seek support. This is in line with the findings of the present study, whereby participants suggested that blame was inherent in the working environment to the extent that they felt prohibited from talking about their feelings and from reporting incidents of violence. This is consistent with other studies, which have also suggested that nurses are reluctant to report patient violence because they assume that they will be reprimanded or blamed for the incident (Moumtzoglou, 2010; Gorini *et al.*, 2012). Clearly, this fear of blame and punishment is a significant psychological hindrance to either sharing experiences of violent incidents with colleagues or reporting them to managers. If psychiatric nurses are to receive emotional support, it is crucial that they discuss their feelings with colleagues as this will not only induce feelings of comradeship, but also allow them to feel less isolated (Low and Lee, 2015). Roets *et al.* (2018) stress that the perceptions of the workplace are directly affected by relationships with colleagues, so support between nurses and their colleagues is of great importance. Delport (2014)

suggests that this support may take a variety of forms and may include clinical supervision.

Participants in this study, affected by the low status of the nursing profession in Saudi Arabia and society's opinion that nursing is not a suitable career for females, received little or no support from their family. Working in a mixed-gender environment such as a hospital remains a contentious issue for individuals in Saudi Arabia as many religious and conservative Saudis regard this as 'haraam' (forbidden), other than in a national crisis. However, Aldossary *et al.* (2008) advise that more liberal-minded Saudi individuals consider that working in this environment is a matter of personal choice, particularly as the health care profession offers a large number of job opportunities. These opposing views present Saudi individuals with a potentially confusing dilemma, as many people consider nursing to be an inappropriate profession for Saudi females (Al-Omar, 2004). Participants in the current study identified this as one of the key reasons why they had scant support from outside the profession when experiencing violent incidents. Participants in this study talked of how social and cultural attitudes towards nursing were challenging, as Saudi culture regards long shift work in general, and overnight shifts in particular, as inappropriate for women. Many of the participants' families were opposed to their female relatives working in a mixed-gender environment (Alotaibi *et al.*, 2016), despite a recent push by the government to direct more Saudis into employment in all sectors (Lamadah and Sayed, 2014). Despite the apparent modernising effects of globalisation, Saudi parents are often opposed to young Saudi women working in mixed

gender settings where they may experience contact with men. The general opposition to females working in the nursing profession thus limits the support nurses receive from friends and family when experiencing aggression from patients, as they may be viewed as having brought this on themselves.

These socio-cultural attitudes arise from the traditional Saudi view that women should remain at home, looking after their families. It is commonly regarded by older generations that education and work for females are contrary to Islamic teaching because they take females away from the home for all or part of the day (Hamdan, 2005; Miller-Rosser *et al.*, 2006). Meanwhile, Gazzaz (2009) draws attention to the fact that gender segregation and the veiling of women are still prevalent among Saudi society. These views are rooted in religious obligations to protect women and uphold family honour, but leave nurses feeling unable to discuss any aspect of violence in the working environment with members of their families.

Moreover, acts of violence directed at nurses can be indirectly made to appear acceptable in light of cultural attitudes. For instance, where it is the cultural norm to regard women as less important than men, it can seem acceptable to hit them or demand that they work for less pay than their male colleagues (Walsh *et al.*, 2010). However, this is not the case within the context of this study, as participants were females who were exposed to violence from female patients.

This unfavourable public perception of nurses in the KSA has been cited by Almalki *et al.* (2011) as leading to scapegoating and violence towards them. Furthermore, gender biases have led to a negative public perception of nursing as a profession, since the majority of nurses are women (Almalki *et al.*, 2011). Even though improvements in the public perception of nursing have occurred in the KSA, with a large number of men embarking on university-based nursing courses, the profession frequently involves unsanitary duties (e.g. changing bedding and washing people) and continues to be regarded as women's work (Lamadah and Sayed, 2014). These factors feed and sustain the negative public view of nurses and enhance the likelihood of violence directed at them.

While this study's participants focused largely on the negative effects of patient violence, they were also able to identify certain positive impacts of the experience, more of which focused on the learning that emerged following these incidents. This ambiguity with other findings is centred largely on positive effects that emerged after the event, with increased vigilance and a heightened awareness of personal safety being identified as the key learning points. Nurses also reported that they would intervene and engage with patients at an earlier stage following exposure to a violent situation, while some participants advised that they felt their level of skill could be increased by dealing successfully with a violence situation, leading them to feel more confident.

Some studies support the positive findings of the current study, with Spector *et al.* (2007) suggesting that these events can lead nurses to become better clinicians, most of whom

remain within the workforce and continue to provide patient care after the incident. Violence having a positive impact is facilitated by nurses being able to reflect and make sense of their experiences through use of psychological strategies, such as debriefing, and physical strategies including personal safety training, resulting in increased feelings of control. Positive evaluation of themselves and colleagues are also critical. Hart *et al.* (2014) argue that the ability to adapt and cope under adverse circumstances is linked to resilience. In addition, Bonner (2012) suggests that patient violence can provide positive outcomes in terms of opportunities for team building and higher levels of empathy for patients and their families.

In addition, participants in the present study demonstrated that when subjected to patient verbal violence, they tried to ignore it and focus on their work; *"I used to accept verbal violence as it occurred frequently… I tried to forget the event and continue my work as usual "(*RN5, p1). This could be construed as a way of developing resilience. Bhamra *et al.* (2011) described resilience as a flexible and multifaceted concept which is applicable to four primary components, namely: (i) the individual, (ii) the organisation, (iii) the population, and (iv) the environment. In each case, the level of resilience is a measure of the capacity for, and extent of, recovery following a disturbance. Burnard and Bhamra (2011) discuss the resilience of the individual in terms of recovery or beneficial adjustment after exposure to a stressful ordeal. Hart *et al.* (2014) reviewed the literature on resilience, indicating that this characteristic helps nurses deal with problems such as bullying and violence in the workplace by building their inner strength. In addition, García

and Ayala Calvo (2012) noted that individual resilience could shield the nurses from emotional collapse, while McDonald *et al.* (2013) suggest individual resilience as an essential factor in the general health and well-being of the nurse.

The individual resilience of mental health nurses employed in inpatient departments has been studied by Rutten *et al.* (2013), who observed that the more resilient individuals gained professional self-assurance and experienced an enhanced degree of job satisfaction. Itzhaki *et al.*, (2015) note that the idea of group resilience is considerably less reported in the literature, yet traumatic circumstances can affect groups as much as individuals. Hence, resilience within an identified group could provide an additional means for managing tense and disturbing situations in the workplace, and particularly in mental health facilities where the staff are often presented with difficult circumstances.

Van Heugten (2013) also observed the emergence of resilience in social workers following violence in the workplace, with a positive outlook being expressed by individuals who had been bullied at work. Rather than focusing on the resilience of individual mental health nurses, Guo *et al.* (2018) and Van Bogaert *et al.* (2013) examined the key impacts of teamwork in mental health hospitals in terms of averting exhaustion and burnout. The findings revealed that teamwork among mental health nurses enhanced levels of job satisfaction, a desire to continue in the nursing profession, and raised the quality of patient care. According to Price *et al.* (2014), mental health nurses are assisted in managing patient aggression by working as a team, as the group empowers, supports and protects them during threatening circumstances. The present study also identified the

potential significance of staff resilience in helping mental health nurses to manage challenging circumstances.

Several paradoxes were found in the data provided by participants in this study. Participants appeared to not be able to readily express their thoughts regarding the positive effects of a violent incident that include; enhanced awareness of risk, an improved focus on the patient, heightened awareness of the nurse's duty of care, and an increased sense of self-regard. These only becoming evident after reflection and a certain amount of time had passed after the event. This was in contrast with the negative effects articulated at the time or directly following the event. Patient violence was a traumatic experience, bringing on mixed emotions and a certain level of inconsistency in the feeling. The way that people view certain events is dynamic, and the same set of questions could have different responses across various times (Iozzino *et al.*, 2015). However, in this study this to an extent was mitigated through the use of semi structured interviews, as participants could reflect on their experiences and expand their answers (Serry and Liamputtong, 2013). There was no mention of the timing of the described event relative to the interview being held, but it was clear that certain events were recent, and others had occurred a few years earlier. Therefore, to understand the phenomena that front-line nurses face today, it is essential that both the positive and negative effects of patient violence are recognised. Nurses could be better prepared through training and knowledge-sharing if there is to be insight into the potentially positive effects of patient violence, as well as actions that can moderate the negative effects of a violent incident.

6.5 Theme 4: The Elimination and reporting of violence

In this study, the participants suggested that hospitals should take a more proactive approach to managing violence and initiate an education programme for nurses on how to communicate effectively and de-escalate potentially violent situations. In addition, the participants considered that training in medication management and providing counselling would also be beneficial.

The gap between nurse education and health care provision has been continually criticised (Wolff *et al.*, 2010; Taylor and Rew, 2011). Wolff *et al.* (2010) tried to address the controversial notion of readiness to practise and set out four common themes: (1) having a general foundation and certain job-specific capabilities; (2) providing safe care for patients; (3) being cognisant with the existing reality and future possibilities; and (4) being able to balance doing, knowing and thinking.

In England and Wales the Nursing and Midwifery Council (NMC) frequently review the standards it sets for registered professions to ensure the standards adequately protect the public. In these reviews, the NMC take account of any changes in contemporary society and healthcare, and the implications they may have for future registered nurses, such as their knowledge and skills. Standards of proficiency for newly registered nurses reflect NMC expectations in terms of what they should know and be capable of doing safely at the beginning of their careers. Key elements of the accountability and responsibility of registered nurses are described under each of the seven platforms

(Figure 4). This approach offers clarity to both the public and professionals about core knowledge and skills they can expect every nurse to demonstrate. The KSA education system could use theses platforms for better preparation of new nurses in term of violence prevention.

Figure 4: the seven platforms produced by the NMC for preparing new nurses for work

Hart *et al.* (2014) suggest nurses frequently find that their education has prepared them inadequately for the reality of practice. The gap that exists between education and practice can be particularly marked with regard to patient violence. According to Baby *et al.* (2014), nursing education programmes should not only prepare nurses to respond to aggressive behaviour, but also provide them with the tools to manage their response to do it. Hewitt (2015) furthers this, suggesting that prevention and management of violence

against nurses at the workplace would be more effectively served by future nursing curriculums that communicate moral identity, interpersonal skills, critical thinking and relationship-building, as well as instilling certain values and attitudes as part of reflective practice. Education which better prepares nurses to moderate the effect of patient violence is more likely to envisage it as something that can be managed, rather than seeing it as inevitable and part of the nursing role (Wax *et al.*, 2016). Gates *et al.* (2011) contend that improved preparation leads to greater levels of self-assurance and the ability to have a more optimistic attitude, enabling RNs to persevere in the face of difficulties and complete the clinical task. This sense of self-efficacy is pivotal to nurses' development and progression, as nurses who are highly efficient not only develop their clinical skills and achieve clinical goals more effectively, but are also more able to deal with difficult and challenging situations (Anderson *et al.* 2010).

According to Hahn *et al.* (2010), nurses who felt more confident that they could manage violence viewed it less negatively when it did occur than those who felt they lacked the capability to manage it. Those who were adequately trained were more prepared and ready to deal with aggressive patients when it occurred. However, this was not the case for nurses who participated in this study, as they felt unprepared for the situation. No matter what the diagnosis or behaviours of the patients, participants felt they were unable and not well prepared to deal with violence and said that they felt '*out of control*'. Patient violence was described as a threatening experience, which had a significant negative impact on them. Both Hahn *et al.*, (2010) and Wilson *et al.* (2013) support this

view, with the latter describing how nurses' responses to anger depended on how able they felt to manage such situations.

Studies such as that conducted by Heckemann *et al.* (2015) have shown that completion of between 1-4 training programmes gives healthcare providers the information and confidence needed to handle aggressive patients effectively (Kynoch *et al.*, 2011; Heckemann *et al.*, 2015). Similarly, Robinson (2010) conducted research on the value of patient aggression management courses in the acute care context, finding that such programmes were successful at equipping nurses with the ability to manage patient aggression. Programmes such as this were desired by participants in this study, who believed through education they could improve their ability to better manage violent events.

Gerdtz *et al.* (2013) found that a year-long course designed to teach professionals in different healthcare settings how to address and manage aggressive patients was successful, as the nurses who completed the programme were better equipped to respond to aggressive patients than a control group of nurses. Professionals who had participated in the training were better able to recognise aggression (50% more able to recognise potential violent incidents than the control group) and were more successful at defusing the situation and mitigating risks related to it. In contrast to a one year course, Gillespie *et al.* (2010) reported on the success of a one-day aggression course for Australian nurses. Results from this study showed that the knowledge and skills of

participating nurses significantly increased after having completed the course. In addition, the nurses became better able to identify and mitigate potential violence and had an improved attitude towards patients who may become aggressive. However, neither study (Gillespie *et al.*, 2010; Gerdtz *et al.*, 2013) measured the long -term effects of their courses and whether knowledge and skills were sustained over a prolonged period.

Despite the success of aggression management training programmes for healthcare providers, and despite the existence of evidence indicating that such programmes are necessary (Gillespie *et al.*, 2010; Gerdtz *et al.*, 2013; Heckemann *et al.*, 2015), it has been noted that some hospitals worldwide provide little or no training to their staff according to a systematic review undertaken by Kynoch *et al.*, (2011). The lack of training is evident in the hospital in the KSA where this research study was undertaken. Although the administration of training can be costly, the benefits of aggression management training ultimately might outweigh the disadvantages of violence in the workplace.

As previously identified in Chapter 4, patient- patient interaction is among the causes that trigger violence towards nurses. For example, inpatient psychiatric wards would greatly benefit from incorporating single bedrooms within suite facilities in their design, since this would allow for patient privacy and lead to a reduction in crowding stress and the aggression which may often result. This design feature could be of major benefit.

An early understanding of patients' needs will help in establishing the potential impact of them sharing the same areas. This involves not only understanding their current mental

illness, but also working alongside other agencies and family members to glean information about a patient's history. When a new patient is considered for admission, the nurse should, therefore, think about how the individual will affect the overall patient group and not just how the individual will function on the ward. It may sometimes be more prudent to move a patient from one clinical care centre to another, with the intention of re-establishing a peaceful therapeutic environment. Patients who have regular visitors such as family, carers and friends value these interactions highly, and these visits can play an important role in a patient's recovery and overall stability on the ward, but can also provide a sharp contrast to those who are shunned by their family and friends.

Since the mid-1980s a large body of research on flat shares and prisons has determined that the greater the number of individuals sharing a cell or a bedroom, the higher the crowding stress, and the less privacy afforded to each individual (Cox *et al.*, 1984; Leger, 1988). In these circumstances, aggressive behaviour, incidents of reported illness and social alienation were commonly encountered (Baron *et al.* (1976). More recently, Papoulias *et al.* (2014) argued that psychiatric patients who share bedrooms lack privacy and find it difficult to rest, which is why those who share a bedroom are less ill-disposed towards seclusion and isolation than those who have single rooms. Based on a study of 92 inpatient wards in England, Allan *et al.* (2018) note that staff reported higher levels of satisfaction with the physical environment if inpatient wards contained single rooms and private bathroom facilities. Certain US researchers and architects have asserted that

sharing a room with someone can lower the risk of suicide in psychiatric facilities, and makes it easier to oversee those in this risk category (Shepley *et al.*, 2017). Nevertheless, many European countries, including Sweden, specify in their guidelines the importance of these patients being monitored by a qualified member of staff rather than a roommate. As a result, single rooms are used to prevent self-harm and lower levels of crowding, but caution needs to be taken over who monitors such environments. No studies in the KSA have assessed the crowding of patient and its relationship with violence against nurses.

There is no scientific formula for creating the perfect ward in which there are exactly the right number of patients whose histories, diagnoses, offences and risks fit together. When talking about 'patient mix' what is often meant is the combined effect and potential risks to everyone within the ward. Identifying the potential effects of the patient mix requires as much understanding of patients as possible. This means that nurses have to grasp precisely how they are feeling in the present moment, and find information on their past history, as well as any experiences they may have had of being in prison, secure services and how they coped within the broader community. Nurses should look at each new patient and consider not only how they will fit in and behave on the ward, but also evaluate how their membership of the patient group might change its risk profile.

Ulrich *et al.* (2018) state that patients who have a record of behaving aggressively need larger personal space than those who have no history of violence. Therefore, it is crucial to make sure communal seating areas and activity rooms contain enough room to meet these patients' needs for greater personal space. Chairs should not be fixed to the ground,

but movable, so that patients can determine the amount of personal space they need when taking part in interactions with others. This initiative could result in fewer incidents of aggressive behaviour in psychiatric facilities' communal spaces (Van Bogaert *et al.* 2013; Ulrich *et al.* 2018). Based on the findings of this research and that in the literature, space within acute care psychiatry should be more fully considered in the KSA.

The findings of this research suggest that post-event reporting is adversely affected by a number of factors, including that of simply acknowledging or defining an incident as violent. For example, not only did workload and time pressures prevent the completion of reports, but many participants felt that the lack of feedback meant that this was a pointless action. In addition, many participants felt that reporting was discouraged within the psychiatric ward due to the extremely high incidence of violent events. The high incidence and lack of reporting have led to the normalisation of such incidents. A plethora of literature supports the view that violence is frequently underreported (Gates *et al.*, 2011; Moylan and Cullinan, 2011; Pinar and Ucmak, 2011; Chen *et al.*, 2013; Arnetz *et al.*, 2015; Hogarth *et al.*, 2016). Speroni *et al.* (2014) found that although nurses report just 20 % of the total number of violent incidents, there has been little research into how to improve the reporting of violence. It is vital that nurses know that violence should be reported, regardless of the fact that it occurs so frequently in psychiatry settings.

With regard to the findings of this study, a number of reasons emerged for non-reporting. Firstly, there is a perception that this is a pointless exercise as '*nothing will be done'*. Secondly, the reporting process is time-consuming, as well as failing to be user-friendly;

nurses' heavy workloads mean that reporting is seen as an additional chore. Thirdly, while some participants were unfamiliar with reporting procedures, others were concerned that their own behaviour would be questioned and they might be accused of contributing to the incident, causing them to be victimised further. These findings are supported in a number of studies (Sohrabzadeh *et al.*, 2015; Henderson *et al.*, 2018). Chen *et al.* (2013) found that nurses felt there was no benefit in reporting and that they did not have time to complete the report. Chen *et al.* (2013) also highlighted the fact that some nurses felt they did not want to be blamed for the violent events. Arnetz *et al.* (2015) discovered similar reasons for underreporting, such as the time and effort involved in the reporting process, possible perception of failure on the nurses' part, increased tolerance for minor incidents and the concerning view that violence is to be expected. Additional factors are indicated by Pinar and Ucmak (2011), who suggest nurses felt there was a lack of reporting follow-up and also that nurses were afraid of being blamed for incidents and losing their jobs. The same study also identified the fear of legal proceedings that might arise from reporting a violent incident (Pinar & Ucmak, 2011). Other studies also suggest that there is scant reporting to hospital managers (Talas *et al.*, 2011; Albashtawy, 2013).

Accurate reporting is vital if the issue of violence is to be addressed. Participants in this study suggested not only that reporting mechanisms should be user-friendly, but also that adequate time must be allowed to report violent incidents, an approach that is echoed by several researchers (Sato *et al.*, 2013; Hogarth *et al.*, 2016). The lengthy reporting process was also noted by Sato *et al.* (2013), who found nurses were keen to receive

feedback after reporting in order to feel their decision to report to the hospital managers or the police was being supported by the relevant authorities.

Reporting of physical and verbal violence in hospitals is seen as a laborious process because of the lack of common procedures, which in turn can result in inaccurate recording of the frequency and severity of violent incidents. Inaccurate recording can lead to hospital managers having no strategy to address this problem, as they are unable to qualify or quantify the issue. This dearth of routine reporting also means that nurses are not given sufficient, timely support or counselling when they experience violence at the hands of patients or visitors and are left to deal with it alone. In the long-term, the exposure to violence and the lack of support is likely to have a demotivating effect on nurses who subsequently might leave the profession.

In the criminal justice literature, the 'broken windows' analogy, is founded on the conjecture that a broken window left unrepaired sends a clear signal that society does not care and quickly results in all the windows being broken (Wilson and Kelling, 1982). The analogy can be applied to incidents of violence and aggression and the reporting of such, and is therefore useful in the present study. The rationale behind the broken windows analogy is that an environment's outward appearance advertises the social standards with respect to what is or is not considered to be socially acceptable conduct (Ramacciati *et al.*, 2018). Moreover, this conjecture intimates that tolerance towards petty offences, such as loitering, littering, verbal threat or attack, leads potential offenders to assume that more consequential antisocial behaviour will go unreported and

not dealt with (Zhou *et al.*, 2017). Thus, the broken window focuses on the social standards of conduct, and asserts the need for social deterrents to curtail the spread of petty crime and so prevent the occurrence of more serious offenses (Boquet *et al.*, 2016; Ramacciati *et al.*, 2018). In short, the broken window analogy asserts that tolerance or negligence of minor criminal acts generates a favourable environment for more extreme forms of crime.

It has been shown that repeated occurrences of aggression and violence on the part of patients can be avoided by the application of protocols that promote the reporting of incidents (Stagg and Sheridan, 2010). Thus, when considering the specific form and seriousness of such incidents, these findings suggest that future occurrences involving more extreme and violent behaviour could be limited if verbal threats and bullying are reported. The core prediction that unreported incidents lead to increasingly serious occurrences is consistent with the above-mentioned findings (Boquet *et al.*, 2016; Ramacciati *et al.*, 2018). In the healthcare setting specifically, Duncan *et al.* (2016) assert that the healthcare worker's tolerance of verbal assault and threats by the patient creates a heightened probability of increasingly severe acts of violence and aggression because the offender perceives a lack of consequences for their behaviour. Moreover, the degree of seriousness of an occurrence will influence the healthcare worker's perception of the implications of that incident and its relation to social standards (Maslach and Jackson, 2013). Other authors (Pich *et al.*, 2011; Duncan *et al.*, 2016) confirm that tolerance of

violent threats and verbal abuse in the healthcare setting leads directly to more extreme violence.

The influence of patient mental health also arises regarding opinions about violence with respect to its tolerability and the reporting of incidents. In view of the evidence suggesting that healthcare workers tend not to place the blame on patients who appear vulnerable, the theory of reasoned action predicts that aggression or violence on the part of such patients is less likely to be reported than in situations in which the healthcare worker is prepared to hold the patient responsible (Pfeiffer *et al.*, 2010). Thus, this may account for why participants in this study are less likely to report an incident involving a patient with arbitrating characteristics, such as patients being under the influence of substances or those suffering acute mental health problems.

The participants in this study recognised the value of being able to manage violence and were able to describe how they used these skills to mitigate the threat of verbal and physical violence from patients. However, it was also clear that participants sometimes felt a tension created by the fact that they wanted to gain control, rather than empowering the patient to take control of their behaviour.

Similar to the finding above, Kynoch *et al.* (2011) suggest some patients with a risk of self-harm or aggression may need to be medically sedated which is considered the last treatment option, only used to protect the patient, nurse and other patients. An alternative to chemical restraints in aggressive healthcare situations is the use of

mechanical restraints. Mechanical restraints are physical restraints attached to the patient's limbs to stop the patient from harming themselves, staff, or others. Participants in this study highlighted mechanical restraints generally being used as a last resort when de-escalation methods, including defusing, negotiation and conflict resolution, fail.

While some employers may have implemented policies in response to violence in healthcare settings, these have been largely ineffective, as violence towards nurses remains unchanged regardless of increased awareness and administrative policy changes (Goetz and Taylor-Trujillo, 2012). Furthermore, Hegney *et al.* (2010) discovered that the implementation of workplace violence management policies did not result in less workplace violence, with 54.5% of the study's population believing that the initiatives in place were insufficient. One reason for the lack of change in violence towards healthcare staff may be due to nurses regarding the reporting of violence to be excessively bureaucratic and complex.

To summarise, the findings relating to this theme within the present study revealed that patient violence in psychiatric inpatient contexts was perceived differently by nurses from different countries. However, the research did not permit the differences in perception to be anticipated properly. It goes without saying that the issue is not simply cultural differences in the perception of violence, but rather shedding light on the factors underpinning those differences. The mechanisms through which perceptions are formed within the workplace are also worth investigating. Different types of social learning, including modelling, are the basis for the formation of perceptions (Bandura, 1999). A

potent element of the socialisation process, social learning, helps nurses to differentiate between acceptable and unacceptable behaviours within their workplace. Any investigation of this topic must begin by addressing how the social learning of nurses exposed to violence is influenced by factors related to the patients and the work environment.

6.6 Chapter Summary

The primary findings of this study reveal the inter-relationship of the first three themes, namely: 1) the occurrence of violence; 2) the determination of violence; and 3) the impact of the violence. These three themes are inter-related, overlap and feed into the various ways that pre-determine a cycle of violence in the workplace. These three themes form the participants' personal experience of violence. Moreover, as shown in Figure 5, an integrated analysis of these themes reveals the need for the fourth theme, 'The elimination of violence'.

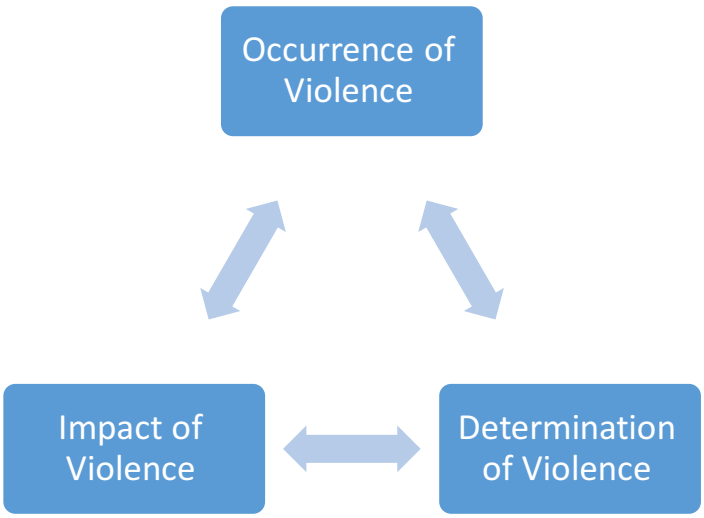

Figure 5: The first three themes of this study

While participants in the present study described both physical and verbal abuse, the most challenging form of frequently experienced abuse is verbal abuse, with the majority of participants regarding it as an integral aspect of their work. Moreover, it has been noted that both verbal and physical violence frequently arise from repeated behaviours which can seem comparatively trivial in isolation, but can build up to a severe type of violence (Papadopoulos *et al.,* 2012). Although there has always been some awareness of physical violence occurring in the workplace, the long-term effects have generally been underestimated (Jacobowitz, 2013). The low rates of reporting and the feelings of shame that are frequently linked with the occurrence of violence in the workplace may have contributed to a continued lack of investigation into this form of abuse.

The precipitating elements underpinning violence in the workplace include the culture of the organisation, the culture of the nursing profession, and variables relating to the

patient (Bentley *et al.*, 2014; Laschinger *et al.*, 2014). Boomer and McCormack (2010) describe culture as the underlying concept of how things are done at the individual, group and organisational levels within a particular society and with respect to healthcare practice.

It is interesting to note the inter-relationship between the three themes that comprise a cycle of violence in the workplace. Although these themes can be viewed as a continuous spectrum of trigger factors leading to violence impacting on nurses working in psychiatric units, such an approach neglects their interdependence. Thus, each element clearly plays its own significant part, as does the overall cycle that the combined themes create. The primary distinction between the themes is that the third theme, 'the impact of violence in the workplace', is regarded as the outcome of the first two. Moreover, the strength of the impact of violence is characterised by the specific form of abuse, which itself is determined by the powerful inter-relationship between the violent event, its type, and the triggering factors for this event. Although the potential for a cyclic process involving the three themes is ever present, the occurrence and impact of violence in the workplace can be reduced or avoided by means of prompt intervention or appropriate precaution at any stage.

The above discussion is mirrored in the work of Gvion *et al.* (2011), which highlights the importance of not underestimating the influence of personality traits upon the occurrence of aggressive and violent incidents. This applies to the personality of the offender and victim alike. This study shows that the personal attitudes, communication

style and characteristics of a member of staff can make them a target for violence. The direct environment can act to increase or decrease the dangerousness of an individual, with the nursing staff becoming the precursors and triggers of violence (Itzhaki *et al.,* 2015; Spector *et al.,* 2014). In the context of mental healthcare, Hallett *et al.* (2014) list several work-related aspects that can raise or lower the chance of exposure to violence, including; form of employment, the specific care setting, working conditions and activities, number of working hours, understaffing coupled with excessive workload, and changes in organisational protocols. This strongly supports the findings of this study presented in Chapter 5.

The processes of assessment and recuperation for abused members of staff should be included in an integrated approach to managing violence in the workplace (Piquero *et al.,* 2013). Gillespie *et al.* (2010) suggest consideration needs to be given as to what actions staff take when faced with workplace violence, the reporting system and rapidness of response during the attack, along with the provision of suitable training and long-term support. The question of how to initiate changes in the way violence in the workplace is managed can only be answered by developing an appreciation of the institution's culture with respect to nursing practice. Participants engaging in this research claimed the institutional culture in which they worked was dominated by blame in the psychiatric ward. Jacobowitz (2013) stresses the need for support in the form of prompt interviewing, training to develop advanced coping skills and routine meetings aimed at fostering resilience by providing support and appreciation of nursing work. Introducing such

systems of support could enable nurses to manage long-term violence by the application of suitable interventions.

Based on the findings of this research and other published studies, the increasing complexity of workloads, decreased resources and hostile environments in which nurses must function, violence in the workplace has become ubiquitous within all parts of the healthcare system, impacting upon the physiological, emotional, mental, social and group behavioural reactions of nurses (Johnson, 2010; Pich *et al.*, 2011). This is further complicated by disparity between the nurse's personal and professional responsibilities, with this research and other authors such as Cornaggia *et al.* (2011) and Jackson *et al.* (2014) noting the presence of divided loyalties between the nurse's personal needs as a victim and the professional imperative to prioritise the needs of the patient.

Violence can be prevented if behavioural cues for aggression are accurately identified (Hallett *et al.*, 2014). Indeed, a good understanding of potential triggers and indicators is crucial for preventing violence. Moreover, nurses have suggested ways in which violent events could be prevented within psychiatric wards. For example, in Bowers *et al.* (2015), the nurses highlighted the need for safer working conditions and continuing education, as well as developing and enhancing the skills necessary to interact with patients. This demonstrates what nurses felt was lacking and is still considered insufficient, despite the physical updates towards, and the practice of, vocational and continual education. In addition, the findings of this research highlight the importance of therapeutic

relationships, adopting a collaborative role with doctors, an appropriate reporting system, and managerial support in preventing violence against nurses in the workplace.

Chapter Seven: Conclusion, recommendations, implications and limitations

7.1 Conclusion

Mental health nurses are critical to the healthcare system (Bradshaw and Pedley, 2012), but unfortunately they are often the recipients of verbal and physical violence by patients. In the KSA, there are limited statistics which record the frequency of violent incidents, as nurses are known for underreporting these events. Patient violence can involve both physical and psychological damage, as well as having wider implications for patients, nurses and organisations. The personal effects of violent incidents on nurses include fear, anger, guilt, lack of job satisfaction, lack of confidence in their role, desensitisation towards violence and believing that this is simply part of their job. From the participants' perspective, such experiences compromise the quality of patient care. Not being able to deliver quality care may lead to frustration and subsequent stress and burnout. This may impact on an already stressful situation whereby there are ongoing problems with nurse recruitment, as well as low retention rates.

This qualitative study aimed to explore the experiences of female nurses working in acute female psychiatric settings in a Saudi hospital context, and the following sections will summarize the main findings of the research, discussing the extent to which the main goals were reached. It will set out the study's recommendations, implications and limitations.

When reviewing existing literature on the topic of patient violence towards nurses in psychiatric settings, extensive data was used to provide a background and context for the current study. Definitions of patient violence, the frequency of these events, contributing factors, subsequent effects, and ways to prevent and manage such situations were found in earlier studies: however, most of these studies originated in Western countries, and no qualitative studies had been undertaken in Arab countries, in particular, in the KSA.

A qualitative, descriptive methodology was used to ensure the experiences of participants were accurately portrayed. Semi-structured, audio-recorded, face to face interviews were used for collecting data, which were later transcribed verbatim by the researcher. A thematic analysis was then undertaken, and four key themes were identified: 1) The Occurrence of Violence; 2) The Determination of Violence; 3) The Impact of Violence; and 4) The Elimination of Violence. Within each of these themes, sub-themes were identified.

The participants in this study believe that patient violence, such as physical and verbal abuse from patients and their relatives, is an unavoidable part of their work. This notion was further explored by examining internal and external aspects impacting on patient violence against nurses. Despite some positive outcomes of patient violence, the effects of patient violence were found in the main to be negative, with substantial psychological impacts being noted. It was found that a violent workplace event can impact a person's quality of life and damage the nurse’s professional self-confidence and their therapeutic relationship with patients. In order to limit the negative impact of these events, participants believe that nurses and their managers must change their mentality towards

these events as being unavoidable in their profession. There must be more awareness of the legal rights of nurses to defend themselves in verbal or physical altercations and nurses must be provided with adequate training to deal with such events. Management and hospital administration must be aware of their legal requirement to offer a safe working environment and make decisions accordingly, discounting any notion of violence being something that will always be part of mental health care.

Findings from this research also identified a low level of support for nurses from colleagues, the organisation and family, following patient violence. Data collected related to the lack of support is concerning, as this appeared to be associated with the tendency for not reporting violent incidents. The non-reporting of violent incidents meant that nurses could not be provided with any support after the event. This establishes a vicious cycle of non-reporting amongst nursing staff, rather than allowing support systems to be created for those who have been affected by such incidents.

A lack of statistical information, together with the under-reporting of workplace violence, was an important finding in this study. There is a need for robust, universal reporting standards to uncover accurate statistics on violent incidents in the healthcare system (Kvas and Seljak, 2014). However, before statistical evidence can be collected, there must be standardised definitions of violence, and guidelines for the reporting of such incidents. Verbal abuse must also be reported to the same extent as physical incidents, due to the psychological trauma suffered by the recipients (Angland *et al.*, 2014). Appropriate safety training related to the work area, as well as self-defence from physical and verbal attacks,

would mitigate the negative impacts associated with these events. The hospital management are in a position to effectively address these issues, and they should show a level of sensitivity towards the topic. Nursing staff must be clear about their right to protect themselves and their right to work in a safe environment (Sammer *et al.*, 2010).

The themes generated within this study were considered in terms of meeting the key aims of this research. The first theme, 'The Occurrence of Violence' was tied to the current study's objective 'To explore female patient violence as experienced by female qualified nurses working in female acute care in-patient psychiatric units in the KSA'. The second theme, 'The determination of violence', relates to the second objective by identifying factors that female nurses believe increase the likelihood of female patient violence. This included personal, workplace and socio-cultural factors which have the potential to initiate patient violence in psychiatric wards. The third and fourth themes, which were 'The impact of violence' and 'Elimination of violence' respectively, both address the study's third objective, which was 'To elicit what implications violence in the workplace has both in the short and long term for female nurses working in female acute care in in-patient psychiatric units in the KSA'.

The aim of this qualitative study was to add useful findings to the existing body of knowledge regarding patient violence within the KSA context, by encouraging nurses working in female acute psychiatric settings to share their experiences. The current thesis provides findings useful to nurses, educators and organizations who have involvement with nursing staff and health care *per se*. Implicit in the findings of this study is that

workplace violence must be dealt with collectively by all three of these parties. Additional studies could examine the longer term impact of being exposed to violent incidents, and using a wider, more varied sample population may produce a deeper understanding of patient violence, and perhaps more efficient methods of countering its negative effects.

This study identified psychotic types of mental illness, and nurses having to impose restrictions, such as refusing patients leave from the ward area, as individual factors relating to violent or aggressive behaviour. Other factors believed to incite patient violence included: relationship factors, encompassing nurse patient interactions or patient to patient interactions; and environmental factors such as limited physical space and patient activity, a low nurse-patient ratio and work overload. Furthermore, the hospital must be considered more widely, as all the factors mentioned above are rooted in its overall structure and organisation. Thus, organisational factors in this study were identified to be lack of internal policies on workplace violence, policies on patient and staff safety, or no user-friendly centralised reporting system to record violent events.

7.2 Significance and Relevance of the Research Study

The Saudi healthcare system has an inadequate supply of native nurses and reliance on expatriate nurses is high. This is a major issue which has to be tackled. At present, most nurses working in the KSA are not local, and this leads to regular shortages precipitated by low retention rates in the nursing profession (AlYami and Watson (2014). In the KSA 60% of registered nurses are females, with a high turnover rate. This rate increases with

the presence of other problems, such as workplace violence faced by Saudi female nurses, and the negative impact this has on their levels of job satisfaction and their intention to continue working in their current employment. This subject has attracted less attention on the part of researchers than the more common approach, which considers Saudi nurse turnover in terms of its financial costs and the effect it has on the organisation of healthcare in the country.

Therefore, It was important to undertake this research during the current period of social, economic and political change in the KSA (Shukri, 2018). The knowledge generated within this study can add to existing literature, examining patient violence towards nurses within the Saudi context, and more specifically within the mental health care setting. This could provide further insight into what could be done to improve the situation and improve the work condition during this time of shortage of mental health nurses across the world.

In addition, it comes at a point when a Saudisation programme is being launched to replace the huge numbers of expatriate professionals in every field with qualified Saudis, and this also applying to the healthcare sector (AlYami and Watson, 2014). Female nurses make up a major proportion of Saudi women who work in non-traditional areas, and their experiences will provide pertinent information on patient violence towards healthcare staff within the Saudi context and how it influences their decision to leave the clinical field. A number of studies have examined patient violence and its effect on job satisfaction in the healthcare sector, and retention rates in nursing. For example, Heponiemi *et al.* (2014) and Galián-Muñoz *et al.* (2016) assert that patient violence has a

significant impact on productivity and the degree of commitment workers have to their jobs, and note that long hours and heavy workloads can affect workers' well-being in what is already a demanding professional role.

Although an ever-increasing number of studies have investigated patient violence within the nursing profession, most of these studies focus on hospital environments in western countries (Hallett *et al.*, 2014; Iozzino *et al.*, 2015). It has to be borne in mind that the issues Saudi nurses have to face may differ from Western nurses. Their working hours are long, particularly when compared with those of women in more traditional roles, such as teachers, who do not work for more than six hours every day. Moreover, nurses have to accept night work and shift work. Taken together, these factors make nursing a profession which has not been acknowledged and valued in some parts of Saudi society, particularly given the fact that many Saudi nurses have children and are responsible for caring for them, and their homes. Lamadah and Sayed (2014) suggests that these reasons may explain why the turnover of female nurses is higher than that of their male counterparts. It is therefore important to gain a thorough understanding of the issues they face, in and outside work, in order to develop a strategy for retaining Saudi nurses within the clinical field and raising their overall levels of job satisfaction and well-being.

Participants in this study asserted that the negative views of nursing in Saudi society, and the socio-cultural attitudes, account for the reaction and low levels of support the participants' received from family, friends and their communities when they were subjected to patient violence. The commonly held view of nursing, and the profession's

image, are damaged by violent incidents and act as a barrier to Saudi families encouraging their daughters to consider nursing as a career. Additionally, the role of the nurse in providing care and assisting doctors to implement patient treatment plans is viewed as an unskilled, passive and demoralising one. This study's findings demonstrate that the low social status of nursing directly influences the amount of support nurses are given, not only because the nurses have low status in Saudi society, but also because of the competitiveness which exists between doctors and nurses, the former being dominated by men.

This qualitative study is valuable due to it being the first study to examine workplace violence in the Arab peninsula, and specifically in the KSA, where it has previously been an overlooked topic of investigation. In tackling this topic individuals who, while working as qualified nurses in psychiatric settings, have experienced patient violence have had chance to share their feelings and experiences providing important data for the KSA and the Arab peninsula. This research provides valuable data regarding workplace violence, by establishing a deeper understanding of the impact workplace violence can have on nurses working in mental health settings in Saudi hospitals. Steps can be taken to prevent such events, and maintain their rights as human beings, as well as professional nurses. After accounting for staff shortage problems, this study offers suggestions to resolve the ongoing problems which can affect the quality of the work environment and may help to improve nurse retention rates in the future and subsequently patient care.

7.3 Recommendations for future research

Based on the findings and the discussion presented in this thesis, the following recommendations for future research are outlined in this section:

1. Studies undertaken in the future regarding the experiences and implications of patient violence could have a wider scope, covering more psychiatric hospital departments in regional public hospitals in order to build a more cohesive national picture in the KSA. This would help elicit why violence occurs, the impact on nurses, their family and wider society, and what policies could be introduced to address this problem.
2. In addition, further research could be undertaken in general wards in Saudi hospitals, particularly where there are high stress levels (e.g. emergency, intensive care and mental health) to make comparisons regarding how often and how severe the violent incidents are and whether or not a wider policy needs to be put in place.
3. Future work could cover additional hospitals, as mentioned, both in the public and private sector, across urban, rural and other locations, to assess the prevalence of violent incidents across these different areas.
4. Since this study's sample was made up entirely of female qualified nurses, future studies could examine the experiences of male nurses.
5. There is a clear need for a more in-depth look into the long-term impact patient violence has on psychiatric nursing staff. It would be important to interview nurses

who have ended their nursing careers due to this type of violent event. Again, this might provide better insight into the impact of violence at a personal level and what could be done to provide better support and hopefully stop nurses leaving the profession.

7.4 Practice Recommendations and implications

Recommendations for nursing practice in Saudi hospital settings:

1. For mental health care to be successful, it should be based on therapeutic relationships which facilitate; accurate diagnoses, treatment plans, and appropriate interventions (Priebe *et al.*, 2011). Early recognition and evaluation of the risk of violence, together with the establishment of empathic, therapeutic relationships involving clear communication on the part of nurses, may reduce violent events (Cornaggia *et al.*, 2011; Richmond *et al.*, 2012). In addition, clear communication should be the responsibility of all members of the health care team, with doctors taking a lead role and not leaving the nurse to tell patients about hospital policy and regulations and their treatment plan. This is particularly pertinent to the Saudi context and the value differential placed on doctors and nurses.
2. The present study findings demonstrate the significance of increasing an individual's resilience, developing a sense of group cohesion, and the importance of nurses working in psychiatric settings having a mutual commitment to one

another in helping them deal with violence in the workplace and enhancing their job satisfaction.

3. Mental health facilities should foster effective teamwork by providing the nursing staff with skills that promote good communication, collaboration and coping strategies that avert or decrease stress at work.
4. In addition, the resilience of nurses working in psychiatric settings can be enhanced by introducing training protocols centred on strategies for managing patient violence and promoting the psychological and physical health of the nurses. Hence, the provision of regular training programmes is essential to enable nursing staff to circumvent or cope with violence in mental health facilities, thereby upholding the security and well-being of staff and patients alike.
5. There are numerous standardised risk assessment tools which can be used to assist in reducing the risk of violence. Clarke *et al.* (2010) offer the example of the Brevet Violence Checklist (BVC), which is a simple and well-established tool that can help to predict violence in acute psychiatry patients. Teaching nurses how to use such assessment tools in an appropriate manner and at an appropriate time may prove helpful in reducing the incidence of violence.
6. Hospital management could implement a more effective way for nurses and all other health care professionals to report occurrences of violence. Many of the participants in this research, and in previous studies regarding patient violence, discussed under-reporting, with researchers believing that the frequency of these

incidents is much higher than what is stated in existing literature (Gates *et al.*, 2011).

7. Systems for nurses going through or having gone through patient violence are of the highest priority. In cases where patient violence is unavoidable, then the focus should be on supporting the nurse involved, with debriefing sessions being put in place.
8. The current study was able to provide a unique and basic insight into how nurses experience patient violence in the specific Saudi context. This knowledge could help establish clear guidelines for interventions for addressing violence in the hospital setting, as well as identifying strategies that could be used to avoid, or at least control, violent events.
9. More attention should be given to the psychiatric environment in which nurses operate being made safe. Best practice guidelines need to be established for dealing with patient violence, which can help limit the role conflict of providing care for others and protecting themselves.

7.5 Recommendations for organizational management

Controlling the factors which may lead to patient violence in the workplace should be at the forefront of any organisation. Based on the findings of this study, the following recommendations for Saudi hospital organisations are recommended:

1. Unit layout and milieu are of value and need careful consideration with regard to the occurrence of violence, since there needs to be enough space for therapeutic endeavour between staff and patients (Fasanya and Dada, 2016).
2. Changes to communication, collaboration and support mechanisms to improve quality of patient care, as well as the working environment, could be implemented in order to increase work satisfaction and reduce nurse and patient stress which could subsequently limit patient violence.
3. A recurrent theme for those participating in this study was their need for support after an incident of patient violence. This involved looking for informal support through family and friends, nurse administration. Therefore, a supportive team is vital for safe nursing practice, and is a source of support that would be appreciated by frontline staff (Wilson *et al.*, 2011).
4. Nurses having to ensure their personal safety while also delivering patient care, and the stress inherent in being in such a position should be acknowledged. This is a critical area of focus for organizations, since job stress has been associated with a number of negative personal impacts, as well as wider organization effects (Tang and Chang, 2010).
5. Organisations should provide nurses with effective user-friendly reporting systems for patient violence.
6. Organizations need to attempt to instigate a cultural shift, from one that blames their staff, to one that supports them. This type of blame causes a feeling of professional failure and increases the trauma experienced.

7. Organizational response towards the traumatized nurse is a crucial component in their recovery (Paterson *et al.*, 2010). When the organisational response does not comprehend the needs of the nurse who has experienced patient violence there are likely to be negative consequences, with secondary injury or trauma. Support of those affected by patient violence should be made mandatory with National guidelines being available to ensure appropriate responses towards patients and healthcare workers alike.
8. It is the responsibility of organisations to ensure policies for the prevention and management of violence are in place and relate to best practice guidelines (Clerc *et al.*, 2011). To maintain a substantial level of policy uptake, suitable guidelines with an appropriate level of credibility and relevance could be implemented. This will be best achieved through collaboration with frontline staff, and strategies used being re-examined and evaluated constantly.
9. This study's sample of female qualified nurses working in a psychiatric setting suggests that there is a need for inter-professional collaboration and teamwork across healthcare workers. This type of cooperation could result in many benefits for all involved, such as higher workplace morale, increase job satisfaction, improved the quality of care and produce healthy working environment (Pasarón, 2013). For these collaborations to be effective, structures need to be in place to facilitate it, and allow the teams to meet and appraise their collaborative status, and assess the standards they have in

place, all the time being educated on collaboration and communication between professionals.

7.6 Recommendations for Nurse Education in KSA

The following are recommendations for nurse education delivered in Saudi nursing colleges:

1. There is a need for educational programmes for staff and management, focusing on awareness about violence, the nature of violence, and ways to better handle these events, as a victim as well as a third person (witness) (Powley, 2013). Individuals who are vulnerable to violent incidents at work, such as less experienced nurses and those working in more high-risk units, should be the initial intended audience of these educational programmes.
2. A greater level of support and education should be provided by the institutions responsible for student training. Students should be informed about workplace violence, how to deal with these incidents, and what support services they can have access to. A greater level of awareness can allow nursing students to deal with workplace violence more effectively throughout their clinical placements and in their future workplace (Wassell, 2009).
3. In this research, the participants' stated that evidence-based education on how to deal with patient aggression and violence, how to build a proper and effective therapeutic relationships with the patient should have been part of their

undergraduate curriculum. This needs to be address together with a programme of continuing education during a nurse's professional work life.

4. As there is a relatively high chance of personal and organizational impacts resulting from patient violence, risk of burnout and job stress should be considered important practice issues, as well as the effects these violent incidents have on quality of care provided by nurses. The provision of support strategies in nursing education are crucial if this matter is to be a priority. Additionally, managers could provide protected time and assistance for staff development.

In summary, the significant number of violent incidents many nurses are exposed to every day necessitates the implementation of systematic policies and practices aimed at reducing and containing violence. Therefore, Saudi nurses should come under a wider multidisciplinary team in hospitals where workplace policies and management strategies are kept under constant review, and educational, training and debriefing opportunities are established. The participants in the current study suggested those working in a hospital management role must operate in line with workplace policies, enforcing and activating existing policies; being accountable for the control of violent situations and taking action based on such policy in situations of verbal or physical violence. Moreover, hospital management is encouraged to establish policies which can limit workplace violence.

7.7 Strengths and Limitations of the Current Study

This qualitative study used a purposeful sample of nine female qualified nurses with experience of working in a psychiatric setting to explore their lived experiences of, and perceptions about, female patient violence. When it comes to self-selection, synonymous with purposeful sampling approaches, there is always a level of inherent bias (Suri, 2011; Noble and Smith, 2015). The findings of this qualitative study presented the experiences of the study's participants, who were taking part of their own free will, and were comfortable in sharing their experiences with me, describing the latter at a given moment in time. Whilst participants were able to pinpoint and describe workplace violence incidents they had encountered, individuals who were not comfortable discussing this topic, or did not want to take part in the research may have offered a different perspective (Noble and Smith, 2015; Roulston and Shelton, 2015). Likewise, the problem of volunteer bias, whereby people interested in the topic become overzealous due to their own interest in the matter, has been noted (Robinson, 2014; Roulston and Shelton, 2015).

However, the benefits of self-selection within this research project were evident due to participants being willing and motivated to discuss their personal experiences of patient violence and how this had impacted on various aspects of their lives. In turn, the interviews were more focused and produced high quality data. Furthermore, participants taking part in the study felt safe in doing so, as they believed voicing their concerns would facilitate solutions to such problems.

While it could be suggested that a sample size of nine participants was small, in keeping with the ethos of qualitative research, this enabled me to carry out interviews with participants on a face to face basis and to audio-record these for accuracy. In addition, I transcribed the interviews directly. As a result of these activities, I was completely immersed in the data process, collecting, transcribing and analysing, through which the quality of the data was maximised.

Concentrating on a single hospital, an in-depth qualitative study could be achieved, producing valuable and specific findings (Castellan, 2010; Carminati, 2018). Moreover, this study exclusively investigated a 'high risk' unit in a regional public hospital, delivering care to those deemed to have serious mental illness and who warranted admission to the hospital. This facilitated the generation of useful data with regard to perhaps the most at-risk staff.

My reason for choosing this qualitative approach was to find whether situation-specific experiences of patient violence supported or provided new data on the topic. Similar to other researchers (Jamshed, 2014; Almalki, 2016), in carrying out this research, I made anticipatory suppositions taken from existing studies with regard to patient violence and used these as a platform for initiating dialogue regarding the experiences of participants and to create a clear understanding of these events. In doing this, the key aim of this qualitative research study was achieved and findings could be used to inform policy-makers who have the ability to impact the health and wellbeing of individuals; nurses' and patients alike.

As the researcher is the main gatherer of data in qualitative research, open mindedness is essential (Qu and Dumay, 2011; Jamshed, 2014). This was maintained as much as possible during data collection, in order to limit the impact of personal pre-conceptions, beliefs and behaviours. All interviews undertaken reached the maximum time limit and some were voluntarily longer, indicating, not only the researcher's skill for collecting data successfully, but also participants' willingness to share their experiences in detail. Participants appeared comfortable and safe in sharing this information, perhaps because of my own previous experience as a female nurse working in a mental health inpatient setting and the empathy, I was able to demonstrate. During the process of data analysis, and following my initial coding of the data, my supervisors also looked at the transcripts and we were able to discuss our different thinking and interpretations of the raw data. This helped me establish the thematic content without solely relying on my own interpretation of the data, as well as increasing authenticity, trustworthiness and credibility of the findings (Gates *et al.*, 2011).

7.8 Original contribution to knowledge

There are no other published research papers that I know of which offer data directly from female Saudi qualified nurses relating to their experiences of exposure to patient violence. This research provides an insight into their experiences of patient violence, as well as how nursing, particularly in relation to psychiatry, is viewed in the KSA, and the effect this had on the participants. While the findings in the present study offer new

insights, further research regarding the impact of culture on nurses working within the context of psychiatry across the Arabian Gulf could be fruitful.

To date, research has shown a consensus that men are mainly responsible for the violence, particularly if they come from a patriarchal society, and this often blights working in the health sector (Kamchuchat *et al.,* 2008; Tarar and Pulla, 2014). As far as I can determine, this is the sole research study which focuses on female patients, demonstrating how they can be aggressive towards female nurses in the KSA. Additionally, it is interesting to note that few participants could find any positive outcomes to workplace patient violence, and yet some nurses did see positive aspects when a period of time had elapsed after the violent incident. The positive outcomes which were reported included: a sharper awareness of risk; greater focus on the patient; a recognition of the nurse's duty of care to patients; and a heightened awareness of the importance of self-respect.

7.9 Personal reflection

This section considers my personal experiences as a novice researcher and will be written in the first person.

The study set out to explore the actual experiences of psychiatric nurses who have encountered patient violence and aggression in the workplace. I decided to employ a descriptive, qualitative approach, in order to faithfully capture what they had lived through and stay true to their experience.

I chose this topic for my PhD since one of my nursing colleagues had been subjected to patient violence and I have also witnessed some aggressive behaviour toward nurses during my practice placement on a psychiatric ward. For me this was unsettling and stressful, and I believe such violence often leads female nurses, particularly those working in psychiatric care in the KSA, to abandon their careers. I also considered leaving the profession.

As soon as nurses become qualified, they find themselves taking on a range of responsibilities and encountering violence and insults on the part of the patients. My colleagues found this challenging, since there is little real understanding of what we face at work, with a lack of support both in the actual workplace and at home. This low level of support is influenced by the general view within the KSA that nursing is a poor career choice, and possibly not a respectable one. Indeed, public opinion views nursing as a distasteful profession, and this along with the belief that women should not work is one of the reasons why Saudi Arabia remains heavily dependent on hiring expatriate nursing staff. As long as nursing continues to have a negative image, families will refuse to allow their daughters to become nurses, blaming them for any problem they face during their career, including patient violence and aggression.

I believe this research was undertaken, at a time when the experiences of psychiatric nurses in the KSA took centre stage, and I was able to shine a spotlight on the violence nurses suffer from patients and their families. Such incidents have a major impact on me. In addition, in order to have a comprehensive grasp of the challenges faced by nurses in

the Saudi healthcare system, outsiders must recognise how cultural views come into play when nurses experience patient violence.

When undertaking the literature review for this study I felt disappointed and that it was limited in scope, because of the preponderance of Western literature on the issues nurses face when encountering violence. Violence against psychiatric nurses in Saudi Arabia is under-represented in the literature, and quite different factors may shape Saudi and Western nurses' experiences and viewpoints. If this is the case, the existing literature could overlook the unique and quite specific issues which form part of psychiatric nursing in the KSA, as well as other developing countries, when compared to the developed world.

This is an important point, given the variations in nursing approaches between the West and Saudi Arabia, which reflect the culture and society within which healthcare systems operate. For example, unlike their Western counterparts, nurses working in the KSA have to deal with particular issues relating to nursing regulations, the workplace itself and traditions and customs. I soon recognised the major role played by the cultural context in this field and realised that no studies had been undertaken in Arab-speaking countries, which meant that the experiences of psychiatric nurses had only been recorded from a Western perspective.

At the very beginning of my studies, I found it challenging to obtain ethical approval, since this needed all the documentation to be submitted in advance and permissions to do the research would only be granted if there were no questions to address. This experience

showed me that participant safety is at the heart of ethical approval, and that research studies have to be designed with great attention to detail by the researcher, if they are to be approved.

I was aware of the importance of confidentiality from the beginning of the study, when I was asking for access to the nurses, and knew this was vital for interviewing. The more interviews I conducted, the more I became aware that the interviewees felt that they were discussing a sensitive issue related to one of their previous bad experience and sharing some personal issues related to their family. I found myself constantly telling them that anything I heard would remain confidential, but I also had to recognise that I was a temporary visitor to their world, and it was their right to determine how much or little they were prepared to share with me.

In the course of carrying out this research, I conducted interviews with nine psychiatric nurses from one hospital in the KSA. I chose to use the semi-structured interview approach, since this allows for participant-led responses and makes up for my relative inexperience in conducting research. Before starting the interviews, I revised my interview guide a number of times, and tried them out on friends. The interviews improved as I gathered pace and became more relaxed, and each contributed to the overall research findings.

I did not have any problems encouraging the interviewees to talk, but I had to find a way of moving from the preliminary, introductory stage to the heart of the matter, where I

could amass relevant data. I needed to build up a good relationship with the interviewee quickly, and to try and keep our interview as focused and clear as possible, since every word had to be transcribed and could have a specific meaning. I used open-ended questions, in order to allow for follow-up questions and examination of inquiry that were significant to the individual. I did find coordinating the interviews significantly more complex than I had first anticipated.

The actual data gathering phase was finished in a number of months, in line with the availability of the participants. I originally worried that the study had too few participants and considered interviewing additional staff from various hospitals in Riyadh, in order to gather comprehensive data on patient violence towards psychiatric nurses. Eventually, I realised that the participants I already had were giving me useful information and that the data I amassed was valuable.

During the interviews, I would express my personal views by agreeing with those stated by the participants. However, I also had a tendency to engage in conversations with participants which could have impacted on the themes I initiated, even though I do not think that any of the participants' views have been distorted.

When I started the interviews, I saw the participants as helpless individuals who found themselves in a difficult, desperate situation, and yet still felt a sense of duty towards their nursing profession. I found myself nodding my head in agreement with the

comments and situations the psychiatric nurses were describing, accepting their thoughts and not discussing them for clarification during the interview.

After conducting one interview, with a nurse who was pregnant and who had been assaulted by a patient, I found myself having to take an extended break before continuing with the next interview. I felt furious that the nursing management had sent this nurse into a dangerous setting on her own, and then did not answer her calls for help or feel any great sympathy for her plight. During this particular interview I became distracted from focussing on my aims and started to tell the participant that she had been through an extremely bad experience. I found myself voicing my anger, my frustration that this has been allowed to happen by the nurse Management and I stated that, had I been in charge, it would never have occurred. I also disclosed that one of my colleagues had gone through something similar and I knew how she felt.

Here, I was working on a number of assumptions and emphasising that both the hospital and the nursing administration were bad and responsible for the incident. In addition, speaking like this made me appear to be an expert on nurse management, and resulted in me overlooking the fact that the nurse was the real expert. I realised that my role was to listen and not offer personal opinions. Similarly, by drawing on my own experiences, I was amplifying the negative experience the nurse had undergone. Now I was aware of this I knew I had to stop doing this. Such awareness allowed me to consciously put my own opinions to one side and focus on the information the participant was sharing with me.

Therefore, after this interview I reminded myself that I had to stay open-minded and let the participants voice their truths, since the only way in which I could fully understand what they wanted me to know was by absorbing and not judging what they were saying. I had to put my personal emotions, thoughts, views and principles to one side, so that I did not foist my own interpretations onto an event, and thereby distort it.

At the beginning, I found this extremely difficult, and however carefully I tried to acknowledge and put aside my own experiences working as a psychiatric nurse, and as someone who had encountered violence in the workplace, my personal experiences tended to come alive and interfere with the interviewing process.

However, my clinical nursing experience did help to some degree, since I had observed workplace violence and aggression. I recognised the importance of side lining myself and not allowing my own feelings and reflections to become entangled with the participants' stories. I found this a cathartic decision, and one which allowed participants to state what they thought without me interjecting my own experiences.

After concluding this study, I was highly struck by how Saudi culture views the nursing profession and the lack of support offered to nurses. I intend to move to Saudi Arabia on finishing my studies and to continue researching patient violence towards healthcare professionals and suggest improvements which could be implemented to tackle this problem. In addition, many of the participants stated that the lack of effective official support was an issue, with some maintaining that what little support was available could

not be considered effective. This surprised me and I believed opened the door for further research on this topic.

Completing this study has provided me with impetus and motivation, as well as a sense of duty towards everyone I met while carrying out this research. I have resolved to grasp every opportunity to put my knowledge to good use and continue learning, possibly by conducting large-scale studies in other hospitals, in the public and private sectors, and changing locations and looking at the urban and rural divide, to see what I can learn about violence towards nurses. Additionally, I wish to assess the long-term effects of patient violence on psychiatric nursing staff and interview nurses who have left the profession because of this issue. This would give me greater insights into how violence affects individuals on the personal level, and the support they need if they are not to abandon nursing.

I set out to ensure that I did not stress my personal background and acquired knowledge of the views of mental health professionals. During my supervision session I was keen to discuss how best to avoid bias, and my impartiality was bolstered by my duty to integrate the perspective of the psrticipants. I recognise that I, as the researcher, was just as susceptible to personifying a number of beliefs and emotions which can lead patients to respond in a violent manner.

Recording the findings and analysing the data by using the TA framework allowed me to be the participants' mouthpiece. The study used Braun and Clarke's (2012) method of

data analysis, a process made up of six phases. By strictly following each phase, I worked hard to ensure I excluded any bias or input which resulted from the relationships I had built with the participants. My supervisor provided me with guidance throughout data collection, data analysis and interpreting the findings, which was key to ensuring the outcomes were valid and credible. All the participants were made aware of the aims of the study and the information sheet they were given clearly stated that it formed part of a PhD degree. I also wore casual clothes and carried an ID card on me, which identified me as a student from Salford University.

I also had to consider whether my presence had an impact on the opinions expressed by the participants and the experiences they chose to share with me. I acknowledged this possibility and ensured that I checked the accuracy of their descriptions from their own words and carried out meticulous data analysis, sharing my interpretations with those of my supervisors to try to ensure I had not missed anything. I found the writing up stage quite problematic in terms of the data analysis, but using the step by step method allowed and helped me to write descriptions of the participants' experiences which were lucid and analytical. In order to make sure my personal interpretations did not creep in during the writing up stage, I regularly referred back to the data to check accuracy. The two supervisors acted as experts, and this ensured the study findings were valid in terms of content, analysis and interpretation. This approach was extremely helpful.

Once the thesis was written, I had to think about its shape and structure for submission, since universities have detailed procedures and policies which must be followed for thesis

presentation. These include the standard of word processing, the size and type of font, margins, ways of presenting photographs and other illustrative materials, and binding specifications. In order to comply with the university requirements, I found myself running out of time, since proof-reading needed to be done, I had to find missing footnotes and compile my references. Once the thesis has been submitted the viva was last hurdle at the end of long, complex journey. There are still a number of details which need to be re-evaluated, such as going back over the thesis, taking notes, carefully reading it again and again to make sure that every detail is correct and all corrections made.

My research skills and my personal and professional development have all benefitted from undertaking this PhD. Undertaking this doctoral research project has allowed me to attend many courses, classes and workshops in Manchester, at the University of Salford, which has honed my skills and my knowledge of research, ethics, developing proposals, literature reviews, methodologies, where to find relevant materials and research analysis. In addition, I took part in a research symposium at Salford University, presenting my research as a poster presentation. These experiences have developed my self-confidence, personality and improved my decision making and thinking, and taught me to be an open-minded researcher, who is flexible and can work in a variety of different settings. Although there were periods when I found the research study stressful and demanding, it remained stimulating and inspirational. I believe that the work carried out is significant for the future of mental health nursing, as well as all the nurses in the KSA who are subjected to patient violence.

Thinking back, drafting my thesis was a laborious process, but I was constantly encouraged by my fellow postgraduate students and everyone around me. I discovered that as well as needing to be alone to work and think, I also needed to share my views and ideas with others. Many people have found their PhD thesis an overwhelming, huge and never-ending task. My experience of writing a thesis has taught me to rely on determination, hard work, excellent time-management and prayer. On a practical note, I also recognised that it is important to keep the main thesis and research questions in mind when writing the chapters.

Writing this thesis has been a wonderful and occasionally difficult metaphorical and literal journey. Metaphorically, when I first started this study, I began at A and then decided on the easiest way of reaching B, and was overcome with enthusiasm and ignoring the possibility of future obstacles. As my plans developed, I had to modify and change them, in order to make room for such a huge undertaking and give it the time it demanded, in my already busy life. However, as is true of every journey, the thrill of experiencing new events, finding new insights and viewpoints, always helps the traveller to concentrate on the path ahead. Once I reached my metaphorical destination, submitting my thesis and undertaking my viva, I did feel a tinge of disappointment that I was not better prepared for arriving at where I wanted to be.

When I think back to my viva, I realise that this was not my actual destination, but simply a stop en route. I was lucky to meet people who provided me with a map for the onward journey to the final stop. it was of major importance in ensuring that I did not lose myself

and stray from the right path. I am at the point where I believe that careful reading of the map will show me new paths through my thesis and will ultimately help me to arrive at my destination. I hope that reaching this goal will benefit me, as a researcher, nurse educator and practitioner, and also benefit the people who have participated with me on the journey, particularly the participants in my research, who helped me to complete my research.

In conclusion, when I started reflecting on the experience of writing this thesis, I realised that for the most part I really enjoyed the process. I am always keen to learn more, both in and outside the classroom, and am particularly interested in learning about topics related to my career in nursing.

This project was highly time-consuming, but it taught me that if I set myself goals, I can achieve them. I believe that this was the most valuable lesson I learned, and I now know that determination pays. I realised that I am capable of achieving more than I imagine, so I will continue to push myself. I am not someone who always pushes myself, but this project provided me with an enjoyable challenge and one which drove me to excel, recognising that I find it easier to do well when I am enjoying the task in question.

Doing my PhD was a fascinating journey, which brought me new colleagues, partners and business friends, with whom I can share my academic and my personal thoughts. On this topic, I would like to note that Dr Sue and Dr Tony's guidance was crucial in showing me which areas of the project were well argued and constructed, and which parts of the

thesis needed revision. I benefitted immensely from their input and saw my thesis through new and critical eyes.

I can now look back and recognise that this study has been extremely helpful to me as a young professional and novice researcher. Research and writing abilities are valued in many sectors, including the academic world and nursing. I have grown in confidence when it comes to my writing and research skills and the experience of working with my supervisors has allowed me to build up a mentor-mentee relationship. In conclusion, I feel this has been a positive and pleasurable experience, and one which has prepared me for the next stage of my academic and professional life.

Appendices

Appendix 1: The University of Salford's Ethics Post-Graduate Research Ethics Panel approval .

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team
G.03 Joule House
University of Salford
M5 4WT

T +44(0)161 295 52280

www.salford.ac.uk/

3 August 2017

Dear Badriah,

RE: ETHICS APPLICATION–HSR1617-148 –'Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in Saudi Arabia Hospital.'

Based on the information that you have provided, I am pleased to inform you that ethics application HSR1617-148 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

S. Pearson

Dr Stephen Pearson
Deputy Chair of the Health Research Ethics Panel

Appendix 2: Consent form

Title of study: Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in Saudi Arabia Hospital

Name of Researcher: Xxxx Xxxx

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and circle yes or no, as applicable in the box on the right hand side.

1-	I confirm that I have read and understand the study information sheet version …1 …dated 24.5.2017…., for the above study. I have had opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2-	I understand that my participation is voluntary and that I am free to withdraw without giving any reason, and without my rights or my career being affected.	Yes/No
3-	f I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, will be destroyed and not used in the study. The timeframe for withdrawal is 1 month after being interviewed.	Yes/No
4-	I agree to participate by being interviewed and for this to be audio-recorded.	Yes/No
5-	I understand that my personal details will be kept confidential and not revealed people outside the research team-However, I am aware that if I reveal anything related to bad practice the researcher will have to share that information with the appropriate authorities.	Yes/No
6-	I understand that my anonymised data will be used in the researcher's Thesis and other academic publications and conferences presentations.	Yes/No
7-	I agree to take part in the study:	Yes/No

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

Appendix 3: The Director of Health Affairs from the KSA Ministry of Health and the Al-Amal Complex Hospital approval.

Dear nurse office administration,

We hope that you will facilitate the researcher's task: Badriah AlHumaidi Alanazi, a PhD student at University of Salford/Uk in the field of Nursing as she is performing a research about" Patient violence Experienced by Nurses in Psychiatric Departments in Saudi Arabia".

Qualitative field study included a sample of nursing staff at Al Amal Complex in Riyadh.

Hope you will facilitate the student for performing the research project and facilitate the data collection in the way that not affect the nursing work during data collection.

accept my sincere greetings.

Dr. Eisha Mohammed Gaffas
Consultant psychiatrist.
Head of training and research and continuous education department
Al Amal Complex for Mental Health City, Riyadh, KSA.
Tel:+966 0114804548 Ext. 7777
E-mail: egaffas@moh.gov.sa

Appendix 4: Invitation letter

Research project titled: Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in a Saudi Arabia Hospital

Dear in-patient psychiatric nurse,

I would like to conduct some interviews as part of a research study to increase our understanding of Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in a Saudi Arabia Hospital. As a psychiatric nurse you are in an ideal position to give provide valuable first hand information from your own perspective.

The interview takes around 60-90 minutes and will be very informal,as I am simply trying to capture your thoughts and perspectives. Your responses to the questions will be kept confidential. Each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of findings.

Data collected from those participating in this study will be used solely for this project. Findings will be presented through aggregated data and no identifying details will be given for either individual staff or institutions who agree to participate in the study.

There is no compensation for participating in this study. However, your participation will be a valuable addition to my research and findings could lead to greater understanding of patient violence among in –patient psychiatric settings.

If you are willing to participate please contact me so I can provide you with further details of the study. If you have any questions please do not hesitate to ask.

Thanks! PhD student, University of Salford

Email: Telephone:

Appendix 5: Participant information sheet

Title of study: Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in Saudi Arabia Hospital

Name of Researcher: XXXX

Invitation paragraph

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The overall aim of this study is to explore how patient violence is experienced by nurses employed in inpatient acute psychiatric units in KSA, encompassing how the short and long-term effects of workplace violence impacts on nurses. The study is designed to be of relevance to a wide audience: nurses, nurse managers, hospital human resources departments, institutional and hospital administrators and researchers and will offer a unique contribution to a growing body of knowledge.

Why have I been invited to take part?

You are invited to take part in the research as you are employed as a psychiatric nurse in an in- patient psychiatric department.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide. If you decide not to take part this will not affect your career or your rights in any way.

What will happen to me if I take part?

I would like to interview you on one occasion. The interviews will last between 60 – 90 minutes, and the time and place of the interview will be agreed between us. I would like your permission to digitally record the interviews, but this is up to you.

Expenses and payments?

You will not receive any payment for your participation in this study.

What are the possible disadvantages and risks of taking part?

Taking part in this study in unlikely to cause you any harm. However, should be become upset while talking to me we will stop the interview so you can take a break or you can chose to withdraw your participation. If you do decide to withdraw from the study the information you have given will be destroyed and not form any part of the research. You can withdraw from the study any time up until one month of being interviewed.

What are the possible benefits of taking part?

You may not benefit from the results of the study directly. However, it is hoped that the findings from the study will help this and other hospitals to improve the work environment and help prevent, minimise and address workplace violence against nurses working in acute psychiatric in-patient care.

What if there is a problem?

If you have any concerns about this study please contact either myself (my contact details are at the end of the information sheet) or my supervisors:

1- Prof xxxxxxx xxxxxxx[xxxxxxx] |School of Health & Social Care, The University of Salford, Mary Seacole Building, Salford, Greater Manchester, M6 6PU.
Email: x.xxxxxx@salford.ac.uk

2- Dr xxxxx xxxxxxx [xxxx]| School of Health & Social Care. Room x.xx Mary Seacole Building, University of Salford, Salford, M6 6PU
t: +44 (0) 161 295 2778 Email: x.xxxxxxx@salford.ac.uk

However, if you remain dissatisfied you can contact the Associate Director for Research Dr Jo Cresswell, email: J.E.Cresswell@salford.ac.uk Telephone Number: +44(0)161 295 6355

Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the research will be kept strictly confidential. Maintaining your confidentiality means ensuring that you as an individual cannot be linked to the data you provide. Pseudonyms will be used in any written reports or presentations to ensure anonymity. Should you wish to take part I will ask you to sign a consent form. This is the only time I will record your name. All consent forms will be kept securely, but physically separate from anonymised data. All data will be transcribed as soon as possible and uploaded to an encrypted pen-drive before being uploaded via a secure password protected link to the University of Salford. However, if you disclose anything related to bad practice the researcher will have to share that information with the appropriate authorities.

What will happen if I don't carry on with the study?

You may withdraw from the study up to one month after being interviewed, without giving a reason. If you do decide to withdraw from the study your data will be destroyed.

What will happen to the results of the research study?

You will receive a copy of the results. These will also be shared with senior staff at the hospital and the Ministry of Health and the Ministry of Education. The results from the study will be published as a PhD thesis and submitted for publication in social and health-care journals. The results may also be shared through poster presentations and conference presentations. I would also like you permission to use the anonymised data for teaching and educational purposes.

Who is organising or sponsoring the research?

I am a self-funded postgraduate research student. The research sponsor is the University of Salford, Manchester, U.K. The research has been approved by the University of Salford, Research and Innovation Ethics Panel.

Further information and contact details:

If you are willing to take part I would like to meet with you to discuss the study and answer any questions you have. Please ask me if there is anything that is not clear or if you would like more information. I would also like you to sign a consent form. However, you will have at least 48 hours from this meeting to decide if you wish to participate. You will be given a copy of this information sheet and a signed consent form to keep.

Contact Details

Researcher: Xxxxx Xxxxxx

E-mail: xxxxxxx@hotmail.com Meanwhile the researcher is in Saudi Arabia can be contacted

at +966567777112

Appendix 6: Demographic questionnaire for participants

Patient Violence Experienced by Nurses in Inpatient Psychiatric Departments in Saudi Arabian Hospitals

Demographic Questionnaire

We really appreciate you taking part in this study of patient violence!

The information and comments you provide will be kept entirely confidential and any identifiable information will be anonymised.

Thank you for taking part in this study. You have been chosen to participate for two reasons: (1) you are a registered nurse, and (2) you have stated that you have recently experienced violence from a patient in an acute psychiatric situation. The following questions are designed to obtain further information about your experience in the work situation.

Questions	
1. Please state your age?	
2. How long have you worked as a registered nurse?	
3. How long have you worked in inpatient acute psychiatry?	
4. Please state your current job title?	
5. Are you employed fulltime or part time?	
6. Do you work:	o 12 hour shifts o 8 hour shifts o Mix of both 12 and 8 hour shifts
7. Do you work:	o Only day shifts o Only evening shifts o Only night shifts o Rotating days/nights
8. Please state all the areas of nursing you have previously worked in	
The following questions are designed to allow us to understand the collective views of the particular group of nurses in this study. Please be assured that all your answers will be anonymised and retained confidentially.	
9. Please tell us the language you usually speak at home.	
10. Please state your country of origin?	
11. If you are not originally from Saudi, please state how long you have lived in the country:	
12. Please tell us your marital status?	
13. Please tell us your highest level of education?	

We would be grateful if you would give us your contact information (remembering that we have guaranteed that all information will be kept confidential) so that we can:

(1) Contact you to check that we have recorded your comments accurately, and

(2) Share the results with you on completion of the study.

Name: _____

Address: _____

_____

Email address: _____

Telephone number: _____

Thank you for taking the time to complete this questionnaire. Your cooperation has been greatly appreciated.

Appendix 7: Interview guide

We are doing some research in KSA into patient violence against nurses, particularly those who work in acute care in-patient psychiatric units. We are keen to learn if you have recently experienced any patient being violent against you, and your views about the possible causes of that violence. We are also seeking your opinion on how these events in particular, and aggressive incidents in general, may be minimised.

Please be assured that your responses will remain entirely confidential and will not be identifiable in any way. Your relationships with your colleagues and other members of staff and management will not be affected and your employment will not be penalised in any way by taking part in this research. All responses will be used solely for research purposes.

We are asking for your help - we are keen to hear your views.

For your information, the description of patient violence includes:

- any incident involving patient aggression (physical, verbal, emotional)
- abuse directed at nursing staff
- threatening behaviour towards nursing staff
- physical assault involving a member of nursing staff
- any other instances of patient aggression within the acute care setting

Description of experience with patient violence

1. What do you understand by the term, 'patient violence'?
2. How many incidents of patient violence against yourself have you experienced? Please describe each individual incident and the type of violence you faced.
3. Please describe each incident in your own words. Include how the event occurred, what was said and by whom, and the type of incident.
4. How did the incident conclude?
5. Can you identify any cause(s) that might have led to the event?
6. Can you identify any specific factors that might have triggered the incident?
7. Please describe your feelings once the incident was over.
8. Do you have any thoughts about how the patient felt once the incident was over?
9. From your earlier acquaintance with the patient, were you aware that his/her aggression was likely to be activated by certain triggers? If so, please describe what these were.
10. Do you know if the patient had a previous history of aggression or was known to be at risk of aggressive behaviour?
11. Please share the patient's diagnosis with us.
12. Were you afraid during the incident? Please rate your level of concern below:

1. The incident did not affect me emotionally

2. I experienced low grade fear/anxiety

3. I experienced moderate fear/anxiety

4. I experienced high fear/anxiety

5. I experienced very high/extreme fear/anxiety

13. Do you know if the patient made any complaint about the incident and/or complained of pain afterwards?
14. Have you felt able to share your experience of this incident with anyone else? If so, how did this happen (e.g. did you seek them out? Was this a friend or colleague? Did you speak to your manager? Other?)
15. At what time of day/night did the incident take place?
16. At the time of the incident, how many staff were on duty in the same area?
17. Immediately following the incident, how do you feel you were affected? Has it altered your personality or your personal approach to your work/patients? Has the immediate impact lessened over time? Can you describe what you feel the longer term impact might be?
18. Please share with us any suggestions you may have about how these violent incidents could be minimised, if not eliminated.

Your participation is greatly appreciated.

Appendix 8: Example of interviews transcript

Interview 1

The researcher asks these question with the interviewer to get a whole idea about the situation:

First, What do you understand by the term, 'patient violence'?

Well, it is understood by the "patient violence" term as it is referring to a patients' negative thought about hospital and healthcare team and their desire to express it using words or body parts .

Regarding the number of incidents, How many incidents of patient violence against yourself have you experienced? And describe each individual incident and the type of violence you faced, Please?

Basically I have experienced physical violence from patient as will as from patient themselves, the last one I remember come from a female patient.

That's fine, could you describe this incident in your own words. Include how the event occurred, what was said and by whom, and the type of incident Please?

The way how the incident took place, the patient was very cooperative and understood what I said to him in all previous occasion, however, on one occasion I accompanied her to a radiology appointment, and she attempted to escape. I held her hand and prevent her from escaping, and we returned to the psychiatric ward, where she began to shout at me, telling me that I had prevented her from gaining freedom, and that she does not like me and hates me. From this incident, she would shout at me continuously and use bad words. One day she came to me to complain about the other nurses in the ward, and walked with me for few minutes. She suddenly attacked me and held my Hijab against my neck. She was very strong, and I felt dizzy and loss of consciousness. It was a really bad experience.

Would you mind telling me how did the incident conclude?

The incident actually concluded when one of the other patients in the ward saw what was happening and tried to help me, and shouted for the other nurses in the ward to save me.

Simply, can you identify any cause(s) that might have led to the event?

I think, I spot a certain cause which led to the event; asked the patient what had caused her to do this, and she told me that she had liked me, but when I prevented her from escaping she began to hate me. She told me like other nurse deal with her as prison and she did not like to be at the word.

Well, what about the specific factors that might have triggered the incident?

Accordingly, there are a few factors triggered it such as

- The patients do not like each other and there are some problems between the patients themselves especially with different type of patient in limited space.Morever, There are no activities or program for patient and this made them feel bored

Could you clarify this factor?

The patients themselves are in continus fighting and bulling, the tried to hit each other, this make them in angry state all the time, this is in part due to high number of patent in small word.

That is fine , what else?

- Some patients think that there are other patients and nurses do evil towards them, and start to fight.

Clarify this please?

This is related to their mental illness some have delusion about all other people.

Ok that is fine what else?

- Some patients do not like the hospital policies and visiting hours, and they express this in the form of violence.

Furthermore, some patients do not like the sleeping and waking hours, and they express their anger violently.

That's great, will you describe your feelings once the incident was over, please?

As soon as the incident was over, I hated myself for being in that situation, and hated nursing and the hospital at that time. Yet, I constantly felt scared and unsafe all the time. I spend less time with patients, it really affedct carrying out my nursing role.

Could you talk more about the effect this event?

I realy want to quit the job, my family encourage me to leave nursing, but because I like to help others, I am still here

Of course, there may be some thought, do you have any thoughts about how the patient felt once the incident was over?

Honestly, I experienced many thoughts jumping in my head after having seen the patient laughed and was very happy, and she repeated that she would continue hitting me until I leave the ward.

Well, from your earlier acquaintance with the patient, were you aware that his/her aggression was likely to be activated by certain triggers? And if so, please describe how these were.

Upon being well-acquainted, I considered the patient was not aggressive towards other patients rather being solely aggressive towards me. So this is a personal thing not related to her mental disease

In your opinion, do you know if the patient had a previous history of aggression or was known to be at risk of aggressive behavior?

Let me put it this way, when looking into the patient's history, I can assume she had a previous history of violence. It is been reported that she attacked her mother and father with a knife.

That's great! Will you share the patient's diagnosis with us Please?

I see the patient is suffering from Schizophrenia.

During the incident, were you afraid? If so, which statement describes your fear, Please rate your level of concern:

1.The incident did not affect me emotionally

2.I experienced low grade fear/anxiety

3. I experienced moderate fear/anxiety

4. I experienced high fear/anxiety

5.I experienced very high/extreme fear/anxiety

Due to the fear, I would rate my level of being concerned, experienced extremely anxious.

Back to the patient, do you know if the she made any complaint about the incident and/or complained of pain afterwards?

The matter the fact she did not make any complaint, and she did not express her hate against me again, either.

About sharing the experience, have you felt able to share your experience of this incident with anyone else? If so, how did this happen (e.g. did you seek them out? Was this a friend or colleague? Did you speak to your manager? Other?)

Generally speaking, I did speak to my mother about this incident since I needed to talk to somebody other than my colleagues, as well as I do not like to talk with my colleagues as I feel this may get the situation worse.

Why you did not do that?

The nurse her will start laughing and blame me for this case

Let me ask you about the time at which the incident take place, day/night?

According to the time that incident was taken place, it was during the afternoon. I did not want to work night anymore after this incidence, I began to look for a day shift

When the incident took place, how many staff were on duty in the same area?

And there were five nurses at the time of the incident.

Immediately following the incident, how do you feel you were affected? Has it altered your personality or your personal approach to your work/patients? Then, has the immediate impact lessened over time? and can you describe what you feel the longer term impact might be?

After the incident was over as we used medication to control the patient, I was affected very badly, particularly with regards to the lack of psychological or financial support from the hospital administration for the shock I experienced during the attack. This is why I feel scared and unsafe all the time, as I expect to face an attack at any stage, and there are no safety procedures available in the hospital.

Through my work, I have learned how to deal with this difficult situation, and how to avoid problem and aggression. I could be sure that the patient is cute and innocent but there some situations that make them aggressive. Mostly, the violence is the result of their negative thoughts developed by their disease. Still, working in the psychiatric ward gave me the patience for dealing with people. However, I think I will retire early I feel exhusted by workload , unrespect and vilnvce atack this ward as this work is very stressful and scary.

Last but not least, would you share with us any suggestions you may have about how these violent incidents could be minimized, if not eliminated?

I am pleased to share other with the following suggestions, and hope they can make a change in minimizing and/or eliminating such those incidents:

- To have more specialist psychiatric nurses as they are better trained to deal with those patients. It is very difficult as general nurse to deal with psychiatric patients, and this increased my fear and stress. Moreover, psychiatric medicine is very difficult, and nurses need more training to be confident in dealing with the patients.
- Improving the hospital safety procedures is very important.

To provide an after-care program for nurses who have experienced a violent incident to make them more relaxed and feel supported by the hospital.

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