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NURSES EXPERIENCES IN DEALING WITH VIOLENT PATIENTS IN THE INPATIENT MENTAL HEALTH INSTITUTIONS.

A Literature Review

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Abstract

The aim of this literature review was to study about the experiences of nurses dealing with violent patients in the mental health institution. The purpose was to provide information that could promote awareness and safety to nurses who work in mental health inpatient institutions. Data search for literature review was from CINAHL (Ebsco) and PubMed data bases. Selection of the 13 articles was conducted using the inclusion criteria regarding the title, abstract, referencing and full text citations.

The study came up with four themes; Nature of the violence, the impact of the violence, providing care after the violence and ethical issues. Three of these themes were further divided into sub themes. During the research it was discovered that nurses in the mental health unit were victims of all forms of violence. The impacts of the violent incidences were severe with very little platform to offer help and consolation. The study suggested that there is need for further research on nurses' education in dealing with violent patient, safe and effective reporting channels and both medical coverage and legal reimbursement.

Keywords : Violence, experiences, mental health institutions, mental health nurses

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1 Introduction

There is growing evidence that nurses working in the mental health institutions are likely to be victims of violence or aggression, which is initiated, by the patient. The study by Steinman shows that 61.9% of all the health care workers interviewed in the targeted mental health institutions had experienced violence of one way or another during the period of 12 months prior to the research studies. (Steinman 2003, 27).

It is good to understand the meaning of, mental health care and mental illness. According to WHO; Assessment for mental health systems (2005), mental health care is the provision of necessary care to the mentally ill patients to improve their mental health while mental health units are health facilities where mentally ill patients receive treatment. Mental illness on the other hand has been defined by Ranna Parekh of American Psychiatric Association (11, 2015) as any health state that necessitates changes in emotion behavior or way of thinking of a person.

Surprisingly when people think about violence towards nurses in mental health care department, the first thing that usually comes to mind is the physical abuse. However, it may include emotional, verbal, sexual violence although physical violence is more common in occurrences. Coping with and understanding violent and threatening behavior in mental health care settings is a challenging, but integral part of a caregiver's job. If not handled well, such situations can result in staff and patient injuries and they can lead to stereotype representations of patients as divergent, unpredictable and dangerous (Bowers, Douzenis, Galeazzi, Forghieri, Tsopelas, Simpson, Allan, 2005).

However, it's notable that some of the important ethical issues and rights for nurses have been left out. Studies provide various reasons why it is difficult for mental health nurses to report violent and aggressive acts by patients (Irwin, 2006.) For instance, heavy workloads, time constraints, the lack of adequate education and resources and of standardized reporting tools have contributed to inaccurate reporting. A good example is that in Australia under-reporting of aggressive and violent incidents by nurses is as high as 25% comparable with international estimates of 20% (Jones & Lyneham, 2000.)Violence is therefore harmful and can advance a culture of non-cooperation in which harm or destruction of others

becomes a primary goal and results in a high level of containment and coercive measures and lack of staff engagement. (Paterson, Mackay & Cassells 2005.)

2 Violence and mental healthcare

In this chapter crucial terms to the topic, such as definition of violence, gender variation, mental health care comparison in different countries, mental illness, alcoholism, drug addiction and the risk factors leading to violence will be discussed.

2.1 Violence

WHO (2002) states that violence is a behavior that involves physical force intended to hurt, damage, or kill someone or something. It can be physical, psychological, sexual abuse, harassment, bullying, or aggression that may occur intentionally or unintentionally (Registered Nurses Association of Ontario, 2009). A typology of violence as indicated below further confirms that there are at least four different natures of violence. The Mind map further shows in whose hands a victim of violence can fall in and what nature of the violence they may encounter.

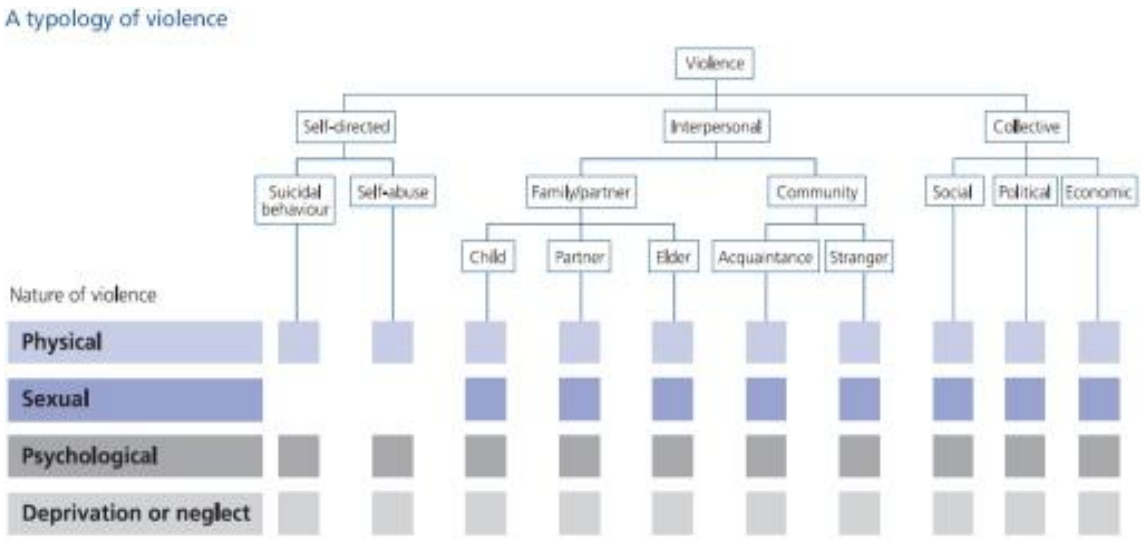

Figure 1: A typology of violence (Source WHO 2002)

The most common forms of violence towards nurses in mental health institutions include physical abuse which involves spitting, scratching, biting, grabbing, shaking, shoving, pushing, retraining, throwing, twisting, slapping, choking, burning, and using of weapons such as objects, knives and guns, while psychological abuse involves threats of violence or physical harm, hurting of victim's pets or property that may cause intimidation and emotional abuse which involves the use of abusive words and humiliation. (Thomas, Albert & Rodgers, 2006).

2. 2 Violence in mental healthcare and a comparision in different countries.

Violence towards healthcare workers in the field mental health care, care of elderly people and in the emergency, department happens too often to the point that some of the health care workers consider it as part of the job. Violence form patients with mental illness has always been a problem to the workers at mental health institutions and this happens in many countries and the results include hospitalization, disrupted work, social and family life changes. Patients with violent tendencies cause problems towards the treatment, other patients and the staff that work there. (Woods & Ashley 2007.)

This is not to say that these violent incidences should be taken lightly as they can at times be fatal. A good example is a case that happened in September 3, 2006, where Wayne Fenton, a prominent schizophrenia expert, was found dead in his office because of a tragic assault by his 19-year-old patient with schizophrenia. This incident raised the controversial debate regarding the potential danger posed by people with mental illness and caused many people in the mental health community to be concerned about their own safety in dealing with patients with mental illnesses. (Friedman, 2006).

The question as to whom could be more prone to violence in mental health institutions was concluded by Ridenour, Bell, Collins, Tiesman, Konda, Wolf and Evanoff (2013), who found that the registered nurses were the ones likely to experience overall aggression and verbal abuse while the practical nurses were most likely to be on the receiving end of the physical violence. The study further showed that it was more likely for the nurses to receive any form of violence than the non-nurses.

Kuivalainen, Vehviläinen-Julkunen, Putkonen, Louheranta, &Tiihonen (2013) from Finland, further supported this when they covered the years 2007-2009 in their research in which they found that within this period 840 incidences of physical violence towards nurses were reported. These results were later compared to violent cases in other countries and it was found that the 840 incidences accounted for about one fifth of the proportion which was the same as the violent cases reported in a setting in Canada. In German speaking Switzerland, 13.3% of the acute mentally ill patients were found to have violent tendencies. In Norway over one third of the psycho-geriatric patients were physically violent while in Italy one fifth of the locked-up patients who were there for a short while were physically violent. The study further found out that comparing this study from the Finnish mental illness violent setting to that of other countries proved to be difficult because each country had a different definition of violence, the hospital setting differed, and the reporting of the violent incidences was also different. (Kuivalainen et al., 2013).

The effect of this violent incidences towards health care organizations and staff, bring about medical expenses, potential legal expenditure, sick leave and a high turnover rate. (Sofield & Salmond, 2003). For patients, these events can mean longer periods of stay, higher medication use and more readmissions and finally for the nurses this can mean having negative physical and psychological effects. (Kisa, 2008.)

2.3 Mental illness, alcoholism and drug addictions in relation to violence

Swanson, Swartz, Van, Elbogen, Rosenheck & Stroup (2006) found that the rate of violence among those with a mental illness was twice that of those without a mental illness, but violence was more common in patients with schizophrenia than among patients with other mental disorders. This was further supported by Harvard health publication (1,2011) who found in their study that the most common types of mental illness that leads to violence are Schizophrenia and bipolar.

Furthermore, a diagnosis of schizophrenia was identified as a significant predictor of violent behavior in acute mentally ill patients in inpatient facilities, and in the community (Fazel, Gautam, Louise, John, & Martin, 2009). However, Swanson, et al. 2006 in his research noted that 92 percent of schizophrenic patients were not violent by their own report. Swanson identified

that the rate of violence increased instantly with the number of findings, and they concluded that dominant mental illness was one risk factor for violence, without the limit of many others.

In another study done by (Buckley, Enfley, Jons & Greenwood, 2003) it was revealed that 55 of 126 (44%) depressed patients reported anger attacks as part of their symptoms; irritability associated with depression and anxiety could culminate in violence.

In addition, alcohol and drug abuse was found to increase the risk of violent behavior in people with or without mental illness because these drugs lead to impairment of judgment, they alter a person's emotional equilibrium, and remove cognitive inhibitions. In people with mental illness, substance abuse may show symptoms such as paranoia, or hostility. Patients who misuse drugs or alcohol are also less likely to comply with treatment for mental illness, and that can make the symptoms of the mental illness worse. (Volavka & Swason, 563-564, 2010).

2.4 Risk factors contributie to violence

Mental illness is seen as one of the main reasons why mentally ill patients are violent and in fact, 45% of mentally ill patients reported aggressive behaviour and 33% demonstrated violent behaviours. Studies have also confirmed that the rate of violence among those with a mental illness was twice that of those without mental illness (Swanson et al., 2006.) However, there are other risk factors leading to violence. The risk factors of violence in the mental health unit have been divided into internal and external factors. Internal factors referring to things owned by the patient himself or herself e.g. character, personality, psychopathology etc. while the external factors are environmental such as the space and privacy offered to the patient and the relationship between the patient and the caregiver. The research further explain that internal factors are brought up by the patient’s psychology and personalities while external are the patients surrounding that may trigger into aggressiveness and violence. (Clarke, Brown & Griffith 2010.)

The reasons as to what makes the patient turn violent has been found to be agitation, when a nurse puts restriction to the patient’s behaviour e.g. the giving of rules, provocation from other patients and even visitors and lastly researchers have

begun looking at the link between the interaction of the staff and patients that results to conflict and in what sense the provocation occurs. (Clarke, Brown and Griffith 2010).

Highly related risk factors of violence have included age, sex of patient, and a historical record of antisocial and violent behaviour in the past, which can also be accompanied with substance abuse problems. Major mental and psychiatric disorders have also shown to be a predator of violence. Environmentally, the violence tends to happen during meal times, in the afternoon, in an area full of other people, in the corridors and in the room that the patients tend to spend their day. (Clarke, Brown and Griffith 2010).

However, another study by Cutcliffe and Riahi, (2013) confirmed the above as correct. The study went on to clarify that the risk factors could not merely be divided into two but into four independent phenomena's. According to the study, the risk factors of violence can be divided further into the relationship between mental health and the environment where the care is being given, the client and nurse relationship, the interpersonal and the mental health system. There is an argument that this phenomenal can be discovered by answering the following questions: how does the violence happens? Why does it happen? Where does this violence happen? And to whom does the violence happen? By answering this they believe that one can be able to derive a model or theory. The authors then used these questions to come to facts e.g. how noise can result to violence in the mental health unit among other things that they have made in the diagram below which is titled the systematic model of aggression and violence (A/V) in the mental health unit. (Cutcliffe & Riahi, 2013).

Systemic A/V Model	
Environmental related phenomena • *Notice level* • *Personal space* • *Structure of the unit* • *Locked doors* • *Degree of privacy*	**Client related phenomena** • *Demography: age, gender, admission status* • *Cognitive***:** *cognitive impaired or paranoid* • *Emotional status*

• *Other clients*	• *Previous response to threat* • *Diagnosis* • *Trauma*
Mental health care system Related phenomena • *Overarching mental health policies e.g. zero tolerance and custody* • *Unit policies and rules* • *Societal attitude towards clients with programme engagement* • *Cultural factors*	**Clinician related phenomena** • *Degree of communication /interpersonal skills* • *Degree of de-escalation and diffusion skills.* • *Attitude towards aggression and violence* • *Clinical stress levels and the degree of burn out* • *Engagement in clinical decision*

Table 1: The systematic model of aggression and violence

The data displays it is ignorant as well as wrong to say the cause of violence among mentally ill patients is the mental illness itself; instead, the current study reveals that mental illness is clearly admissible to violent prospect but that its contingent roles are complicated, indirect and fixed in a web of other relevant (agreeably more) important individual and circumstantial co-factors. (Cutcliffe & Riahi, 2013).

According to other studies alcohol and drug abuse was found to increase violent behaviour in people with or without mental illness because these drugs lead to impair of judgment, they alter a person's emotional equilibrium, and remove cognitive inhibitions. In people with mental illness, substance abuse may show symptoms such as paranoia, or hostility. Patients who misuse drugs or alcohol are also less likely to comply with treatment for a mental illness, and that can make the symptoms of the psychiatric disorder worse. (Volavka, 2010.) In conclusion the knowledge of the patient, their history, beliefs, their mental situation and their

violent incidences helped the nurses who participated in the survey reduce the risk of patients being violent towards them. The nurses seemed to have an idea about the patients expected behaviour and had a chance to be ready for violent situation and know how to manage this situation. (Trenoweth, 2003.)

2.5 Prevalence of violence according to gender variation in the mental health unit

It is clear that nurses are the ones that are most prone to work place violence, which negatively influences nurses who are victims in these situations in terms of quality of work and motivation to continue working. A lot of factors, such as age, gender, education, job position, working hours, and the nurse-patient relationship, have an effect that trigger violence among patients towards healthcare nurses (Susan, Timothy, Patricia, Helen, Nancy & Mindy, 2005).When the gender of the nurse is factored in, female nurses are most prone to being attacked by patients in terms of sexual abuse either by words, actions or behaviours, when compared to male nurses and it does not help when the male patients tend to look down upon female nurses. It is further notable that female nurses reported more physical abuse than males and since the females were generally smaller in physical structure than their male counterparts thus making them an easy target. (Paola, Monica, Cecilia, Rosaria, 2016).

In some cases, it happens that just because the patients feel that they have lost power and control to the illness, they tend to lash out their frustrations to female nurses as they perceive them as weak. It is unimaginable and sad to think that 13,935 women were the victims of violence in their various job placements in the year 2000 according to a research conducted by National Victimization Survey from the United States of America (2016).

Majority of nurses in the current world are women, and most of the time works in unsafe environments. When compared to any other professional group nurses are three time more likely to experience violence. There may however be a relationship between the risk of violence experienced by women in general and the violence risk of female nurses. (NIOSH, 2006.)Studies on violence against women served as a precursor to later studies on violence in the workplace, healthcare sector, and against nurses. From research it’s been found out that violence against women is globally pervasive and cuts across all ethnic, racial, religious, and socioeconomic

"(American Nurses Association, 2000.) However, when it comes to the patients, female patients were just as likely as male patients to have been violent towards the nurses and the characteristics of the violent attacks were the same for the two genders.(Krakowski & Czobor, 2004.)

3 Aim and Purpose

The aim of the research was to find out experiences of nurses dealing with violent patients in mental health institutions. The purpose was to describe the nurses' experiences with violence in the mental health care and to provide information that could promote awareness and safety.

This study sought to address the research question:

- What are the experiences of nurses dealing with violent patients in the inpatient mental health institutions?

4 Methodology

4.1 Literature review

This study was established on a literature review of elected articles. Literature review is an analysis that is done of previous empirical studies. When it comes to health care, Literature review's main aim is to answer questions whose goal is to inform healthcare workers and patients of the best available outcome when making healthcare decisions, in policy making and to point out future research arranged preference. The main purpose of a literature review is to exploit and discover more information about the topic. Always the reviewer goes to the extent of critically analyzing the research material from the published sources as long as the content tries to answer the research question, also finding more information and to illustrate more about the relevant topic. In the health care sector systematic reviews aim to increase the evidence-base behind professional interventions and to assess, as well as improve, the effectiveness of clinical work. (Joanne & Hellen, 2015.)

According to Kiteley and Stogdon (2014), a literature review is a summary of ideas, approaches and findings of previously published topics and issues. The University of Toronto (2008), goes further by stating that literature review is an

evaluative report of information found in the literature related to your selected area of study. It should give a theoretical base for the research and help the author determine the nature of their research. Studies that are irrelevant should be discarded and those that are parallel to the study critically analysed. A literature review is more than the search for information and goes beyond being a descriptive organized list of sources. Instead, all studies included in the research much be read, evaluated and analysed. The literature should also go hand in hand with the researched studies. The idea of all this is so that the readers can identify what the research is about, what is the knowledge behind the study and what are its strengths and weaknesses. The research question must be answered at the end of the study. This literature review sought to answer the research question: What are the experiences of nurses dealing with violent patients in the inpatient mental health institutions? During the research it was important to critically analyse what to include and exclude from the found studies and to make sure that the selected studies answered the research question at hand. (The University of Toronto, 2008.)

The process of doing literature review begins by formulating a research question or questions based on the topic of interest and managing the search to have relevant articles, then synthesizing the research and finally writing an assessment. Different articles are narrowed down to get relevant information step by step then data analysis and synthesis are carried out. (APU writing center, 2015.) The authors of this this literature review chose this method because it answered the research question and provided adequate and accurate information that was crucial in accomplishing an evidence-based research.

4.2 Data search

The data search was done from mid-November 2016 to early April 2018. The articles selected for this research were obtained from CINAHL (Ebsco) and PubMed data bases. Other data bases were also used to find more research data but were excluded because they were either irrelevant or not freely accessible. The articles obtained addressed the topic of research which was nurses' experiences in dealing with violence in inpatient mental health institutions, and the key words that were used in the search were "violent patients" or” brutal patients" or "aggressive

patients " and from these keywords target group was obtained of patients who are violent towards nurses. The next category of key words was "mental health unit " or "mentally ill" these was used to define the department setting where the research is being conducted, and articles that presented hospital departments and municipal care units were excluded from the search. The last category of key words was "Nurses experiences" or "nurses view" or" nurse's perspective", which guided the search into the nurse's perception on violence, nature of violence and the support they received after the violence.

The first stage of data search, the authors used CINHAL data search engine. However, some of the articles were in link form which lead the authors in using PubMed search engine to acquire them. At first the key word used in the search engine was "nurse's experiences" or "nurse's perception" or "nurse's view" and the number of articles obtained from the two search engines were 8,479. But the research was narrowed down the search to focus the search on "violent patients" or "aggressive patients" and those articles that were relevant to the search reduced to 3,458. The final key words to narrow down the search were "mental unit" or" psychiatry" and these reduced the number of articles down to 2,151.

The second stage of article selecting was mainly exclusion of articles that did not meet the criteria.The result of the research was then compared to the inclusion Table 2 and any limitations during this process where acknowledged.

- **Literature published in English**
- **Full text article citations**
- **Published 2003 to 2018**
- **Evidenced based published literature**
- **Academic journals provided for free for JAMK students**
- **Adolescents, young adults and adults**

Table 2: Inclusion criteria for articles.

Since the research was mainly focused on years 2003 to 2018 those that did not meet these criteria were excluded and articles remaining were 1,575 articles. The

search was further conducted according to the abstract and those articles that did not meet the criteria were eliminated and 518 articles remained. The research further deduced this to articles that had references and 492 articles remained. Then articles that had full-text citations were selected which reduced the number of articles to 204. The remaining articles were narrowed down by selecting only academic articles whereby only 176 articles remained, from the remaining the search was directed into a specific age group which was the adults only and finally, only 76 articles remained. This is described in Figure 2 below.

Data base	Key words	Results	Based on abstract	Based on full text	Based on age	Based on title and year.	Based on relevant study
CINAHL	¨Nurses experiences¨ OR ¨view¨ OR ¨perception¨	8479	518	204	76	13	9
&	¨Violent or brutal OR aggressive patients¨	3458					4
PUBMED	¨Mental health institution OR mentally ill¨	2151					

Table 2: The process of article selection

The articles that were deduced for this study were N=13 which had been published between the years 2003- 2018.The reviewed articles are listed in the Appendix 1 in the Appendices chapter below.

4.3 Analysis and Syntheses of Data

Analysis and synthesis of data from the selected articles in this study resulted in answering the research question. Content analysis is a method of analyzing written, verbal or visual communication messages and it is used in many nursing studies. Content analysis is mostly used in psychiatry, gerontology and public health studies. (Elo & Kyngäs 2007.) Content analysis as a research technique is a systematic and impartial means of describing and measuring phenomena (Krippendorff 1980). It involves cataloging the phenomena into the identical categories, words and phrases that share the same meaning. This gives the researcher an opportunity to test hypothetical issues to make it easy to interpret the data. The content analysis process also enables the researcher to break down the words into fewer content-related categories. (Elo & Kyngäs 2007.) Content analysis is also a research method for making replicable and valid implications from collected data putting them into context, with the purpose of providing in-depth knowledge, new insights, a thorough representation of facts and a hands-on guide to action (Krippendorff 1980).

The figure 3 below describes the process in which articled obtained were analysed and synthesised to create the themes and subthemes that were used in the results.

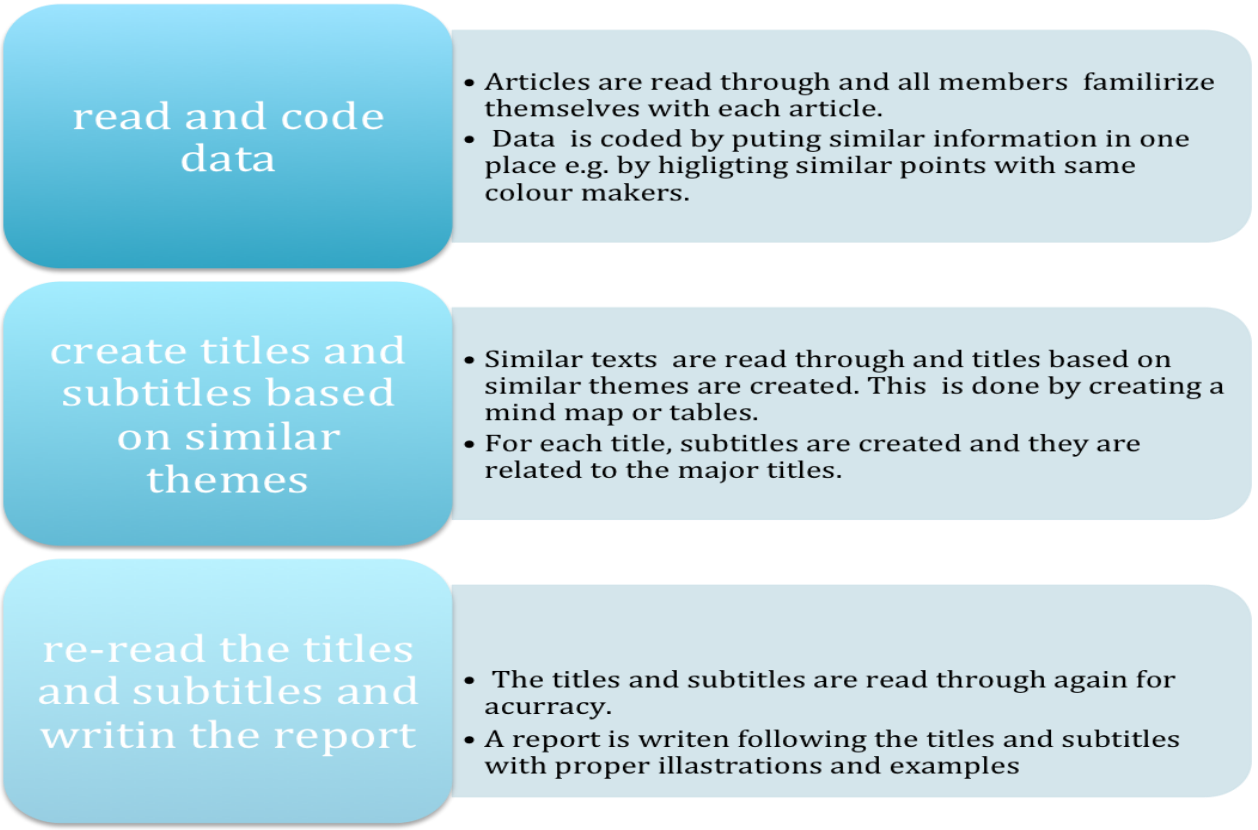

Figure 2: Guideline of data analysis

5 Results

Through extensive analysis of the 13 articles four themes emerged that illustrated nurses expeiences dealing with violent patients in the inpatient mental health institutions. The themes were further supported by the sub-themes as illustrated in table 4 below.

Research question: Experiences of nurses dealing with violent patients in the inpatients mental health institutions	
Themes	***Subthemes***
Nature of the violence	• Types of the violence which included; physical violence, verbal violence, sextual and psychological violence. • Hectic work environment.
Impact of the violence	• Emotional, physical, financial and educational outcomes. • Feeling unsafe in the work environment.
Providing care after the violence	• Support and coping strategies After violence. • Discretion to work with violent patient. • Attitudes of nurses towards Violence. • Motivation to stay and empathy
Ethical issues	• Nurse patient relationship

Table 3: Themes (Maria, Glue, Carlyle, 2014)

5.1 Nature of the violence

According to the nurses, violence towards them was usually brought about by the patient's internal factors which were the mental illness and the drug abuse problems, the external factors which consisted of environmental things and situations that surrounded the patient or the interactional factors that mainly

revolved around patient to patient relationships or nurse and patient relationship. (Duxbury & Whittingtons, 2005).

Types of violence

Through the nurse's narrative of their experience to violence, it was clear that factors such as personal behaviour, professional expertise, and clinical roles, static or dynamic factors contributed directly to the violence. Violence was something that all nurses agreed was very present in the mental health care and that as much as they did not like the idea of it happening, it was due to happen as long a nurse worked in mental health institutions (Maria, Glue, Carlyle, 2014) and one could argue that the perception of what is an aggressive act can vary between groups and cultural settings, which made violence endured by nurses at their work places having negative impact in one or more aspect of their lives in one way or another, but in different ways (Duxbury & Whittingtons,2005.)

Nurses are the professionals who face the highest risk of violence. The nurses felt that the violence had violated not just their work life but extended to their social circles and their personal space as well. It was difficult for them not to feel threatened even when they were not in the environs of their work. (Currid, 2009.) The reason as to why there is more female nurses experiencing violence, is because the number of female nurses in a working place is usually higher (Atawneh et al, 2003.) and despite all the forms of violence, verbal abuse was stated by most of the nurses as being the most prevalent. Verbal abuse was something that they expected to happen each day and termed it as being part of their job. (Maria, Glue, Carlyle, 2014.) Nurses described that the nature of violence involved; being shoved, chased and being cornered by the patient, being kicked, bite and strangled to inflict pain. Sometimes the patients used weapons to attack the nurses. The patients would go to the extreme where they would break windows, doors and furniture and use them to attack the nurses. When it came to verbal abuse, the nature varied from swearing, cursing, intimidating gestures, inappropriate sexual comments and there was psychological abuse that involved blackmail and guilt trips. Some nurses also encountered sexual abuse with the content of rape (Kelly, Susan, Linda &Jeannette, 2015.)

Hectic schedules

The nurses termed most of their days as being hectic, chaotic and quite busy. This was because of the shortage of staff as compared to the number of patients. Due to this the nurses were unable to care for the patients appropriately and sometimes in aggressive situations heightened the chances of a nurse getting injured because of lack of enough staff to help in this critical situation. (Van Niekark et al., 2009.) In other cases, they needed to give medications, food, deal with the crisis and council their patients. Due to the chaos of the day, meal times and medication times were sometimes delayed. Other times nurses had no break at any given time making them feel tired and sleepy. Occasionally, the much-needed assessment of the patient did not happen, and it is during this window of vulnerability that anything was possible, and the nurses were quite prone to violence. (Bonner, 2012.)

5.2 Impact of violence.

Around thirty three percent of the interviewed nurses who were victims of violence in the mental health unit developed physiological issues after violence. Twenty six percent of these suffered from serious physical injuries while Ten percent of the violated nurses ended up suffering from post-traumatic stress disorder. (Pellicani & Gabriela, 2016.)

Emotional, physical, financial and educational outcomes.

Currid (2009), stated that nurse's emotions after the violence ranged from fear of their lives, anxiety, frustrations, vulnerability, a feeling of distress, to even anger. However, when these were not dealt with they later lead to other profound and long-term side effects that affected their personal and professional status. Some of the nurses not only felt angry towards the patients but at some point, they found that they consequently poured their anger towards their fellow workmates. This in turn created a non-therapeutic working environment. (Maria, Glue, Carlyle, 2014). The anger towards colleagues was because they felt that their fellow co-worker did not engage in team work and collaborate during care giving which could have been prevented or at least minimized the impact. Some of the nurses opted to leave their profession and work somewhere else, gave accounts of nurses who stated that some of their colleagues had left their job due to violence as it was too much for them to handle. (Kelly, Susan, Linda, 2015.)

Feeling unsafe at the place of work.

After the violence, the Nurses were concerned about their physical health, mental health and general well-being after incidents of abuse. They were terrified and scared. For some nurses they felt that they were left with a permanent scaring suffered from trauma. They felt angry that the patients had scarred them and very unhappy because this scar was something that they had to see throughout their lives. Nurses also felt hopeless and worried in cases where nothing was done after they were violated as they felt that the same incidence was prone to happen again and even if not towards them then to one of their workmates. (Bonner, 2012.) In some other instances nurses lost their self-esteem, their confidence and always had a burnout. Since violence aftermath has no boundaries, the negative impact was evident outside work. Families of the victim could notice that the victim looked exhausted and was even unable to do more chores at home after work while others were unable to handle their parental responsibilities forcing the rest of the family to step in. This extended even to their social circles. (Maria, Glue, Carlyle, 2014.)

Physical effects ranged from mild to serious. Mild consequences were for example having bruises, abrasions and swelling while serious conditions ranged from head injuries, sensory defects and asphyxia. In some cases, the physical consequences caused long-term effects such as memory loss, which made it very hard for the nurses suffering from this to do their job. (Kelly, Susan, Linda &Jeannette, 2015.) Physical violent injuries later paved way to financial problems. After the violence some of the nurses needed to stay home for a while and this resulted to having a loss of regular income. The injuries incurred by the nurses needed treatment, which they had to take care of by themselves with money that could have otherwise been saved or used somewhere else. After the assault some nurses stated that the patients behind the violence showed no remorse for their actions and to make matters worse some of the patients even went ahead and intimidated or threatened the nurse they had violated. (Maria, Glue, Carlyle, 2014.)

Atawneh et al. 2003, conducted a research to determine the degree of the violence among nurses working in the general hospital in Kuwait, of which in his study he managed to point out at how nurses were worried about work place violence violence. From his findings roughly seventy eight percent of the nurses were worried about work place violence, fourty four percent believed that draining to deal

possible violent patient could help curb mental violence despite the fact that fifteen percent of the nurses had received necessary training. According to the number of assaults five out of fourty incidents involving physical attacks had the offender charged by the police but non the less none of the nurses had been advised to report any incident to the police. The nurses attitude towards violence in general is negative and this influences their attitude towards the patients nursing interventions, they prefer medication therapy and restrain to interview therapy which is one on one with the patient. (Martina et al., 2016.)

After violence occurrence, there was a heightened sense of awareness. These emotions expressed did not only occur in the work place but also outside the patient ward. Someone becomes more vigilant and self-cautious to fellow colleagues and were in a constant scanning mode of the premises where they are seated. Every place they were in felt very insecure and exposed (Kelly et al, 2015). For some, the violence was educational as it prompted them to learn more about taking care of their own safety as well learning new skills on how to approach their patients and so be careful with their actions as this could trigger a violent episode at any given time. (Chapman, Styles, Perry & Combs, 2010)

Nurses felt safer when safety programs that could help the nurses know how to keep themselves safe were implemented. Other issues that impacted on feeling unsafe were the nurses hectic work life, the stress that was brought about by their line of work and the lack of support when the violent incidences happened. Most of the safety measures taken were mostly for the patients and rarely for the nurses. Even if the measures were there, there were not enough to protect the staff adequately against violence. Having the buzzer or the panic button and using it when something happened did not always guarantee that the security personnel would be able to come to your aid and most of the time your fellow work mates were the only ones who came to the aid. Going through dark corridors where the nurses could not see quit well raises concerns as anything could happen to them in this area while they were alone. (Bonner, 2012.)

Having patient who were involved in gangs and people who were from jail because they had assaulted someone close to them like relatives, made most nurses feel unsafe. Some of these patients could be big and strong, and it could get dangerous when the female nurses were the ones available to restrain such a patient. Facilities

were seen to sacrifice the wellbeing of the nurses for the safety of the patients and the legal and political stand required accountability on the interest of the patients and not the nurses. (Bonner, 2012).

5.3 Providing care after the violence

Support and coping strategies after violence

Peer support was the most common form of support that all the nurses reckoned with. They gave a reason to this as the fact that they felt close to some of their workmates and the fact that the colleagues are the ones who are always present during and after the violence. Nurses acknowledged that they felt safe and cared for when their work mates called to check in on them after a violent attack. Nurses felt that although the management support was better compared to past years, there is still so much they need to do in making the nurses feel safe. The management just did not seem to care about their personal wellbeing. (Maria, Glue, Carlyle, 2014.) Sometimes the management acted cold and uncaring towards the nurse who had been assaulted. Most nurses did not feel that the management came to their aid when a nurse was a victim of violence. (Van Niekerk et al., 2009.) To make matters worse the management could go ahead and blame the nurse for the violence stating that it was something they did wrong or failed to do. They furthermore give you 2 days off and then expect you to resume back to work as thought nothing really happened (Bonner, 2012.) The less experienced nurses felt that the senior nurses did not offer them moral support after a violence episode. The senior nurses claimed that they need not to worry these incidences are meant to thicken their skins (Nicola et al., 2011.)

Discretion to work with violent Patients

According to Chapman et al. (2010), nurses felt disenfranchised on which patients they wanted to work with. They found it unfair since the head nurse and the nurses in charge of the shifts had this discretion. Sometimes a nurse had no desire to work with a patient who had violated them, but they still found themselves assigned to the same patients. Other times the nurses could bring the issue to the head nurse and the head nurse would still expect them to work with this patient as it was part of their job. Even when the patient kept threatening the nurse and the management

knew about it, the nurses were supposed to lick their wounds and get back to work as though nothing had happened (Bonner, 2012).

In Some instances, the nurses were quite upset because they felt that most of the security officers just watched as the patients were hurting the nurses. In some instances, they had called them only for them to reply that they were unable to avail themselves as they were occupied somewhere else and sometimes the nurse was severely hurt with no one to really come to their aid. (Bonner, 2012.) Other times they did show up, but it was too late, and a nurse was already hurt or had received help from other people (Kelly, Susan, Linda, 2015). Stress debriefing was brought out as a factor that had positive influence after the violence. However, for it to work it had to be done at the right time and when the assaulted nurse was in their right mind frame (Bonner, 2012).

Legally, it seemed that there was no clear support. This is because in some cases there was a clear notion that the nurses were supposed to accept the violence as part of their job. Both the management and the police brought about the issue that since the nurses were working in mental health they were supposed to be aware that at one point or another a patient could hit them. (Maria, Glue, Carlyle, 2014.) The state further denies any kind of claims even from nurses who have been disabled during the violence leaving the victims with no support at all (Bonner, 2012).

Motivation to stay and empathy

Dealing with the violent issue as soon as possible helped the nurses get over the fear of being attacked and if this was not addressed then it easily got out of hand. Furthermore, the nurses suggested that if they received enough support after the violent situations then they could be able to get back to work much sooner than they normally do. (Maria, Glue, Carlyle, 2014.) Many nurses narrated how they quickly had to recollect themselves after the violence and give care to the patient. Some of them did not even think twice about it and even those who felt afraid, angry and lacked confidence knew they were obligated to provide the care. (Bonner, 2012.)

Apart from peer support and management resolutions, nurses had their own ways in dealing with the assault whether it was spiritual, or philosophical. The Christians for example stated that prayers helped and being brought up in the Christian

environment had helped them a great deal in persevering. Their Christian partners also offered their time to listen to their grievances and helped in coming up with new ideas of coping with situations. Other nurses sought refuge from inspirational quotes that helped them go through most of their days. In some of the quotes there were reminders that the patients were not the problem, but the illness was. (Bonner, 2012).

5.4 Ethical issues

Nurse patient relationship

Nurse – patient relationship in the mental health care needs to have trust, choice and mutuality for there to be a therapeutic outcome. However, whenever a violent incidence happens, the trust is broken, and the nurses somehow withdraw themselves from the patients due to the fear for their safety. Mostly the nurses have a dilemma in choosing between the obligation to give full care to a patient to taking care of themselves and in most cases the nurses choose their own safety other than treating the patient properly. The term that nurses are always supposed to “do well” seems to be taken for granted and the nurses wondered when enough is enough especially when dealing with patients who were demanding, angry and non-cooperative. Duty to help the patients was found to be a painful pill to swallow in cases when a patient had violence tendencies. The nurses felt that they had no obligation to also put themselves to harm's way even if the patient was in dire need of their help (Maria, Glue, Carlyle, 2014).

6 Discussion

6.1 Reliability, validity and ethics

The research was conducted according to the principles of reliability and ethical principles of JAMK 2013 that involved honesty and credibility. In addition, all articles were up-to-date between years 2003 and 2018 for the authors to achieve credible results within the time limits that was being targeted. All the articles were evidence-based accordance to the JAMK thesis writing requires. All the authors involved in the research contributed in comparing, obtaining, analysing and presentation of information to outline vigorous, reflective and credible opinions. It can be stated that all the data presented was theoretically based and had proper referencing to its respective authors.

The study had some limitations. First off, studies viewed violence differently and some did not include all forms of violence in their studies. It was clear that violence needed to be clearly defined universally first before any other further action could be taken. The reason for this was because every county had different policies in accordance to violence. The literature also had difficulty on choosing the perfect recommendation of what really should be done in violent situations. This was because every country had different setting in their mental health institutions, the cultures differed and the ethical question of what was wrong and what was right. A good example was the retraining of the patients which was ethically agreeable to some countries while to some the thought it was inhuman an ethically wrong. Even if there were a large number of studies which offered solutions, our study tried to narrow the recommendations of this study to what were the most prevalent recommendations and also choose Finland as a prototype of the methods that were already in place. This means that there is still room for more studies to be conducted and a more universal approach to be found. The last limitation was that in some studies they used the registered nurses, in others they used both the practical nurses and the registered nurses. The study cannot therefore be said to target a branch of nurses.

In literature review, researchers are always advised to avoid getting involved in writing misconduct that entail fabrication, falsification, plagiarism and biasness in rendering information during the process of conducting a research, recommending results and reviewing of results. (Steven, 2007) (University of Melbourne, 2013.) Fry and Johnstone (2008) detailed that ethical principles are there to aid in the process of conducting a research specifically in making an upright and moral decision and ethical actions. Any kind of research done had got an aim to facilitate though better understanding of the materials that are involved in the study and using the materials according to the stated law to avoid any potential harm towards the research. This ethical principle guided the literature review in question to ensure that the results were reliable, acceptable and credible. (Fry& Johnstone, 2008.)

The authors through conducting the research followed proper stated ethical principles that have been laid down to avoid plagiarism, and by doing this the study avoided taking other authors information and ideas and passing them directly as the researchers owns work without acknowledging the original writer (Steven, 2007).

Falsification was also observed which aided the study to abstain from manipulating any kind of study by compressing any given data and tampering with the results obtained without following the laid guidelines and procedures that is scientific and already justified. Lastly, fabrication was put in consideration to present correct information. (University of Melbourne 2013). In this research, all studies that used the interview and questionnaire analysis method acquired ethical approval from the relevant departments. However, in some of the studies they laid down what the ethical consideration were while in others they failed to do so. For this reason, it was difficult in knowing in those studies if the nurses were treated with respect, if their privacy was protected and if the interview was free of any bias. However, in some of the studies the ethical issues were addressed. In those cases, the nurses were first briefed about the survey before it commenced, it was disclosed that the survey was voluntary and anonymous, it was confidential and the period of when they could return the survey was clearly stipulated.

The authenticity of the thesis was maintained by acknowledging the sources used and citations were added throughout the thesis. This thesis was based on previously researched material and any suggestions and propositions that have been made will require further research and analysis to either prove or modify the contents to get to a conclusion which is scientifically obtained by the standard research methods leading to an established evidence-based practice.

6.2 Discussion of main results

A significant number of nurses had fallen victim to some form of violence in the study. In some cases, the incidences were so bad that the nurses had to be sent to the hospital and even worse some nurses succumbed to the injuries from the violent incidences. (Clarke, 2003.) Some of the nurses wondered how far the violence had to go before any action had to be taken. To some of the nurses either the verbal or physical abuse was a daily occurrence that it took them by surprise if it did not happen in a particular day. The new nurses were afraid that if they reported the cases they would be viewed as people who enjoyed complaining or that they were incompetent and unable to handle their patients. (Bonner, 2012.)

It was unfortunate some of the nurses thought that encountering the violence during their work was part of the job. Once the violence had taken place, they

had to take a second, put their work face on and continue with their work shift as if nothing had happened.(Bonner, 2012).The study also brought across an interesting fact that most of the recipients of the violence were the female nurses. The reason behind this was because they apparently appear smaller and weaker than their male co-workers. It was also suggested that sometimes it could be because some male patients were frustrated about both their mental illness and the fact that they were being given orders by female nurses whom they thought little of. (Maria et al., 2014).

The events leading to the violence showed that some of the nurses had little to no education about how to deal with violent patients. Sometimes the colleagues might not have been quick enough to help and more, so the security personnel came too late when violence had already happened and sometime time's one or more of the nurses was already injured. Reporting of the violent cases was undermined which in turn lead to so many unreported cases. Since it did not matter if they reported the incidences because nothing was going to be done. The management could at times act cold towards this situations and worst of all in other cases there was no legal platform for these nurses. (Bonner, 2012)

The reason for the violence happening in the first place was thought to be purely due to the mental illness of the patient or their drug abuse. However, the reviewed articles showed that researchers have found the root to be more than the two. It would be naive to say that just because the patient had a mental illness or was under the influence of drugs and alcohol that they had to be violent. While this might be the case, external factors were also seen to be the provocative to violent situations. (Swanson et al., 2006).

There have been plenty of studies conducted on the research topic which have immensely contributed in provision of the know-how about nurses and violence in the mental health institutions. There was however contradictory knowledge which was justifying nurses' experiences with violence patients. The studies explained that, to some extend it is the nurse's fault that one is violated because they failed to do what was expected or did it wrong. For instance, due to the busy nature of their work, sometimes the nurses forgot to give patients medication or sometimes they gave it too late. The patients' illness without the medication which might be the

reason as to why the patient keeps calm, leads to episodes of mania, restlessness, anxiety and even violence. (Bonner, 2012.)

In another study done by Isaac (2016), the author gave other reasons as to why a nurse can be responsible for the violent nature of the patient. The author argued that issues of unresponsiveness to the patient's demands or questions can cause the patient to be agitated and anxious because a good number of patients think that nurses should be able to respond quickly and effectively to their demands and sometimes this is not the case. The other reason was that some of the nurses also lucked the inter-personal skills where their body language and verbal skills were not so good. Some nurses seemed to have very bad attitude towards their job and sometimes they could be rude to the patients, be sarcastic and even abusive. Its issues like this that escalated from the patient being agitated to being violent. However, it's sad that innocent mental healthcare nurses sometimes undergo violence in their everyday work. Bonner (2012) thought that it was unfair for people to take advantage that nurses should always do good or that it was their job to be physically, verbally and sexually violated. According to him, violence should never be part of the job considering nurses have to work with limited resources, limited staff and limited salaries.

Nurses could benefit from regular participation in skill development workshops to promote self-protection from all kinds of violence, how to recognize it, and what to do about it. Nurses should be encouraged to note hostile events accurately, as when pursuing action against a bully such records are invaluable. This is especially important when one considers the very lengthy duration of some episodes of bullying. It is also important that all nurses be empowered to intervene where they witness victimization and bullying of colleagues (Dellasega 2009, 57). It was also suggested that making training more accurate to staff needs and offering a selection of modules should be a priority. Simultaneously, staff must be made more aware of their responsibilities in this area in alerting managers to their training needs, be encouraged to voice their violence experiences and the administration should provide avenues for assisting casualties of workplace violence. When nurses are well trained, they will be heightened awareness of violence and aggression and being more diligent in reporting incidents (Institute of Psychiatry, 2002.)

In Finland, the National Program for prevention of violence (2005) has layer guidelines on how nurses should deal with violence. The Hospital of central Finland for example has the Avekki, which is an educational security simulation on how nurses should approach agitated or violent patients. Avekki has simulations YouTube videos that can be accessed by anyone. Furthermore, the hospital has insurance for their workers, they provide emergency mobile gadgets that nurses can press in case of a violent or urgent situation, the security guards make routine rounds in the hospital just to ensure that everything is okay and also they have provided an online program called Haipro- työturvallisuusilmoistus in which there is a form where a nurse can fill in a complaint about a violent situation, when and what happened and if there were any injuries. The program allows the victim of the violence to follow the progress of the claim (Ksshp, 2018.)

Violence by patients should be punishable by law and patients even got jail sentence for the violence against a health professional. Having such systems could help nurses find justice because of violence in their line of work and for the general public to learn and stop misusing the good will of nurses and perceiving that violence is part of a nurse's job. (Kuivalainen et al. 2013.)

6.3 Conclusion

Majority of nurses working in the mental health institution are more likely to encounter violence in their day to day work life which brought about negative effects in both personal and professional lives. It was evident that most nurses had difficulties working with patients who had violated them while still being professional. For the nurses to uphold proper care and for their profession to be dignified, it was clear that that they needed peer support from their colleagues and management, education on how to avoid or deal with violent incidences, a legal platform, financial assistance for medical aid after violence, moral support, better working hours and more staff and quick security response. From the study it was evident that a lot of research about nurses' experiences dealing with violence patients has been conducted, but there is need for further research to help in curbing, predicting and preventing violence against nurses in the mental health institutions.

This study sough to enumerate the previously existing studies and initiated four topics; nature of the violence, impact of the violence, providing care after

violence and ethical issues. According to this literature review, the purpose was to describe the nurses' experiences with violence in the mental health institutions and to provide information that could promote awareness about violence, what the situation is now, what can be done better and if there is need for further studies. This literature review can be used by student nurses, nurses and nursing lecturers to promote awareness on violence and come up with solutions, and education on how to deal with violent patients.

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Appendices

Appendix 1: Reviewed articles

Author	Year/Country	Title	Method	Main findings
Clarke, D., Brown, M., & Griffith, P.	2010, Canada.	Clinical utility in a secure psychiatric intensive care	Qualitative research and interview	The fear of violence from patients may affect the

2010. The		setting: Broset Violence Checklist.		quality of care that mental health nurses provide.
Chapman R; Styles I; Perry L; Combs S	2010, Australia and New Zealand	Making a world of difference: workplace violence and nursing, Nebraska Nurse.	Qualitative research	Found how nurses used the violent incidences to finding meaning, gaining mastery and enhancing the self to adapt to workplace violence
Atawneh, F, A., Zahid, M, A; Al-Sahlawi, K, S; Shahid, A, A; Al-Farrah, M, H.	2003, Kuwait.	Violence against nurses in hospitals: prevalence and effects. Mental health nursing.	Comparative analysis	Our findings suggest that doctors experience more violence but nurses suffering from more after-effects of violence at work.
Currid, T.	2009, UK.	Experiences of stress among nurses in acute mental health	Interpretative phenomenological analysis	Study indicates that staff are frequently subjected to

		settings.		violent and aggressive behaviour from patients.
Kelly, N, S., Susan, M, J., Linda, O., & Jeannette, L.	2015, Canada.	Registered nurses' experiences of patient violence on acute care psychiatric inpatient units. An interpretive descriptive study.	Thematic and comparison analysis	Registered nurses were not supported in their roles while they faced different forms of violence
Maria, B., Glue, P., Carlyle, D .2014. '	2014, New Zealand.	Psychiatric Mental Health Nurses' Experiences of Patient Assaults from a New Zealand Perspective. Violence is Not Part of Our Job	A Thematic Analysis of Psychiatric Mental Health	Healthcare employers needed to provide better support services to the healthcare professionals who are assaulted, and the legal system also needs to acknowledge that assaults against nurses

				are a violation of human rights and violence should not to be tolerated as part of working in mental healthcare settings.
Martina, T., Ivana, B., Martina, L., & Juraj, C. 2016.	2016, Slovakia.	Nurse's experience and attitudes towards inpatient aggression on psychiatric wards.	Quantitative analysis.	Internal factors foster patient aggression
Bonner, P.	2012, USA.	The lived experiences of nurses who were assaulted by their patients in psychiatric settings. Touched by violence and caring for the violator.	Thematic analysis.	Nurses who worked in mental health inpatient institutions were concerned about their safety.
Van Niekerk,	2009, South	Violence and	Narrative	There is need

A., Seedat, M., Jewkes, R., Ratele, K.	Africa.	injuries in South Africa: prioritising an agenda for prevention	literature review	to develop preventive measures in order to cab the burden of injury and impact of violence.
Pellicani, V., Gabriele, D.	2016,Italy	Workplace Violence toward Mental Healthcare Workers Employed in Psychiatric Wards.	Systematic Literature review	Need to better investigate the psychologic consequences of work place violence.
Maguire, J., & Ryan, D.	2007, Ireland and U.K	Aggression and violence in mental health services.	Descriptive and inferential analyses	Nurses in the Mental Health Service experienced high levels of verbal aggression, with distinctions obvious between threatening and non-threatening

				aggression.
Nicola Magnavita, N., & Heponiemi, T.	2011, Italy.	Workplace Violence against Nursing Students and Nurses. An Italian Experience.	Comparative analysis	There is urgency in preventive response in controlling patient to worker and worker to worker violence in mental health institutions.
Duxbury & Whittingtons	2005, UK	Causes and management of patient aggression and violence: staff and patient perspectives	Quantitative research and interview	There is need for more crisis and aggression management.