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Nurses' Perceptions regarding Types of Aggressive Behaviour displayed by Patients in a Selected Psychiatric Hospital in Lesotho

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Abstract

Aggressive behaviour of inpatients in mental health facilities occurs globally and is a serious nursing problem. Consequently, there is insufficient research studies conducted among nurses regarding the types of aggressive behaviour displayed by patients in psychiatric institutions. The purpose of this study was to determine nurses' perceptions regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho. A quantitative descriptive survey was used to collect data from 119 nurses who were selected by quota sampling. The data were collected by means of a self-administered questionnaire, analysed by using SPSS (version 25), and displayed by using tables, frequencies, standard deviations, means and Pearson's chi-square test. The findings reported that the types of aggressive behaviour included verbal aggression (86%, $n = 103$), physical aggression against objects (79%, $n = 94$), physical aggression against self (65.5%, $n = 78$), and physical aggression against other people (81.5%, $n = 97$). This study concludes that the perceptions of the nurses were positively inclined towards violent behaviour displayed by patients. The study recommends that nurses be equipped with comprehensive psychiatric skills and information to enable them to manage and cope with patients' aggression.

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Keywords: aggression, nurses' perceptions, patient behaviour, psychiatric hospital, Lesotho

Introduction

Aggressive behaviour of inpatients in mental health facilities is a serious clinical and nursing problem (Van Wijk, Traut, and Julie 2014, 1). Aggression is behaviour characterised by anger, and hostile thoughts, words and actions towards other people that manifest in speech, tone of voice, body language, outward expression of anger or rage that is threatening, and actual or physical actions (Franz et al. 2010, 51). The causes of aggression include environmental adversity, high stress levels, the time of the day, and an increased risk at night attributed to hallucinatory tendencies (Oyelade and Mobolaji-Olajide 2019, 24).

The prevalence of aggression in mental institutions varies from 80–100 per cent in upper income countries whereas in lower income countries it is 50–85 per cent (Oyelade and Mobolaji-Olajide 2019, 23). Bader, Evans, and Welsh (2014, 179) indicated that international and sub-Saharan African studies report the prevalence of aggressive incidences of patients against mental healthcare nurses and other healthcare workers as ranging between 49.5 per cent and 96.7 per cent, respectively. The prevalence of verbal and physical abuse in a Hong Kong hospital was 73 per cent and 18 per cent respectively, indicating that workplace aggression against nurses was a significant problem (Fute et al. 2015, 9).

The nurses reported abuse of any kind from patients (Fute et al. 2015, 9; Guay, Goncalves, and Boyer 2016, 4), and they were exposed to verbal, physical and sexual aggression (Bekelepi, Martin, and Chipps 2016, 151). Furthermore, the nurses have been exposed to aggressive behaviour from patients at least once in their lives and they had a greater dysfunctional perception of aggression than those with no such experience (Pazvantoglu et al. 2011, 496). Chambers et al. (2015, 289) stated that many nurses, nursing students and nursing aids reported that they were repeatedly seriously threatened in their professional life. The exposure of nurses to aggression hampers recruitment and retention and engenders numerous problems such as heightened risk of burnout, anxiety, and the intent to leave the profession (Heckemann et al. 2015, 212; Pazvantoglu et al. 2011, 495).

Aggressive behaviour towards nurses is regarded as the product of interactions of more than one factor and the main factor being perceived as negative emotions and opinions (Pazvantoglu et al. 2011, 496). Aggressive behaviour was reported to affect the quality of care and perceived to be highly offensive, least communicative, destructive, not protective, intrusive (James, Isa, and Oud 2011; 132), offensive (Lickiewicz et al. 2019, 63), and dysfunctional (James, Isa, and Oud 2011, 132; Pazvantoglu et al. 2011, 495). Conversely, nurses have been reported to behave empathetically towards

patients with aggressive behaviour and that they might not only perceive it as an undesirable situation which has to be prevented (Pazvantoglu et al. 2011, 496).

However, further theoretical advances are required to clarify perceptions of viciousness prevention among nurses (Hallet, Huber, and Dickens 2014, 502). Currently there are no data or evidence-based research on nurses' perceptions regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho. It is in this context that this study described the nurses' perceptions regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho.

Problem Statement

Anecdotal evidence and insight through work experience indicate that nurses face challenges when managing aggressive patients in the selected psychiatric hospital in Lesotho. This may be owing to limited or a lack of recent knowledge and skills regarding the management of aggressive patients, which may affect the confidence of nurses when managing or interacting with aggressive patients. This study therefore sought to gain insight into nurses' perceptions regarding the types of aggressive behaviour displayed by patients at the selected psychiatric hospital in Lesotho. The study sought to answer this research question: What are the perceptions of nurses regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho?

Aim of the Study

This study determined nurses' perceptions regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho.

Methodology

The study was conducted at a selected psychiatric hospital in Lesotho which provides specialised psychiatric referral services for all district hospitals in the country and also serves as clinical area for mental health placements for students who study psychology, general nursing (diploma and degree), social work and occupational therapy. A quantitative, descriptive design was used to collect data from all cadres of nurses who worked in the selected psychiatric hospital or had experience in the management of aggressive patients in the psychiatric hospital from 1 July 2017 to 31 August 2018. The researcher reviewed the register of staff at the selected hospital to determine the sampling frame. The sampling frame ($N = 133$) included 15 psychiatric nurses, 16 registered nurses, 88 nursing students and 14 nursing assistants who were all conveniently sampled to complete a self-administered questionnaire. Healthcare professionals who were not nurses and nurses who had not been exposed to aggressive patients were excluded from the study.

Data Collection

Data collection occurred in September 2018. Thackrey's (1987) tool was adapted to suit the objective of this study as the study focused mainly on nurses' perceptions regarding the types of aggressive behaviour displayed by patients in the psychiatric hospital. The questionnaire consisted of four sections: Section A had 5 items on socio-demographic characteristics; Section B had 16 items on the types of aggressive behaviour displayed by patients; Section C had 10 items on nurses' current skills in minimising patients' aggression; and Section D had 9 items on nurses' confidence in coping with patients' aggression. There were a total of 40 questions and it took about 20 minutes to complete the questionnaire.

The questionnaire had 5 scores (strongly disagree, disagree, uncertain, agree and strongly agree). On the types of aggressive behaviour displayed by the patient, the expected minimum score was 17, whereas the expected maximum score was 85. Consequently, 17–56 was regarded as low whereas 57–85 was regarded as high. Therefore, 20.2 per cent ($n = 24$) of the respondents had low scores as compared to 79.8 per cent ($n = 95$) of the respondents who had high scores. One of the respondents, 0.8 per cent ($n = 1$), scored low (21), whereas 5.9 per cent ($n = 7$) of the respondents scored high (85).

After obtaining ethical approval and permission to conduct the study, the researcher contacted the Nursing Service Coordinator to ask for permission to recruit the respondents. The researcher then contacted the Unit Managers of the different wards in the hospital to arrange a suitable time schedule to avoid disturbing the ward routines and also requested permission to speak to their nurses. The researcher also contacted the heads of programmes at the schools of nursing to request permission to collect data from the student nurses. The researcher met with the respondents in their ward and schools of nursing and explained the purpose of the study to them. The researcher was available to clarify any misunderstandings and collected the questionnaires after they were completed by the respondents. The data collection was done every Monday, Wednesday and Friday for one month because not all the respondents were available at the same time (rotating shifts). A total of 119 out of 133 questionnaires were returned completed and the response rate was 89 per cent.

Validity and Reliability

Validity was confirmed by conducting a pretest and checking all the items in the data collection tools against the study objectives, questions and concepts to establish whether they measured all the elements to be investigated. Cronbach's alpha coefficient was used to ascertain the reliability of the tool and it was 0.85.

Data Analysis

The data were analysed by using the Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics used were frequencies, standard deviations and means while inferential statistics used were Pearson's chi-square test. Graphical presentations were done using tables.

Ethical Considerations

Permission to conduct study was obtained from the Research Ethics Committee of the University of KwaZulu-Natal (ID-HSS/0607/018M), the Lesotho Ministry of Health (ID-110/2018), the Director Mental Health Services and the selected psychiatric hospital in Lesotho. The purpose of study was explained to all the nurses and their participation was entirely voluntary. They had a right to withdraw from the study at any time if they felt uncomfortable without fear of any negative effects. No harm to the respondents directly from their participation in the research study was anticipated, however, negative perceptions of aggressive incidents and painful memories can be traumatic. Therefore, a contingency plan was put in place by which the respondents who would experience emotional or psychological problems, would be referred to professionals at the hospital for counselling.

The respondents signed an informed consent form before completing the questionnaire. Their anonymity and confidentiality were respected by using codes on the questionnaires. The data were kept safely in a locked area to which only the researcher and supervisor had access. The researcher explained that the findings of the study would be helpful to nurses as they would have knowledge of the perceptions regarding the types of aggressive behaviour displayed by patients.

Results

Demographic Characteristics

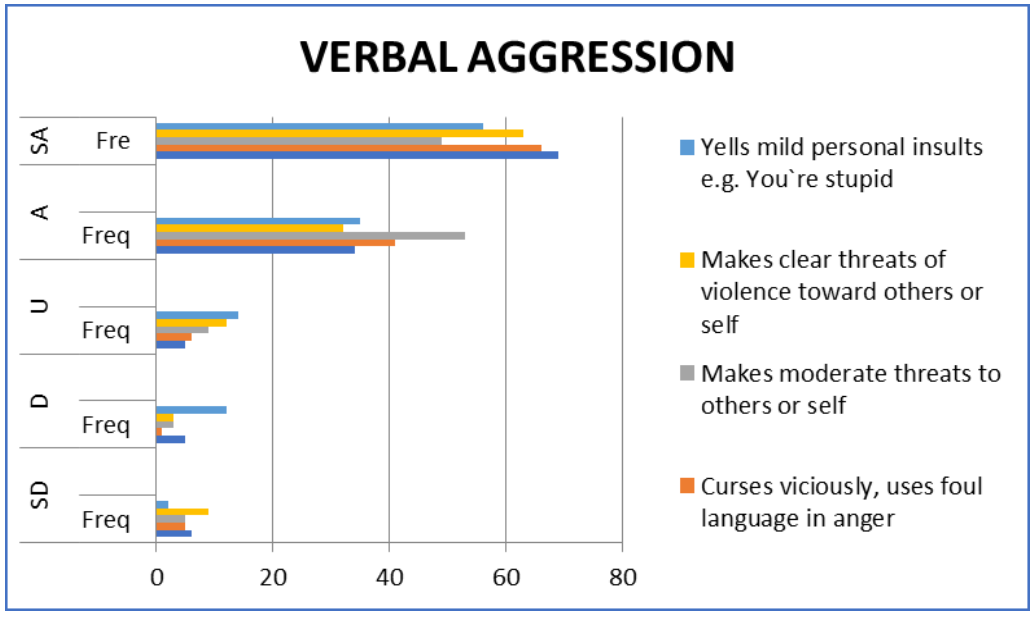
The minimum age of the respondents was 20 years and the maximum age was 56 years. The median was 27 years old, whereas the mode was 21 years old. The mean age was 29.8 years (± 9.2). The majority of respondents, 71.4 per cent (n = 85), were females and 28.6 per cent (n = 34) of the respondents were males. Of all the nurses, 67.2 per cent (n = 80) were student nurses, 10.1 per cent (n = 12) trained nursing assistants, 11.8 per cent (n = 14) registered nurses, and 10.9 per cent (n = 13) registered psychiatric nurses. The number of years of experience was less than one year for 67.2 per cent (n = 80) of the respondents, 6 to 10 years for 13.4 per cent (n = 16) of the respondents, 1 to 5 years for 9.2 per cent (n = 11) of the respondents, 11 to 20 years for 7.6 per cent (n = 9) of the respondents, and 20 to 30 years for 2.5 per cent (n = 3) of the respondents. Pearson's chi-square test showed no statistically significant association between age and the types of aggressive behaviour [$X^2(3, N = 119) = 5.493$, $p = .126$], gender and the

types of aggressive behaviour [$X^2(1, N = 119) = .1889, p = .665$], and years of experience and types of aggressive behaviour [$X^2(4, N = 119) = 4.124, p = .390$].

Types of Aggressive Behaviour Displayed by Patients

Verbal aggression

When exploring the statement that a patient makes a loud noise, and shouts angrily, 86.6 per cent ($n = 103$) of the respondents answered positively, 9.3 per cent ($n = 11$) opposed, and 4.2 per cent ($n = 5$) stated that they were not sure of the statement. The mean was 4.3 and standard deviation (SD) 1.078. On the statement that a patient curses viciously, and uses foul language in anger, 90.0 per cent ($n = 107$) of the respondents answered positively, 5.0 per cent ($n = 6$) opposed, and 5.0 per cent ($n = 6$) indicated that they were uncertain of the statement. With regard to the patient making moderate threats to other people or themself, 85.7 per cent ($n = 102$) of the respondents answered positively, 6.7 per cent ($n = 8$) answered negatively, and 7.6 per cent ($n = 9$) were uncertain. The mean was 4.36 and SD 0.945. With regard to whether the patient makes clear threats of violence towards other people or themself, 79.8 per cent ($n = 95$) of the respondents answered positively, 10.1 per cent ($n = 12$) opposed, and 10.1 per cent ($n = 12$) were not sure of the statement. The mean was 4.15 and SD 1.183. When exploring whether the patient yells mild personal insults, 76.5 per cent ($n = 91$) of the respondents answered positively, 11.8 per cent ($n = 14$) opposed, and 11.8 per cent ($n = 14$) indicated that they were uncertain. The mean was 4.1 and SD 1.069. Figure 1 illustrates the results.

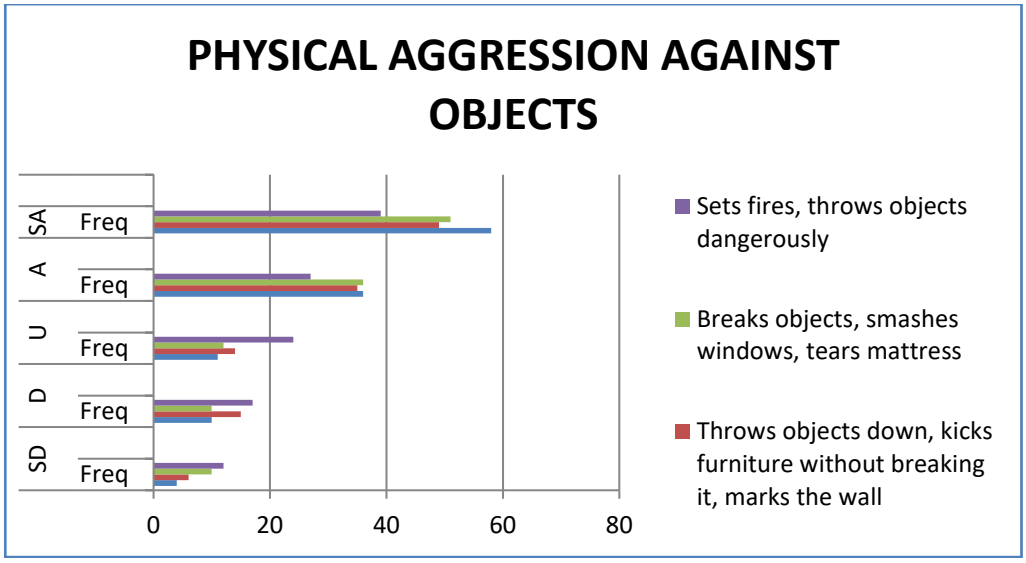


Key: SD = strongly disagree, D = disagree, U = uncertain, SA = strongly agree, A = agree

Figure 1: Verbal aggression

Physical aggression against objects

In responding to the statement that a patient slams the door, scatters clothing, and makes a mess, the majority of the respondents, 79 per cent (n = 94), answered positively, 11.8 per cent (n = 14) opposed, and 9.2 per cent (n = 11) reported that they were uncertain. The mean was 4.13 and SD 1.101. On whether a patient throws objects on the floor, kicks the furniture without breaking it, and marks the wall, 70.6 per cent (n = 84) of the respondents answered positively, 17.6 per cent (n = 21) opposed, and 11.8 per cent (n = 14) were uncertain. The mean was 3.89 and SD 1.22. With regard to a patient breaking objects, smashing windows, and tearing the mattress, 73.2 per cent (n = 87) of the respondents answered positively, 16.8 per cent (n = 20) opposed, and 10.1 per cent (n = 12) were uncertain. The mean was 3.91 and SD 1.276. Consequently, in responding to the statement on whether a patient sets fire, and throws objects dangerously, 55.5 per cent (n = 66) of the respondents answered positively, 24.4 per cent (n = 13) opposed, and 20.2 per cent (n = 24) were uncertain. The mean was 3.54 and SD 1.345. Figure 2 illustrates the results in more detail.



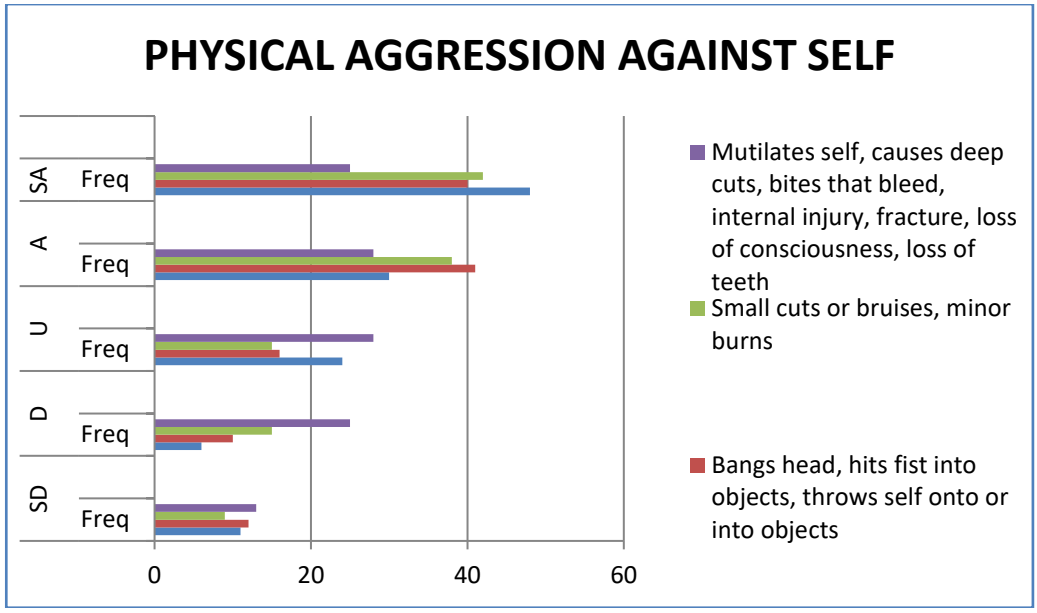
Key: SD = strongly disagree, D = disagree, U = uncertain, SA = strongly agree, A = agree

Figure 2: Physical aggression against objects

Physical aggression against self

When exploring the statement that a patient picks and scratches their skin, hits themself, and pulls their hair, 65.5 per cent (n = 78) of the respondents answered positively, 14.2 per cent (n = 1) opposed, and 20.2 per cent (n = 24) reported that they were not

sure. The mean was 3.82 and SD was 1.273. On the statement that a patient bangs their head, hits fist into objects, throws themself onto or into objects, the majority of the respondents, 68.1 per cent (n = 81), answered positively, the minority, 18.5 per cent (n = 22), opposed, and 13.6 per cent (n = 16) indicated that they were uncertain. The mean was 3.73 and SD 1.287. With regard to a patient who causes self-harm such as small cuts or bruises, and minor burns, 67.2 per cent (n = 84) of the respondents answered positively, 20.2 per cent (n = 24) opposed, and 12.6 per cent (n = 15) were uncertain. The mean was 3.75 and SD 1.270. On the statement that a patient mutilates themself, and causes deep cuts, bites that bleed, internal injuries, fractures, loss of consciousness, and loss of teeth, 44.5 per cent (n = 53) of the respondents answered positively, 31.9 per cent (n = 38) opposed, and 23.5 per cent (n = 28) indicated that they were not sure. The mean was 3.23 and SD 1.298. Figure 3 illustrates the results in more detail.



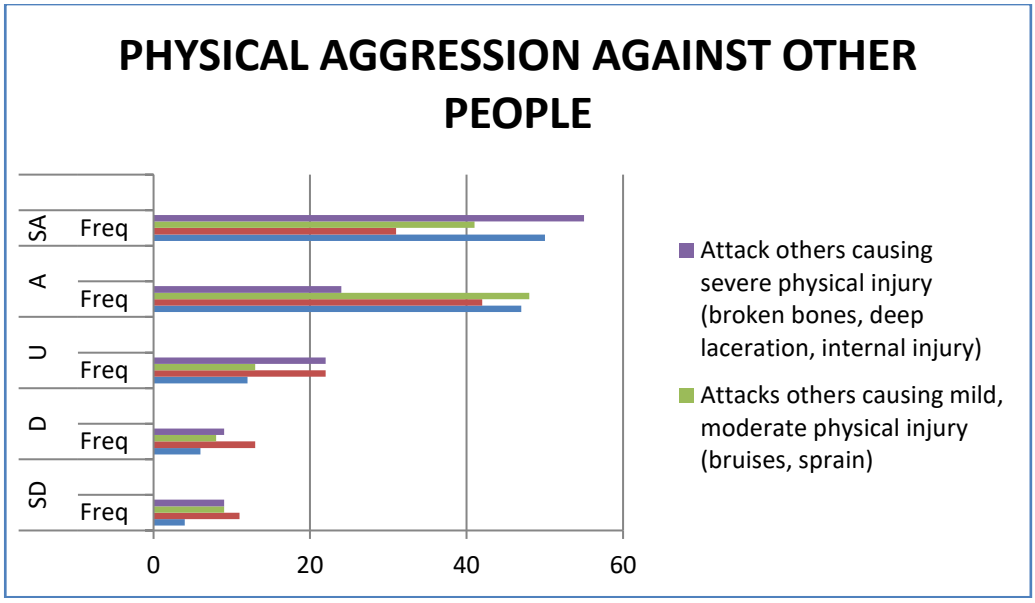
Key: SD = strongly disagree, D = disagree, U = uncertain, SA = strongly agree, A = agree

Figure 3: Physical aggression against self

Physical aggression against other people

When exploring the statement that a patient makes threatening gestures, swings at people, and grabs at clothing, most of the respondents, 81.5 per cent (n = 97), answered positively, 8.4 per cent (n = 10) answered negatively, and 10.1 per cent (n = 12) indicated that they were uncertain. The mean was 4.12 and SD 1.010. In responding to the statement that a patient strikes, kicks, pushes, and pulls hair (without causing injury), 61.4 per cent (n = 73) of the respondents answered positively, 20.1 per cent (n = 24)

opposed, and 18.5 per cent (n = 22) reported that they were uncertain. The mean was 3.58 and SD 1.245. On the statement that a patient attacks other people, causing mild, moderate physical injuries (bruises, sprains), 74.8 per cent (n = 89) of the respondents answered positively, 14.3 per cent (n = 17) opposed, and 10.9 per cent (n = 13) indicated that they were uncertain. The mean was 3.87 and SD 1.183. With regard to a patient attacking other people, causing severe physical injury (broken bones, deep lacerations, internal injuries), most of the respondents, 62.4 per cent (n = 79) answered positively, 15.2 per cent (n = 18) answered negatively, and 18.5 per cent (n = 22) indicated that they were uncertain. The mean was 3.9 and SD 1.278. Figure 4 illustrates the results in more detail.



Key: SD = strongly disagree, D = disagree, U = uncertain, SA = strongly agree, A = agree

Figure 4: Physical aggression against other people

Discussion

Utterances of Hostility

The nurses perceived verbal aggression to be utterances of hostility. In verbal aggression the patient makes a loud noise, shouts angrily, curses viciously, uses foul language, makes moderate threats to others or themself, makes clear threats of violence towards other people or themself, and yells mild personal insults. This may be owing to the patient's psychiatric condition, confusion, long-term admission and unstable mental state. Bekelepi, Martin, and Chipps (2016, 151) and Fortinash and Worret (2014) reported that patients become loud and agitated, and the tone and volume of the voices

of aggressive patients include sharp or caustic sounds demanding inflection and with increased volume. This also correlates with Stephens (2017, 58) and Campbell, Burg, and Gammonley (2015, 314) who reported threats of assault to be either verbal or written intending harm; the patient shouts angrily at people threatening to cause harm, and curses and yells at other people.

Furthermore, Edward et al. (2014, 653) and Stevenson et al. (2015, 35) explained that the patients yell, curse and harass using sexual language and innuendos, swear, and pass demeaning or sexually inappropriate comments. Stevenson et al. (2015, 35) also agreed that in verbal aggression, patients swear at and make forms of threats to other people. Furthermore, this study concurs with Edward et al. (2014, 653) and Stevenson et al. (2015, 35) who asserted that common types of verbal aggression against nurses included yelling and that threats of assault were verbal, written or emotional.

Physical Ferocity against Items

The nurses perceived physical aggression against objects to be physical ferocity against items which included patients slamming doors, scattering clothing, making a mess, throwing objects on the floor, kicking furniture without breaking it, marking the wall, breaking objects, smashing windows, tearing the mattress, setting fire or throwing objects dangerously. This may be owing to the patient's history of previous aggressive incidents, impulsiveness, hostility and the psychiatric diagnosis. Campbell, Burg, and Gammonley (2015, 314) explained that physical aggression included hitting with the body and objects, slapping, banging doors, and kicking by the patient. Sato et al. (2017, 602) and Varghese, Khakha, and Chadda (2016, 62) reiterated physical aggression as being highly scored incidents of aggression reported by the majority of the respondents. Al-Sagarat et al. (2016, 172) and Stevenson et al. (2015, 35) reported forms of aggression that included breaking things, hanging and using a weapon or environment such as breaking a window to elicit violence. Varghese, Khakha, and Chadda (2016, 62) indicated that only a minority of the respondents reported that patients can set fires.

Self-inflicted Injuries

The nurses perceived physical aggression against the self to be self-inflicted injuries and included that the patient picks and scratches their skin, hits themself, pulls hair, bangs the head, hits fists into objects, throws themself onto or into objects, causes self-harm by small cuts or bruises, and minor burns, mutilates themself, causes deep cuts, bites that bleed, internal injuries, fractures, loss of consciousness, and loss of teeth. This may be owing to the unstable mental status of patients. Campbell, Burg, and Gammonley (2015, 314) and Simpson (2015) explained physical aggression against the self to include hitting the body, hitting with objects, scratching skin, pulling hair, and having an irresistible urge to pull hair from skin. Al-Sagarat et al. (2016, 172) and Chester and Alexander (2018, 557) reiterated that it includes hanging or jumping from high places;

229 incidents of head banging behaviour by patients during a one-year time frame with a further five incidents of attempted head banging in a forensic mental health hospital were reported. This is congruent with a press release in the Democratic Republic of the Congo (Aljazeera 2019) which reported forms of aggression to include hurting the self with sharp instruments, causing minor injuries. Simpson (2015) stated it to involve intentional cuts, burning or mutilating the skin for purposes of regulating emotions.

Bodily Harm to Other People

The nurses perceived physical aggression against other people to be causing bodily harm to other people and included that the patient makes threatening gestures, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair (without causing injury), attacks others causing mild, moderate physical injuries (bruises, sprains), and attacks other people causing severe physical injuries (broken bones, deep lacerations, internal injuries). This may be owing to the patients' previous history of aggression, long stay in hospital, unstable mental status, and state of confusion. Stevenson et al. (2015, 35) and Varghese, Khakha, and Chadda (2016, 62) explained bodily violence to include verbal or written threats intending harm with threatening gestures, and making threatening gestures. Stevenson et al. (2015, 35) reiterated it to be in the form of spitting, biting, pushing or knocking down, striking, kicking, and pulling hair. Varghese, Khakha, and Chadda (2016, 62) opined that the patient strikes, kicks, pushes, and pulls hair (without causing injury), and attacks other people, causing mild to moderate physical injuries to them. Al-Sagarat et al. (2016, 172) also asserted that the patient chases and hits other people, causing severe injuries.

Conclusion

The nurses' perceptions of the types of aggressive behaviour were utterances of hostility, physical ferocity against objects, self-inflicted injuries, and causing bodily harm to other people. The perceptions were positive indicating the existence of both verbal and physical types of aggression at the selected psychiatric hospital. Aggression was evident among all nursing cadres that took part in this study.

Recommendations

We recommend that nurses working at this hospital in the management of aggression from the patients be capacitated through short courses or in-service training to enhance their confidence in coping with patients' hostility and violent behaviour. More male staff should be placed in the psychiatric hospital. It is recommended that a qualitative study be conducted on the same topic to obtain more information on the types of aggressive behaviour by patients.

Limitations of the Study

The study was localised at a referral psychiatric hospital which is the only one in the country, and did not include mental observation treatment units found in other districts. The use of convenience sampling could have introduced statistical bias in the study. More information could have been obtained if the data were collected using unstructured interviews.

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