Attitude of psychiatric nurses to de-escalation as a strategy for management of psychiatric patient aggression in a Nigerian psychiatric hospital

A research project submitted to the College of Health Sciences

School of Nursing and Public Health

University of KwaZulu-Natal

In partial fulfillment of requirements for the

Course Work Master's Degree in Nursing

(Mental Health Nursing)

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2016

DECLARATION

I, Oyeyemi Oyelade, declare sole ownership and originality of this dissertation titled "**ATTITUDE OF PSYCHIATRIC NURSES TO DE-ESCALATION AS A STRATEGY FOR MANAGEMENT OF PSYCHIATRIC PATIENT AGGRESSION IN A NIGERIAN PSYCHIATRIC HOSPITAL**" as my original work.

This thesis was developed using theoretical background, clinical observation, trends of clinical practice and the scientific input of my supervisors. It has never been submitted before for any degree or examination in any university. Relevant resources were consulted and appropriately referenced.

This research project has been read and approved for submission by supervisors, Ms A.A.H. Smith and Mrs M.A. Jarvis.

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DEDICATION

This project is dedicated to the creator of life, the lord of the universe, without whom my life would have become history.

To my late father, who encouraged me to keep moving, but died shortly after my departure from my home country, thank you for being a caring, responsible and exemplary father. If l had a second chance, I would still have chosen you as a father. Daddy, I love you.

ACKNOWLEDGEMENTS

ABSTRACT

Aim

The aim of this study was to present an intervention and describe the response of psychiatric hospital-based South West Nigerian mental health nurses.

Methods

A content analysis qualitative approach, using audio recordings of pre- and post- intervention focus group discussions was adopted. The intervention -one oral and visual de-escalation presentation - bisected the focus group discussions. The objective for the pre-intervention focus group: to describe participants' current experiences and practices towards verbal aggression and violence management in order to inform relevant application of information within the intervention. The objective of the post-intervention focus group discussion: to describe participants' responses to the intervention. Purposive sampling, comprised of nurses at unit or ward manager level, yielded eight participants.

Results

Participants felt betrayed by all role players within the mental health care service system, were disappointed that de-escalation was considered the evidence-based practice, and hopeless about its introduction. Participants' fears for their safety are suggested to have informed a more militant approach to the management of aggression to strengthen nurses' control over patients' physical and emotional welfare, as well as their own.

Review of Nigerian mental health legislation to set the context for human rights of both nurses and mental health patients is recommended. A need exists for further research utilizing a participatory action research approach that addresses 'on the spot' management of verbal aggression and includes trauma counselling and support for nurses.

Key words: De-escalation, Nigerian mental health nurses, violence and aggression.

ABBREVIATIONS

DATER	Drug Addiction, Treatment, Education and Research Unit
HSSREC	Humanities and Social Sciences Research Ethics Committee
LIMIC	Low income and low middle income countries
NHIS	National health insurance scheme
NMCN	Nursing and Midwifery Council of Nigeria.
OPC	Outpatient clinic
PN	Psychiatric Nurse
Prn	Give when necessary (prescription order for routine medication)
SA	South Africa
UKZN	University of KwaZulu-Natal
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1. BACKGROUND

Violence is a significant global problem in health care settings, specifically mental health care settings (WHO, 2002, 8; Child and Mentes, 2010, 89). Linguistic and hence conceptual forms of violence are often used interchangeably with aggression (Child and Mentes, 2010, 90; Franz, et al., 2010, 2; DeWall, Anderson and Bushman, 2011, 249). The World Health Organization (WHO) (2002,36) definition of violence is inclusive of concepts denoting physical force /aggression, purposeful intent, direction of intent and the possibility of actual physical or psychological harm. Violence, and the risk of violence, has attracted attention from the WHO and has become an increasing focus of public health research (WHO, 2002, 36; Child and Mentes, 2010, 89; Franz, et al., 2010, 1; Gates, Gillespie and Succop, 2011, 59; Reingle, et al., 2014, 525). Violence in healthcare settings can include several forms namely: patient to fellow patient, objects, patients' relative or to health care worker (Rasmussen, Hogh and Andersen, 2013, 2758).Current research indicates that nurses have the highest risk of being prone to violence (Anderson and West, 2011,34; Hahn, et al., 2013, 381; Pompeii, et al., 2013,58; Steiman, 2013, 30; Bader, Evans and Welsh, 2014, 179).While Mitchell, Ahmed and Szabo (2014, 148) specify that nurses are three times more likely to experience violence than any other healthcare worker. This pattern of the direction of violence is particularly evident in mental health care settings (Large and Nielssen, 2011, 210).

International studies have revealed prevalence of violence against psychiatric nurses (PNs) to have ranged from 80% to 96.7% (Franz, et al., 2010, 3; Moylan and Cullinan, 2011, 526). However, a recent South African (SA) study reported a lower prevalence of 49.5%, where the majority (73.6%) of these PNs considered the incident typical (Steinman, 2013, 23). This perception confers with Nigerian studies that reported violence in mental health care settings to be predominantly perpetrated against PNs (James, Isa and Oud, 2011, 130; Ukpong, et al., 2011, 46). Ukpong and colleagues (2011, 48) reported that similar to Steinman's (2013, 23) study, 66.7% of Nigerian nurses considered the experience of workplace violence to be part of their job. Despite this similarity in Nigerian and SA, PNs' perceptions, South West Nigerian prevalence of violence against PNs is reported as 82.3% - more similar rates to international studies (Ukpong, et al., 2011, 47). A similarity exists in that both the Nigerian and SA studies emanate from low middle income

countries (LMIC). However, the wide variation in the reported prevalence of aggression against PNs is suggestive to be due to Nigerians having limited access to mental health care services with delayed medical treatment being an important causative factor of aggression (Jack-Ide, Uys and Middleton, 2012, 50). In addition, variations in incidence and prevalence rates, both internationally and within Sub-Saharan Africa are possibly due to reporting policy and procedure guidelines and may not reflect actual figures (Child and Mentes, 2010, 89,93; Poggenpoel and Myburgh, 2011,920; Kitaneh and Hamdan, 2012,1; Maina, et al., 2013,140). These policy and institutional guideline differences may also apply to the reported disabling nature of injury following violence.

Literature provides research reports, not only on incident rates of violence but also about the extent and nature of injury (Jennings, Piquero and Reingle, 2012, 21; Yang, et al., 2012, 1091). International literature categorizes the nature of injury to range from minor to disabling (Anderson and West, 2011, 37). Briefly, a workplace injury is deemed as disabling when an employee cannot cope with work as a result of the emotional or physical injury sustained from violence (Yang et al., 2012, 1092; Bader, et al., 2014, 179). These injuries can lead to either temporary loss of psychological wellbeing or hyper psycho-somatic reactions, and frequently necessitate time off duty or resignation from the job (Child and Mentes, 2010, 90; Yang, et al., 2012, 1091). As stated previously, prevalent rates of violence and disabling injuries against PNs are suggested to differ between LMIC countries and upper income countries (Franz, et al., 2010, 3; Moylan and Cullinan, 2011, 526; Ukpong, et al., 2011, 48; Steinman, 2013, 23). However, the difference is suggested to be within the range of reporting (Large and Nielssen, 2011, 210). These vary from 80% - 100% in upper income countries, while the prevalence range in LMIC countries is 50% to 85% (Franz, et al., 2010, 3; Gates, et al., 2011, 60; Moylan and Cullinan, 2011, 526; Ukpong, et al., 2011, 46).

There appears to be no single reported cause of violence in mental health care settings (Amoo and Fatoye, 2010, 352; Child and Mentes, 2010, 90; Franz, et al., 2010, 2; Chukwujekwu and Stanley, 2011, 163; Virtanen, et al., 2011, 149; Papadopoulos, et al., 2012, 425; Bader, et al., 2014, 180). These authors described causes that are interrelated and summarized as including; environmental adversity (specifically increased noise leading to perceived chaos); high stress levels; and time of the day, with Amoo and Fatoye (2010, 352) reporting increased risk at night attributed to hallucinatory tendencies which are considered higher in the dark . In addition, the relationship between certain psychiatric labels or conditions and the risk of violence is well documented (Child

and Mentes, 2010, 90; Gray, Taylor and Snowden, 2011, 248; Large and Nielssen, 2011, 209; Bader, et al., 2014, 180; Nestor, 2014, 1974; Swartz, et al., 2014, 226). Specifically, a history of (or current) substance abuse (Child and Mentes, 2010,90; Vaidyanathan, Patrick and Iacono, 2011,533; Swartz, et al., 2014, 226) is noted as increasing the risk of violence, while schizophrenic illnesses have been linked to the highest predisposition to violence irrespective of any substance abuse history (Volavka and Swanson, 2010,563; Gray, et al.,, 2011,248; Soyka, 2011,918; Van Dorn, Volavka and Johnson, 2012,488; Bader, et al., 2014, 180).

Swanson, et al. (2015, 374) suggest that within the mental health care setting causes of violent behavior have their origin within mental healthcare legislation and policy, or lack thereof. Firstly, mental health care legislation has the purpose of determining safe and ethical care of the mental health patient. Legislation, such as the South African Mental Health Care Act (no 17 of 2002), is frequently supported by provincial or regional treatment protocols related to the assessment of risk for violence and practitioners response (KZN DoH, 2007, 4). The absence of national legislation, and provincial / regional protocols to support national legislation, results in a lack of risk assessment and treatment guidelines for the prevention of violence. Nigeria, like 64% of LMIC, has no mental health legislation (Westbrook, 2011, 397; WHO, 2013, 10). Nigeria continues to use the Lunacy Ordinance formed in 1916. Within this document some procedural elements, specifically pertaining to detainment and confinement of patients, leave room for potential abuse and thus increased patient distress (Westbrook, 2011, 403).

The description of a psychiatric patient as a "lunatic" in Nigerian mental health policy has been asserted as a potential source of abuse, the label denoting the diminished status of the person (Nursing and Midwifery Council of Nigeria (NMCN), 2006, 24; Westbrook, 2011, 404). It is therefore not a surprise to discover that the findings of Chukwujekwu and Stanley (2011, 163) indicated that 63% of psychiatric patients in North East Nigeria exhibit violence of unknown causes. Secondly, despite mental health legislation and protocols providing guidelines for the protection of patients and staff through assessment and treatment procedures their content may not suit the patients' need for self-determination at the point of admission, or during the process of care delivery (Drew, et al., 2011, 1664; Maj, 2011,1672; Papadopoulos, et al., 2012,434; Becker and Kleinman, 2013, 70,71). Some authors report this loss of self-determination as core to violent incidents (Drew, et al., 2011, 1665; Swanson, et al., 2015, 374). Having one's movements

restricted and self-determination curtailed is suggested as characteristic of many in-patient mental health care settings and requires skilled empathic understanding from mental health care professionals.

Studies suggest that the actual practices of mental health professionals, specifically the nurse, are directly linked to incidents of violent behavior (Jonker, et al., 2008, 7; Bader, et al., 2014, 185). Firstly, authors argue that within nurse-patient interactions, confidence, knowledge and skills, obtained through experience, are necessary to manage, assess for, and prevent violence (Papadopoulos et al., 2012, 435,436; Björkdahl, Hansebo and Palmstierna, 2013,397; Mitchell, et al., 2014,213). This focus on practitioner knowledge and skill derived through experience is supported by research that reports increased violence rates associated with the reduction in the number of experienced nurses and the use of casual and agency nurses rather than specialized professionals (Child and Mentes, 2010, 90). However, violence against PNs in Nigeria is reported to be higher among older nurses (James, et al., 2011, 132). Thus experience may not be as relevant as specific content received in training. Jonker, et al. (2008, 6) suggested direct links between the type of training of psychiatric nurses and workplace violence incidence. These authors stated that the occurrence of violence is highly dependent on the type of training psychiatric nurses receive, specifically related to preparedness for practise of assessment, prevention and management of violence (Jonker, et al., 2008, 6). Interalia it is suggested that this specific training be inclusive of regular risk assessment involving structured professional judgement and de-escalation techniques (Björkdahl, et al., 2013, 397; Yao, et al., 2014, 85).

A review of the Nigerian nurses' curriculum suggests that deficits within Nigerian nurse training are core to the mismanagement of aggression and violence (NMCN Psychiatry/Mental Health Nursing Curriculum, 2006, 26). The researcher, a Nigerian psychiatric nurse, suggests that gaps specific to the prevention and management of violence exist within Nigerian psychiatric / mental health nursing training. While the current curriculum provides extensive information on the use of restraints, it does not provide any content related to risk assessment and aggression management strategies such as de-escalation (NMCN Psychiatric/Mental Health Nursing Curriculum, 2006, 26). The curriculum seemingly does not recognize that the psychiatric patient has a right to freedom from violence (WHO, 2012, 5). Briefly, de-escalation is a specific psychosocial approach of violence management which entails the use of verbal and non-verbal cues to prevent the

occurrence of violence and curb or reduce the gravity of occurred violence (Richmond, et al., 2012, 17). It is possible that the inclusion of de-escalation within nursing curricula and in-service training programs can make a positive contribution to the management of aggression, counter to suggestions that the reaction of Nigerian psychiatric nurses towards violence has made reoccurrence inevitable (James, et al., 2011,133).

1.2. POSITIONING THE RESEARCHER

The researcher is a registered psychiatric nurse who obtained a diploma in psychiatric / mental health nursing, gained eight years clinical practice experience, and is currently completing a Masters in Nursing (Mental Health) degree. The researcher, post her initial training felt ill-prepared for violence management. Through her work experience the researcher has identified that psychiatric skill acquisition is predominantly through observation of senior nursing colleagues, and that management of the patient who displays aggression is through the use of overpowering by the security agencies. In the cases where there are no security agencies nurses, inclusive of the researcher have been brutally assaulted and sustained extensive and varied injuries. The extent of these injuries (fracture, biting resulting in muscle loss and profuse bleeding, dislocation, head injury sustained by heavy object, fall, and damage to the ear drum resulting in partial and total deafness, scrotal laceration, loss of teeth) has resulted in PNs being fearful with a tendency towards favoring brutal restraining measure employed by security officers.

1.3. PROBLEM STATEMENT

Verbal aggression and violence within mental healthcare settings, inclusive of Nigeria, persists (Chukwujekwu , & Stanley, 2011:163; Nelson, 2014:1373; James et al., , 2011:130). Studies related to Nigerian mental health nurses' verbal aggression and violence management practices have emphasized that improvement of practice is essential (Chukwujekwu, & Stanley, 2011:166; James et al., 2011:133). Improvement of mental health nurses' practice is related not only to the presentation of specialized training, but also mental health nurses' decisions to accept or reject new knowledge (Björkdahl,et al., 2013:396; Mc Andrew, et al., 2014:215). There is a lack of local research and if James and colleagues (2011:133) report that the reaction of Nigerian mental health nurses towards violence has made violence reoccurrence inevitable is to be addressed, research is

imperative regarding the interrelatedness of 'new' knowledge, attitudes and practice of psychiatric nurses in Nigeria.

1.4. PURPOSE OF THE STUDY

The purpose of this study was to present an intervention, de-escalation, as a management strategy for use with psychiatric patients and describe the response of psychiatric hospital-based South West Nigerian mental health nurses.

1.5. RESEARCH OBJECTIVES

In order to describe the implementation of a new aggression management strategy it is firstly important to establish and confirm current aggression and violence management strategies employed by Nigerian PNs. To this end the research objectives are twofold;

1.5.1 Research objective one*:* Describe Nigerian PNs current attitudes and practices towards violence management in a selected hospital in South West Nigeria.

Research Questions

- What are PNs attitudes towards the display of aggression and violence by psychiatric patients?
- How do PNs currently engage in management of aggression and violence?
- What informs the aggression and violence management decisions of PNs?
- Do PNs consider there to be a gap in their current aggression / violence management practices?

1.5.2. Research objective two*:* Identify the PNs attitudes towards the introduction of a measure to decrease the risk of verbal aggression escalating to violence.

Research Questions

- What agreement do PNs present for the introduction of de-escalation into their practice?
- What resistance do PNs present towards the introduction of de-escalation into their practice?

1.6. SIGNIFICANCE OF THE STUDY

1.6.1 Legislation, policy and nursing practice

This research study is particularly significant at present in Nigeria in light of the WHO's recent publication of a Quality Rights toolkit where inpatient violence is recognised (WHO, 2012, 5). Added to this, the WHO (2013,7) through the Mental Health Action Plan (2013-2020) has made a standpoint on the need to reverse the violation of human rights of those with mental disorders. Namely; right to highest attainable level of health. In this regard, the WHO (2013, 12) has suggested the introduction of policies as well as strategy changes, which are to be based on the principle of evidence based practise. This is echoed by other authors who have recognized that current approaches seem punitive and acknowledged the need for psychiatric nurses to engage in training programs centred on violence management (James, et al., 2011, 133; Amoo and Fatoye, 2010, 351). Participation in this study, and the study results, have a potential to motivate reflective thinking among participating PNs and impact practice, with regards to care of psychiatric patients as it relates to the management of violence. It is possible that the results, in conjunction with reflective practice, can inform institutional policy and procedure. This may in turn contribute towards improved patient care and reduction in the frequency of violent acts within in-patient units of mental health care settings.

1.6.2. Nursing research

According to Rice (2010, 308) there are many psychiatric-mental health care issues that are inadequately researched or defined, the issue of violence being one. This work will therefore add to the few available Nigerian resources on violence and mental health, and possibly to the international body of knowledge.

1.6.3 Nursing curriculum development

As stated in the background to the study, violence prevention and management is not effectively included in the current 18 months diploma programme of Nigerian psychiatric nursing training (NMCN, 2006, 26). The study results, through publication, can draw attention to the need to review the curriculum in Nigerian schools of psychiatric nursing for training on violence and management skills.

1.7. OPERATIONAL DEFINITIONS

1.7.1. *Attitude* can be defined as a "core social psychology construct referring to a tendency to respond positively or negatively towards a social object" (Suter, et al., 2014, 669). In this study, attitude is operationalized as the verbal contributions of participating PN as a reflection of his/her psychosocial disposition towards the introduction of de-escalation as an evidence-based practice for mediation of violence.

1.7.2. *A psychiatric nurse* in a Nigerian context is a nurse who after her basic three year nursing diploma has completed an 18 month psychiatric nursing diploma allowing him/her to be licensed by the Nursing and Midwifery Council of Nigeria to practise (NMCN, 2006, 12).

1.7.3. *Practice* can be referred to as observable actions or individual responses to a stimulus or expected task (Hamric, et al., 2013, 136; Moon, 2013, 39). Within this study, practice and management will be used interchangeable to report PNs' verbal descriptions of their actions and responses to aggression and / violence within the inpatient mental healthcare setting.

1.7.4. *Violence* is the use of extremes of force with the intention to inflict injury, psychological or physical (WHO, 2002,36; Large and Nielssen, 2011,209) while ***Aggression*** is a function of individual attitudes and beliefs, shaped by values, opinion and circumstance and is described as having a stronger connotation than violence (Large and Nielssen, 2011,209). Differences exist in the definitions of aggression and violence, with some authors depicting violence to have a stronger connotation than aggression. However, this study will use the word aggression to depict violence. This is supported by studies that aggression and violence can be used interchangeably (Child and Mentes, 2010, 90; Franz, et al., 2010, 2; DeWall et al., 2011, 249).

1.8. CONCEPTUAL FRAMEWORK

1.8.1. Introduction to Avedis Donabedian's model

This study is framed within Donabedian's tripartite model (1988) of quality (See figure 1; pg. 9). Donabedian's model has been embraced by many healthcare researchers, especially nurse researchers, who recognize that outcomes alone cannot be used to measure the quality of care (Forster and van Walraven, 2012,75; Wilson, 2013,1;Fitzpatrick, 2014,1: Zoëga, et al., 2014,1).

Donabedian discussed the significance of structure and process and how they serve as the determinant of outcome standards for an organization (Donabedian, 1988, 46-52). Structure, process and outcome are seen as important yardsticks in quality improvement and quality assessment (Wilson, 2013, 1). As presented in figure 1, structure standards in Donabedian's description are expressed in terms of the infrastructural facilities, organizational modalities such as financing, policy and equipment; and aspects of human resources that include not only number and qualifications but also personal qualities such as beliefs and attitudes. Process standards are explained as the action taken within actual service delivery, while the outcome is described as the result attained via the structural and process standards; what is available to provide the service; and how the service is actually provided (Donabedian, 1988, 50; Forster and van Walraven, 2012, 77)

Figure 1: Donabedian's framework applied to health care services

1.9.2. Application of conceptual framework to this study

Donabedian (1988, 50) suggests the re-engineering of structures and processes to improved desirable outcome (Donabedian, 1988, 52; Forster and van Walraven, 2012, 75). This study focuses on structure and describes aspects of process standards only; it is beyond the scope of this study to engage in the permission processes required to examine the records of patients and PNs to confirm PNs descriptions of their current practices and their outcomes. Primarily the focus is on structure standards. As is displayed in figure 2 below, within this study "structure" refers to the PNs knowledge of, and attitudes towards, current legislation and hospital policy related to management of displays of aggression and violence by psychiatric patients within the acute psychiatric hospital setting. In addition, the researcher will introduce de-escalation as new knowledge, and describe knowledge of, and attitudes towards, implementation of de-escalation as

a violence prevention nursing management strategy. Donabedian's model (1988) serves to frame within the structure component the PNs preparedness for integration of a "new" violence prevention modality. Process standards are only measured according to PNs descriptions of their current practice in managing aggressive and or violent mental health care patients. In essence, the nursing response, actual practice, aggressive and or violent psychiatric patients in South West Nigeria receive will be examined through PN's description of their practice only. Therefore this study considers the structural and the process standards as components of Donabedian's model of healthcare.
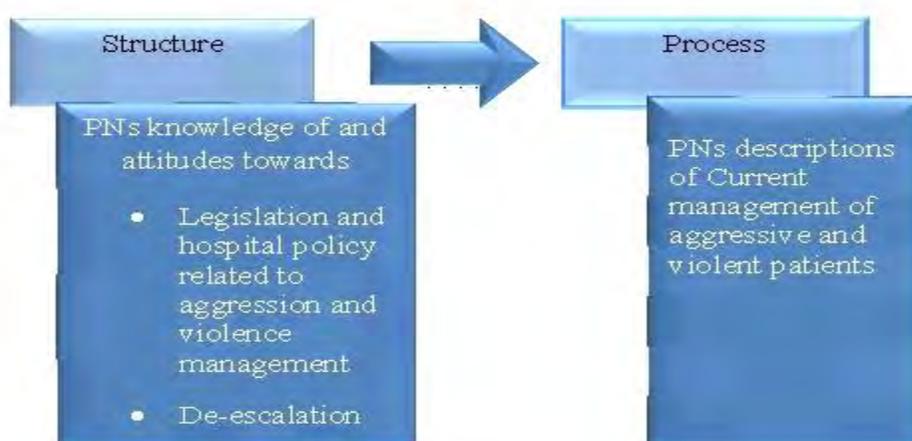
Figure 2: Application to this study of Avedis Donabedian's tripartite model

1.10. SUMMARY OF THE CHAPTER

This chapter comprised of general description of the concept "violence" in mental health care settings and its causes, specifically, in low-income countries with focus on Nigeria. It also established an introduction to the de-escalation approach of violence management and established a relationship between quality of care in mental healthcare settings and violence management, based on the approach and the outcome of violence management.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

The literature search was done using the following search phrases: global perspective of aggression; history of aggression; view and definition of aggression in contemporary terms; aggression in mental health care settings; attitude of nurses to mentally ill patients' aggression and mode of management; knowledge of, and attitude towards, aggression de-escalation approaches among psychiatric nurses; barriers to adoption of de-escalation techniques of aggression management; training need of psychiatric nurses.

Search engines used included; ProQuest, PsycINFO (Psychological Information), PubMED, Sabinet, Science direct, and Google Scholar. The parameters used were: year of publication (maximum of five years), context of the study (hospital setting, specifically, mental health care settings), and focus of the study (aggression and aggression management).

This chapter explores the concepts of anger and aggression. Specifically, the progression of anger to aggression and violence; the general overview and legal implications of violence; and the violence management approach of nurses and its impact on violence reoccurrence. Also discussed are the attitudes of nurses to aggression management techniques and mode of aggression management as quality care indicators in psychiatric / mental healthcare settings.

2.2. OVERVIEW OF ANGER AND AGGRESSION

Anger can be framed as a conscious or willful decision to commit an aggressive act, seen as violation of an accepted social norm (Berkowitz, 2012, 322). The progression of anger leads to aggression and can become an attitude (Large and Nielssen, 2011, 209; Berkowitz, 2012, 322). It is an emotional reaction (Franz, et al., 2010,4) and rarely is this an autonomic response, but rather one that develops in intensity over a period of time (Berkowitz, 2012, 322) and might extend to the intent of inflicting injury or causing death to an innocent person – the victim (Berkowitz, 2012, 325). This might be cyclical in nature involving offense and retaliation, termed as "aggression breeds aggression" (DeWall, et al., 2011, 245). This is supported by findings of Franz, et al. (2010, 4) who describe anger as one of the emotional reactions that arise in a victim of violence, that leads to fight-or-flight responses.

History reveals aggression having been used as a socially adaptive method to maintain boundaries (DeWall, et al., 2011, 245). As social integration occurred, aggression became unacceptance and the skill of negotiation developed until ultimately in 1945 when it was legislated internationally as a crime, described as unlawful actions of discrimination, intimidation and excommunication (DeWall, et al.,2011,245; Sayapin, 2014,3). Aggression, as stipulated in the global decree, is a crime, irrespective of where, when, how, why, and by whom it is perpetrated (Sayapin, 2014, 3). Despite the declaration of criminality of aggression, unresolved expressions of anger result in violation of law by the offender or the offended in the form of gender-based aggression, social aggression and self-directed aggression (Sayapin, 2014, 4; Vives-Cases, et al., 2011, 15).

2.3. THE CONCEPT OF ANGER AND AGGRESSION IN MENTAL HEALTH CARE SETTING

National surveys portray the public's perception of aggression being a defining characteristic of mental illness (Ünsal, et al., 2013,887; Corrigan, et al., 2014, 577; Nestor, 2014,1977). This perception is seen to extend to the work setting where, despite aggression not being accepted internationally, psychiatric nurses consider it part of their jobs where anger and aggression have become more of a norm than an anomaly (Child and Mentes, 2010,89; Moylan and Cullinan, 2011,531; James, et al., 2011,133; Ukpong, et al., 2011,48; Steinman, 2013,23). It is therefore not a surprise to discover that, in the face of violence, mental health care professionals' display anger as a form of emotional reaction. (Franz, et al., 2010, 4). The perceptions of mental health professionals around violence can constitute stigma and affect the mode of management (Ünsal, et al., 2013, 887; Nestor, 2014, 1977). This leads to fight-or-flight responses exhibited in the form of forceful detention; restraint; forced medication; use of armed responses or police; and/ or withdrawal (Franz, et al., 2010, 4). The tendency to retaliate to aggression with violence leads to a self-perpetuating circle of aggression and retaliation (DeWall, et al., 2011, 245). However, therapeutic communication is effective as an evidence-based approach of violence resolution, but is less utilized by mental health care professionals (Björkdahl, et al., 2013, 397; Cleary, et al., 2012, 74).

Therapeutic communication is also required to develop insight into mentally ill patients (Stenhouse, 2011, 78; Cleary, et al., 2012, 78, McAndrew et al., 2013, 214), but psychiatric nurses have been criticized for their lack of interaction and therapeutic engagement with patients both in

terms of quality time and use of standard psychological interventions (Thibeault, et al., 2010, 216; Sharac, et al., 2010, 909; McAndrew, et al., 2013, 215). From the patients view, this is regarded to have developed from the culture of the busy schedules and time constraints of nurses (Stenhouse, 2011, 76). While on the other hand, nurses view such accusations from the angle of lack of knowledge of therapeutic communication (McAndrew, et al., 2013, 215). However, McAndrew, et al. (2013, 215) declare that the need to address the barriers that prevent nurses from engaging with the patient, either by training or removal of non- nursing duties that consume nurses' time.

2.4. PSYCHIATRIC NURSES' KNOWLEDGE AND TRAINING ON AGGRESSION MANAGEMENT

Psychiatric nurses in both high and low-income countries have reported lack of educational preparation and knowledge of aggression management (Liu, et al., 2011, 33; Koukia, et al., 2013, 195; Coban, et al., 2015, 324). Studies have established the need for specialized training for psychiatric nurses on aggression management (Mc Andrew, et al., 2013, 215; Björkdahl, Hansebo and Palmstierna, 2013, 396; IIkiw-Lavalle and Grenyer, 2014, 389). De-escalation techniques was embraced in the U.K in 2002 after the United Kingdom Central Council for Nursing, UKCC, (2002, 7) conducted a study on the knowledge of psychiatric nurses on aggression management and discovered that nurses have no formal training that prepares them to prevent aggression. UK psychiatric / mental health nursing curriculum addressed the use of restraint but provided no information on aggression management (UKCC, 2002, 6). The U.K report is similar to Nigeria where the nursing curriculum does not include aggression management, but provides extensive information on the use of restrain (NMCN, 18). In the UKCC (2002), 61% of the psychiatric nurses reported that they were trained to inflict pain on patients to achieve compliance with restraint. This is also similar to the report of Nigeria mental health legislation in which some of the procedural element give room for abuse (Westbrook, 2011, 403). However, training of psychiatric nurses on verbal de-escalation techniques has been widely embraced and found to be effective by psychiatric nurses in U.K unlike Nigeria where the concept is still alien and abuse still persists (Committee of Public Accounts, 2003,3; Inglis and Clifton, 2013,100; Westbrook, 2011,403).

A Greek study examining aggression against psychiatric nurses, reported that nurses consider overpowering and restraining patients to be wrong and unhealthy for both the nurse and the patient, but know no alternative means to curtail aggression (Koukia, et al., 2013, 195). In another study

conducted to elicit the knowledge and training needs of psychiatric nurses on aggression management in China, 76% of the psychiatric nurses reported never to have had any form of training on aggression management, while 97% requested to be trained (Liu, et al., 2011, 33). Also in Turkey, Coban, et al. (2015, 323) highlighted that the level of knowledge of a non-punitive mode of aggression management among nurses is low with a very high rate of dysfunctional reactions which serve as a means of controlling the patient, but with corresponding high rates of aggression that showed a reduction after training and a change in approach. Though studies have established the need for specialized training for psychiatric nurses on aggression management, the decision to accept or reject the approach is still largely vented in the nurse (Mc Andrew, et al., 2013, 215; Björkdahl, Hansebo and Palmstierna, 2013, 396). Cleary, et al. (2012, 76) argue that attributes of a caring nurse originate primarily from intrinsic characteristics and not as a product of training. Further to this, the structure of the practice setting can make the implementation of therapeutic strategies gained in any training challenging if the willingness of nurses does not coincide with supportive structures (Laker, et al., 2014, 10). These supportive structures are: Legislation/institutional policy; managers' directive; occupational hazard/job satisfaction (Laker, et al., 2014, 1).

Lack of mental health legislation in the majority of low income countries (64%) has constituted major barriers to effective mental healthcare as against the minority (8%) of high income countries that have no standardized mental health legislation (WHO, 2013,8). Legislation being a major determinant of mode of practice, lack of such invariably affects the mode of care and the therapeutic milieu of a psychiatric unit (Alhasnawi, et al., 2012, 84; Laker, 2014, 1; Swanson, et al., 2015, 374). Further to legislation, the direction of the flow of care is from the managers, to the key change agents, to their subordinates (Letlape, et al., 2014, 2). Letlape, et al.(2014, 2) also note the need for updating psychiatric nurses' knowledge on new research, laying emphasis on the recognition of ward managers' input in training needs and hindrances before decision-making on the commencement of training. Therefore, success of any training programme may depend on the opinion of nurse leaders before and after training. The significance of this participative relationship between researcher and nurse leaders is seen in a study conducted in Turkey by Coban, et al. (2015,325) during which aggression management training led to change in nurses attitudes and practise which resulted into reduction in the aggression incidence. This positive result was in

contradiction to the initial subjective bias expressed by Coban, et al. (2015, 325) that nurses will be resistance towards change.

2.5. DE-ESCALATION TECHNIQUES OF AGGRESSION MANAGEMENT

One such training that can be conducted to manage aggression is de-escalation. De-escalation has been declared an evidence based approach of aggression management (Price and Baker, 2012, 310; Richmond, et al., 2012, 17; Inglis and Clifton, 2013, 101). These techniques offer a communication approach that emphasizes the expression of an understanding and respect for each other's' opinion in the face of anger (Price and Baker, 2012, 315). It emphasizes the need for the respect for human dignity and also serves as an evidence based approach for a desirable outcome in aggression management (Price and Baker, 2012, 315; Richmond, et al., 2012, 20; Inglis and Clifton, 2013, 102). Further, it serves as a rehabilitative approach through therapeutic nurse-patient communication, the lack of which has been emphasized as a causative factor of aggression (Cleary, et al., 2012, 74; Mc Andrew, et al., 2013, 215). Aggression management through de-escalation techniques is considered essential to achieve a therapeutic milieu in the mental health setting (Björkdahl, Hansebo and Palmstierna, 2013, 397). Loewenstein and McManus (2014, 171) have identified the importance of verbal de-escalation techniques above the punitive and restrictive approaches, and declared the need to update nurses knowledge accordingly. A punitive approach, and the failure of nursing staff to engage early with de-escalation to prevent aggression progression can trigger further incidences of aggression (Franz, et al., 2010, 2; Moylan and Cullinan, 2011, 531; McAndrew, Chambers, Nolan, et al., 2013,216; Loewenstein and McManus, 2014, 171).

Richmond, et al. (2012, 16) provides a detailed description of de-escalation techniques as involving; therapeutic communication skills; respect for human rights; and maintaining situational and self-control. Therapeutic communication, besides being an aggression de-escalation technique, is also an essential skill every nurse must acquire to maintain professionalism and quality of service delivery (Arnold and Boggs, 2015, ix). This is because the mode of information dissemination does not only affect the reception and response to the information, it also says a lot about the knowledge and character of the disseminator (Arnold and Boggs, 2015, ix). In the management of aggression, the way messages are conveyed to the angry person can either aggravate or calm the anger (Richmond, et al., 2012, 20).

Psychiatric nurses' mode of communication has been declared a contributory factor to incidents of aggression in mental healthcare settings (IIkiw-Lavalle and Grenyer, 2014, 389). Communication techniques required in de-escalation involve initiating discussion and establishing the verbal contact in a friendly rather than an accusation manner (Richmond, et al., 2012, 2). The ability to listen carefully, understand the needs of an individual and provide suggestions on the way forward is not only a quality psychiatric nurses should develop to be able to de-escalate aggression, it has also been declared as the hallmark of professionalism (Richmond, et al., 2012,19; Arnold and Boggs, 2015,ix).

Similarly, dissemination of information by verbal briefing and accurate report writing in a clear and concise way is regarded as an essential communication skill in aggression management (Richmond, et al., 2012, 20). Communication cannot be effective if the nurse is unable to achieve self and situational control (Richmond, et al., 2012, 21). Self-control is the ability to maintain a calm disposition in case of threat and displeasure (Inzlicht and Schmeichel, 2012, 452). This is important because aggression will naturally breed aggression, but a professional will remain focused if able to achieve self-control in case of provocation (DeWall, et al., 2011, 245; Richmond, et al., 2012, 19). Situational control can be regarded as the ability to put disruptive behavior under control without inflicting physical or emotional injury on another person (Schmidt and Diestel, 2015, 54). A psychiatric nurse needs to engage with situational control to be able to prevent aggression and this can be achieved by determining the level of control and setting clear limits in a respectful manner (Richmond, et al., 2012,22). According to Richmond, et al. (2012,22) it is important to let the person know the limit to which they can act in response to ventilation of their anger, example of such is, stating the non-allowance for destruction of life or property of self or others.

The WHO (2012, 5) quality right tool kit recognizes lack of respect for human dignity as the cause of aggression in mental healthcare setting. Respect for human dignity, besides being an aggression de-escalation technique, is also an essential human quality, the lack of which can show the perpetrator as being inhumane (Richmond, et al., 2012, 22). This requires; respecting the opinion and personality of others by consenting to their view or disagreement in a non-provocative manner, admitting one's fault; a sign of respect for the self-dignity and the dignity of another person. . It is important for psychiatric nurses to agree with the truth as opposed to defend the institution and its

policy as a sign of respect for the mentally ill individual (Richmond, et al., 2012, 22). It is of interest to note that older Nigerian nurses are greater victims of aggression as compared to other international healthcare settings (James, et al., 2011, 133).

2.6. QUALITY OF CARE IN THE MENTAL HEALTHCARE SETTING

Quality in healthcare settings can be expressed as the process of translating evidence into action to achieve the required standard for products and services (McAndrew, et al., 2013, 216; Rosenfeld, Shiffman and Robertson, 2013, 147). From WHO standards, quality mental health care is the criteria for global health (WHO, 2013, 5). Quality mental health care service is determined by the extent to which mental health care professional especially nurses are able to engage in therapeutic service delivery which brings about improvement of care outcome (McAndrew, et al., 2013, 213). However, studies show that there are many aspects of mental health care that are poorly defined and described (Alhasnawi, Sadik and Rasheed, 2012). The definition and description is in terms of legislation and policy that guide mental health care with legislation being an essential legal document that guides the discharge of duty and it serves as a guiding principle for discharge of mental health care (Alhasnawi, et al., 2012, 84). In Avedis Donabedian's description of quality of care, structure and process are determinants of outcome (Donabedian, 1988, 53).

The rate of aggression in mental health setting is a factor of professionals' attitude towards mentally ill (Pulsford, et al., 2013, 98). The belief that mental illness increases aggression tendency will affect the mode of service delivery, more so in Nigeria, where policy indirectly gives the health care professional the right to abuse of a mentally ill (Westbrook 2011,397; Corrigan 2014,557). Considering the structure and process of care in the face of aggression in mental health care setting in Nigeria, it is not a surprise that the outcome of care in cases of aggression is violence (Amoo and Fatoye, 2010, 353). The WHO (2012,4) has declared the quality of care mentally ill individuals receive in health care settings of many countries as not only poor, but also harmful and that it prevents recovery as the mentally ill are subject to abuse and aggression. As such, the quality of care can be improved by advocating for increased verbal engagement of professionals with care-recipients and this can only be achieved by professionals' preparedness to inculcate a non-punitive manner of aggression management as against the traditional punitive approach they

have been used to (WHO 2012, 42). Therefore, this study has assessed nurses' attitude towards de-escalation approach of aggression management.

2.7 SUMMARY OF THE CHAPTER

This chapter highlighted literature describing the knowledge of mental health professionals (psychiatric nurses) about aggression and aggression management and the attitude of nurses towards new approaches of aggression management. It explained de-escalation techniques as an evidenced-based approach of aggression management which emphasized the need for respect for human dignity. Finally, quality service delivery in mental health is regarded as approaches of translating research evidence into clinical practice which is related to de-escalation, an evidence-based approach of aggression management through which mental health care setting can achieve quality improvement and, or maintenance.

CHAPTER THREE: METHODOLOGY

3.1. INTRODUCTION

The research methodology referred to the plan of conducting a study (Brink, van der Walt, and van Rensburg, 2012, 50). This section described how this study was conducted.

3.2. RESEARCH PARADIGM

This study is underpinned by a constructivist paradigm. The ontological perspective of this paradigm is based on the belief that reality is subjective and multiple (Brink, et al., 2012, 120). This study takes the stance that PNs realities regarding aggression and aggression management are subjective and contextually constructed over time. Specifically, within this study, both realities pertaining to aggression as well as aggression itself are proposed to be constructed through interaction. This interaction includes PNs (especially the junior and student PNs) observations of how senior nursing management persons' deal with the aggression displayed by their psychiatric patients. Nurses in psychiatric units make subjective interpretations of what they experience and therefore by interpreting the manner of aggression management they construct their own reality about aggression management. The epistemology of this study (that is, how reality came to be known within the study) is within the constructivist paradigm where knowledge is defined by the "knower" (Brink, et al., 2012, 120). What this epistemological premise means as far as aggression management in mental health care settings is concerned, is that nurses who have experienced this aggression are deemed as the "knowers", and what is known is the result of their practices.

Methodological interpretation describes the process via which the researcher and the research participants collected valid and reliable data, and described PNs attitudes towards (and current management of) the aggressive psychiatric patient; as well as their attitudes towards the integration of new practice, specifically de-escalation, into current practice. A constructivist research paradigm was used to facilitate contextual understanding of South West Nigerian PNs reality as it relates to aggression, as opposed to the predictive explanation from the existing research resources on aggression against Nigeria PNs conducted through positivist paradigms in quantitative research (Ukpong, et al., 2011,46; James, et al., 2011,130; Chukwujekwu and Stanley, 2011,163; Amoo and Fatoye, 2010, 351). The constructivist paradigm is considered most suitable for this research

because it is seen as the most relevant avenue to assess and describe nurses' attitudes towards the introduction of evidenced-based practices within their current aggression management strategies.

3.3. RESEARCH DESIGN

A content analysis qualitative approach, using audio recordings of pre- and post-intervention focus group discussions to collect data, was adopted. The intervention (one oral and visual de-escalation presentation) bisected the pre- and post-focus group discussion.

The objective for the pre-intervention focus group was to describe psychiatric hospital based Nigerian mental health nurses' current experiences and practices towards verbal aggression and violence management in order to inform relevant application of information within the intervention. Semi-structured questions (Appendix 3: First focus group semi-structured questions, page 82) facilitated narratives of personal experiences and informed clinical application examples used within the oral and visual de-escalation presentation to enhance the presentations' relevance and accessibility. The objective of the post-intervention focus group discussion was to describe psychiatric hospital based Nigerian mental health nurses' responses to the intervention – visual and oral presentation of de-escalation - as an evidence based practice for reducing verbal aggression and averting violent behavior. This second focus group discussion also was facilitated by semi structured questions (Appendix 4: Second focus group semi-structured questions, page 82).

One group of eight participants (sampling, point 3.6) attended both the pre and post intervention focus group discussion, the oral and visual de-escalation presentation, and one confirmation of data meeting.

3.3.1. Validation of intervention

The intervention (an oral and visual de-escalation presentation) was subjected to two forms of content validity: content validity based on a review of current evidence based practice literature, and face validity via presentation to an expert panel (Appendix 8: content validation, page 99). The expert panel composition included: two mental health nurse academics, one advanced clinical specialist mental health nurse, and one nurse educator academic who is also a mental health nurse.

Written feedback was reviewed by all three researchers and the presentation modified to include local, Sub-Saharan African evidence of the use of de-escalation.

3.4. RESEARCH SETTING

The setting of this study is one of the tertiary institutions that offer mental health care services in Nigeria. The institution was selected using purposive sampling (see sample and sampling methods, point 3.5, page 25). It is a psychiatric hospital in South-West Nigeria. The hospital, like other psychiatric hospitals in Nigeria, has two distinct sections: a main hospital that is the general mental health care setting; and 'the annex' that is the forensic section of the hospital. These two sections are separated by a distance of 18 kilometers. The hospital rather than 'the annex' provided the research setting and is described in detail below.

Within this psychiatric hospital wards are, for the purpose of nursing management, divided into two units. Each unit consists of between two and eight thirty-bedded wards. The first unit has an assessment focus, although treatment can and does occur, and includes: emergency assessment mental health care (one mixed-gender thirty-bedded ward) and a mixed gender thirty-bedded assessment ward for National Health Insurance Scheme (NHIS) patients. The NHIS patients are people who work for, and are provided with health insurance by, the Nigerian Government. In addition, this unit includes an outpatient assessment department accessed by approximately eighty people per day for follow-up care. The second unit focuses on treatment rather than assessment, although assessment is part of the treatment process, and includes: drug addiction care (two thirty bedded wards, one male and one female), and general psychiatric treatment (three male and three female wards each with a bed capacity of thirty). Within these general psychiatric treatment wards, one male and one female ward are considered to be long-term care. Throughout both units, all wards, child and adolescent mental health care and psychogeriatric mental health care are incorporated within adult mental health care services. .. Each ward has between twenty and twenty five nurses working over three different shifts per day. Bed occupancy is commonly between twenty and twenty five patients per ward. Taking into account absenteeism, leave, and administrative roles, the nurse patient ratio is usually 1:10 for every shift. Unit managers are mental health nurses who are responsible for all of the wards within their unit. Each ward has a ward manager and a deputy ward manager, both mental health nursing posts. The ward manager liaises directly with the unit manager to facilitate implementation of directives related to service

delivery. Typically a total of twenty security officers, all male, are allocated across all wards for the morning shift and to the hospital entrance and exit routes during the other shifts.

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The total nursing staff strength is 130 (Sources; Hospital record book). Typically, the charge nurse perpetually runs the morning shift concentrating on administrative tasks, professional rounds, and emergency cases. There are 12 managers who perpetually run morning and administrative shift, while the remaining 119 nurses (101 females and 9 males) run the three shift duties: morning, afternoon and night. These gender statistics are significant due to the findings of Zuzelo, Curran and Zeserman (2012, 118) that female dominance can increase nurses subjection to violence. Contrawise, Beghi, et al. (2013, 20) believe violence against nurses only increases when they are the same gender as the patients. However, it is evident from the findings (Zuzelo, Curran and Zeserman, 2012, 118; Beghi, et al., 2013, 20) that gender plays a significant role in violence occurrence and management. Bed occupancy ranges from 20-25 in each ward. Nurse-to-patient ratio is usually 1:10 for every shift and sometimes 1:15 in cases of full-bed occupancy. The average rate of monthly admission in 2014 was calculated as approximately 27, the total for the year being 296. Mean value was arrived at by dividing the value with 11 (www.mathsisfun.com/mean.html). The divisional figure is 11 and not 12 because December was excluded due to an industrial strike the hospital embarked on (from December 2014 to 5th February 2015) during which there was no admission. The admission rate from then till time of assess to the research site (February- October) was 518 which account for duration of 8months. The average monthly admission for 2015 is approximately 65. Mean value was arrived at by dividing the total number of admission (518) with number of months of admission in the year, 8 (www.mathsisfun.com/mean.html). There is a significant difference (38) in the mean value of monthly admission of 2014 (27) and 2015 (65).

This significant difference makes it difficult to use the value to arrive at a concrete average rate of monthly admission of the hospital, which would have been calculated by dividing each whole year figure by 12 and calculating the ratio based on the difference between the two years (www.mathsisfun.com/mean.html). This is not possible due to the incompleteness of the statistical value for current and previous year coupled with non-accessibility of the researcher to admission statistics of much older years. However, it was also noted that the gender ratio of admission in 2014 is approximately 1:2 with females being 93 and 203 males, this is calculated by dividing the figure with smallest divisible unit of number to get the lowest fraction (www.mathsisfun.com/mean.html). However, in 2015, the ratio of female-to-male admission is

approximately 1:1.4 with 208 females and 310 males. Though the 2015 female-to-male admission ratio is smaller than that of 2014, there is still a higher number of male admissions than female. However, the gender ratio of patients is the opposite of that of the nurses, with a higher number of male than female patients, and higher number of female than male nurses. The statistical ratio of male patients to female nurses in 2014 is 1; 3 (www.mathsisfun.com/mean.html). This is significant to violence incidence. Zuzelo, et al. (2012, 118) believe this ratio can increase incidence of violence, while Beghi, et al. (2013, 20) believe it will reduce the occurrence of violence.

In a similar study conducted on violence in Nigeria, Amoo and Fatoye (2010, 353) declare that there is high percentage of male patient admission (69.8%) but a higher percentage of male patient 61% have record of violence as against the 40% of female counterparts and another study, also in Nigeria, reveals that violence is perpetrated more against against female nurses than their male counterpart (James, et al., 2011, 132). The findings of Beghi, et al. (2012, 118) and Amoo and Fatoye (2010, 353) are similar despite being conducted in high and low-income countries respectively. Though the ratio of nurses is not provided in the findings of Amoo and Fatoye, (2010, 353), the likelihood of having more female than male nurses in the research setting is supported by 2011 Nigerian national statistics reporting more female than male nurses in Nigeria (www.nursingworldnigeria.com). This confers with another study on violence in South Africa, also a LMIC, where Tema, et al. (2011, 920) declare shortage of male nurses as core to violence incidence.

3.5. POPULATION AND TARGET POPULATION

The population included all nurses working within mental health care in-patient settings in Nigeria. The target population was the professional nurses providing in-patient care at the unit and ward management level (Brink, van der Walt, and van Rensburg, 2012, 123).

3.6. SAMPLE AND SAMPLING STRATEGY

The sampling was a two-part process.

Firstly, convenience sampling was used to select one hospital based on the positive response by the selected hospital to requests for research support, further the selected hospitals approached offered geographical access to the researcher. A request letter was sent to five institutions in South West Nigeria but only one responded (Appendix 5: Letter of request for gate keepers' permission, page 83).

Secondly purposive sampling, that included the researcher and the research site manager, was used to identify potential participant PNs from ward management level to facilitate contributions to the nursing practices / management of aggression in the mental health care setting (Brink, et al., 2012, 124). The purposive selection of potential participants was done in consultation with hospital nursing management. This consultation began in discussion with the assistant director of nursing services to obtain support for the study. Unit and ward managers were targeted due to their position of authority to implement directives in the management of psychiatric care, specifically emergency-care responses such as an incident of escalating aggression or violence. Both unit managers and all eleven ward managers were invited to participate (N= 13). Both unit mangers agreed to participate. Due to lack of availability, six ward managers agreed to participate, two (2) sending deputy ward managers in their stead. A total of eight participants (n=8) were obtained: two (2) unit managers, four (4) ward managers and two (2) deputy ward managers.

INCLUSION CRITERIA

All unit and ward managers of not less than 10 years of experience

EXCLUSION CRITERIA

The most senior nursing manager was excluded to allow free expression which can be hampered by the presence of the overall manager.

3.7. DATA COLLECTION TECHNIQUES AND PROCESS

Data collection commenced on 5th October, 2015 after full ethical approval was obtained from the gatekeepers on 31st August, 2015 and UKZN on 3rd September, 2015 (Appendix 11: Ethical approvals, page 110). As indicated in the introduction to the methodology section (page 19) this study used focus group discussions to gather qualitative data. There were two focus sections, bisected by one presentation by the researcher, and followed by one confirmation of data meeting.

The two meeting days of focus group discussion were audio recorded and transcribed copy was included as appendix 12, page 114. The third confirmation of data meeting was not audio recorded.

3.7.1. Consultation with key stakeholders in preparation for data collection

Consultation occurred via emailed communication to the hospital chaplain who is also the manager of DATER phase 1, through whom other stakeholders were contacted (Appendix 7: Consultation through emailed communication, page 94). The researcher arranged a face-to-face meeting with the director of nursing services of the selected hospital on the 5th October, 2015, but the deputy was seen in his absence in the morning at 10am after managers general meeting in order to plan selection of potential participants and agree upon the venue, dates and times for implementation of the data collection process. The venue allocated for the focus groups as stated in the request for support letter (Appendix 5: Letter of request for gate keepers' permission, page 83) provided for privacy and comfortable seating of all participants. In addition the researcher negotiated the use of a data projector, stabilizer and electricity generator, but it was not available for use at the period of data collection and will not be available for the next two weeks. So the researcher used her own laptop loaded with the required software, printed the materials for each participant and packed for each participant in conference folder with pen.

The hospital management agreed and allowed this study to constitute on-duty time and treated the process as a form of continued education (Appendix 5: Letter of request for gate keepers' permission, page 83). In order to prevent impeding service provision, it was indicated that the participants attend sessions on consecutive afternoons (Appendix 5: Letter of request for gate keepers' permission, page 83) and thus the three meeting days was scheduled for afternoon between 1 and 4pm. It was envisioned that the first two meetings would take place on consecutive afternoons, and the third meeting, to member check data collected, in the afternoon a week later. However, participants preferred two days later due to other schedules high marked for the following week which may have impeded their availability. Time allowance was negotiated for one and a half hours for the first two days of the meeting and one hour for the final meeting (Appendix 5: Letter of request for gate keepers' permission, page 83). In addition, participants' potential emotional distress that may result from discussion of current aggression management practice and referral for counselling within existing hospital referral pathways was confirmed. This consideration and process is presented in greater detail within the ethics section (point 3.9, page

29) of the proposal. Details of the researchers' introduction to potential participants and the data collection process are provided below under descriptions of each contact.

After a formal introduction of the researcher by the hospital management representative to the assistant director of nursing services, there was a private meeting with both representative and assistant director of nursing services where the assistant director requested for detailed explanation of the research process. The researcher was taken along with the assistant director to the general managers meeting forum where nurse managers converge every Monday morning for general report between the hours of 8 and 9am and after a brief introduction by the assistant director, the researcher was asked for self-introduction during which the researcher stated the topic and aim of the research, voluntariness in participation, the time commitment required, the allowance for on duty participation and the process of the study. Thereafter, the manager expressed their willingness to participate and it was concluded that being the month of mental health awareness with other programmes high marked by the institution for managers, the three day meeting should be that same week and the first meeting should commenced in the afternoon of same day. Time was given for questions and a participant asked for maximum time commitment of each day discussion with response from the researcher that it will not be more than 2:30hours.

To avoid coarseness to participate (which may have occurred due to the presence of the assistant director of nursing services) the researcher communicated the time and venue to all the prospective participant and ask and interested managers or subordinates to come to the meeting venue in the afternoon. The total number of manager and assistant present at the morning meeting were 12 in number, but 7managers and 1deputy manager came in the afternoon as a representative of each unit. The manager of DATER unit phase 1 was also excused from participation, being the hospital management representative and the chaplain of the hospital chapel which may have impeded the process of free expression among participants. An invitation to participate was disseminated by the researcher to the eight potential participants through the provision of the information sheet (Appendix 1: Information sheet, pg. 79) and written consent form (Appendix 2: Consent affirmation by research participants, page 81).

The participants agreed and written consent (Appendix 2: Consent affirmation by research participants, page 81) was obtained. The researcher informed the participants that the whole process would be audio-recorded and every content of the consent form was re-stated. Prior to

each focus group, the researcher used a self-developed checklist to -ascertain the availability and soundness of the recording equipment. These included a mini amplifier; two audio recorders; electrical extension boxes for centralizing the power source of the equipment if the need arose due to the unpredictability of power supply in Nigeria; a pen and notepad for field notes; the focus group question guide; and a laptop.

3.7.2. Conducting the first focus group

The focus group commenced by greeting the participants in a friendly manner to establish positive rapport. The researcher provided participants with her background in the clinical setting to establish credibility and align herself with the PNs context. The researcher then briefly described the steps of the focus group, reminding the participants of the three meeting dates and time commitments. The researcher used semi-structured interview questions (Appendix 3: First focus group semi-structured questions, page 82) to facilitate a discussion relating to participants' knowledge and attitudes toward current legislation, hospital policy and practices related to the aggressive behavior of psychiatric patients. In addition, the researcher, herself a psychiatric nurse, used communication and group-facilitation skills to facilitate a discussion related to the groups' contributions, with emphasis placed on the need to respect each other's opinions. The discussion was audio-recorded, and ended with words of appreciation and a take-away pack of refreshment for each participant.

3.7.3. Conducting the second focus group

After greeting participants, the researcher used a PowerPoint presentation to share information on de-escalation as a possible PN preventative intervention for aggression (Appendix 9: Power point slides for presentation of information on de-escalation techniques, page 105). After the presentation, the second audio-recorded focus group discussion commenced without a break to avoid contamination of data through participants' attitudes being influenced by each other (Stewart and Shamdasani, 2014, 52).

 The discussion was focused on the information shared and their attitudes and thoughts about de-escalation as potentially useful in the mental health clinical setting and possible use in PN clinical practice within the research setting. Again semi structured open ended questions were used to facilitate sharing of thoughts and feelings (Appendix 4: Second focus group semi-structured

questions, page 82). The researcher took the position of facilitating discussion in a non-influential manner, recognizing the inputs of all participants, inclusive of the more and less vocal contributors (Nihei, et al., 2014, 137).

3.7.4. Confirmation of data

The final meeting confirmed with all the participants, through member checking, that the data gathered was a true reflection of participants' input in the two focus group meetings (Holloway and Wheeler, 2013, 129). This verification of the accuracy was done by reading to the participants the transcripts for verification of data, and the inferences derived by the researcher from the participants' responses. Checking, as a continuous process by the researcher's academic supervisors ensured confirmability. Participants were provided with an opportunity to make corrections as indicated. After this, participants were thanked for their time, and told that a written report would be provided to the hospital, with the full dissertation available for reading on the UKZN library website within a month of the dissertation being successfully examined. The meeting was then brought to a close. Member checking was done to verify accuracy (Carlson, 2010, 1105). When credibility, transferability and dependability had been established, confirmability occurred (Thomas and Magilvy, 2011, 154).

3.8. DATA ANALYSIS AND MANAGEMENT

This study (which was focused on describing the existing approach of aggression management, and the perception towards the adoption of de-escalation techniques which are suggested to be contextually new in Nigeria) adopted the inductive approach of content analysis by Elo and Kyngäs (2008,109). These authors describe three main phases which include preparation, organizing and reporting.

Preparation phase: The audio taped interviews in this study were transcribed using verbatim transcription. The unit of analysis selected was relevant to the research objectives. The researcher read through the transcripts in their entirety and thoroughly and in this way become immersed in the data collected (Elo and Kyngäs, 2008, 109).

Organizing phase: This phase included the process of open coding, creating categories and abstraction (Elo and Kyngäs, 2008, 110). Open coding started with underlining key words within

the transcripts. This involved a structured (unconstrained) categorization matrix which entails grouping the data that are relevant to the set objectives together, and then reviewing the categorized data for congruence with each corresponding category given a code. The codes generated are the meaning unit/content unit. The codes were generated from the key words of the participants' categorized responses (condensation); (Elo and Kyngäs, 2008, 109). These were transcribed verbatim onto coding sheets and categories were generated (Elo and Kyngäs, 2008, 109). This was followed by themes derivation. Elo and Kyngäs (2008, 109) have described the themes to mean the voice of participant with highest pitch, meaning, re-occurring regularity developed within categories or cutting across categories. In this study, the themes were generated based on categorized responses that depicts the two forms of attitude the study intends to describe (attitude toward aggression management and attitude towards de-escalation).

Reporting phase: This phase involved the analysis process and the results, being described as the meanings of the categories (Elo and Kyngäs, 2008, 109). The data collected was used solely for the purpose of this study. All recordings of the discussion forum were labelled using participants' pseudo-details and dates, and then downloaded on a personal computer which was protected by a password known only to the researcher. Back-up copies were stored on a compact disc (CD). Once data analysis was completed and the final report written, it was copied to a second CD disc to be stored by the researcher's supervisor for five years according to UKZN policy. The data saved on the researcher's computer will be deleted and the recycle bin emptied (Holloway and Wheeler, 2013, 304).

3.9. TRUSTWORTHINESS

Trustworthiness was achieved by convincing the reader about the truthfulness of every stage of the research and how they coincided with the research objectives (Holloway and Wheeler 2013, 302). This was achieved through the principles of credibility, confirmabilty and dependability (Holloway and Wheeler, 2013, 304).The application of each is presented below.

3.9.1. Credibility

For the purpose of this study credibility was achieved as follows;

3.9.1.1. Content validity

To validate the appropriateness, clarity and level of congruence of the content of the presentation with the set objectives, the research supervisor set up a panel of assessors. The study was presented to this panel comprising of a group of professionals in nursing, two lecturers in the UKZN department of nursing, and one nurse manager. The presentation took place at Desmond Clarence building, 5th floor, class room two on 22nd April, 2015. 3-4:30pm. Questionnaires were distributed before the presentation and completed questionnaire was collected thereafter. The comments were reviewed together with the supervisor and co. the next day, after which presentation was modified based on the comments and suggestions (Appendix 8: Verification of content validity questionnaire and responses, page 97). The semi-structured interview guide for this study was made available to the research supervisor. In addition, the researcher's psychiatric nursing background facilitated the focus groups contributions (Holloway and Wheeler, 2013, 129).

Progress briefing: During the process of data collection, the researcher ensured continuous briefing of the research supervisor on each stage of research, the distance barrier was handled through electronic media of video-chat, and debriefing was done through video-chat after the collection was finalised. In addition, the original audiotapes were provided to the research supervisor to allow for confirmation of the transcribed data and proof that data collection had occurred.

Scrutiny of the research project: Besides the ongoing scrutiny by the supervisor and co-supervisor, the researcher made the work open to scrutiny by the ethical committee of University of KwaZulu-Natal (HSSREC). Paper trail was achieved by th submission of hard copies of the research process to the authority of the research site alongside an application letter for permission to conduct the study. The researcher provided, as Appendices, a paper trail of proof of contact and data collection at the research site.

3.9.2. Confirmability

There was member checking with the participants as a group at the third session - data confirmation group. The researcher achieved this by giving a short summary to the participants of the content of the first and second focus group sessions to enable them to check that their ideas have been

properly captured and to provide an opportunity for correction or clarity where necessary. In addition the transcriptions of the audio tapes was provided to the supervisor and co-supervisor to co-code and check the researcher's data analysis process and themes identified.

3.9.3. Dependability

English being the only official language in Nigeria, the focus group discussion was in English. In this study the interview was audio-recorded to ensure that the researcher did not misinterpret the participants' own wording. The researcher completed all transcriptions of focus group data into hard copies. A detailed description of the data analysis process was provided in the data analysis section (point 3.7, page 26). In addition, the researcher engaged in in-depth literature review after collection of data to establish connection between the research findings of this study with other evidenced base scientific findings. Further, the completed study was evaluated by two external examiners.

3.9.4. Transferability

Transferring the recommendations and the findings from this study to other mental health care settings, within and outside Nigeria, will depend on the readers or implementers' assessment of the suitability of the study to their context. This is facilitated by rich and thorough descriptions of the study background, research setting, methodology (including context, processes, successes and any restrictions encountered at any level of the research execution or data collection, the number of participants involved and also the time duration) and analysis is included in this study (Speziale, Streubert and Carpenter, 2011,50).

3.10. ETHICAL CONSIDERATION

Review: The proposal was submitted to the HSS Ethics Committee of the University of KwaZulu-Natal and the hospital management for ethical approval.

Consultation with stakeholders: As presented in the data collection process (point 3.6, page 23) consultation with stake holders began in July 2014 and continued to final negotiations re time, place and potential participants till ethical approval from both UKZN and Nigeria, was granted. In addition to the description of stakeholder consultation presented in this data collection process

section,   two   consultative   processes   are   elaborated   on   here.   Firstly,

Letter of release for participants: As presented under the data collection process (point 3.6, page 23) the researcher at negotiations requested a release letter from the hospital management for participating PNs to facilitate their release from the units. Secondly, the *risk vs benefit* aspect of the study that is linked to beneficence.

Beneficence: Beneficence is a fundamental ethical principle that seeks to prevent harm and maximize benefits for study participants (Holloway and Wheeler, 2013, 53). Beneficence was promoted in this study as there were no physical risks and participants, psychiatric nurses, were not considered a vulnerable population in the same way as psychiatric patients. Although limited, it was acknowledged that there were psychological risks involved in participating in the study. Specifically, this study being descriptive in design, involving a possible recount of the participants' experience/s of aggression management or exposure, brought about uncomfortable emotional responses. In the event thereof as the researcher, an experienced psychiatric nurse, carried out initial intervention by showing respect for the emotional feelings of the participants which required some moments of silence, sober reflection and later enquiring if the participant is able to continue or needs a break. The distressed participant was offered a referral to access the supportive counselling services pathway negotiated prior to the commencement of data collection, but refused (point 3.6, page 23). The affected participant was a victim of aggression two days before data collection commenced. She expressed pleasure at the opportunity of self-expression and she was given ample time to express herself. She was the last person to contribute and looked calm while the others were contributing. However, when it was her turn to narrate her experiences, unlike others who narrated one or two experiences, she narrated four previous experiences and at the point of narrating the most recent one, which occurred two days before data collection commenced, her face suddenly changed and her eyes were full of tears. There was a moment of silence for her to talk, after which the researcher inquired if she wish to excuse herself and see the hospital psychotherapist, but she refused and said that her self-expression and participation in the research was therapeutic, and that the forum was an opportunity for her to express her feelings and hear others share their experiences.

Apart from the psychological risk discussed, social risk was envisaged in the process of group discussion, in form of risk of disagreement with one another's opinion, but not experienced. To counter this risk, the researcher emphasized the importance of respect for each other's opinion at first stage of the data collection (point 3.6, page 23), but no form of disagreement was encountered throughout the period of data collection. Every one's opinion was respected even if contradictory to others opinion. No one try to correct the other or enforced his or her opinion. The potential benefit involved in participating in this study are; motivation for reflective thinking among participating nurses and positive impact on practice with regards to care of psychiatric patients and management of aggression. Beneficence was promoted as information provided was not used against the participants as no names were used. Further, an information sheet was provided to all potential participants before the data collection began. The content of which was confirmed at the data collection session (Appendix 1: Information sheet, page, 79).

Respect for human dignity: In order to ensure respect for human dignity, the researchers provided all the information to help the participants make an informed consent. Participants were informed that participation in the study is voluntary and that they can withdraw anytime they choose to or abstain from contributing in the focus groups. This choice did not have any negative consequences, neither was there any form of coercion to participate in the study (Holloway and Wheeler, 2013, 143). Two of the participants could not take part in the confirmation section due to their personal academic pursuit which require their attention outside the state.

Justice: The researchers did not provide prejudicial treatment for the participants who refuse to participate or withdraw from the study.

Confidentiality and anonymity: Participants' identity and the name of the hospital was represented with codes that can only be traced to the participants by the researcher, these codes were used during transcription and publications that may arise from this research. Signature alone was required for the consent form (Brink, et al., 2012, 35).

The research materials remained with the researcher in a save and pass worded computer, and stored in the confidential custody of the research supervisor's office for duration of the study. After scanning, written copies of transcripts were destroyed by fire and tapes were stored in the research

supervisor's office for a period of five years according to UKZN policy. The data saved on the researcher's computer was deleted and the recycle bin emptied.

***Results dissemination*:** The report will be provided to the management board of the institution where the study was conducted after examination by UKZN internal and external examiner, also to each of the participants through the director of nursing services, this will be done once the dissertation has been passed, followed by publications of results through a peer review journal.

3.11. SUMMARY OF THE CHAPTER

This chapter outlined the how the research data was collected, which shall henceforth serve as a roadmap to understanding the next chapter which is the description of data presentation and analysis.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1. INTRODUCTION

This chapter begins with a presentation of the participants' demographic data. This presentation, in conjunction with the description of the research setting (point 3.3, page 20) facilitates the readers' decision regarding transferability of the study results. The data analysis process and presentation and interpretation of the collected data from the two focus group discussions with nurse managers in a South West Nigerian psychiatric hospital follows. The process descriptions embedded within the presentation of the data are used to highlight the rigour of the data analysis process. Data presentation flows according to the research objectives, with links to the conceptual framework underpinning the study.

The first focus group discussion explored nurses' experience with aggression and present mode of management, descriptions of structure and process standards within the conceptual framework. This data is presented separate from the second focus group discussion which explored the attitude of nurses towards de-escalation techniques in aggression management, as presented within the methodology chapter (page 19) a focus group that occurred after they had received a research evidence supported presentation related to the 'how' of de-escalation implementation. This focus group data pertains to the second research objective and focuses on the structure standard component, specifically attitudes, within the conceptual frame work guiding the study. The transcribed audiotaped raw data from both focus groups can be found in appendix 12: Transcribed script (page 112) for reference. Presentation of the data is supported by extracts from the transcribed raw data, and content from filed notes are used to provide additional contextual information.

4.2. DEMOGRAPHIC CHARACTERISTIC OF THE PARTICIPANTS

The researcher anticipated involvement of seven psychiatric nurse managers (point 3.5, page 22), but eight gave consent. As displayed in table 4.1: Demographic characteristics of participants (page 35) the participant group included two nursing managers overseeing more than one ward; four ward managers and two deputy ward managers who accepted to participate as the ward managers were unavailable as a result of leave.. Gender demographics were seven females and

one male participant. This is a representation of the hospital gender statistics where females account for nine (75%) ward manager positions (Sources; Hospital record book) Participants' gender distribution also coincides with WHO statistics reporting gender inequality in work force, with females being the disadvantaged of increase exposure to risk especially in low income countries (WHO,2006, 15). Participating nurses reported high levels of mental health care experience, from eleven to thirty years, including experience within all the units within the hospital. All eight participants had a diploma in general and psychiatric nursing, seven had a bachelor degree in health related disciplines and at the time of data collection were pursuing a degree in nursing. One participant had already completed a bachelor of nursing science degree following completion of a public health degree.

In addition to participants' demographic data, Table 4.1 (page 35) presents participants' codes names to facilitate contextual reference, application to raw data presented in appendix 12, and the extracts used to illustrate themes identified during data analysis. The provided years of experience and current worksite linked to code names allow for rich descriptions of participants and for the reader to consider transferability of the data.

Table 4.1: Demographic characteristics of participants

Participants Gender	Current Unit and / Ward	Management position	Years of service
Female	Unit 1: Assessment	Unit manager	22
Female	Unit 2: Treatment	Unit manager	26
Male	Long-term care ward	Ward manger	30
Female	Female drug addiction ward,	Deputy ward manager	11
Female	Out Patient Clinic within Emergency Assessment ward	Deputy ward manager	15
Female	National Health Insurance Scheme assessment ward	Ward manger	19
Female	Emergency Assessment ward	Ward manager	15
Female	Male drug addiction ward	Ward manager	19

4.3. THE PROCESS OF DATA ANALYSIS

Data analysis followed the content analysis process of Elo and Kygas (2008) described in chapter three (point 3.7, page 26). The application of the process to this study's raw data is presented to add to the credibility of the study.

The researcher began the process of analysis by verbatim transcription of the audio recorded discussion. This involved listening to the recording and typing at the same time, and then listening to the recording while simultaneously reading the typed transcript to be sure no sentence or phrase was omitted which facilitated the researcher's familiarity with the data. The transcript was thereafter read and re-read independently of the audio recording. Copies of the audio recording and verbatim transcription were given to the supervisor and co-supervisor. The researcher then started the stage of open coding, categorisation and abstraction of the transcribed data from the first focus group identifying statements and phrases that indicated attitudes towards, violence and/or aggression management practices, the first research objective. The same coding and categorising process was followed for the second focus group data focusing on the second research objective, Significant statements were highlighted (open coding) and ruminated on to identify through coding of similar statements potential categories and themes within the raw data. To facilitate this reflection, similar statements identified were grouped together by copying and pasting them together on a separate sheet to form a categorisation matrix (Elo and Kygas, 2008). The researcher's initial categorisation matrix generated ten categories from the first focus group (reaction formation, defence mechanism, opportunistic attack, intention to molest, psychiatric symptomatology, overpowering, creation of crisis awareness, forceful sedation, intimidation by numerical strength, instrument of self-defence and three categories for the second focus group (counselling to control, resistance to change , fixed bias about change). The researcher then generated themes for the first focus group data by ruminating on –'what is the statement saying about the attitude and practise', and   how this statement can be presented in a summarised form without altering the meaning. This helped the researcher to arrive at the three emerging themes for the first focus group (culture of deception, culture of normative action, culture of contention) and one emerging theme from the second focus group data (culture of guilt creation, attitude of lordship and intimidation). At this point in time, the researcher sent her data analysis to the supervisor and co-supervisor. As mentioned earlier in this section, the supervisor and co-supervisor had been

presented with the audio transcripts and transcribed raw data prior to the researcher's submission of her data analysis

The meeting with the supervisor and co-supervisor to discuss coding, categories and themes led to initial themes and categories being reduced and reframed. Table 4.2: Presentation of themes and corresponding categories, page 37, presents the final themes and categories used to present the analysed data for focus group one and focus group two. The records of this coding and statements identified are highlighted in bold, tagged with the code name of the participant and presented in Appendix 12: Transcribed script (page112) to facilitate the trustworthiness of the study. What follows is the reporting phase of the data analysis process, first the presentation of themes generated for the first focus group and the theme generated from the second focus group data as presented in table 4.2 below.

Table 4.2: Presentation of themes and corresponding categories

FOCUS GROUP	THEME (T)	CATEGORY (C)
PNs current attitudes and practices towards violence management.		
1	T1- Betrayal	C1-Deliberate harm
		C2-Ineffective response
		C3-Heightened threat
		C4-Home- hospital transit
	T2-Power versus Powerlessness	C5-Asserting authority through intimidation
		C6-Questionable practice
PNs attitudes towards the introduction of a measure to decrease the risk of verbal aggression escalating to violence.		
2	T1-Hopelessness	C7-Relationships
		C8- Crisis to crisis
		C9- Disarm and disable

4.4. PRESENTATION OF DATA

4.4.1. Focus group one.

Two themes, betrayal, power versus powerlessness, were generated to express participants' attitudes and practices as they related to responding to aggression and/or violence within the mental health care setting, and related to the structure and practice standard components within the conceptual framework. Categories are embedded within the presentation of the two themes and highlighted in bold.

Theme 1: Betrayal

The theme of betrayal emerged early in the analysis process. Participants reporting that the potential for aggression and violence began during the admission process '**home-to-hospital transit**' Some statements point to the fact that aggression against the professionals occurs as a result of betrayal of trust in the family members- *A19C4b- "Some of them are told they are only going out on a stroll and will find themselves in the hospital"- A21C4b- "They come very wild because of maltreatment and not because of illness".* Participants point to the fact that patients' relatives are cruel to patients in an attempt to force them to come to the hospital- *A19C4c –"Some of them come in chains"- A19C4d – "They are brought tightly tied"- A19C4g-"The patient are brought in tied with a rope like an animal".* This confers with the findings of Davis (2010, 141) in a study conducted in Greece that domestic violence against mentally ill is recognised as a greater cause of hospital based violence (homicide and suicide) than psychiatric symptomatology.

Participants of this study also believed that the brutal experience patients have received has actually positioned the patient for aggression and this subjects nurses to being attacked, despite being in a caring role. Specifically participants referred to feeling betrayed by mental health patients that they were trying to help, their attempts at caring, resulting in patients' intentions to do '**deliberate harm**' - *A19C1a- "I thought she is my friend, but she rose up and suddenly gave me a heavy slap"- A20C1a- "l tried to intervene by settling it, but the patient turned back and held my neck"- A18C1a- "I persuaded her to use her drug , but she turned back and tried to hit me with iron chair".* Participants consider such experience of being subjected to aggression from the patient as a form of betrayal of the caring and respectful relationship that should exist between caregiver and care receiver. This finding confers with the report of an African and international

study. A study conducted in South Africa by Poggenpoel and Myburgh (2009, 8) reveals that psychiatric nurses consider patients' aggression towards them as a form of ingratitude to their effort of caring, a betrayal of their efforts. Another study conducted in Germany shows that nurses feel disappointed when they are attacked by the patient they are caring for, a betrayal of their sacrifice (Franz, et al., 2010,6).

Another form of betrayal emerged from participants' responses relating to the betrayal of workers rights to a safe working environment by the institution/employer, '**ineffective response**'. Participants believed that their life and safety is presently not secured and that the institution does not care about it- *A19C2b- "If she had killed me, nothing would have been done"-A19C2c- "Someone gave us alarm watch, it got spoilt, but never repaired"*. This confers with a study conducted in Turkey that reports violence as a form of violation of the right to a safe working environment for nurses (Ünsal, et al., 2013, 887). Participants expressed that in cases of aggression, they have no means of being rescued, but rather have to shout for help- *A19C2a- "Relations came to rescue me". A15C2a –"Co-patient started shouting at her". A15C2b- "I had to shout for attention of other nurses on the ward". A15C2c- "I shouted for help, though he was not successful in his intention, but he could have". A21C2a –"I had to call for help using intercom". A20C2a-"Nobody came to help, l was alone and could not shout". A16C2a- "Everyone ran away and left me alone with the patient". A11C2a-"We had to run away in search of help". A11C2a- "I shouted for help, but my voice is not loud enough".* Ineffective response has been recognised by participants to have been the cause of **heightened threat/injury**- *"A19C3a- She made second attempt to slap or strangulate me". A19C3d -"She said her intension was to kill me if not for the intervention of the rescuer". A21C3a- "They all came together in group to attack me". A15C3a- "She was fuming". A16C3a-"Then she replied and said you know you are pregnant, so keep away from me". A11C3a- "She then removed her slippers and banged on my head". A21C3e –"Patient was angry and came to grab my penis"*. Participants also recognise that threats most time lead to injury- *A19C3b- "l lost sense of hearing". A11C3b –"I was so traumatised that l sustained neck injury". A11C3c-"The ward manager and the residence on duty were also injured". A21C3b – "They have killed many"*. This is supported by Franz, et al. (2010, 5) in a study conducted in Germany, the report shows that workers regard being victim of violence as a result of institutional negligence about their welfare and safety and thus tagged the institution as "bad".

Theme 2: Power versus powerlessness

Participants' perceptions of their own powerlessness and their need to establish power within the clinical environment resulted in the first category of '**asserting authority through intimidation'.** Intimidating patients through numerical strength, weight and height is believed to be a violence prevention approach by participants. *A20C5e –"When they see we are many, they behave themselves". A19C5b- "Patients are usually scared when there are many nurses who are experienced". A19C5a- "The height and size of the nurse can be intimidating to the patient and they will watch their actions". A16C5a –"Also when the nurse is bold".* Contrary to participants' beliefs, that their size instills fear, studies show that the psychology behind body size, weight and height, doesn't confer with perceptions of violent tendencies. In a study conducted in Sweden on body size and perceived threat of violence, Beckley, et al. (2014, 836) declare that height has no relationship with perceived tendency of being violent, but rather infers emotional balance and stability. An American study conducted by Farhat, et al. (2015, 1512) reports that large, overweight individuals are more prone to being the recipient of violent behaviour than the perpetrator of such acts. However, participants' perceptions of the role of numerical strength is supported in literature as a strategy of terrorising or intimidating victim of violence (Heger, Jung and Wong, 2012, 3). Participants also believe that engaging the patient in discussion rather than issuing a warning may present the nurse to the patient as a soft person who can be easily conquered. *A18C5a –"They also capitalize on the level of firmness and permissiveness of nurses". A18C1a- "I went to her and persuaded her so she stood up and l started following her to the drug station. She got to the side of an iron chair carried the chair and turned back to hit me with it".* Participants are suggested to consider dialogue a higher violence risk than giving commands. In a study conducted in Nigeria exploring communication skill of doctors and nurses, results reported that these professionals have a knowledge deficit and ineffective communication skill (Adebayo, et al., 2013, 205). Koukia, et al.(2013,195) reported that Greek mental health nurses considered therapeutic communication a non-nursing approach and expressed lack of knowledge about effective communication skills. The same results emerge from an American study (Shen, Staples and Bolstad, 2014,3). This coincides with the findings of Stenhouse (2011, 75) who reported that mentally ill patients reported a willful avoidance by nurses of attempts to establish communication.

This attitude of asserting authority is suggested to lead to '**questionable practice**'. Participants' descriptions within the category of **asserting authority through intimidation** were frequently linked to questionable nursing practices. Participants considered confrontation as an effective form of violence management, confronting aggression with a higher level of aggression. *A18C6d-"Thank God l was proactive, I quickly took the chair and pin her to the bed with it". A20C6c-"Physical restrain prevents possible damage during violence". A18C6a-"Another method we use is distracting them and covering their head with counterpane".* Participants made reference to the use of armed forces and provision of debilitating equipment necessary to empower them to prevent and combat violence. *A19C6g- "I learnt some developed countries, l believe, have gun to cause temporary paralyses for aggressive patient, also electro-conductive belt, those are the things we need". A19C6c-"Recently the hospital started using ex-military men for crisis management, but patients went to court that they were mal-handled and the hospital stopped it. We need it".* This conform with findings of Franz, et al., (2010, 5) that psychiatric nurses seek for armed responses to combat violent psychiatric patient(s). Also, these statements seem to support the findings of DeWall, et al. (2011, 245) that aggression breeds aggression and can continue in a circle of offense and retaliation. It therefore is not a surprise that participants note opportunistic violence against new, female, and pregnant nurses linked to theme 1, **betrayal, within the category of deliberate harm** -*A19C1a-"Sometimes they take undue advantage of the pregnant women knowing that pregnancy can incapacitate someone from being able to handle them". A18C1a –"They also take the advantage of the size and height of the nurse, patients find it easier to attack small statured nurses". A17C1a-"They attack junior nurses more".* This also confers with the findings of Child and Mentes (2010, 90) that violence is more prominent against young nurses, but is against the findings of James, et al. (2011, 133) in a South East Nigeria study that reported violence as more prominent against older nurses. Participants in this study believed that more experienced nurses are less prone to violence.

4.4.2. Focus group two

One theme emerged in the second focus group, hopelessness, to express participants' responses to the possible implementation of de-escalation as an aggression management strategy within the mental health care setting, and relates to the structure standard component within the conceptual

framework, specifically knowledge and attitudes. Categories are embed within the presentation of the two themes and highlighted in bold.

Theme 1: Hopelessness

Yoshizawa, et al. (2014,2) reported in their Japanese study that sychiatric nurses are prone to occupational hazards that inflict both physical and psychological injury, and that have the poorest mental health compared with other fields of nursing. These authors specifically reported an increased incidence of depression and abuse of analgesics. Participants in this study gave the impression of perceiving themselves as moving from **crisis to crisis** with both verbal and non-verbal expressions of being emotionally drained as related to the re-occurrence of aggression in their setting. Participants' reports of assaults and injury reported in the first focus group under the theme of betrayal *(A11C3a –"She then removed her slippers and banged on my head". A21C3e – "Patient was angry and came to grab my penis". A19C3b- "For three days l lost sense of hearing". A11C3b – "l sustained neck injury". A18C3a- "They have killed many". A21C3b-"So many have sustained injury". A21C3f-"The pain was so severe". A11C3h-"I could not sleep despite analgesics")* are suggested to continue to impact on their openness and or willingness to consider de-escalation as a viable nursing intervention. Participants expressed their desire to get help, but assumed a position regarding what could or would help. They rejected de-escalation as irrelevant to their situation and believed that nothing but restraint would work as they perceived themselves as moving from **crisis to crisis -** *A18C8a- "We hope something good will come out of this discussion so that nurses will not continue to suffer". A20C8a-"with drug cases, there is nothing you can do to make them calm apart from physical restraint and sedation". A18C8b-"but in some situation there is nothing you can do".* Participants' responses indicated their belief that de-escalation is dependent on an existing **relationship** with the patient and that this was not the case within their context -. *A18C7a-"The approach is not new to us, but it can only be used on the ward after a relationship has been established with the patient". A18C7d-"a nurse that is closer to a particular patient may find it easier to de-escalate the patient aggression".* This conform with the findings of Björkdahl, et al. (2013, 397) that violence de-escalation is possible only with existing nurse-patient relationship which allow for openness and trust and can also be built (Björkdahl, et al., 2013, 402). Also, Van Offenbeek, Boonstra and Seo (2013, 434) describe non-enthusiastic acceptance as a form of resistance that confers with the response of the participants

within this study who expressed a form of non- enthusiastic "non-use" by asserting existing knowledge of de-escalation approach, but believing the approach cannot precede nor replace restraint, **disarm and disable** being the focus of their perception of successful management. Participants who acknowledged the potential effectiveness of de-escalation were only able to conceive of this with physical interventions *A18C9b*-"de-*escalation and traditional approach has to go hand in hand". A20C9b-"Talking to them does not usually yield positive result in every situation, physical restraint might be needful to prevent possible damage that may arise from aggression"*.

4.5. SUMMARY OF THE FOCUS GROUP DISCUSSIONS

4.5.1. Focus group one: PNs current attitudes and practices towards violence management.

Psychiatric nurses' responses on attitude towards the violence management reveal preference for cohesive method. They declare their practice of violent management to include use of restraint, both physical and chemical, which is most times proceeded by overpowering the violent patient before restraint is applied. Participants' fears for their safety are suggested to have informed a more militant approach to the management of aggression to strengthen nurses' control over patients' physical and emotional welfare, as well as their own.

4.5.2. Focus group two: PNs attitudes towards the introduction of a measure to decrease the risk of verbal aggression escalating to violence.

Psychiatric nurses believe de-escalation techniques can predispose them to further aggression. They are of the opinion that the skills of de-esalation is not applicable to their care setting, because violence is an occurrence patients are familiar with before admission and are always at alert to execute violence as a management strategy and are not used or ready for any negotiation.

4.6. SUMMARY OF THE CHAPTER

This chapter presented the gathered information from the participants and also the process of data condensation from the researcher's initial open coding of ten categories into nine categories, linked to two themes for the first focus group (betrayal and power versus powerlessness) and one theme (hopelessness) for the second focus group. This discussion was framed within the structure and process standards of Donnabedian's model.

CHAPTER FIVE: DISCUSSION OF RESULTS, RECOMMENDATIONS, AND CONCLUSION

5.1. INTRODUCTION

This chapter focuses on the essential findings that emerged from the data analysis and is based on research objectives directed by the conceptual framework and supported with current literature. This is followed by discussion on study limitations including the challenges the researcher encountered with bracketing of her personal experience as a psychiatric nurse. The chapter closes with recommendations for psychiatric nursing practise, education, research and policy making as related to aggression/ violence management in Nigeria and framed by the conceptual framework, specifically the influence of structure standards on practice standards.

5.2. DISCUSSION

5.2.1. Attitude of Nigerian psychiatric nurses to de-escalation

Despite the WHO (2012,47) introduction of a Quality Rights Tool Kit which gives recognition to the need for a humane approach in in-patient psychiatric settings the participants' attitudes towards de-escalation techniques showed their preference for a traditional (overpowering and restrain) approach to aggression management over the adoption of de-escalation.. Contrary to the WHO recommended rights based approach, Nigerian nurses sought a power focused step-up in aggression management, favoring a more militant approach with an expressed desire for the involvement of armed forces to strengthen the capacity for nurses' control. This is unlike international studies (Inglis and Clifton, 2013, 101; Koukia, et al., 2013, 195). These international studies reported recognition of malpractice as accompanied by expressed desires for, and actual change. Firstly; a Greek study identified that where nurses knew that the practice of over-powering and restraint was incorrect they expressed a desire to know of an alternative means of curtailing aggression (Koukia, et al., 2013, 195). Secondly, a UK study reported nurses desired to move from the previously trained technique of inflicting pain on aggressive patients to achieve compliance with restraint, and their effective adoption of de-escalation (Inglis and Clifton, 2013, 102).

Despite participants declaring that they 'know de-escalation' it could be questioned as to whether a barrier to the acceptance of de-escalation is lack of understanding. In a study, specifically on

barriers to mental health nurses use of de-escalation in aggression management, Hallett and Dickens (2015, 326) describe lack of knowledge and understanding as the main challenges of mental health nurses. Lack of knowledge is expressed in terms of lack of previous training or awareness of the rules of the technique while lack of understanding is portrayed through nurses conceptualizations of de-escalation to mean any approach that subjects the patient to the professional's authority, inclusive of force and restraint. This however fails to fully answer the posed question as Nigerian nurses expressed adequate knowledge of de-escalation, possibly their conceptualizations of its implementation are in keeping with the finding of Hallett and Dickens (2015,326) and illustrate limited understanding.

5.2.2. Resignation to the status quo with a resistance to change

Participants expressed knowledge of the de-escalation approach, but believed it was contextually unsuitable for their setting. Laker, et al. (2014,6) recognized that resistance to change among mental health nurses is context specific, context described as ranging from staff perception, occupational status and job satisfaction, in essence structure standards within a health care context. Briefly, these authors operationalized staff perception as the level of research awareness and research consciousness of nurses. Occupational status as the hierarchical order of decision making and lastly, job satisfaction is linked job description and the level of hazard a professional has been exposed to. Linking the findings of this study with those of Laker, et al. (2014,6), these authors reported the presence of research awareness, in this study awareness of de-escalation, but a lack of research consciousness which is the willingness to impact practice through implementation of research evidence. A further possible cause of resistance might be provided through considering the level of exposure to occupational hazards and the varied injuries from violence without seeming care or compensation being offered (Laker, et al., 2014, 1). Lastly, within this study occupational status was high, all participants in-charge of wards and from whom direction of command flows to subordinates. This occupational status was the reason for their inclusion within the study (Point 3.5, page 22) and yet seems to have not positively influenced perception as suggested by Laker, et al. (2014, 6).

In further examination of the possible barriers to the use of de-escalation participants considered de-escalation to increase the professionals' risk of being a victim of violence and injury. This sense of certainty gives no allowance for openness toward other approaches that are evidenced

based and has been shown to be a barrier to the adoption of new evidenced based methods of mental health care (Gallo and Barlow, 2012, 93). Misconception is regarded to mean bias against the new approach arising from misjudgement without wiliness of trial (Appelbaum, et al., 2012, 748). Similar to Gallo and Barlow (2012,93)'s findings in Boston, Nigerian psychiatric nurses expressed feeling of adequacy in terms of their method of aggression management, overpower and restrain, but reported requiring greater manpower, or enhanced restraint technologies, to ensure effective application. Laker, et al. (2014,1) describe mental health care professionals perceptions about existing structures of care, and bias about change, as a determinant of the process and quality of care. In this study, the existing structure of violence management in mental health care in Nigeria has been asserted as requiring a change of approach to be able to achieve quality care (point 1.8, page 8). However, the required change of approach encountered resistance from professionals who justify their current management of aggression, with the agreement to adopt the evidence-based approach of de-escalation viewed as an adjunct to their existing approach of violence management.

Kodellas, Fisher and Wilcox (2015,321) declares victimization as a factor that affects the occupational disposition which leads to "negative affectivity" and "situational tenets" especially in routine job with little diversity of function and contacts. This describe the situation of participants in this study by their expression of deliberate victimization from patients which turned the natural affection of care nurses have for patients to negative affection that encourage brutal treatment. It is therefore not a surprise that participants hold on to their situational "tenets"- use of force and restrain as more contextually applicable and practicable than de-escalation,

5.3. RESEARCHER'S REFLEXIVITY

The researcher is a psychiatric nurse clinician (point 1.2, page 5) who held personal bias about the subject of violence in mental health care setting. This bias made it difficult for the researcher to progress in writing at the initial stage of the project due to the researchers' sentimental mode of writing to suit personal believe. This bias was identified by the research supervisor after which the researcher was given additional task of literature review on the areas of bias which helped the researcher to gain a broad, scientific and evidence based knowledge of violence and violence management in mental health care setting.

The bias was twofold:

1. The researcher believed violence is a defining characteristic of mental illness, but this believe has no scientific basis, originated from stigma of mental illness and limited knowledge about scientific findings on violence in mental health care settings. This is supported by Reavley, et al. (2013, 1) that stigmatizing attitudes toward mental illness are the same and sometimes worse among individuals who are familiar with the mentally ill than the general population. The first bias led to the second one which though was unexpressed, but forms the basis for the researcher's attitude towards mentally ill patients while in practice.

2. The researcher's period of clinical practice was guided by violence preparedness before its occurrence. This is based on the bias that violence is a defining character of the mentally ill and the thought of previous injuries sustained (point 1.2, page 5), the researcher goes to practice setting with mind of self -defense and violence preparedness. This affected the mode of relationship and any trace of aggression was confronted with commensurate or higher level of aggression. This is explained from studies that show that the mode of violence management among professionals is born out of stigma of mental illness (Ünsal, et al., 2013, 887; Nestor, 2014, 1977).

5.4. RECOMMENDATIONS

The institution

The institution is encouraged to adopt the service of training consultant for on spot in-service training on management of aggression and make the consultant available to assist staff and debrief staff in cases of violence.

Occupational health policy of Nigeria (2006, 12) is guided by Nigeria Federal Ministry of Labour and productivity under Factories Act F1 LFN 2004, which encourages safety and protection of right of employee. While the Nigeria employee compensation act (2010, 10) under the Workmen's Compensation Act Cap. W6 2004, state clearly different forms of compensation for employee injured physically or psychologically in the process of discharge of duty, ranging from monetary compensation to physical and psychological care. In view of the concern of participants about lack of care of the institution about their safety and injury, the management of the institution is hereby

enjoined to institute workers compensation, according to the country's policy, especially in case of injury.

Policy makers

Legislation affects the mindset of people to change (Laker, 2014, 1). Therefore, this study encourage the development of an aggression management policy that is aligned with the WHO rights based approach as opposed to the Mental Ordnance of 1916 that guides current Nigerian nurses psychiatric practise. Action research to implement de-escalation skills over a period of time with the help of a cooperative inquiry group is vital.

Nursing research

Lack of post incident care and gap in research on after care for victim of violence in mental health care setting has been recognised by Franz, et al. (2010, 2,7). Laker, et al. (2014, 4) also recognize this as a barrier to change in practice. This is supported by participants' report that no one cares about their welfare in case of violence. This study therefore recommend further research on after care of victims of violence among psychiatric nurses in Nigeria.

Nursing training and curriculum development

As indicated in background to the study (point 1.1, page 1). Review of the Nigerian nurses' curriculum suggests that deficits within Nigerian nurse training are core to the mismanagement of aggression and violence (NMCN Psychiatry/Mental Health Nursing Curriculum, 2006, 26). Supportively, participants believe restrain should proceed de-escalation techniques. This is similar to the believe of nurses in the Netherlands and indicative of a training need for nurses on the impact of coercive method on aggressive behaviours among patients and benefit of improved communication without restrain on violence reduction and management (Jonker, et al., (2008,7). The introduction of violence management inclusive of de-escalation techniques (not just restraint) in student nurses training and a continuous education programme for trained nurses may impact practice (UKCC, 2002).

5.5. SUMMARY OF THE CHAPTER

This chapter has highlighted that the retention of traditional approaches in aggression management in the Nigerian context is primarily linked to the resistance to change.

5.6. CONCLUSION

The report of this study shows that despite Nigerian nurses being exposed to information on de-escalation with reference to evidence based studies of its effectiveness, they are not ready to adopt de-escalation as an approach to violence management. This is centred on the belief that it has the potential to increase the likelihood of their subjection to violence from the patients and possibly sustaining injury. Literature suggests that this fear is believed to have originated from legislation and context bias (Laker, 2014, 1; Swanson, et al., 2015, 374). The answer to its adoption might lie in the recommendations made to relevant stakeholders which focused on the areas of policy, nursing education, nursing research.

Dismissing de-escalation as an intervention to manage verbal aggression within mental health care settings: attitudes of psychiatric hospital based Nigerian mental health nurses

Abstract

The risk of violence within mental health care settings is high. Although literature does indicate certain mental illness symptoms, and or labels, as associated with increased risk for violence there is no definitive causative factor. Interrelated environmental factors directly influence verbal aggression and risk of violence. Specifically within mental health care settings, lack of, or inadequate, mental health care legislation and policy, and practitioner attitudes, knowledge and skill are noted as core influential factors

The purpose of this study was to present an intervention and describe the response of Psychiatric hospital based Nigerian mental health nurses.

A content analysis qualitative approach, using audio recordings of pre and post intervention focus group discussion was adopted. The intervention - one oral and visual de-escalation presentation - bisected the focus group discussions. The objective for the pre intervention focus group: to describe participants' current experiences and practices towards verbal aggression and violence management in order to inform relevant application of information within the intervention. The objective of the post intervention focus group discussion: to describe participants' responses to the intervention. Purposive sampling, nurses at unit or ward manager level, yielded eight participants.

Participants felt betrayed by all role players within the mental health care service system, were disappointed that de-escalation was considered the evidence based practice, and hopeless about its introduction. Participants' fears for their safety are suggested to have informed a more militant approach to the management of aggression to strengthen nurses' control over their own, and patients, physical and emotional welfare.

Review of Nigerian mental health legislation to set the context for human rights of both nurses and mental health patients is recommended. A need exists for further research utilizing a participatory action research approach.

Key words: De-escalation, intervention, Nigerian mental health nurses, verbal aggression and violence.

Introduction and background

Current research argues the risk of violence within health care, specifically mental health care, settings is high (Anderson, & West, 2011:34; Hahn, Müller, Hantikaine et al., 2013:381; Chukwujekwu, & Stanley, 2011:163; Pompeii, Dement, Schoenfisch et al., 2013:58; Rasmussen, Hogh & Andersen, 2013:2758). International (Nelson, 2014:1373; Moylan & Cullinan, 2011:526) and Sub-Saharan African (Chukwujekwu, & Stanley, 2011:163; James, Isa & Oud, 2011:130; Mitchell, Ahmed & Szabo, 2014:148: Ukpong, Owoeye, Udofia et al., 2011:46; Steinman, 2013:23) studies report the prevalence of workplace violent incidences against mental health nurses as ranging between 49.5% and 96.7%, or three times that of other health care workers. This broad prevalence range has been linked to limited reporting facilitated by differing reporting policy and procedure, and mental health nurses perceptions of

violent incidents as 'typical' and 'part of the job' (Jack-Ide, Uys, & Middleton, 2012:50; Maina, Munguti, Mwai et al., 2013:140; Steinman, 2013:23; Ukpong et al., 2011:48).

There is/are no definitive causative factor/s of violence within mental health care settings (Bader, Evans, Welsh, 2014:180; Chukwujekwu & Stanley, 2011:163; Papadopoulos, t et al., 2012:425). Literature does link certain mental illness symptoms, and labels, as greatly influencing risk for violence (Bader et al., 2014:180; Nestor, 2014:1974;). However, current research clearly argues that interrelated environmental factors, specifically; lack of, or inadequate, mental health care legislation and policy (Becker, & Kleinman, 2013:70-71; Drew, et al., 2011:1664; Papadopoulos et al., 2012:434; WHO, 2013,10), and practitioner attitudes, knowledge and skill (Bader, et al., 2014:185; Björkdahl, Hansebo, & Palmstierna, 2013:397; Papadopoulos et al., 2012:435; Mitchell et al., 2014:148) directly influence risk of violence within these settings.

Nigeria, like 64% of low and low middle income countries (LIMIC), has no mental health legislation (Westbrook, 2011:403; WHO, 2013:10). Nigeria continues to use the Lunacy Ordinance formed in 1916. The label used - lunatic- and detainment and confinement procedural elements within this ordinance facilitate the diminished status of the mentally ill person increasing the risk of abuse (Westbrook, 2011:404; WHO, 2012:5). The belief that a mentally ill person is a lunatic affects service delivery, with the Nigerian Lunacy Ordinance suggested to indirectly facilitate negation of human rights (James, et al., 2011:133; Westbrook, 2011:397). James and colleagues (2011:133) reported that the reaction of Nigerian mental health nurses towards violence has made violence reoccurrence inevitable.

De-escalation is internationally recognised as evidence based psychosocial approach of verbal aggression management (Björkdahl, et al., 2013: 397; Richmond, Berlin, Fishkind, et al., 2012: 17). De-escalation entails the use of verbal and non-verbal clues to prevent the occurrence of violence and curb or reduce the gravity of occurred violence (Björkdahl, et al., 2013:397; Cleary, Hunt, Horsfall, et al., 2012:74; Loewenstein & McManus, 2014:171; Mc Andrew, Chambers, Nolan, et al., 2014:215; Richmond et al., , 2012: 17;). In essence, a 'talking therapy' essential in mental health care settings. De-escalation offers a communication approach that emphasises the expression of understanding and respect for each others' opinion in the face of anger (Richmond, et al., 2012:20). Communication techniques required in de-escalation involve establishing verbal contact and initiating discussion in a friendly rather than accusatory manner (Richmond, et al., 2012:2). The ability to listen carefully, understand the needs of an individual mental health patient and provide suggestions on the way forward is essential to mental health nurses' practice (Arnold & Boggs, 2015:ix; Loewenstein & McManus (2014:171; Richmond, et al., 2012:19). A punitive approach and failure to engage early with de-escalation to prevent aggression progression can trigger further incidences of aggression (Loewenstein & McManus, 2014:171; McAndrew, et al., 2014:216; Moylan & Cullinan, 2011:531). Training of mental health nurses in the use of verbal de-escalation techniques has been embraced throughout Europe and South Africa, but seems to not feature within Nigerian psychiatric hospitals (Westbrook, 2011:403).

Problem statement
Verbal aggression and violence within mental healthcare settings, inclusive of Nigeria, persists (Chukwujekwu , & Stanley, 2011:163; Nelson, 2014:1373; James et al., , 2011:130). Studies related to Nigerian mental health nurses' verbal aggression and violence management practices have emphasized that improvement of practice is essential (Chukwujekwu, & Stanley, 2011:166; James et al., 2011:133). Improvement of mental health nurses' practice is related

not only to the presentation of specialized training, but also mental health nurses' decisions to accept or reject new knowledge (Björkdahl,et al., 2013:396; Mc Andrew, et al., 2014:215).

The purpose of the study
The purpose of this study was to present an intervention strategy to manage verbal aggression and describe the response of Psychiatric hospital based Nigerian mental health nurses.

Methodology and Design
A content analysis qualitative approach, using audio recordings of pre and post intervention focus group discussion to collect data was adopted. The intervention -one oral and visual de-escalation presentation- bisected the pre and post focus group discussion.

The objective for the pre-intervention focus group was to describe psychiatric hospital based Nigerian mental health nurses' current experiences and practices towards verbal aggression and violence management in order to inform relevant application of information within the intervention. Semi-structured questions - How do you manage aggressive psychiatric patients in your unit/ward? How effective has this been? – facilitated narratives of personal experiences and informed clinical application examples used within the oral and visual de-escalation presentation to enhance the presentations' relevance and accessibility. The objective of the post-intervention focus group discussion was to describe psychiatric hospital based Nigerian mental health nurses' responses to the intervention – visual and oral presentation of de-escalation - as an evidence based practice for reducing verbal aggression and averting violent behavior. This second focus group discussion was facilitated by three semi-structured questions - Was the use of de-escalation clear? Could you incorporate it (de-escalation) into your practice? What barriers do you envisage?

One group of eight participants attended both the pre and post intervention focus group discussion, the oral and visual de-escalation presentation, and one confirmation of data meeting.

The intervention - oral and visual de-escalation presentation- was subjected to two forms of content validity: content validity based on a review of current evidence based practice literature, and face validity via presentation to an expert panel. The expert panel composition included; two mental health nurse academics, one advanced clinical specialist mental health nurse and one nurse educator academic who is also a mental health nurse. Written feedback was reviewed by all three researchers and the presentation modified to include local, Sub Saharan African, evidence of the use of de-escalation.

Research setting and positioning the researchers
The researchers sent letters requesting involvement and support for the proposed research to five Nigerian psychiatric hospitals. The research setting was the only psychiatric hospital to respond. The participating hospital, like other Nigerian psychiatric hospitals, has two distinct sections; a main hospital that offers mental health care, and an annex, separated from the main psychiatric hospital by 18 kilometers, that provides forensic mental health care services. The main psychiatric hospital, not the annex, was the research setting for this study.

Within this psychiatric hospital wards are, for the purpose of nursing management, divided into two units. Each unit consists of between two and eight thirty bedded wards. The first unit has an assessment focus, although treatment can and does occur, and includes: , emergency assessment mental health care (one mixed gender thirty bedded ward, and a mixed gender thirty

bedded assessment ward for National Health Insurance Scheme (NHIS) patients. The NHIS patients are people who work for, and are provided with health insurance by, the Nigerian Government. In addition, this unit includes an outpatient assessment department accessed by approximately eighty people per day for follow up care. The second unit focuses on treatment rather than assessment, although assessment is part of the treatment process, and includes; drug addiction care (two thirty bedded wards, one male and one female), and general psychiatric treatment (three male and three female wards each with a bed capacity of thirty). Within these general psychiatric treatment wards one male and one female ward are considered to be long term care. Throughout both units, all wards, child and adolescent mental health care and psychogeriatric mental health care are incorporated within adult mental health care services. ... Each ward has between twenty and twenty five nurses working over three different shifts per day. Bed occupancy is commonly between twenty and twenty five patients per ward. Taking into account absenteeism, leave and administrative roles the nurse patient ratio is usually 1:10 for every shift. Unit managers are mental health nurses who are responsible for all of the wards within their unit. Each ward has a ward manager and a deputy ward manager, both mental health nursing posts. The ward manager liaises directly with the unit manager to facilitate implementation of directives related to service delivery. Typically a total of twenty security officers, all male, are allocated across all wards for the morning shift and to the hospital entrance and exit routes during the other shifts.

The Nigerian researcher completed her undergraduate training in Nigeria, and was placed within the research site hospital as a student nurse, some six years previous to the research. Although some of the participants remembered the Nigerian researcher as a previous student nurse this seemed to reassure them of her ability to relate to their working context rather than hinder their willingness to participate. Both South African researchers have working experience within South African psychiatric hospitals, specifically acute assessment units, and continue to work collaboratively with local psychiatric hospitals to improve mental health care outcomes.

Population and sampling
Invitations to Nigerian stakeholders to participate began in July 2014. As stated above only one psychiatric hospital responded. Purposive sampling, in consultation with hospital nursing management, was used to access the target population; hospital based mental health nurses providing in-patient care at unit and ward management level. Unit and ward managers were targeted due to their position of authority to implement directives in the management of psychiatric care, specifically emergency care responses such as an incident of escalating aggression or violence. Both unit managers and all eleven ward managers were invited to participate (N= 13). Both unit mangers agreed to participate. Due to lack of availability six ward managers agreed to participate, two (2) sending deputy ward managers in their stead. A total of eight participants (n=8) was achieved and included; two (2) unit managers, four (4) ward managers and two (2) deputy ward managers.

Ethical considerations
Final negotiations regarding time, place and potential participants occurred after full ethical approval was granted from the Psychiatric hospital's research ethics committee (31st August, 2015), and the University of KwaZulu-Natal Human and Social Sciences Research Ethics Committee (3rd September, 2015). Data collection commenced on the 5th October 2015. The study held minimal risk for participants, mental health nurses are not considered a vulnerable population in the same way that mental health care users are. However, several ethical considerations were highlighted within the 'participant information sheet'. Firstly, that

complete confidentiality could not be assured due to the group nature of data collection although requests that each participant maintain group confidentiality were made. Secondly, it was acknowledged that participants recounting experiences of violence management or exposure may result in uncomfortable emotional responses and a counselling referral pathway was established with hospital management. This did occur for one participant, who had been a victim of a violent encounter with a mental health care patient two days prior to data collection. This participant was counselled and offered access to the supportive counselling services pathway, but refused stating that the chance to talk within the focus group, and after, was sufficient.

Data collection
Data collection, facilitated by the Nigerian researcher, occurred over two consecutive days, data confirmation occurred on day four. Data collection was facilitated by the Nigerian researcher, to reduce social desirability bias that can occur with 'outsiders'.

As is Nigerian custom, snacks and liquid refreshments were provided at each encounter with the researcher. The pre-intervention focus group discussion followed a non-recorded 'meet and greet' session where the researcher shared details of her own nursing career in Nigeria to build rapport, and confirmed that all participants had received and understood the information sheet before asking participants to sign an informed consent. Once the pre-intervention focus group began audio recording was used and the group lasted one and a half hours. On day two participants received the intervention - an oral presentation, facilitated by the use of power point visuals, on de-escalation as an evidenced based practice for verbal aggression and violence prevention management. This was immediately followed by the post-intervention focus group which lasted one hour. The final meeting on the fourth day confirmed data collection through member checking of written transcriptions of both focus group discussions lasted one and a half hours, approximately 45 mins focused on confirmation of transcribed data and a further 45 minutes retelling stories.

Data analysis
Data analysis followed the content analysis process of Elo and Kyngas (2008:13). The Nigerian researcher transcribed verbatim the pre and post intervention audio recorded focus group discussions. All three researchers independently listened to the audio recordings while simultaneously reading the typed transcript to ensure accuracy. Each researcher independently implemented content analysis of the raw data. A meeting followed of all three researchers and final themes and categories were reduced and reframed.

Measures to ensure trustworthiness
Credibility began with a process to validate the appropriateness, clarity and completeness of the content of the de-escalation intervention presentation. The Nigerian researcher attended a presentation related to the concepts of anger and violence within mental health care at a higher education institution in South Africa. All three researchers, two considered mental health nurse experts, designed the de-escalation intervention presentation before it was presented to the mental health nursing expert panel described previously under methodology and design. The Nigerian researcher kept in daily contact with one South African researcher throughout the data collection process through electronic media of video chat and debriefing was done. In addition, the original audiotapes being provided to both South African researchers, and the process of member checking of the transcribed data facilitated confirmation of the transcribed data and provided proof that data collection occurred.

Dependability of the study data was facilitated by consistent language use. English being the only official language in Nigeria, the pre and post intervention focus group discussions and the presentation of the de-escalation intervention occurred in English. The use of audio recording of the pre and post intervention focus group discussions ensured that the researchers did not misinterpret the participants' own wording. Both South African researchers received copies of the audio recordings, the raw data, and were able to check the dependability of the transcriptions of the pre and post intervention focus group discussion transcribed by the Nigerian researcher. The data analysis process of Elo and Kyngäs (2008, 109) was used by each of the three researchers to independently analyse the raw data. In addition, this completed study was evaluated by two external examiners who were provided with copies of transcribed raw data.

Measures to ensure transferability
Transferring recommendations from this study to other mental health care settings, within and outside Nigeria, will depend on the reader's assessment of the suitability of the study to their context. This is facilitated by rich and thorough descriptions of the study background, research setting, methodology, data collection, sample size, and extracts from raw data (Speziale, Streubert, & Carpenter, 2011:50).

Results
Participants' demographic data
Table 1 provides the participants gender, managerial position within a unit and years of experience.Gender demographics were representative of hospitals statistics where female nurses' accounted for the majority (75%) of ward manager positions, and with 2011 Nigerian national statistics reporting more female nurses than males (www.nursinworldnigeria.com).

Table 1: Demographic characteristics of participants

Participants Gender	Current Unit and / Ward	Management position	Years of service
Female	Unit 1: Assessment	Unit manager	22
Female	Unit 2: Treatment	Unit manager	26
Male	Long-term care ward	Ward manger	30
Female	Female drug addiction ward,	Deputy ward manager	11
Female	Out Patient Clinic within Emergency Assessment ward	Deputy ward manager	15
Female	National Health Insurance Scheme assessment ward	Ward manger	19
Female	Emergency Assessment ward	Ward manager	15
Female	Male drug addiction ward	Ward manager	19

The eight participating nurse managers reported high levels of psychiatric / mental health care nursing experience, from eleven to thirty years. All eight participants had a diploma in general and psychiatric (mental health) nursing. At the time of data collection, one had completed, and seven were pursuing, a Bachelor of Nursing Science degree.

Pre- intervention focus group discussion data
As displayed in table 2, participants' current verbal aggression and violence management experiences and practices generated two themes; betrayal, and power versus powerlessness, each with categories.

Table 2: Pre intervention focus group themes and categories

Themes	Categories
Betrayal	Home – hospital transit Deliberate harm Ineffective response Heightened threat
Power versus powerlessness	Asserting authority through intimidation Questionable practice

The theme of betrayal emerged early in the analysis process, with it and its categories, linked to the second theme of power versus powerlessness and its categories. This link highlighted the influence of personal experience; predominantly fear, on current practices and participants' hopelessness.

Theme 1: Betrayal
Participants stated that the potential for aggression and violence began during the admission process, specifically transportation of the patient from home to hospital, **home–hospital transit,**. Participants emphasised that aggression against professionals was a result of patients' anger at perceived betrayal by families and community members who deceive and restrain the patient to facilitate admission. The 'harsh' measures used by family members to bring the acutely ill patient to the hospital were believed to increase the risk of violence against nurses who are the targets of the patients' anger on admission.

> "Some of them are told they are only going out on a stroll and will find themselves in the hospital"
> "They come very wild because of maltreatment and not because of illness".
> "Some of them come in chains"
> "The patients are brought in tied with a rope like an animal".

The theme of betrayal also manifested in descriptions of participants' belief that patients' deliberately harm nurses. Participants referred to feeling betrayed by mentally ill patients who they were trying to help, their attempts at caring resulting in patients' intention to do them (the nurses) **deliberate harm**.

> "I thought she is my friend, but she rose up and suddenly gave me a heavy slap. She later admitted that her intention was to kill me if not for rescuers"
> "I tried to intervene by settling it, but the patient turned back and held my neck".
> "They (patients) also take the advantage of the size and height of the nurse. Patients find it easier to attack small statured nurses"
> "They attack junior nurses more. Even if bold, they still attack to see how he/she will handle the situation".

Another form of betrayal emerged from participants' responses. This related to betrayal of workers' right to a safe working environment, namely **ineffective response**. Participants

expressed that in cases of escalating aggression they have no means of being rescued other than to shout for help or run away.

> *"I had to shout for attention of other nurses on the ward".*
> *"I had to call for help using intercom".*
> *"Nobody came to help, l was alone and could not shout".*
> *"We had to run away in search of help".*

Help and assistance from hospital structures, including co-workers was presented as unpredictable.

> *"I don't know what happened the doctor holding one of the legs left it. Then the person also holding her other leg also left it and ran away. The patient then stood up and everyone ran away"*
> *"……. a doctor was around and ran out with a promise that he will look for more hands to support me. Chorus group interruption- " Hum! and did he come back?"* Participant *"Hum! Never. He did not come back".*

One participants' narrative highlighted the ineffectiveness of 'alarm or alert and response systems'.

> *"They all came together in group to attack me. Before l know what is going on, the patients just broke the louvers and said he would kill me if l don't open the gate. I immediately called the attendant at the other end of the gate to please open the gate immediately and quickly. But he thought l was joking. Thank God for intercom, so I called one of the consultant that stay in the compound to notify him of the situation of my unit (A21C2a). So he called and order that the gate should be opened, so they all left and he also came later to rescue me. After then, any patient that is admitted in drug unit is made to sign that they will not abscond from the hospital again.'*

And limited maintenance of what has been installed to raise the alarm
> **"We had it, all got spoilt and they never repair".**

Ineffective response was recognized by participants to result in **heightened threat of injury,** including the severity of injuries sustained by nurses.

> *"She made second attempt to slap or strangulate me".*
> *"Patient was angry and came to grab my penis. Then they carried me. The pain was so severe".*
> *"For three days l lost sense of hearing".*
> *"I was so traumatised that l sustained neck injury. I got home and was so traumatised that I could not sleep despite analgesics".*
> *"The nurse was brutally injured and was admitted; afterward she had some off days to rest".*
> *"They have killed many".*

Theme 2: Power versus powerlessness
Participants' perceptions of their own powerlessness and their need to establish power within the clinical environment resulted in the first category of **asserting authority through intimidation.** Intimidating patients, specifically verbally aggressive patients and patients with

a history of violent behaviour, through numerical strength, weight and height was believed to be a violence prevention approach.

> "When they see we are many, they behave themselves".
> "The height and size of the nurse can be intimidating to the patient and will make then l watch their actions".
> "Half of the participants verbally agreed with another participant who stated "If they know you will not take nonsense, they will behave well"
> "Patients are usually scared when there are many nurses who are experienced".

Participants reported that engaging the patient in discussion rather than issuing a warning may present the nurse as 'soft' and easily conquered. Dialogue was rejected by participants' in favour of commands.

> "They also capitalize on the level of firmness and permissiveness of nurses".

This attitude of asserting authority is suggested to lead to descriptions of nursing practice that were categorised as **questionable practice**.

> "Thank God l was proactive, I quickly took the chair and pinned her to the bed with it".
> "I also put on a bold face and remove one of my shoes as if I want to attack her (the patient)"
> "Another method we use is distracting them and covering their head with counterpane".
> "I learnt some developed countries, l believe, have gun to cause temporary paralyses for aggressive patient, also electro-conductive belt, those are the things we need"
> "Recently the hospital started using ex-military men for crisis management, but patients went to court that they were mal-handled and the hospital stopped it. We need it"

The information gleamed from the pre-intervention focus group provided the Nigerian researcher an opportunity to identify the participants' attitudes and practices towards displays of aggression by the psychiatric patients in their setting. This information was used to inform the de-escalation presentation as through video-chat calls the researchers were able to have access to the data gathered and discuss the need for emphasis to be placed on practice benefits of de-escalation.

Post intervention focus group discussion data
As displayed in table 3, participants' comments post the presentation on de-escalation as an intervention were all encapsulated by one theme – that of hopelessness. Comments within the post intervention focus group were again returned tothe data confirmation meeting with specific emphasis on the creation of a crisis team.

Table 3: Post intervention focus group theme and categories

Hopelessness	Heard it before
	Relationship dependent
	Crisis team

Hopelessness, emerged to express participants' responses to the possible implementation of de-escalation as an aggression management strategy. Categories within this theme represented participants substantiation of their rejection of de-escalation

Participants' indicated having heard of de-escalation previous to this intervention and discounted its value to them. In essence, it was mostly perceived as irrelevant to participants' context. This context was reported, and linked to the stages of anger, as almost always involving a patient who is out of control.

> *I was surprised when you talked about the use of restrain and de-escalation in western world because l feel there is a more sophisticated approach they have that you can introduce to us".*
> *"Talking to them does not usually yield positive result in every situation, physical restraint might be needful to prevent possible damage that may arise from aggression".*
> *"We also use de-escalation approach but it does not yield positive results".*
> *"The way their relations behave with them before they bring them is somewhat traumatizing. The way they treat them at home before bringing them is usually annoying and they would have been so upset by maltreatment before bringing them down here that the issue of de-escalation at that time cannot work".*
> *"....but some especially with drug cases, there is nothing you can do to make them calm apart from physical restraint and sedation".*
> *"Thank you for your presentation you were able to compare the traditional approach with the de-escalation approach. The approach is not new to us, but it can only be used on the ward after a relationship has been established with the patient, but not in emergency or assessment that is the entry point of the hospital, in such unit de-escalation cannot work. But on the ward de-escalation and traditional approach has to go hand in hand. The two are effective depending on the situation at hand".*

As illustrated in the last extract, there was acknowledgment that the nurse-patient relationship could mediate the effectiveness of de-escalation. However, the nurse-patient relationship was perceived by participants as requiring time to develop. The possibility of communication strategies used within de-escalation to build rapport with a patient in that moment of verbal aggression was rejected. Participants' responses indicated their belief that the effectiveness of de-escalation was **relationship** dependent

> *".De-escalation may not be possible always is if a nurse that the patient can listen to is not on duty, then what is going to happen? De-escalation technique is possible in ward setting, but it depends on the level of relationship the nurse has built with patients over time".*
> *"It can only be used on the ward after a relationship has been established with the patient".*
> *"A nurse that is closer to a particular patient may find it easier to de-escalate the patient aggression".*

Descriptions of aggressive and violent incidence reported in the first focus group were returned to as justification of de-escalations lack of value. Descriptions suggested that participants perceived themselves as moving from **crisis to crisis** in attempts to combat the re-occurrence of aggression, and prevent injury to self in what is perceived as an uncaring environment.

> *"They have killed many". "So many have sustained injury". "If she had killed me, nothing would have been done".*

Participants wanted a crisis team that would come to their aid. Description seemed to suggest rescue. Participants reminded the researcher of their comments within the pre-intervention session indicating that there was a need for more staff, at least a crisis team to essentially assist with restraint and sedation.

> "Physical restraint might be needful to prevent possible damage that may arise from aggression".
> "She then asked me to narrate the story which I did and she immediately called for the file of six men, who were previously interviewed to serve as crisis intervention team for immediate employment"
> "They employ the crisis intervention team so that they will be readily available to intervene by preventing aggressive patient from harming the nurses or co-patents".

This was reiterated in the confirmation of data group meeting

> "You were able to capture all we said but don't forget the issue of crisis intervention team. You did not mention it. We need them to rescue in case of aggression Chorus answer "Yes". "We really need that".

Discussion of research results

Global movements have highlighted the maltreatment of the mentally ill, in particular those in psychiatric hospitals in low-income counties. (WHO 2012: This called for international development of policies and tool kits (WHO 2012). Despite the WHO (2012:47) introduction of a Quality Rights Tool Kit which gives recognition to the need for a humane approach in in-patient psychiatric settings and the participants' expression of knowing about de-escalation they ' sought a power focused step-up in aggression management,. The participants favored a more militant approach with an expressed desire for the involvement of armed forces to strengthen the capacity for nurses control. This power focused approach that allows for the practice choice of a "traditional approach" is contrary to Bowers (2014) suggestion that for de-escalation to work it requires expressions of empathy and respect which by definition show genuine concern.). This lack of understanding of the de-escalation strategy holds in question the participants' declaration that they 'know de-escalation' and adamant in their belief that it was contextually unsuitable. It illustrates their limited understanding of their conceptualizations of its value, which is in keeping with the findings of Hallett and Dickens (2015:326) where participants (n=72) chose seclusion and medication when de-escalation would have been preferable. . In further examining the participants' choice of a "traditional approach" it is apparent that although occupational status was high, all participants in-charge of wards and from whom direction of command flows to subordinates, yet seems to have not positively influenced perception as suggested by Laker et al. (2014:6). Laker and colleagues , (2014:6) recognized that resistance to change among mental health nurses is context specific, context described as ranging from staff perception, occupational status and job satisfaction, in essence structure standards within a health care context.

A further possible consideration to the rejection of de-escalation might be provided. This is through considering the level of exposure to occupational hazards, injuries sustained from violence, perceived lack of management support and perceived ingratitude of psychiatric patients. The extent of occupation risk is reflected in Yoshizawa et al., (2016:11) Japanese study that reported mental health nurses (n=238) to be prone to occupational hazards that inflict both physical and psychological injury. Yoshizawa and colleagues (2016:11) identified a 37% probability of depression linked to occupational stress; however this could be mitigated

by the provision of support from supervisor – apparently lacking in this study's participants' presentation of a sense of betrayal. Considered within the light of Poggenpoel and Myburgh (2009)'s report that South African mental health nurses consider patients' aggression towards them as a form of ingratitude and a betrayal of their efforts, it is perhaps understandable that within this context a survival attitude of 'us and them' prevails.

What was clear in this study was that the participants' sense of certainty gave no allowance for openness. Gallo and Barlow (2013:101) in examining the literature relevant to the adaption or rejection of evidence based practise in mental health was the failure to recognise the lifelong nature of learning. Participating Nigerian psychiatric nurses expressed feelings of adequacy regarding their method of aggression management , yet contradiction prevailed in their expressed requirements for greater manpower, or enhanced restraint technologies to ensure effective application.

Conclusions and recommendations

The report of this study shows that despite Nigerian nurses being exposed to information on de-escalation with reference to evidence based studies of its effectiveness they are not ready to adopt de-escalation as an approach to aggression management. This is centered around the belief that it has the potential to increase the likelihood of their subjection to violence from the patients and possibly sustaining injury

A necessity exists for the development of an aggression management policy that is aligned with the WHO(2012) rights based approach as opposed to the Mental Ordnance of 1916 that guides current Nigerian nurses' psychiatric practice. Legislation affects the mind-set of people to change (Laker et al., 2014:1) and it is recommended that a change in Nigerian legislation will be core to nurses' investment in change. In addition, further research utilizing a participatory action research approach is strongly recommended. Such an approach will allow the participants to reflect on, understand and respond to a specific context as it pertains to their fear and safety. .

References

Anderson, A., & West, S.G. 2011. Violence against mental health professionals: when the treater becomes the victim. *Innovations in Clinical Neuroscience*, 8(3), 34-39.

Arnold, E.C., & Boggs, K.U. 2015. Interpersonal relationships: Professional communication skills for nurses. (7th ed.). Missouri, U.S.A: Elsevier Health Sciences. ISBN 978-0-323-24281-3.

Bader, S., Evans, S.E., & Welsh, E. 2014. Aggression among psychiatric inpatients The relationship between time, place, victims, and severity ratings. *Journal of the American Psychiatric Nurses Association*, 20(3), 179-186.

Becker, A.E., & Kleinman, A. 2013. Mental health and the global agenda. *New England Journal of Medicine*, 369(1), 66-73.

Björkdahl, A., Hansebo, G., & Palmstierna, T. 2013. The influence of staff training on the violence prevention and management climate in psychiatric inpatient units. *Journal of Psychiatric and Mental Health Nursing*, 20(5), 396-404. DOI: 10.1111/j.1365-2850.2012.01930.x.

Bowers, L. 2014. A model of de-escalation. *Mental Health Practice*, 17(9), 36-37.

Chukwujekwu, D.C., & Stanley, P.C. 2011. Prevalence and correlates of aggression among psychiatric in-patients at Jos University Teaching Hospital. *Nigerian Journal of Clinical Practice*, 14(2), 163-167.

Cleary, M., Hunt, G.E., Horsfall, J., & Deacon, M. 2012. Nurse-patient interaction in acute adult Inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33(2), 66-79. DOI: 10.3109/01612840.2011.622428.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L & Saraceno, B. 2011. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378(9803), 1664-1675.

Elo, S., & Kyngäs, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. DOI: 10.1111/j.1365-2648.2007.04569.x

Gallo, K.P. & Barlow, D.H., 2012. Factors involved in clinician adoption and non -adoption of evidence-based interventions in mental health. *Clinical Psychology: Science and Practice*, 19(1), 93-106.

Hahn, S., Müller, M., Hantikainen, V., Kok, G., Dassen, T., & Halfens, R.J. 2013. Risk factors associated with patient and visitor violence in general hospitals: Results of a multiple regression analysis. International Journal of Nursing Studies, 50(3), 374-385.

Hallett, N. & Dickens, G.L., 2015. De-escalation: A survey of clinical staff in a secure mental health inpatient service. *International Journal of Mental Health Nursing*, 24(4), 324-333.

Jack-Ide, I.O., Uys, L.R., & Middleton, L.E. 2012. A comparative study of mental health services in two African countries: South Africa and Nigeria. *International Journal of Nursing and Midwifery*, 4(4), 50-57.

James, B.O., Isa, E.W., & Oud, N. 2011. Patient aggression in psychiatric services: the experience of a sample of nurses at two psychiatric facilities in Nigeria. *African Journal of Psychiatry*, 14(2), 130-133.

Laker, C., Callard, F., Flach, C., Williams, P., Sayer, J. and Wykes, T., 2014. The challenge of change in acute mental health services: measuring staff perceptions of barriers to change and their relationship to job status and satisfaction using a new measure (VOCALISE). *Implementation Science*, 9(1), 23. DOI:10.1186/1748-5908-9-23

Loewenstein, K., & McManus, M. 2014. 13:"Don't Tell Me to Calm Down!" De-Escalation of the Agitated Patient in a Hospital Setting. Building a Culture of Patient Safety *Through Simulation: An Interprofessional Learning Model*, NewYork, U.S.A: 171. ISBN: 978-0-8261-6007-5.

Mc Andrew, S., Chambers, M., Nolan, F., Thomas, B. and Watts, P. 2014. Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23(3) 212-220. DOI: 10.1111/INM.12044.

.

Maina, W.K., Munguti, N., Mwai, W. G., Butchart, A., & Cannoodt, L. 2013. Estimating the annual incidence of violence related injuries in Kenya: A Derivation from review of hospitalreports in 2007, *Public Health Research*, 3(5), 136-141

Mitchell, A., Ahmed, A., & Szabo, C. 2014. Workplace violence among nurses, why are we still discussing this? Literature review. *Journal of Nursing Education and Practice*, 4(4), 147-150. DOI: 10.5430/jnep.v4n4p147
.

Moylan, L.B., & Cullinan, M. 2011. Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain. *Journal of Psychiatric and Mental Health Nursing*, 18(6), 526-534. DOI: 10.1111/j.1365-2850.2011.01699.x

Nelson, R. 2014. Tackling violence against health-care workers. *The Lancet*, 383(9926), 1373-1374.

Nestor, P.G. 2014. Mental disorder and aggression: personality dimensions and clinical features. *American Journal of Psychiatry*, 59(12), 1973–1978.

Nursing and Midwifery Council of Nigeria NMCN, 2006. Mental health- psychiatric nursing curriculum for Nigeria.

Nursing World Nigeria. Male nurses on the rise and making more money. Retrieved fromhttp://www.nursingworldnigeria.com/2013/02/study-male-nurses-on-the-rise-and-making-more-money . (Accessed 30/11/2015)

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. 2012. The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica*, 125(6), 425-439.

Poggenpoel, M., & Myburgh, C. 2009. The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution. *Curationis*. 32 (3), 4-13

Pompeii, L., Dement, J., Schoenfisch, A., Lavery, A., Souder, M., Smith, C., & Lipscomb, H. 2013. Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence (Type II) on hospital workers: A review of the literature and existing occupational injury data. *Journal of Safety Research*, 44, 57-64.

Rasmussen, C.A., Hogh, A., & Andersen, L.P. 2013. Threats and physical aggression in the workplace: A comparative study of four areas of human service work. *Journal of Interpersonal Aggression*, 28(13), 2749-2769. DOI: 10.1177/0886260513487987.

Richmond, J.S., Berlin, J.S., Fishkind, A.B., Holloman, G.H., Zeller, S.L., Wilson, M. P., & Ng, A. T. 2012. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17-25. DOI: 10.5811/westjem.2011.9.6864

Speziale, H.S., Streubert, H.J., & Carpenter, D.R. 2011. Qualitative research in nursing: Advancing the Humanistic Imperative (5th ed.). China: Lippincott Williams and Wilkins. ISBN 978-0-7817-9600-2

Steinman, S. 2013. Workplace violence in the health sector. Country Case Study: South Africa. Geneva: International Labour Organisation/International Council of Nurses/WHO/Public Services International Joint Programme Working Paper, viewed, 9.

Ukpong, D.I., Owoeye, O., Udofia, O., Abasiubong, F., & Ukpong, S. 2011. Violence against mental health staff: a survey in a Nigerian psychiatric hospital. *The Psychiatrist*, 35(2), 46-49.

Westbrook, A.H. 2011. Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform. Washington University Global Studies Law Review, 10(2), 397-418

World Health Organization 2012. WHO Quality Rights tool kit: assessing and improving quality and human rights in mental health and social care facilities. World health organization, Geneva, Retrieved from: http://apps.who.int/iris/bitstream/10665/70927/3/9789241548410_eng.pdf. (Accessed 05/11/2013).

World Health Organization 2013. Mental health action plan 2013-2020. World Health Organization. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/.(Accessed 15/10/2015).

Yoshizawa, K., Sugawara, N., Yasui-Furukori, N., Danjo, K., Furukori, H., Sato, Y., Tomita, T., Fujii, A., Nakagam, T., Sasaki, M. and Nakamura, K. 2016. Relationship between occupational stress and depression among psychiatric nurses in Japan. *Archives of Environmental and Occupational Health*, 71(1)10-15

6.1. PROOF OF SUBMISSION FOR PUBLICATION

REFERENCES

Adebayo, P. B., Abayomi, O., Johnson, P. O., Oloyede, T., and Oyelekan, A. A. (2013). Breaking bad news in clinical setting-health professionals' experience and perceived competence in southwestern Nigeria: A cross sectional study. *Annals of African Medicine*, *12*(4), 205-211. DOI: 10.4103/1596-3519.122687.

Alhasnawi, S., Sadik, S., Rasheed, M., Broadhead, W. E., Blazer, D. G., and George, L. K. (2012). Judicial involuntary admission under the mental health act in Goa, India: profile, outcome and implications. *Guest Editorial*, *9*(4), 98. ISSN 1749-3676.

Amoo, G., and Fatoye, F. O. (2010). Aggressive behaviour and mental illness: A study of in-patients at Aro Neuropsychiatric Hospital, Abeokuta. *Nigerian Journal of Clinical Practice,* 13(3), 351-355.

Anderson, A., and West, S. G. (2011). Aggression against mental health professionals: When the treater becomes the victim. *Innovations in Clinical Neuroscience,* 8(3), 34-39.

Appelbaum, P. S., Anatchkova, M., Albert, K., Dunn, L. B., and Lidz, C. W. (2012). Therapeutic misconception in research subjects: development and validation of a measure. *Clinical Trials*, *9*(6), 748-761. DOI: 10.1177/1740774512456455.

Arnold, E. C., and Boggs, K. U. (2015). Interpersonal relationships: Professional communication skills for nurses. (7th ed.). Missouri, U.S.A: Elsevier Health Sciences. ISBN 978-0-323-24281-3.

Averill, J. R. (2012). Anger and aggression: An essay on emotion. Springer Science and Business Media. New York, U.S.A: Macmillan publishing.

Bader, S., Evans, S. E., and Welsh, E. (2014). Aggression among psychiatric inpatients: The relationship between time, place, victims, and severity ratings. *Journal of the American Psychiatric Nurses Association*, 20(3), 179-186. DOI: 10.1177/1078390314537377.

Becker, A. E., and Kleinman, A. (2013). Mental health and the global agenda. *New England Journal of Medicine*, 369(1), 66-73. DOI: 10.1056/NEJMra1110827.

Beckley, A. L., Kuja-Halkola, R., Lundholm, L., Långström, N., and Frisell, T. (2014). Association of height and violent criminality: results from a Swedish total population study. *International Journal of Epidemiology,* 43(3), 835-842. DOI: 10.1093/IJE/DYT274.

Beghi, M., Peroni, F., Gabola, P., Rossetti, A., and Cornaggia, C. M. (2013). Prevalence and risk factors for the use of restraint in psychiatry: a systematic review. *Rivista di psichiatria*, 48(1), 10-22.

Berkowitz, L. (2012). A different view of anger: The cognitive-neoassociation conception of the relation of anger to aggression. *Aggressive behavior*, *38*(4), 322-333. DOI: 10.1002/ab.21432.

Björkdahl, A., Hansebo, G., and Palmstierna, T. (2013). The influence of staff training on the aggression prevention and management climate in psychiatric inpatient units. *Journal of Psychiatric and Mental Health Nursing*, 20(5), 396-404. DOI: 10.1111/j.1365-2850.2012.01930.x.

Brink, H., Van der Walt, C., and Van Rensburg, G. (2012). Fundamentals of Research Methodology for Healthcare Professionals (2nd ed.). Cape Town, South Africa: Juta and Company Limited. ISBN 0-7021-6680-4.

Carlson, J. A. (2010). Avoiding traps in member checking. The Qualitative Report, 15(5), 1102-1113. Retrieved from *http://www.nova.edu/ssss/QR/QR15-5/carlson.*pdf (accessed on 23 April, 2014).

Child, R. H., and Mentes, J. C. (2010). Aggression against women: the phenomenon of workplace aggression against nurses. *Issues in Mental Health Nursing*, 31(2), 89-95. DOI: 10.3109/01612840903267638.

Chukwujekwu, D. C., and Stanley, P, C. (2011). Prevalence and correlates of aggression among psychiatric in-patients at Jos University Teaching Hospital. *Nigerian Journal of Clinical Practice*, 14(2), 163-167. DOI: 10.4103/1119-3077.

Cleary, M., Hunt, G. E., Horsfall, J., and Deacon, M. (2012). Nurse-patient interaction in acute adult Inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing,* 33, 66-79. DOI: 10.3109/01612840.2011.622428.

Coban Arguvanli, S., Karataş, N., Başer, M., and Zararsiz, G. (2015). Effect of aggression management training program on knowledge and attitudes of nurses working at psychiatric clinics. *Anatolian Journal of Psychiatry/Anadolu Psikiyatri Dergisi*, *16*(5), *323-328.*

Committee of public Accounts (2003). Health and safety in NHS Acute Hspital Trsuts in England (HC 641, Session 2002-2003). A safer place to work: Protecting NHS hospital and ambulance staff from violence and aggression thirty-ninth Report of Session 001-03.

Corrigan, P. W., Watson, A. C., Warpinski, A. C., and Gracia, G. (2014). Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services*.5 (5), 577-580.

Davis, E. A. (2010). The antisocial profile: deception and intimacy in Greek psychiatry. *Cultural Anthropology*, *25*(1), 130-164. *DOI: 10.1111/j.1548-1360.2009.01054.x*.

DeWall, C. N., Anderson, C. A., and Bushman, B. J. (2011). The general aggression model: theoretical extensions to aggression. *Psychology of Aggression*, 1(3), 245-258. DOI: 10.1037/a0023842.

Donabedian, A. (1988). The quality of care: How can it be assessed? Jama. NewYork, U.SA: Oxford University Press, Inc. 260(12), 1743-1748. ISBN 0-19-515809-1.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., and Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: An unresolved global crisis. The Lancet, 378(9803), 1664-1675. DOI: 10.1016/S0140-6736(11)61270-1.

Elo, S., and Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. DOI: 10.1111/j.1365-2648.2007.04569.x.

Farhat, T., Haynie, D., Summersett-Ringgold, F., Brooks-Russell, A., and Iannotti, R. J. (2015). Weight perceptions, misperceptions, and dating violence victimization among US adolescents. *Journal of Interpersonal Violence*, *30*(9), 1511-1532. DOI: 10.1177/0886260514540804.

Fawole, O. I., Van Wyk, J., and Adejimi, A. (2013). Training on prevention of aggression against women in the medical curriculum at the University of Ibadan, Nigeria. *African Journal of Health Professions Education*, 5(2), 75-79.

Federal ministry of health: List of Nigeria specialty hospital location. Retrieved from *https://www.health.gov.ng/index.php/parastatals/specialty-hospitals*.

Fitzpatrick, J. J. (2014). Quality and Safety in Nursing Education. *Nursing Education Perspectives*, 35(4), 211-211. DOI:10.1111/J.1468-0009.2005.00397.X.

Forster, A. J., and van Walraven, C. (2012). The use of quality indicators to promote accountability in health care: the good, the bad, and the ugly. *Open Medicine*, 6(2), e75.

Franz, S., Zeh, A., Schablon, A., Kuhnert, S., and Nienhaus, A. (2010). Aggression and aggression against health care workers in Germany-a cross sectional retrospective survey. *Bio Medical Central Health Services Research*, 10(1), 51. DOI: 10.1186/1472-6963-10-51.

Gallo, K. P., and Barlow, D. H. (2012). Factors involved in clinician adoption and nonadoption of evidence-based interventions in mental health. *Clinical Psychology: Science and Practice*, *19*(1), 93-106.

Gates, D. M., Gillespie, G. L., and Succop, P. (2011). Aggression against nurses and its impact on stress and productivity. *Nursing Economic*, 29(2), 59-66.

Gray, N. S., Taylor, J., and Snowden, R. J. (2011). Predicting aggression using structured professional judgment in patients with different mental and behavioural disorders. *Psychiatry Research*, 187(1), 248-253. DOI:10.1016/J.PSYCHRES.2010.10.011.

Hahn, S., Müller, M., Hantikainen, V., Kok, G., Dassen, T., and Halfens, R. J. (2013). Risk factors associated with patient and visitor aggression in general hospitals: Results of a multiple regression analysis. *International Journal of Nursing Studies*, 50(3), 374-385.

Hallett, N., and Dickens, G. L. (2015). De-escalation: A survey of clinical staff in a secure mental health inpatient service. *International Journal of Mental Health Nursing*. 24, 324-333.DOI: 10.1111/INM.12136.

Hamric, A. B., Hanson, C. M., Tracy, M. F., and O'Grady, E. T. (2013). Advanced practice nursing: An integrative approach (5th ed.).Missouri, U.S.A: Elsevier Health Sciences. ISBN 978-1-4557-3980-6.

Heger, L., Jung, D., and Wong, W. H. (2012). Organizing for resistance: How group structure impacts the character of violence. *Terrorism and Political Violence*, *24*(5), 743-768. DOI.ORG/10.1080/09546553.2011.642908.

Holloway, I., and Wheeler, S. (2013). Qualitative research in nursing and healthcare (3rd ed.). Southern Gate, United Kingdom: John Wiley and Sons Blackwell Publishing Limited. ISBN 978-1-4051-6122-0.

How to calculate mean value: Math is fun; Central measure on how to find mean value. Retrieved from *https://www.mathsisfun.com/mean.html*.

International Labour Organisation (ILO): International Council of Nurses (ICN); World Health Organisation(WHO); Public Services International (PSI), 2002. World Report on Aggression and Health. WHO, Ginebra. Retrieved from

http://www.who.int/violence_injury.../world_report/en/summary_en.pdf(accessed 5 December, 2013).

Inglis, P., and Clifton, A. (2013). De-escalation: the evidence, policy and practice. *Journal of Intellectual Disabilities and Offending Behaviour*, 4(3/4), 100-108. DOI 10.1108/JIDOB-01-2013-0001.

Inzlicht, M., and Schmeichel, B. J. (2012). What is ego depletion? Toward a mechanistic revision of the resource model of self-control. *Perspectives on Psychological Science*, 7(5), 450-463.

Jack-Ide, I. O., Uys, L. R., and Middleton, L. E. (2012). A comparative study of mental health services in two African countries: South Africa and Nigeria. *International Journal of Nursing and Midwifery*, 4(4), 50-57. DOI: 10.5897/IJNM12.002.

James, B. O., Isa, E. W., and Oud, N. (2011). Patient aggression in psychiatric services: The experience of a sample of nurses at two psychiatric facilities in Nigeria: *African Journal of Psychiatry*, 14(2), 130-133. DOI: 10.4314/AJPSY.V14I2.4.

Jennings, W. G., Piquero, A. R., and Reingle, J. M. (2012). On the overlap between victimization and offending: A review of the literature. *Aggression and Violent Behaviour*, 17(1), 16-26. DOI:10.1016/J.AVB.2011.09.003.

Jonker, E. J., Goossens, P. J. J., Steenhuis, I. H. M., and Oud, N. E. (2008). Patient aggression in clinical psychiatry: Perceptions of psychiatric nurses. *Journal of Psychiatric and Mental Health Nursing*, 15(6), 492-499.

Kitaneh, M., and Hamdan, M. (2012). Workplace aggression against physicians and nurses in Palestinian public hospitals: A cross-sectional study. *Biomedical Central Health Services Research*, 12(1), 469. DOI: 10.1186/1472-6963-12-469.

Kodellas, S., Fisher, B. S., and Wilcox, P. (2015). Situational and dispositional determinants of workplace victimization The effects of routine activities, negative affectivity, and low self-control. *International review of victimology*, *21*(3), 321-342. DOI: 10.1177/0269758015591930.

Koukia, E., Mangoulia, P., Stathopoulos, T., and Madianos, M. (2013). Greek mental health nurses' practices and attitudes in the management of acute cases. *Issues in Mental Health Nursing,* 34(3), 192-197. DOI: 10.3109/01612840.2012.733908.

KwaZulu Natal Department of Health response. (2007). KwaZulu-Natal Treatment Protocols for

Mental Health Disorders. Department of Psychiatry NRMSM UKZN, available at: Retrieved from *http://www.kznhealth.gov.za/townhill/protocol*.pdf (accessed 2 November, 2014).

Laker, C., Callard, F., Flach, C., Williams, P., Sayer, J., and Wykes, T. (2014). The challenge of change in acute mental health services: measuring staff perceptions of barriers to change and their relationship to job status and satisfaction using a new measure (VOCALISE). *Implementation Science*, *9*(1), 23. DOI: 10.1186/1748-5908-9-23.

Large, M. M., and Nielssen, O. (2011). Violence in first-episode psychosis: a systematic review And meta-analysis. *Schizophrenia Research*, *125*(2), 209-220. DOI:10.1016/J.SCHRES.2010.11.026.

Letlape, H. R., Koen, M. P., Coetzee, S. K., and Koen, V. (2014). The exploration of in-service training needs of psychiatric nurses. *Health SA Gesondheid (Online)*, *19*(1), 1-9. DOI:10.4102/HSAG.V19I1.763.

Liu, J., Hou, A. Y., Tian, M., Hu, Z. Z., and Li, K. Q. (2011). A study on the training need for psychiatric nurses of Hebei province on management of aggression and aggression. *Chinese Hospital Management*, 31, 33-35.

Loewenstein, K., and McManus, M. (2014). 13:"Don't Tell Me to Calm Down!" De-Escalation of the Agitated Patient in a Hospital Setting. Building a Culture of Patient Safety Through Simulation: An Interprofessional Learning Model, NewYork, U.S.A: 171. ISBN: 978-0-8261-6007-5.

Maina, W. K., Munguti, N., Mwai, W. G., Butchart, A., and Cannoodt, L. (2013). Estimating the Annual Incidence of Aggression Related Injuries in Kenya: A Derivation from Review of Hospital Reports in 2007, 3(5): 136-141. DOI: 10.5923/j.phr.20130305.05.

Maj, M. (2011). The rights of people with mental disorders: WPA perspective. *The Lancet*, 378(9802), 1534-1535. DOI.ORG/10.1016/S0140-6736 (11)60745-9.

Mcandrew, S., Chambers, M., Nolan, F., Thomas, B. and Watts, P. (2013). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*. DOI: 10.1111/INM.12044.

Mitchell, A., Ahmed, A., and Szabo, C. (2014). Workplace aggression among nurses, why are we still discussing this? Literature review. *Journal of Nursing Education and Practice*, 4(4), 147. DOI: 10.5430/jnep.v4n4p147.

Moon, J. A. (2013). Reflection in learning and professional development: Theory and practice. New York, USA: Routledge Falmer. ISBN 10-07494-3452-X.

Moylan, L. B., and Cullinan, M. (2011). Frequency of assault and severity of injury of psychiatric nurses in relation to the nurses' decision to restrain. *Journal of Psychiatric and Mental Health Nursing*, 18(6), 526-534. DOI: 10.1111/j.1365-2850.2011.01699.x.

Nelson, R. (2014). Tackling aggression against health-care workers. *The Lancet*, 383(9926), 1373-1374.

Nestor, P. G. (2014). Mental disorder and aggression: personality dimensions and clinical features. *American Journal of Psychiatry*, 59(12), 1973–1978.

Nigeria employee compensation act. (2010) Workman compensation act cap. W6 2004, Federal ministry of labour and productivity. *Retrieved from http://www.nassnig.org/document/download/5889.* Pdf (accessed 2 December, 2015).

Nihei, F., Nakano, Y. I., Hayashi, Y., Hung, H. H., and Okada, S. (2014). Predicting influential statements in group discussions using speech and head motion information. In Proceedings of the 16th International Conference on Multimodal Interaction (pp. 136-143). ACM. Retrieved from *https://www.naturalpoint.com/optitrack*. Pdf (accessed 4 June, 2015)

Nursing and Midwifery Council of Nigeria NMCN. (2006). Mental health- psychiatric nursing curriculum for Nigeria. Retrieved from *http:// www.nmcn.gov.ng/portal.nmcnigeria.org*. Pdf (accessed 5 April, 2014).

Nursing World Nigeria. Male nurses on the rise and making more money. Retrieved from *http://www.nursingworldnigeria.com/2013/02/study-male-nurses-on-the-rise-and-making-more-money*.pdf (accessed 30 November, 2015).

Occupational health policy of Nigeria. (2006). Federal ministry of labour and productivity. Retrieved from http://*www.ilo.org/legacy/english/protection/.../cis/.../pnga_mlpid*.pdf (accessed 2 December, 2015).

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., and Bowers, L. (2012). The antecedents of aggression and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica*, 125(6), 425-439. DOI: 10.1111/j.1600-0447.2012.01827.x.

Poggenpoel, M., and Myburgh, C. (2009). The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution. Curationis.

Pompeii, L., Dement, J., Schoenfisch, A., Lavery, A., Souder, M., Smith, C., and Lipscomb, H. (2013). Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated aggression (Type II) on hospital workers: A review of the literature and existing occupational injury data. *Journal of Safety Research*, 44, 57-64. DOI.ORG/10.1016/J.JSR.2012.09.004.

Price, O., and Baker, J. (2012). Key components of de-escalation techniques: A thematic synthesis. *International Journal of Mental Health Nursing*, *21*(4), 310-319. DOI: 10.1111/J.1447-0349.2011.00793.x.

Pulsford, D., Crumpton, A., Baker, A., Wilkins, T., Wright, K., and Duxbury, J. (2013). Aggression in a high secure hospital: Staff and patient attitudes. *Journal of Psychiatric and Mental Health Nursing,* 20(4), 296-304.

Rasmussen, C. A., Hogh, A., and Andersen, L. P. (2013). Threats and Physical Aggression in the Workplace: A comparative study of four areas of human service work. *Journal of Interpersonal Aggression*, 28(13), 2749-2769. DOI: 10.1177/0886260513487987.

Reavley, N. J., Mackinnon, A. J., Morgan, A. J., and Jorm, A. F. (2013). Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community. *Australian and New Zealand Journal of Psychiatry*, 0004867413500351.

Reingle, J. M., Jennings, W. G., Piquero, A. R., and Maldonado-Molina, M. M. (2014). Is aggression bad for your health? An assessment of chronic disease outcomes in a nationally representative sample. *Justice Quarterly*, 31(3), 524-538. DOI.org/10.1080/07418825.

Rice, M. J. (2010). Evidence-based practice problems: form and focus. *Journal of the American Psychiatric nurses Association*, 16(5), 307-314. DOI: 10.1177/1078390310374990.

Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., and Ng, A. T. (2012). Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17-25. DOI: 10.5811/westjem.2011.9.6864.

Rosenfeld, R. M., Shiffman, R. N., and Robertson, P. (2013). Clinical Practice Guideline

Development Manual. A Quality-Driven Approach for Translating Evidence into Action. *American Otolaryngology--Head and Neck Surgery*, 148(1 suppl), S1-S55. DOI: 10.1177/0194599812467004.

Sayapin, S. (2014). Historical Background of the Criminalization of Aggression. In *The Crime of Aggression in International Criminal Law* (pp. 3-73). TMC Asser Press. DOI: 10-1007-978-90-6704-927-6-1.

Shen, J. J., Xu, Y., Staples, S., and Bolstad, A. L. (2014). Using the Interpersonal Skills tool to assess interpersonal skills of internationally educated nurses. *Japan Journal of Nursing Science*, *11*(3), 171-179. DOI:10.1111/JJNS.12018.

Steinman, S. (2013). Workplace aggression in the health sector. Country Case Study: South Africa.Geneva: International Labour Organisation/International Council of Nurses/WHO/Public Services International Joint Programme Working Paper, viewed, 9(1), 1-58.

Stewart, D. W., and Shamdasani, P. N. (2014). Focus groups: Theory and practice (3rd ed.). London, U.K: Sage Publications. ISBN 978-1-4522-7098-2.

Speziale, H. S., Streubert, H. J., and Carpenter, D. R. (2011). Qualitative research in nursing: Advancing the Humanistic Imperative (5th ed.). China: Lippincott Williams and Wilkins. ISBN 978-0-7817-9600-2.

Suter, M., Pihet, S., de Ridder, J., Zimmermann, G., and Stephan, P. (2014). Implicit attitudes and self-concepts towards transgression and aggression: differences between male community and offender adolescents, and associations with psychopathic traits. *Journal of Adolescence*. 37(5), 669-680. DOI.ORG/10.1016/J.ADOLESCENCE.

Swanson, J. W., McGinty, E. E., Fazel, S., and Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of epidemiology*, *25*(5), 366-376. DOI: ORG/10.1016/J.ANNEPIDEM.2014.03.004.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Borum, R., Wagner, H. R., and Burns, B. J. (2014). Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry*. 155:226–231.

Tema, T. R., Poggenpoel, M., and Myburgh, C. P. H. (2011). Experiences of psychiatric nurses exposed to hostility from patients in a forensic ward. *Journal of Nursing Management*, 19(7), 915-924. DOI: 10.1111/j.1365-2834.2011.01304.x.

Thibeault, C. A., Trudeau, K., D'entremont, M. and Brown, T. (2010). Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. *Archives of psychiatric nursing*, 24, 216-226.

Thomas, E., and Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Paediatric Nursing*, 16(2), 151-155.

UKCC. (2002). The Recognition, prevention and therapeutic management of aggression in mental health care. United Kingdom central council for nursing, midwifery and health visiting: Report prepared for the UKCC. Retrieved from http://*www.teamteach-tutors.co.uk/guidance/documents/Nursing_violence.*pdf(acces*sed* 10 August, 2015).

Ünsal Atan, Ş., Baysan Arabaci, L., Sirin, A., Isler, A., Donmez, S., Unsal Guler, M., and Tasbasi, F. (2013). Violence experienced by nurses at six university hospitals in Turkey. *Journal of Psychiatric and Mental Health Nursing*, *20*(10), 882-889.

Ukpong, D. I., Owoeye, O., Udofia, O., Abasiubong, F., and Ukpong, S. (2011). Aggression against mental health staff: a survey in a Nigerian psychiatric hospital. *The Psychiatrist*, 35(2), 46-49. DOI: 10.1192/PB.BP.110.030098.

Vaidyanathan, U., Patrick, C. J., and Iacono, W. G. (2011). Patterns of comorbidity among mental disorders: a person-centered approach. *Comprehensive psychiatry*, *52*(5), 527-535. DOI:10.1016/J.COMPPSYCH.2010.10.006.

Van Dorn, R., Volavka, J., and Johnson, N. (2012). Mental disorder and aggression: Is there a relationship beyond substance use? *Social Psychiatry and Psychiatric Epidemiology*, 47(3), 487-503. DOI 10.1007/s00127-011-0356-x.

Van Offenbeek, M., Boonstra, A., and Seo, D. (2013). Towards integrating acceptance and resistance research: evidence from a telecare case study. *European Journal of Information Systems*, *22*(4), 434-454. DOI:10.1057/EJIS.2012.29.

Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., and Kivimäki, M. (2011). Overcrowding in psychiatric wards and physical assaults on staff: data-linked longitudinal study. *The British Journal of Psychiatry*, 198(2), 149-155. DOI: 10.1192/BJP.BP.110.082388.

Vives-Cases, C., Ruiz-Cantero, M. T., Escribà-Agüir, V., and Miralles, J. J. (2011). The effect of intimate partner aggression and other forms of aggression against women on health. *Journal of Public Health*, 33(1), 15-21. DOI:10.1093/PUBMED/FDQ101.

Volavka, J., and Swanson, J. (2010). Violent behaviour in mental illness: the role of substance abuse. *The Journal of American Medical Association*, 304(5), 563-564.

Westbrook, A. H. (2011). Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform. Wash. U. Global Stud. L. Rev., 10, 397.

Wilson, C. B. (2013). Quality improvement by promoting relationships in care environments: The Price model. *International Journal of Integrated Care*, 13(8).

World Health Organization. (2002).Guide to United Nations resources and activities for the prevention of interpersonal aggression (WHO/NMH/VIP/02.05). (4th ed.). Geneva. Retrieved from http://*www.who.int/violence_injury_prevention/media/en/633.*pdf (accessed 16 March, 2014). ISBN 92 4 159027 0.

World Health Organization. (2006). Gender equality, work and health: A review of the evidence. Retrieved from http://*www.who.int/gender/documents/Genderworkhealth.*pdf (accessed 3 December, 2015). ISBN 92 4 159353 9.

World Health Organization. (2012). WHO Quality Rights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Retrieved from http://*www. who. Int/iris/bitstream/10665/70927/3/9789241548410_eng.* pdf (accessed 5 November, 2013). ISBN 978 92 4 154841 0.

World Health Organization. (2013). Mental health action plan 2013-2020. World Health Organization. Retrieved from *http://www.who.int/mental_health/publications/action_plan/en/.* Pdf (accessed 5 March, 2014). ISBN 978 92 4 150602 1.

Yang, L. Q., Spector, P. E., Chang, C. H. D., Gallant-Roman, M., and Powell, J. (2012). Psychosocial precursors and physical consequences of workplace aggression towards nurses: A longitudinal examination with naturally occurring groups in hospital settings. *International Journal of Nursing Studies*, 49(9), 1091-1102. DOI.ORG/10.1016/J.IJNURSTU.2012.03.006.

Yao, X., Li, Z., Arthur, D., Hu, L., and Cheng, G. (2014). Validation of the Aggression Risk Screening 10 instrument among clients discharged from a psychiatric hospital in Beijing. *International Journal of Mental Health Nursing*, 23(1), 79-87. DOI: 10.1111/J.1447-0349.2012.00890.X.

Yoshizawa, K., Sugawara, N., Yasui-Furukori, N., Danjo, K., Furukori, H., Sato, Y., and

Nakamura, K. (2014). Relationship between occupational stress and depression among psychiatric nurses in Japan. *Archives of Environmental and Occupational Health,* 1-7, 00-00. DOI.ORG/10.1080/19338244.2014.927345.

Zoëga, S., Gunnarsdottir, S., Wilson, M. E., and Gordon, D. B. (2014). Quality pain management in adult hospitalized patients: A concept evaluation. *In Nursing Forum*. DOI: 10.1111/nuf.1208.

Zuzelo, P. R., Curran, S. S., and Zeserman, M. A. (2012). Registered Nurses' and Behavior Health Associates' Responses to Violent Inpatient Interactions on Behavioral Health Units. *Journal of the American Psychiatric Nurses Association*, *18*(2), 112-126. DOI: 10.1177/1078390312438553.

APPENDICES

Appendix 1: Information sheet

Research topic: A description of psychiatric nurses responses to de-escalation as a strategy for management of psychiatric patient aggression in a South West Nigerian psychiatric hospital.

I, Oyeyemi Oyelade, a master of Mental Health nursing student from the University of KwaZulu-Natal South Africa, am conducting a study on exploring aggression and violence within a Nigerian psychiatric hospital. Specifically psychiatric nurses' (PNs) input on their experiences and thoughts about current practices, and suitability of other recommended aggression and violence management practices is being sought. I would like to invite you to voluntarily participate in discussions based on your experience.

Your voluntary participation will be highly appreciated. Participation involves a time commitment, which is on duty time. This will require 1-2hours per day for the three days. The first two afternoons will follow consecutively and then a week later the third afternoon meeting will take place. Day, time and venue, will be based on most suitable allowance for on duty participation as requested in the permission to conduct study. The three part interaction will involve two discussion groups on aggression management as well as exposure to an intervention strategy for aggression. Your involvement will be highly appreciated as alternate nursing strategies for aggression are to be considered.

Your confidentiality and anonymity will be maintained through: Neither your name nor the name of your hospital will appear on any documentation or any publication that may arise from the research study. Participants will also be asked to keep comments confidential but the researcher cannot ensure confidentiality of content within the focus group interviews

The sessions will be tape recorded, but all recordings and transcriptions will remain with the researcher and stored in the confidential custody of the research supervisor's office for duration of the study. After scanning, written copies of transcripts will be destroyed by fire and tapes will be stored in the researcher supervisor's office for a period of five years according to UKZN policy. You have time to think about participating and asking me, my supervisor, co-supervisor or the UKZN HSS ethics committee any questions. The contacts are provided below. After you have decided to participate you will be required to complete the informed consent form. There are no

forseen physical risks. However, respect for each person's opinion is advocated in order to avoid social risk. Reflection might arise the need for psychological referral – the voluntary access thereof will be available for you at no cost. Referral for counselling within the hospital pathway will be done based on the preference of the participant. At any stage of data collection, you have the right to decline to continue with the study without any prejudice or sanction.

With much appreciation l wish to say thank you for your attention. For further question or further clarification, provided below are the details of the researcher and that of the supervisors and ethical committee of the University of KwaZulu-Natal, South Africa.

Oyeyemi Oyelade (Researcher)
Phone number: +27784196523 (South Africa)
Email address: 213568603@stu.ukzn.ac.za

Ms Amanda Smith (Supervisor)
Email address: Smitha1@ukzn.ac.za
Phone number: +27(03)12603578

Mrs Ann Jarvis (Co-supervisor)
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4000
KwaZulu-Natal, South Africa
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Appendix 2: Consent affirmation by research participant

In regards to the information l have received in relation to the study and implication of my participation and clarification of my queries with full explanation from the researcher and clear understanding l have attained about the study and my willingness to participate.
Please tick the relevant box.

	Yes	**No**

I declare that:

I have received detailed information about my voluntary participation in the research. ☐ ☐

I willingly giving my consent to participate in this study in on duty time. ☐ ☐

I have been assured of freedom to withdraw my consent to
participate at any stage in this study without
any sanction either physical or psychological. ☐ ☐

I am aware of the audio recording/ focus group discussion. ☐ ☐

I am aware that in the process of discussion and reflection should the need for counselling be revealed I have an opportunity to receive this at no cost to me and will be provided with the opportunity to be referred. ☐ ☐

Please do not include name signature alone is required

Participant's signature: _____

Date and Time: _____

Researcher's signature: _____

Date and Time: _____

Appendix 3: First focus group semi structured questions

    A. Please describe how you manage aggressive psychiatric patients in your unit?

    B. Please explain how effective your mode of aggression management appears to have been?

Appendix 4: Second focus group semi structured questions

A. Please explain what you understand by de-escalation techniques of aggression management?

B. What do you see in your opinion the possibility of incorporating this method into your practice of violence management in your unit?

C. What barriers do you envisage in your unit with regards to the implementation of de-escalation?

Thank you for participating in this research.

Appendix 5: Letter of request for gate keepers' permission

College of health sciences

School of Nursing and Public Health

Howard College Campus

Durban, South Africa

22nd August, 2014.

The Chief Medical Director,

Through; Director of Nursing Services,

Neuropsychiatric hospital,

Aro, Abeokuta,

Nigeria.

Dear Sir/Madam,

RE: Gate Keeper permission to collect data

l, Oyeyemi Oyelade, am a Nigerian who is currently studying the Masters of Nursing, Mental Health Nursing, at the University of KwaZulu-Natal, South Africa. As part of my studies I am required to complete a research project. My proposed project title is *A description of Nigerian nurses attitudes to the management of the aggressive psychiatric patient and their perceptions of the value of new evidence based interventions.*

In order to implement this project, gather data, I will need access to approximately ten (10) nurses, currently working within a psychiatric hospital, who would be prepared and able to participate in individual interviews and three half day workshops. I am writing to elicit the possibility of including your institution in the project, before I finalise my research proposal and submit for ethical approval.

Your participation in essence would mean that you would

- Allow me access to nursing staff employed within your hospital
- Give permission for a selected 10 nursing staff to attend the 3 half day groups (the first two will occur consecutively and the third a week later)
- Provide me with   a suitable room on the hospital premises to conduct the groups.

Your participation, and those of the 10 nurses, would be anonymous. The name of the institution and the participating nurses would not appear in the final dissertation not the publication within a peer reviewed journal that would follow.

I hope for your support and look forward to hearing from you.

Should you have any questions of concerns please contact me or my research supervisor. Contact information is provided below.

Thank you.

Yours faithfully

Oyeyemi Oyelade RN, RPN, BSc (O.A.U)

Research supervisor	Ms. A.A.H Smith (Mandy)	Smitha1@ukzn.a.za
Research co-supervisor	Mrs. M.A. Jarvis (Ann)	Jarvism@ukzn.ac.za
Researcher: Student	Oyeyemi Oyelade	yemilad13@gmail.com
	Student number	(213568603)

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School of Nursing and Public Health

Howard College Campus

Durban, South Africa

22nd August, 2014.

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School of Nursing and Public Health

Howard College Campus

Durban, South Africa

22nd August, 2014.

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Ile-ife, Osun-state.

Nigeria.

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Researcher: Student   Oyeyemi Oyelade   yemilad13@gmail.com
                          Student number   (213568603)

Appendix 6: Gate keeper's permission

NEUROPSYCHIATRIC HOSPITAL, ARO, ABEOKUTA

Provost & Medical Director: **DR. A. O. AKINHANMI**
MB. Ch. B. (Ife), MPsych Med., FWACP

Director of Clinical Services: **DR. T. O. ADEBOWALE**
MBBS (Lagos), D. Psych. (UK), FWACP

Director of Research & Training: **DR. G. AMOO**
MD (Czech), FWACP

P.M.B. 2002 Abeokuta,
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Ref. No   DRT/REF/Vol.1/15   Date 4th October, 2014

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MBBS (Unilag),
FWACP

Oyeyemi Oyelade,
c/o Pastor A. O. Ogbebor,
Mount Zion Christian Faith Assembly,
Neuropsychiatric Hospital,
Aro, Abeokuta.

Dear Oyeyemi Oyelade,

RE: GATE KEEPER PERMISSION TO COLLECT DATA

1) Thanks very much for your letter dated 26th September 2014 on the above subject matter.

2) On behalf of the management of the Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria, I appreciate you for choosing our facilities for your study.

3) After extensive deliberations, it is resolved that:

  (i) The Neuropsychiatric Hospital, Aro, Abeokuta can be included in the project subject to ethical clearance by the Research Ethics Committee of the Hospital (Neuropsychiatric Hospital Aro Research Ethics Committee – NPHAREC).

  (ii) A complete protocol has to be presented to the NPHAREC for ethical consideration since you will be dealing with human subjects (biomedical research).

  (iii) The protocol must include among other things: Introduction/definition of research problem, rationale for the study, aims and objectives, research methodology: study setting, study design, procedure, ethical considerations; data analysis, literature review, reference and appendix.

  (iv) The hospital will be prepared to give all necessary support to make a success of the research work.

4) I am seizing this opportunity to call for fruitful years of collaboration with your University – The University of Kwazulu-Natal, South Africa.

I wish you success in the project.
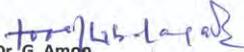
Dr. G. Amoo
DRT & Chairman NPHAREC

Appendix 7: Consultation through emailed communication

File Edit View History Bookmarks Tools Help

News | Afri... | de-escalati... | http...ebdd1 | Strategies for N... | Key comp... | Download... | Install Add... | Success | effective d... | De-escalati... | M Letter t... | Google Cal... | +

https://mail.google.com/mail/u/0/?tab=wm#search/arochapel%40yahoo.com/148175c0f20395c2

Google | arochapel@yahoo.com

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Gmail ▾ | 4 of 4

COMPOSE

Inbox (167)
Starred
Important
Sent Mail
Drafts (125)
Circles
More ▾

Warm regards

W letter for Yomi to ...

What's New

Service Center

Add to circles

Show details

Service Center <arochapel@yahoo.com>   9/9/14

to me ▾

Beloved,I have read through your letter and made a slight adjustment to it. I had submitted it at our Provost & Medical Director's office today and I will personally follow it up and as soon as I get his reply,I will get it across to you by the grace of God. Please,see adjustment included. Greetings from mummy and brethren here. Remain rapturable in Jesus name. Amen. Shalom.

Your Pastor,
A.O Ogbebor

Google

arochapel@yahoo.com

+Oyeyemi

Click here to enable desktop notifications for Gmail. Learn more Hide

Gmail ▾

Move to Inbox   More ▾

2 of 4

COMPOSE

Inbox (167)
Starred
Important
Sent Mail
Drafts (125)
▸ Circles
More ▾

Oyeyemi Oyelade <yemilad13@gmail.com>   10/16/14
to Service

Dear Sir,

I am very grateful to God for His grace I am enjoying in you.
I am amazed by how God has used you to help me.
Some people have to fly to Nigeria before being able to achieve.
But you supported me whole heatedly despite your busy schedule.
My God will reward you sir.
It is a privilege to be in the fold of Christ and that is what I am
enjoying even here.

Thank you very much sir. I am so grateful. My regards to Mummy and
family of Christ in general.
Your daughter in Christ.
Yemi

Amanda Smith <Smitha1@ukzn.ac.za>   10/16/14
to me

Hoe wonderful :)
Regards
MAndy

What's New

People (3)

Service Center

Add to circles

Show details

Appendix 8: Verification of content validity questionnaire and responses

Thank you for agreeing to assist with evaluating the content validity of this presentation

The presentation you are about to see is scheduled for presentation to a group of psychiatric nurses in Nigeria. The purpose of this presentation in Nigeria is to facilitate discussion about the possible implementation of de-escalation in the management of aggression.

To gain input on the content validity of the presentation we have asked you to listen and then provide your honest opinion on the following questions related to the presentation.

Please tick the answer that best suits your response and write clearly and briefly additional comments.

1. Was the presenter audible?

Yes	No

2. Did the evidence for why de-escalation should be used interest you and motivate you to pay attention to the rest of the presentation

Yes	No

3. Was the content on **How to do** de-escalation clear?

Yes	No

If not briefly tell us what aspects were unclear?

_____

4. Was the information on **How to do** de-escalation comprehensive enough to guide practice?

Yes	No

If not briefly state content you think should be included

_____

_____

Could you implement de-escalation tomorrow with the information

you have been given today?

Yes	No

Thank you for agreeing to assist with evaluating the content validity of this presentation

The presentation you are about to see is schedule for presentation to a group of psychiatric nurses in Nigeria. The purpose of this presentation in Nigeria is to facilitate discussion about the possible implementation of de-escalation in the management of aggression.

To gain input on the content validity of the presentation we have asked you to listen and then provide your honest opinion on the following questions related to the presentation.

Please tick the answer that best suits your response and write clearly and briefly additional comments.

1. Was the presenter audible?

Yes	No
X	

2. Did the evidence for why de-escalation should be used interest you and motivate you to pay attention to the rest of the presentation

Yes	No
	X

3. Was the content on **How to do** de-escalation clear?

Yes	No
X	

If not briefly tell us what aspects were unclear? _See reverse for minor_
_____

4. Was the information on **How to do** de-escalation comprehensive enough to guide practice?

Yes	No
X	

If no briefly state content you think should be included

Content was clear. Suggest summary slide of 10 domains See reverse for comments ✓
_____

5. Could you implement de-escalation tomorrow with the information you have been given today?

Yes	No
X	

1. Slowed when present - might allow for re-engagement

2. Project voice more at beginning. Improves as progesses. ✓

3. Familiarise self with topic - reading +, off slide

4. Need slide to summarily say it works + then go into studies

5. 10+ minutes promoting thru studies - needed to be more gripping

6. ✓ involvement exercise
   - ? on seperate slide

7. Non- verbal cue - this slide - "come for meal"
   verbal cue - ? "laughter"

8. ✓ Start de-escalation with 10 domains in summary - guide of where going ✓

   Domain VIII - "arm self" + charge to harm ✓

9. ✓ refer back to slide with examples
   - good re-inforcement
   ✓ link with "normality" of response

   Can pull points together - with us commonality was being lied to - help audience to make it personal to their practice + draw examples

Thank you for agreeing to assist with evaluating the content validity of this presentation

The presentation you are about to see is schedule for presentation to a group of psychiatric nurses in Nigeria. The purpose of this presentation in Nigeria is to facilitate discussion about the possible implementation of de-escalation in the management of aggression.

To gain input on the content validity of the presentation we have asked you to listen and then provide your honest opinion on the following questions related to the presentation.

Please tick the answer that best suits your response and write clearly and briefly additional comments.

1. Was the presenter audible?

Yes	No
X	

2. Did the evidence for why de-escalation should be used interest you and motivate you to pay attention to the rest of the presentation

Yes	No
X	

3. Was the content on **How to do** de-escalation clear?

Yes	No
X	

If not briefly tell us what aspects were unclear? _However, some of the questions in Domain IX were not clear._ _____

4. Was the information on **How to do** de-escalation comprehensive enough to guide practice?

Yes	No
X	

If no briefly state content you think should be included

_____
_____
_____
_____

5. Could you implement de-escalation tomorrow with the information you have been given today?

Yes	No
X	

1

— different font size. be careful ✓

This APP. IS
ALIEN to Nurses?

Domain 3.

Domain 8   arm / harm — spelling error ✓
       9
✗ "use" open ended or will you like to take a
walk with me. (not really phrased correctly)

Oyeyemi Oyelade

Thank you for agreeing to assist with evaluating the content validity of this presentation

The presentation you are about to see is schedule for presentation to a group of psychiatric nurses in Nigeria. The purpose of this presentation in Nigeria is to facilitate discussion about the possible implementation of de-escalation in the management of aggression.

To gain input on the content validity of the presentation we have asked you to listen and then provide your honest opinion on the following questions related to the presentation.

Please tick the answer that best suits your response and write clearly and briefly additional comments.

1. Was the presenter audible?

Yes	No
✓	

with increased level of concentration due to pronunciation

2. Did the evidence for why de-escalation should be used interest you and motivate you to pay attention to the rest of the presentation

Yes	No
✓	

I would recommend inclusion of the data/information of the hospitals in Africa that are using de-escalation

3. Was the content on **How to do** de-escalation clear?

Yes	No
✓	

✱ If not briefly tell us what aspects were unclear?___ *However inclusion of calming exercises*_____

_____

on escalators

Involving audience to reflect was excellent, however more literature of patient escalators would make presentation more interesting.

4. Was the information on **How to do** de-escalation comprehensive enough to guide practice?

Yes	No
✓	

If no briefly state content you think should be included

_____

_____

_____

_____

5. Could you implement de-escalation tomorrow with the information you have been given today?

Yes	No
✓	

1

Appendix 9: Power point slides for presentation of information on de-escalation techniques

Presentation on De-escalation techniques to a group of psychiatric nurses in South West Nigeria

Oyeyemi Oyelade
Masters student (mental health)
UKZN
South Africa.

Introduction

Violence means an action or intention suggestive of physical force / aggression, directed to perpetrate physical or psychological harm (WHO, 2002)

It is usually perpetrated in mental health care setting and nurses are the most-vulnerable (Anderson and West, 2011; Campbell, Messing, Kub et al., 2011; Hahn, Müller, Hantikainen et al., 2012; Pompeii, Dement, Schoenfisch et al, 2013).

Studies on violence in mental health care shows that although it may be inevitable IT CAN BE managed effectively (Franz et al, 2010; Virtanen, Vahtera, Batty et al., 2011; Papadopoulos, Ross, Stewart et al., 2012; Mitchell Ahmed and Stadio et al., 2014)

A Schematic representation for the management of Aggression and Violence

Anger - Increasing anxiety and agitation
Challenge level Includes; outward signs of anger and verbal aggression
Crisis level equals a loss of control and can lead to physical violence

De-escalation → Rapid Tranquilization

Debriefing   Mechanical restraint/Seclusion

What is De-escalation?

➢ "A gradual resolution of a potentially violent and/or aggressive situation
➢ through the use of verbal and physical expressions of empathy
➢ through alliance and non-confrontational limit setting
➢ that is based on respect" Cowin and colleagues (2003, pg.65).

Objectives of De-escalation

1. Ensure the safety of the patient, staff, and others in the area. Because, we are experiencing an increasing rate of violence in clinical setting (Hahn, 2012).
2. Help the patient manage his emotions, distress, and maintain or regain control of his behaviour. Reason being, evidence from research pointing to the centrality of de-escalation to violence management and practical evidence of its effectiveness of the approach (Price and Baker, 2012; Bowe, Evans, Lakes et al., 2013).

Objectives of De-escalation

3. Avoid coercive interventions that escalate agitation like threatening to sedate or restrain. substitute to the incessant use of restraint and reduces incidence of physical injuries (Cole, 2014).

105

Why De-escalation is preferred to traditional approach

4reasons why De-escalation is preferred to traditional approach

1. When staff members physically intervene to subdue a patient, it tends to reinforce the patient's idea that violence is necessary to resolve conflict.

2. Patients who are put in restraints have tendency of subsequent or opportunistic aggression and are more likely to have longer duration of hospitalisation.

4reasons why De-escalation is preferred to traditional approach

3. The Joint Commission and the Centres for Medicare and Medicaid Services consider low restraint rates a key quality care indicator in psychiatric setting.

4. Staff and patients are less likely to get hurt when physical confrontation is averted(Richmond et al., 2012).

Evidence for De-escalation

1980 = Gertz conducted a two day violence de-escalation training in an American mental health care setting for 317 staff and achieve 33% violence incidence reduction within two years.

1983 = Lehmann and colleagues delivered a five hour lecture to 144 staff which was reported to have reduced acceleration of violence incidence.

1990 = Goddykoontz and Herrick implemented a four month de-escalation training program for 27 psychiatric nurses and reported evidence of fewer injuries amongst this group.

Evidence for De-escalation

U.K statistics of violence in mental health care settings
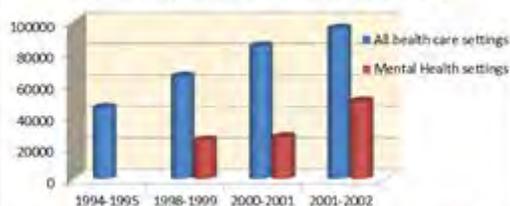
(Wells and Bowers, 2002; Committee of Public Accounts, 2003; Winstanley and Whittington, 2004)

Evidence for De-escalation

2002 = UK introduced and intensified psychiatric hospital staff de-escalation training programs after other strategies failed to achieve a 20% reduction in violence rate by 2001 (Committee of Public Accounts, 2003; Inglis and Clifton, 2013).

This change in attitude can be mapped from 1994 negative attitudes reported by Collins to full support and integration of the strategies by psychiatric nurses as reported by Duxbury and Whittington (2005).

De-escalation techniques

- Step I: Determine level of control and respect personal space
- Step II: Do not be provocative in non-verbal or verbal response
- Step III: Establish verbal contact
- Step IV: Maintain self-control and calmness (respect human right)
- Step V: Identify wants and feelings

De-escalation techniques

- Step VI: Listen closely to what the patient is saying
- Step VII: Agree or agree to disagree
- Step VIII: Set clear limits
- Step IX: Offer choices and optimism
- Step X: Debrief the patient and staff

The End.

References

- Beech, B., and Leather, P. (2006). Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behavior*, 11(1), 27-43.

- Cole, R. (2014). Reducing Restraint Use in a Trauma Center Emergency Room. *Nursing Clinics of North America*, 49(3), 371-381.

Reference

- Collins, J. (1994). Nurses' attitudes towards aggressive behaviour, following attendance at 'The Prevention and Management of Aggressive Behaviour Programme'. *Journal of Advanced Nursing*, 20(1), 117-131.

- Committee of Public Accounts (2003). Health and Safety in NHS Acute Hospital Trusts in England (HC 641, Session 2002–2003) A safer place to work: Protecting NHS hospital and ambulance staff from violence and aggression thirty-ninth Report of Session 2002–03.

References

- Duxbury, J., and Whittington, R. (2005). Causes and management of patient aggression and violence: staff and patient perspectives. *Journal of Advanced Nursing*, 50(5), 469-478.

- Gertz, B. (1980). Training for prevention of assaultive behaviour in a psychiatric setting. *Psychiatric Services*, 31(9), 628-630.

References

- Hardin, D. (2012). Strategies for nurse leaders to address aggressive and violent events. *Journal of Nursing Administration, 42*(1), 5-8.

- Inglis, P., and Clifton, A. (2013). De-escalation: the evidence, policy and practice. *Journal of Intellectual Disabilities and Offending Behaviour, 4*(3/4), 100-108.

References

- Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., and Allen, D. (2003). Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing, 10*(1), 3-15.

- Price, O., and Baker, J. (2012). Key components of de-escalation techniques: A thematic synthesis. *International Journal of Mental Health Nursing, 21*(4), 310-319.

References

- Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., and Ng, A. T. (2012). Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine, 13*(1).

References

- Rose, D., Evans, J., Laker, C., and Wykes, T. (2013). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, 1-7.

- Wells, J., and Bowers, L. (2002). How prevalent is violence towards nurses working in general hospitals in the UK?. *Journal of Advanced Nursing, 39*(3), 230-240.

References

- Winstanley, S., and Whittington, R. (2004). Aggression towards health care staff in a UK general hospital: variation among professions and departments. *Journal of Clinical Nursing, 13*(1), 3-10.

- World Health Organization, (2002). Guide to United Nations resources and activities for the prevention of interpersonal violence (WHO/NMH/VIP/02.05). Geneva.

Appendix 10: Research ethics certificates

Certificate 1

Zertifikat **Certificat** **Certificado** **Certificate**

TRREE

Clinical Trials Centre — The University of Hong Kong

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Mary Ann Jarvis

a complété avec succès - has successfully completed

Introduction to Research

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

September 18, 2014
CID : DysbbrGeF

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

Certificate 2

Zertifikat **Certificat** **Certificado** **Certificate**

TRREE

Clinical Trials Centre — The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Mary Ann Jarvis

a complété avec succès - has successfully completed

Informed Consent

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

September 18, 2014
CID : Rah6X18gWD

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

FMH — Continuing Education Program (5 Credits) / Programmé de Formation Continue (5 Crédits)

FPH — Programme de formation continue

Ce programme est soutenu par - This program is supported by :

Certificate 3

Zertifikat **Certificat** **Certificado** **Certificate**

TRREE

Clinical Trials Centre — The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Mary Ann Jarvis

a complété avec succès - has successfully completed

Good Clinical Practice (GCP)

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

September 18th, 2014
CID : gz8Qhq8S4

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

FMH — Continuing Education Program / Programme de Formation Continue

FPH — Programme de formation continue

GCP training program for investigator recognized by Swissmedic / Programme de formation GCP pour investigateur reconnu par Swissmedic

Ce programme est soutenu par - This program is supported by :

European and Developing Countries Clinical Trials Partnership (EDCTP) (www.edctp.org) - Swiss National Science Foundation (www.snf.ch) - Canadian Institutes of Health Research (http://www.cihr-irsc.gc.ca/e/2891.html) -

Certificate 4

Zertifikat **Certificat** **Certificado** **Certificate**

TRREE

Clinical Trials Centre — The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Mary Ann Jarvis

a complété avec succès - has successfully completed

Research Ethics Evaluation

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

September 18, 2014
CID : Hnpa54l1fa

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

FMH — Continuing Education Program (5 Credits) / Programmé de Formation Continue (5 Crédits)

FPH — Programme de formation continue

Ce programme est soutenu par - This program is supported by :

Zertifikat
Certificat
Certificado
Certificate

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Amanda Smith

a complété avec succès - has successfully completed

Good Clinical Practice (GCP)

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

April 29th, 2014

Professor Dominique Sprumont
Coordinator TRREE Consortium

Appendix 11: Ethical approvals

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

3 September 2015

Ms Oyeyemi Olajumoke Oyelade 213568603
School of Nursing and Public Health
Howard College Campus

Dear Ms Oyelade

Protocol reference number: HSS/0454/015M
Project title: Attitude of psychiatic Nurses to de-escalation as a strategy for management of psychiatric patient aggression in a South West Nigerian Psychiatric Hospital

Full Approval – Expedited Application

In response to your application received on 8 May 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully
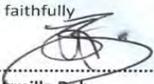
....
Prof Urmilla Bob
University Dean of Research
On behalf of Dr Shenuka Singh (Chair)

/pm

Cc Supervisor: Ms Amanda Smith & Ms Mary Ann Jarvis
Cc Academic Leader Research: Prof M Mars
Cc School Administrator: Mrs Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za
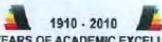
1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

Ref No. NPHA/276/VOL.II/689   Date: 31st August, 2015

NPHAHREC Registration Number: NHREC/24/07/2013

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW
RE: Attitude of Psychiatric Nurses to De-escalation as a strategy in the management of patient aggression in a Nigerian Psychiatric Hospital.

|	
NPHA Ethics Committee assigned number:	**PR014/15**
Name of Principal Investigator:	**Oyeyemi Oyelade**
Address of Principal Investigator:	**School of Nursing and Public Health, Howard College, UKZN, Durban, South Africa.**
Date of receipt of valid application:	**9th July, 2015**

Date of meeting when final determination on ethical approval was made **25th August, 2015.**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the NPHA Ethics Committee.

This approval dates from **25th August, 2015** to **26th August, 2016.** If there is delay in starting the research, please inform the NPHA Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the NPHA HREC assigned number and duration of NPHA HREC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the NPHA HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the NPHA REC. No changes are permitted in the research without prior approval by the NPHA HREC except in circumstances outlined in the Code. The NPHA HREC reserves the right to conduct compliance visit to your research site without previous notification.

You are to submit a copy of your report to the secretariat upon completion of your research.
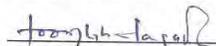
Dr. G Amoo
Chairman, NPHA Ethics Committee

E-mail: hrec@neuroaro.com   Phone No: +234 - 8133970504

Appendix 12: Transcribed script

First focus group discussion

Researcher - Can you please explain your experience with aggression management?

Participant - A19

Please can l start the discussion?

Researcher- Yes

Participant A19- When l said l work in nursing admin does not mean l have not worked in other units, l worked in emergency unit for 8years and l have also worked in drug unit for quite some time and different other units before l move to nursing admin. Let me narrate one of my particular experience with a patient in emergency that really affected my life. The patient was an auxiliary nurse who was given a warm reception and thereafter clerked. The relation reported days of not eating and we requested that the relations should get her food which she ate and thereafter went quietly to bed to sleep. In the process of caring for this new patient, another patient became troublesome and l had to restrain, In the process of trying to restrain the patient causing trouble, the new one lying down that **l thought she is my friend rose up suddenly and gave me a heavy slap (A19C1a)**, **at the attempt to slap the second time or strangulate me (A19C3a), the relations came to my rescue (A19C2a)** and she was restrained and sedated. For three days **l lost sense of hearing (A19C3b)** and after attacking me **she hit a student and another nurse (A19C3c)**. Few days after admission my HOD narrated the incidence to her, but **she said she consciously did that (A19C1b)** because she is an auxiliary nurse and she knows how wicked her matron is, she further stress that **immediately she entered the facility and heard people addressed me as a matron, she developed hatred for me (A19C1c)** and immediately she saw me trying to restrain someone, she feel she should deal with her first and **her intension was to kill me if not for rescuer (A19C3c)**. After she had parole, she came back to apologize, **but if she had killed me, nothing would have been done (A19C2b).**

Researcher- You mentioned, physical and chemical restrain and psychotherapy. How effective was each method of management?

You heard that l said her intention was to kill me. So the restraint was so effective, the chemical restraint would not have been possible if not for the physical restraint, which helped her to sleep off. Both physical and medical restraint was most effective. The third one, l mean the way my H.O.D talked to her was also effective, that was why she came to apologize, but it is good that it came later. The fourth one was the crisis intervention team that started sequel to my report of the incidence. I went to see the provost and while waiting for her, l frowned due to pains, but she responded by saying- am l wasting your time, then my H.O.D responded to her that l am in pains from the attack. She then asked me to narrate the story which l did and **she immediately called for the file of six men, who were previously interviewed to serve as crisis intervention team for immediate employment (A19C2d).**

Researcher- What is the major role of the crisis intervention team?

You know l told you assessment is the first point of contact of this hospital with patients. The **patients in assessment come in wild and so aggression because the of the treatment they have received from their relatives before coming (A19C4a), some of them are told they are only going out on a stroll and will find themselves in the hospital (A19C4b)**. **Some of them come in chains (A19C4c)**. They employ the crisis intervention team so that they will be readily available to intervene by preventing aggressive patient from harming the nurses or co-patents. Also if there are only female nurses, they will not be able to cope with wild patient by preventing them from harming nurses, co-patients or relatives and also destroying properties.

Researcher- Can we have more view more views about our experience with aggression and its management

Participant A15 - I want to say something about the report of the previous speaker, l think the psychological intervention really help to elicit the cause of the aggression which can also help us to know those thing that can really make a patient to be violent

Researcher- Can we hear your own experience with aggression and the mode of management?

Participant A15 -Well! It is quite a number, but the one l can easily remember was at male ward 1, no, male ward 2. I was then pregnant and on duty with a male staff who had to leave the ward

to do something outside the ward. This particular patient is huge, a new admission and lying on the floor. I ask him to get up, but he refused and asked me to rather come and carry him than tell him to get up. I told him you know l am heavily pregnant and that will not be possible, so l left him and l was walking back to the nurses station, unknown to me, she had got up and quietly following me, but it was known to the other patients and they left him to follow me while they only follow him. Immediately l entered the nurses station they shouted that l should lock the door and l did that immediately, but watching from the key hole, l saw **she was fuming (A15C3a)** and **co-patient started shouting at her (A15C2a)** that how would she expect me to be able to carry him and him to go back to his bed or they will deal with him. Hearing that, **I had to shout for attention of other nurses on the ward (A15C2b)** and other nurses came from other ward restrained him physically and chemically**, though he was not successful in his intention, but he could have (A15C2c)** if not for the timely intervention.

Researcher- I also want others to discuss their experiences knowing that experience is varied.

Chorus answer- Our experiences are many, so many

Participant A17- shook her head A17C6e

Participant A11- Had a look of weariness A11C6g

Participant A21 - The experiences are many, so numerous, but l can remember one which happened at drug unit. I was on night duty and about 9pm as l came in **l did not know the patients has plan (A21C1a)** to go and smoke Indian helm that night. The second nurse went to buy something and the patients came and ask me to open the exit gate. I told them l didn't have the key and **they all came together in group to attack me (A21C3a).** Before l know what is going on, the patients just broke the louvers and said he would kill me if l don't open the gate. I immediately called the attendant at the other end of the gate to please open the gate immediately and quickly. But he thought l was joking**. Thank God for intercom, so I called one of the consultant that stay in the compound to notify him of the situation of my unit (A21C2a)**. So he called and order that the gate should be opened, so they all left and he also came later to rescue me. After then, any patient that is admitted in drug unit is made to sign that they will not abscond from the hospital again.

Researcher- Did they come back to the ward

Participant A21- Their parent brought them back, but not all of them.

Researcher – Who signed the consent? Parents or patients

Participant A21- Patients, they were made to sign consent that they will not abscond with force or intention to smoke anymore

Researcher- Did they consent

Participant A21- Yes they did.

Researcher- Apart from our experience with newly admitted patients or the ones with drug history, can we discuss what our experience is with patients who have been stable on the ward, but suddenly became aggressive?

Participant A20- I had an experience in 1998, then it used to be one nurse on duty. I was pregnant and was the only one on duty. It was on an afternoon while an aggressive patient was trying to fight a co-patient. **l tried to intervene by settling it, but the patient turned back and held my neck (A20C1a). I could not shout, but he left me without any intervention probably by divine intervention (A20C2a)**. As soon as she left me, I could not alter a word l was too shocked, but after a while, l was O.K and l went outside the ward to call for help and people came to intervene by restraining and giving the patient PRN medication. My husband was furious and asked me to resign, but l was moved to another ward because seeing that patient will hamper my feelings and disrupt my emotional stability if l continue to work in that same unit where that patient is and also where l had such an experience.

Researcher- I notice there are reports of aggression in pregnancy, peculiar shift and, being alone at time of aggression. Is feminine nature and pregnancy taken as opportunity to be aggressive towards an individual?

Participant A16- No and why l said no is based on my experience in female ward one, then l was 8months pregnant and this patient was calm. The mother came to attend ward round, but during that time, there was restriction on the use of hand set, especially with calling and call reception. Then you cannot just give a phone to patients, but when they come, you listen to the patient's

discussion with relations on phone. On this particular day, the relations of the patients came visiting, and usually we don't allow them to handle phone. We help them to call and put it in speaker to hear what the person is saying, on this particular day, the relations did not come to ask if they can give the patient the phone to make or receive call, but gave the phone to her to talk and all of a sudden, the patient started shouting- Eh!! Egbami O meaning help please! I am in trouble, you know l was pregnant, l rushed down there, then she started banging the door. When l heard l asked the relation what happened and she said the message she overheard is that someone died. Then patient reacted with a shout and went ahead with breaking of louvers. We were two on duty with an attendant and we could not handle her, so we ask her to go into the ward, but she refused and said she has to go immediately to see the person before burial. We called for more hands of support, there was ward round in the other ward, so some doctors were around to assist and we are trying to restrain the patient, l don't know what happened, the doctor holding one of the legs left it. So the patient became so restless and tried to stand up. Then the person holding the other leg also left it and ran away. The patient then stood up and **everyone ran away. At that point, l was left alone with the patient (A16C2a)**. Then the patient said 'don't move close to me' and l responded that she can do whatever you want to do. **Then she replied and said you know you are pregnant**, **so keep away from me (A16C3a)**. She then made attempt to run out, but before she ran out, some doctors at the entrance double cross her and brought her back to bed and she was physically restrained. The relations came to apologize immediately, so also the patient on the third day. So that is my reason for saying it is not intentional for the patient to attack based on pregnancy but depends on the mental state.

Respondent A19

Sometimes they take undue advantage of the pregnant women knowing that pregnancy can incapacitate someone from being able to handle them. Even when they have an agenda to be violent, they wait till there is a pregnant woman on duty or a small nurse (A19C1a). But sometimes it can also be their mental state.

Participant A18- They also take the advantage of the size and height of the nurse. Patients find it easier to attack small statured nurses (A18C1a)

Researcher-Can you please expatiate on that, what input will height and size of the nurse contribute to the discharge of duty?

Participant A18- They take undue advantage of small statured nurses

Participant A19- The height and size of the nurse can be intimidating to the patient and will make them watch their actions (A19C5a). So also the height of the nurse.

Participant A16-Also when the nurse is bold (A16C5a)

Participant A18- Also the sex especially female nurses. The size and weight of the nurse (A18C5a)

Researcher-What l can deduce is that patients take advantage based on the size and weight of the nurse.

Chorus answer yes. If they know you will not take nonsense, they will behave well. Echoed by A18ech

Participant A20- Even if they observe we are not many on duty (A20C5a).

Researcher- So the numerical strength helps to curb aggression?

Chorus answer-Yes. When they see we are many, they behave themselves. Echoed by A20C5e

Participant A17- So also is experience. **They attack junior nurses more. Even if bold, they still attack to see how he/she will handle the situation (A17C1a).**

Participant A18- They also capitalise on the level of firmness and permissiveness of nurses (A18C5a). I can remember my experience with a patient in female ward 1. There is a patient on the ward that has been there for a while and l try to persuade her whenever she is reluctant to take her medication. This particular day she was called to come for her drug, but was reluctant. **I went to her and persuaded her so she stood up and l started following her to the drug station. She got to the side of an iron chair carried the chair and turned back to hit me with it (A18C1a). Thank God l was proactive, I quickly took the chair and pin her to the bed with it A18C6d**. She was shouting for her and l also was shouting for help. Then the other nurse we are on duty

came together and said but l have always told you to be firm with this patients. Then she was restrained.

Another experience l had was when a patient was restrained and shouting for help to be released. One director came and ask us to loosen but the patient stood up and broke a glass, took the broken pieces and said he will injure anyone that try to obstruct him from going home. Another method we use is distracting them and **covering their head with counterpane** (A18C6a) after which they will be moved to the bed with closed eyes.

Participant A11- I will also like to share my experience. I was working with a senior colleague and there is a patient we met on restrain who had not had his bath for a while, he was loosen to have his bath and he went to the toilet after which she went to the bathroom and kept bathing. We asked her to leave the toilet but **he refused and came back naked claiming he will rape us (A11C1a). We had to run away in search for other help to get him restrained (A11C2a)** due to the history of raping his wife we have heard. He was then retrained and sedated. There is another patient from America who likes to walk naked and we always have to restrain him because he like to walk about naked. Sometimes he makes unusual request like asking for salad. We even find it difficult to hear when she speaks due to the pronunciation. This day he came making a request which l don't understand. He also prefer some food which we don't have available and she is high tempered. She called one day and requested that l should come right where she was, at her bed side, to answer her. She thereafter came to my side and shouted on me that she expect me to come right to her in response to her call or is it that l did not hear her call? **She then removed her slippers and banged on my head (A11C3a). I was scared, but did not show it (A11C3g).** I also shouted at her and moved as if l was up to something, but that is just to keep her away from me. A doctor was around and ran out with a promise that he will look for more hands to support me.

Chorus interruption- Hum! and did he come back?

Participant A11 (continued) - Hum! Never. He did not come back. I also put on a bold face and removed one of my shoes as if l want to attack her. Then she ran away. The recent one that happened was on the 2nd October, 215. 2days ago precisely this patient went to shower at the female arm of the ward. We told him he is not meant to use the female side, but he refused. He thereafter came and demanded for writing pad, and after exhausting the one he had he said he took

the case note in front of the nurse and started scribbling on it. We tried to take it from him, but he refused and landed on us with serious beating. He stood at the exit door of the office and there is no way of escape for us, so he continued to beat mercilessly. He backed the door and throw things at us at every attempt to escape. **I was so traumatised that l sustained neck injury (A11C3b). I shouted for help, but my voice is not loud enough (A11C2a)**. I got home and felt so traumatised. **I could not sleep despite analgesics (**A11C3h), he broke the watch hand basin in the nurses' station. **The ward manager and the residence on duty were also injured (A11C3c).**

Researcher- This is still very recent and it sound emotionally draining. What form of intervention did you receive for relief of the tension, stress and injury?

Participant A11- There was nothing. I only bought drug for myself and continued work the next day.

Participant A19- If l may come in, the institution has a policy people that people should go to NHIS to be treated. There is a form usually with a supervisor that the person has to fill and then the supervisor will sign and with that the person will be treated. Did you do so?

Interrupted by participant A19- It happened during morning shift. The person that was taken to NHIS got the form filled on her behalf and that is her partner. But because she did not come to NHIS that is why she was not treated.

Researcher -Is there any other form of care like break from work?

Participant A17- It depends on the severity of injury. Like a case at male ward 1. The nurse was brutally injured and was admitted afterward she had some off days to rest.

Participant A18- If l may come in. Some nurses keep working even if injured. They continue to manage themselves until they can no longer cope. May be because they are conscientious and know the work demand. If you look at the situation of your ward where before are very few.

Chorus answer- Short staffed and work consciousness

Researcher- I hope this discussion is not too emotionally draining for you?

Participant A18- We hope something good will come out of this discussion. So that nurses will not continue to suffer (A18C8a). Many have

Participant A21 – Interrupt- **They have killed many (A21C3b)**

Participant A18- So many have sustained injury (**A18C3a)** and they spend personal money to treat themselves.

Participant A21- I can remember the day a female **patient was angry and came to grasp my penis (A21C3e)**. I don't know if she was sex starved or what. They then carried me. The pain was so severe **(A21C3f)**

Question- What we feel about our preparedness for aggression management, do we feel there is more to learn or know about the way others to manage aggression.

Participant A15-we assess the situation and the courses is used to manage. We use prevention and all in our power to manage aggression. We have risk assessment tool for aggression, vulnerability, self-neglect.

Participant A19- Can l say something? All the methods that we have narrated at one time or the other depending on the nature of aggression and the patients. But l think there are two things we need more. 1. Additional personnel. Patients are usually scared when there are many nurses who are experienced (A19C5b). If you look at it critically, most of the aggression cases occur when the patients know that there are few number of nurses on ground especially afternoon and night. In the morning they know there are large number of people and experienced nurses. That is number one. So need improved staff strength. Secondly, **I learnt some developed countries, l believe, have gun to cause temporary paralyses for aggressive patient, also electro-conductive belt, those are the things we need A19C6g**. If this is put in place in all the psychiatric hospitals in Nigeria, it will kind of minimize the aggression tendency against nurses. **Recently the hospital started using ex-military men for crisis management, but patients went to court that they were mal-handled and the hospital stopped it. We need it (A19C6c).**

Participant A21- we need improved staff strength

Participant A21- There is something l heard is used to raise alarm. We need that again (A21C6a)

Participant A19- We had it all got spoilt and they never repair (A19C2c)

Participant A15- Someone gave us alarm watch

Chorus-it is all spoilt

Second focus group discussion

Report of non-verbal communication during Presentation on de-escalation

Participant A20- Fixed look

Participant A19-Look away, turned face to the other side and later closed eyes.

Participant A21-Closed eyes and later started coughing which led to moving out and came in after 2minutes

Participant A11- Maintain usual look

Participant A15- looking down

Participant A15- What l understand about de-escalation technique is an approach of preventing aggression from getting out of control.

Researcher- Based on our just concluded discussion on de-escalation and the explanation on demarcation made between aggression and aggression and our understanding of de-escalation techniques, is it possible for us to use that to replace management of aggressive patient.

Participant A18- Thank you for the presentation. You were able to compare the traditional approach with the de-escalation approach. **The approach is not new to us, but it can only be used on the ward after a relationship has been established with the patient (A18C7a)**, **but not in emergency or assessment that is the entry point of the hospital (A18C9a)**, in such unit de-escalation cannot work. **But on the ward de-escalation and traditional approach has to go hand in hand (A18C9b)**. The two are effective depending on the situation at hand.

Researcher- Please can l know if it is possible for us to engage more with de-escalation as against traditional approach on the wards? Especially in situation of provocation of these patients over issues that can be naturally provocating to us also as individuals.

Participant A18- If l get you right, you are talking about the use of de-escalation more than the traditional approach especially in management of our patients on the ward? Yes! De-escalation approach is possible on the ward, but it may not be possible with the same nurse the patient start interacting with. **It may require the involvement of another nurse (A18C7b)** before a patient

can be successfully de-escalated. Especially **a nurse that is closer to a particular patient may find it easier to de-escalate the patient aggression (A18C7d)** if he has an issue with another nurse if called to intervene. But you see as l said yesterday the way we approach situation differs. We have different ways of approaching situation and why l said de-escalation may not be possible always is if a nurse that the patient can listen to is not on duty, then what is going to happen? **De-escalation technique is possible in ward setting, but it depends on the level of relationship the nurse has built with patients over time (A18C7c)**. Here **after using de-escalation approach by talking the patient down, it will still require physical or chemical restraint to prevent further damage (A18C9c).**

Participant A20- I will like to add to what my colleague has said. **We also use de-escalation approach, but it does not yield positive result (A20C9a).** Talking to them does not usually yield positive result in every situation. **Physical restraint might be needful to prevent possible damage that may arise from aggression (A20C6c)**.

Question- You said de-escalation techniques does not yield positive result? Please can you expatiate on that?

Participant A20- Aggressive behaviour has stages, when patients get to the ward, we establish rapport with them to make them comfortable and make them know we are here to care for them. That help some of them to relax and cooperate, **but some especially with drug cases, there is nothing you can do to make them calm apart from physical restraint and sedation (A20C8a)**.

Researcher- Thank you. Please can l know the opinion of others?

Participant A21- It depends on the cause of the aggression. These patients are also human beings and the at times **the way their relations behave with them before they bring them is somewhat traumatising. The way they treat them at home before bringing them is usually annoying and they would have been so upset by maltreatment before bringing them down here that the issue of de-escalation at that time cannot work (A21C4a). On getting to the hospital the patient look very wild, not because they are sick, but because of the aggression they have been subjected to (A21C4b).** At that point the patient is not listening to anyone.

Participant A15- There are some situation where de-escalation can work, **but there are times where you can do nothing than to restrain (A15C8a)**, it depends on the situation on the ward.

Participant A19-I was surprised when you talked about the use of restrain and de-escalation in western world because **l feel there is a more sophisticated approach they have that you can introduce to us A19C5e,** but looking back at some of my experiences I had in emergency unit, **the patient are brought in tied with a rope like an animal A19C4g**. Looking at that, you can easily figure it out that the patient was very aggressive. But in such situation, you will see that **the patient is tightly tied (A19C4d)** in such a way that if you don't loosen the restrain on time in can cause problem. In such a situation, what do you do? You can talk to them patient first to see if loosening the restraint will be helpful, **but in some situation there is nothing you can do (A18C8b)**, you have to remove the relations restrains and put your own immediately and you apply chemical restrain as well. So l want to believe that the nature of patient and the environment can determine the kind of de-escalation you use.

Researcher- What l can deduce from our discussion is that de-escalation techniques is possible, but with so many constraints. At this point l want to finalise this discussion.

Third focus group discussion

Data confirmation day

The inference l was able to make from our discussion goes thus; during the first meeting, l was able to discover that the main method of aggression management is physical restrain, chemical restrain and psycho-therapy which will consider effective if instituted early. Other methods that will help to reduce aggression as we said include sustainable aggression alarm and alert creation. Also increase in staff employment. We said the numerical strength of the nurses is not enough to manage the situation of aggression. Also equipping nurses for self-defense like provision of electro-sensitive device is also mentioned by one of the participants. We said nurses are subjected to aggression because patient knows nurses cannot harm them and therefore mal-treat nurses, but self-defense mechanism will help to curb them from such. That is the inference l made from our first discussion.

During the second day of the focus group

There was a presentation on de-escalation technique and based on our discussion that it's not a new approach to us. We discuss the possibility of that replacing the traditional approach and these are the responses made from our discussion.

The de-escalation technique is a psychotherapeutic and communication approach of reducing the tendency of aggression. It is also said that the physical and chemical restraint are more effective due to the peculiarity of this setting. We said patient believe aggression is necessary in a mental health setting especially those who have history of aggression. We also said the mental state determines their reaction in case of aggression which also fluctuates.

Participant A21- You were able to capture all we said but don't forget the issue of crisis intervention team. You did not mention it. We need them to rescue in case of aggression

Chorus answer- Yes

Participant A20- we really need that

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