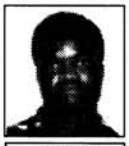
PROFESSIONAL NURSES' EXPERIENCE OF VIOLENCE WHEN NURSING MENTALLY ILL PEOPLE IN GENERAL HOSPITAL SETTINGS: A PHENOMENOLOGICAL STUDY



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ABSTRACT

Due to a lack of the knowledge and skills required for nursing mentally ill people, professional nurses in general hospital settings tend to not apply appropriate techniques when dealing with mentally ill people. This increases the problem of violence in units of general hospitals. As a result, a qualitative study aimed at exploring the experience of violence by professional nurses was carried out at a tertiary institution in Durban.

An explorative, qualitative, descriptive and contextual design was followed as the basis for conducting the study. The above-mentioned research design was achieved through fieldwork conducted in an urban-based general hospital. A sample of twelve professional nurses was selected from a population of 800 professional nurses employed in this setting using a purposive sampling technique. This sample size was determined by saturation of data as reflected in repeating themes.

Both individual phenomenological semi-structured interviews and field notes in the form of observations were used as methods of data collection. The fieldwork was conducted without any pre-set theoretical framework of reference by using bracketing and intuiting. During interviews, participants were asked only one research question, namely: "How do you experience nursing a violent mentally ill patient?" Communication skills were employed to encourage participants to verbalise their experience of nursing a violent patient within a general hospital setting. A tape recorder was used to collect data and the data was transcribed verbatim. Data collected was analysed following a descriptive method of Giorgi (1986). The researcher and an independent expert who is a psychiatric nursing specialist and a qualitative research expert carried out coding. After data analysis, the results were reflected within patterns of interaction of the Nursing for the Whole Person Theory in order to give structure to the research findings.

Eight themes emerged and formed the results of the study. The measures for ensuring trustworthiness proposed by Guba (Lincoln & Guba, 1985) were used as the basis for ensuring reliable and valid findings. It became clear that the nurses' experience of violence when nursing mentally ill people within a general hospital setting was negative and affected their social and psychological functioning. It was recommended that a model for facilitative communication be developed and tested within the institution in which the study was conducted, with the aim of improving the interaction of nurses with mentally ill people and their families, the nurses' superiors, and doctors.

OPSOMMING

Weens die gebrek aan kennis en vaardighede benodig vir die verpleging van geestesversteurde persone, hanteer professionele verpleegkundiges in algemene hospitale geestesversteurde persone sonder bogenoemde kennis en vaardighede. Dit verhoog die probleem van geweld binne eenhede in 'n algemene hospitaal. Weens bogenoemde is 'n kwalitatiewe studie beoog, met ondersoek na die ervaring van geweld deur professionele verpleegkundiges by 'n tersiêre instansie in Durban.

'n Verkennende, kwalitatiewe, beskrywende en kontekstuele ontwerp is gebruik as die basis vir die studie. Die bogenoemde navorsingontwerp is bereik deur veldwerk in 'n stedelike algemene hospitaal. 'n Steekproef van 12 professionele verpleegkundiges is geneem vanuit 'n populasie van 800 professionele verpleegkundiges werksaam in die omgewing, deur gebruik te maak van doelgerigte steekproef tegnieke. Die steekproefgrootte is bepaal deur versadiging van data deur herhaling van temas.

Beide individuele fenomenologiese semi-gestruktureerde onderhoude en veldnotas, in die vorm van observasies, is gebruik as metodes van datainsameling. Die veldwerk is voltooi sonder enige vooropgestelde teoretiese raamwerk deur gebruik te maak van "braketering" en "intuisiering". Slegs een navorsingsvraag is aan alle deelnemers gestel gedurende die onderhoud: "Wat is u ervaring van verpleging van 'n gewelddadige geestesversteurde pasiënt"? Kommunikasievaardighede is gebruik om deelnemers aan te moedig met die verbalisering van hulle ervaring van verpleging van 'n gewelddadige geestesversteurde pasiënt binne 'n algemene hospitaal. 'n Bandopnemer is gebruik om data in te samel en die data is woordeliks getranskribeer. Die ingesamele data is ontleed volgens die beskrywende metode van Giorgi (1986). Kodering is uitgevoer deur die navorser en 'n onafhanklike deskundige wat ook 'n psigiatriese verpleegkundige spesialis en 'n kwalitatiewe navorsingsdeskundige is. Na voltooiing van die data-analise, is die resultate gereflekteer in patrone van interaksie van die verplegingsteorie vir mensheelheid (VTMH). Sodoende is begrip verkry binne die beramingseenheid.

Agt temas is ontwikkel en vorm die resultate van die studie. Om geldige resultate te verseker, is n' modelbetroubaarheid wat deur Guba (Lincoln & Guba, 1985) voorgestel is, gebruik. Dit het duidelik geword dat professionele verpleegkundiges se ervarings van geweld gedurende die verpleging van geestesversteurde persone binne 'n algemene hospitaal negatief is. Dit affekteer die sosiale en psigologiese funksionering van die geregistreerde verpleegkundiges. Daar is 'n aanbeveling gemaak dat kommunikasie ontwikkel en getoets word, binne die instansie waar die navorsing gedoen is, met die doel om interaksie tussen die geestesgesverteurde persoon, gesinne, hoofde en dokters te verbeter.

INTRODUCTION

Aggression and violence constitute a major problem within psychiatric care (Wiesterd, 1989:1). Furthermore, violence and aggression readily occur in in-patient units of general hospitals (Mavundla, 1992:1; Morrison, 1993:51).

Increased research is being conducted in psychiatry, focusing on the danger of violence by mentally ill patients in in-patient settings. Some researchers have identified factors that are associated with violence (Monahan, 1984:11). These factors include the presence of psychosis in violent mentally ill patients. However, other researchers argue that there is no exclusive relationship between violence and psychosis (Taylor, 1989:5; Monahan, 1984:11; and Morrison, 1993:54). These researchers further reveal that many violent acts are committed by people free of mental illness.

Apart from the presence of psychosis in violent mentally ill people, research associates age with the presence of violence. Reid, Bollinger & Edwards (1989:54), who found that adolescent patients are implicated in violence, support this. Gender is seen as another predisposing factor. Bornstein (1985:176) reveals that males are more aggressive than females.

Apart from age and gender, provocation is another important factor that predisposes mentally ill people to violence. Morrison (1993:55) and Roper & Anderson (1991:210) reveal that aggressive acts within in-patient settings are provoked. In addition, poor communication may be a stumbling block that may lead to violence in in-patient units (Mavundla, 1997:88). This background information leads to the following statement of the problem.

PROBLEM STATEMENT

In an urban general hospital in which the researcher worked during the period 1992-1993, most nurses were not psychiatric trained. These nurses considered themselves to be inadequately equipped to nurse mentally ill people effectively. Owing to their lack of knowledge about mental illness they tended to speculate about the origins or cause of mental illness in-patients they encountered, and at times they would even go further and conclude that the condition of a patient was *"due to dagga"* or *"pretence"*. As a result of their speculation, the nurses would generally be uncertain about the patient's condition, and at times they failed to comprehend the patient's condition. This led to these nurses' inability to read warning signs/symptoms of violence in the unit (Mavundla, 1997:57). Due to ignorance some would communicate in a provocative manner with patients, which led to aggression and violence. The presence of violence in units of this general hospital caused a great deal of frustration among nurses and was a source of stress in the nurses' internal environment. This statement of the problem led to the following research question:

- How do general hospital nurses experience nursing violent mentally ill people?

The above-mentioned research question could only be understood in the light of the appropriate statement of the purpose of the research as set out below.

PURPOSE OF THE RESEARCH

The main purpose of this research was to explore and describe the general hospital nurses' experience of violence when nursing mentally ill people. To achieve the above-mentioned purpose and to give structure to the results of this research, the researcher pursued a specified paradigm in the following manner.

THE PARADIGMATIC PERSPECTIVE OF THE RESEARCH

The paradigmatic perspective of the research consisted of meta-theoretical, theoretical and methodological assumptions. Therefore, the assumptions of the Nursing for the Whole Person Theory (Oral Roberts University: Anna Vaughn School of Nursing, 1990:196; Rand Afrikaans University: Department of Nursing, 1992:2) were used to guide this research. Fieldwork was carried out without any pre-set theoretical framework of reference using bracketing and intuiting. After data analysis, the results were reflected within the paradigm guiding this research.

RESEARCH DESIGN AND METHODS

A qualitative, explorative, descriptive and contextual design was used as the basis for carrying out this research. To achieve this research design, a qualitative research strategy, which is explorative, descriptive and contextual, was used. This was attained through field research carried out in an urban-based general hospital. The activities involved in field research include identifying and gaining access to a field in which research was done. This also involved paying attention to ethics.

ETHICAL RIGOUR

The necessary permission to conduct this research was obtained from the Provincial and selected hospital authorities. Additional permission was obtained from the participants in the form of consent for the interviews (Polit & Hungler, 1991; Burns & Grove, 1993). This consent contained all the rights to which subjects were entitled, which included the following: anonymity and confidentiality, the right to privacy, the right to fair treatment, and protection from discomforts and harm (Burns & Grove, 1993).

POPULATION AND SAMPLING

The population of this research consisted of all professional nurses working in an urban general hospital who at one time

or another are involved in nursing mentally ill people in their departments, including the out-patient department, hospital theatre, etc. In research terms, to talk about the population is not enough: one should clearly specify the criteria by means of which participants qualify to participate in the research.

Criteria for inclusion in the population

According to Polit & Hungler (1991:254) and Wilson (1989:261) it is important, when identifying a population, to be specific about the criteria for inclusion in the population. These criteria are referred to as eligibility criteria. In this instance, the eligibility criteria were as follows:

- subjects could be male or female
- subjects had to fall within an age range of 25-65 years
- the ability to converse in either Zulu, Xhosa or English was a strong recommendation
- participation had to be voluntary
- informed consent had to be obtained permitting audio recordings to be made during interview sessions
- a relevant working experience of at least two years in a general hospital, as this period guaranteed that the subject was well acquainted with the atmosphere of a general hospital
- subjects had to have nursed violent mentally ill people during this period in order to report personal experiences of nursing the mentally ill in a general hospital
- subjects must not have been registered with the South African Nursing Council as psychiatric nurses; this criterion was set in order to minimise the number of variables in the study and prevent biased results from people with training in psychiatric nursing
- subjects had to be of the same ethnic group (e.g. Zulus); it is very important for the participants to belong to the same ethnic group, since results are readily understood within a certain context, and are not value-free

SAMPLING TECHNIQUE

For the purpose of this research, a purposive sampling technique, which is one of the non-probability sampling techniques, was used. This non-probability sampling technique involves non-random sampling of subjects (Wilson, 1989:260; Polit & Hungler, 1991:255; Burns & Grove, 1993:243). The number of nurses who were interviewed was determined through saturation of data as reflected in repeating themes (Morse, 1995:147-149).

DATA GATHERING

Two methods of data collection were used for this research, viz. phenomenological semi-structured interviews and obser vations with field notes. These methods are described briefly below.

In-depth phenomenological interviews

According to Kvale (1983:173-178) this type of interviewing technique is centred on the interviewee's life-world and his or her relation to it. It is qualitative, descriptive, specific, open to ambiguities, and has no presuppositions. Moreover, it is theme-focused and has the ability to change. It depends on the sensitivity of the interviewer and takes place solely in the form of an interpersonal interaction between the interviewer and interviewee.

In-depth, semi-structured individual interviews were conducted with nurses who met the prescribed criteria. After initial contact with nurses selected according to the sampling criteria chosen for this research, informed consent was obtained to use a tape recorder. Date, time and place of interview were confirmed (Chenitz & Swanson, 1986:69-90).

The interviews were conducted in a quiet place and the participants made comfortable for the duration of the interview session. A tape recorder was used to capture the dialogue between the interviewer and the interviewee. The following question was asked to all the interviewees: "How do you experience nursing violent mentally ill people in your ward/unit?" Facilitative communication skills were employed to encourage participants to talk about their experiences.

Field notes

During the period of data collection, the following field notes were collected as validation of observations and taped comments:
Observational notes dealt with descriptions of events experienced through watching and listening. These notes contained the who, what, and how of the situations.
Theoretical notes were used to derive meaning from the observational notes. They were used to interpret or infer in order to build analytic schemes.
Methodological notes were instructions or reminders of the researcher's tactics concerning methodological approaches. They were used in the event of an interesting case.
Lastly, **personal notes** contained the researcher's reactions, reflections and experiences. When the process of data collection was completed, the process of data analysis began.

DATA ANALYSIS

I made use of all the data collected in the field in terms of field notes and tape recordings in order to analyse data. The data analysis was completed by another independent expert and myself (an advanced psychiatric nursing practitioner). Giorgis' (1985:10-19) method formed the basis for data analysis. The following steps were applied in data analysis:

- Data (all transcribed discussions and field notes) were coded independently by both the independent expert (coder) and myself. The coders used bracketing (placing preconceived ideas within brackets) and intuiting (focusing on the

nurses' experience of violence when nursing mentally ill people within their environment of a general hospital setting) when reading through the transcripts and field notes for the first time. The universum consisted of all transcriptions and field notes.

- The independent coder and I identified major categories represented in the universum.
- The independent coder and I then underlined units of meaning that related to the identified categories.
- The units of meaning were placed in these major categories.
- Sub-categories within the major categories were identified.
- Relationships among major categories and sub-categories were identified and reflected as themes.
- Consensus discussions between the researcher and the independent coder were held.
- The results were then reflected within the patterns of interactions of the Nursing for the Whole Person Theory.

Due to the inductive nature of qualitative research and the explorative character of this research, insufficient literature was reviewed at the beginning. The literature found was used to control findings of the present study in the following manner.

LITERATURE CONTROL

Themes that emerged from the results were discussed in the light of relevant literature and information obtained from similar studies (Poggenpoel, Nolte, Dörfling, Greeff, Gross, Muller, & Roos, 1994). This was done in order to identify the similarities, differences and contributions of this research to that of previous research. In research terms, it is not enough merely to have research results, the research results must be accepted by all members of the scientific community as authentic without reasonable doubt. This was achieved by applying measures for ensuring trustworthiness as follows.

MEASURES FOR ENSURING TRUSTWORTHINESS

Guba's model for trustworthiness was utilised to ensure the validity and reliability of this research (Lincoln & Guba, 1985: 290). The four criteria for trustworthiness are truth-value, applicability, consistency and neutrality. The truth-value was ensured by applying the strategy of credibility, and applicability by applying strategies of transferability. Consistency was ensured by strategies of dependability, and neutrality by strategies of conformability. See table 1 for the application of the model for trustworthiness.

TABLE 1 - MEASURES FOR ENSURING TRUSTWORTHINESS

STRATEGY	CRITERIA	APPLICABILITY
Credibility	Prolonged engagement	The researcher spent three years in the clinical field in which the research was conducted. Three to four months were spent in preparation for field work, and field notes were also kept.
	Reflexivity	A field journal was used to reflect researcher behaviours and experience. Consensus discussion with independent coder.
	Triangulation	Both phenomenological individual interviews and field notes were used as methods of data collection. A combination of qualitative research design and explorative, descriptive and contextual research was used.
	Member-checking	Research was constantly checked with the informants. Literature control was done.
	Peer examination	Independent expert coded the data.
	Structural coherence	Focus was on nurses nursing mentally ill people. Findings discussed within the framework of Nursing for the Whole Person Theory.
	Researcher's authority	The researcher is experienced in qualitative research, is a consultant and supervises research. Holds a doctorate.
Transferability	Nominate sample	A purposive sample of professional nurses was used.
	Dense description	A comprehensive description of methods was given, including illustrative direct quotes.
Dependability	Dependability audit	Question checking with expert in research methodology; data analysis protocol developed; independent expert for coding data.
	Dense description	As discussed under transferability.
	Code-recode procedure	A consensus discussion between the researcher and the independent expert was held to identify themes and categories.
Conformability	Conformability audit	Audit by independent expert researcher.

THE DISCUSSION OF FINDINGS AND LITERATURE CONTROL

The sample of this research was drawn from a population of all professional nurses working in an urban general hospital. The sample comprised twelve (12) professional nurses, all of whom volunteered for in-depth individual phenomenological semi-structured interviews. See table 2 for the distribution of professional nurses who participated in the study among the various departments of the hospital.

TABLE 2 -SAMPLE DESCRIPTION

DEPARTMENT	NO. OF NURSES
MEDICAL	2
SURGICAL	2
MIXED UNITS	2
ORTHOPAEDICS	2
MATERNITY	2
OPD	2
TOTAL	**12**

THEMES REVEALED BY THE ANALYSIS OF DATA

Eight themes were identified. Table 3 forms the basis for discussion of the themes revealed by data analysis.

TABLE 3 - PROFESSIONAL NURSES' EXPERIENCE OF VIOLENCE

Professional nurses' experience of violence

1. Physical violence as experienced by nurses
2. Feelings experienced by nurses
   - 2.1. Fear associated with lack of safety
   - 2.2. A feeling of despair
3. Need for support from security staff, superiors and doctors
4. Strategies used by nurses for coping with violent patients
   - 4.1 Physical restrainers
   - 4.2 Chemical measures
5. Lack of protocols or policies for dealing with emergency situations
6. Victim blaming of nurses by their superiors
7. Incidentation or writing of statements in the ward
8. Consequences of violence for nurses

Physical violence as experienced by nurses

Affected nurses recounted the following experiences of physical violence:
"...When the patient is violent, he fight; the one I'm talking about was fighting even other patients..." "...they are usually violent, one patient wanted to rape a nurse..." "...One patient just grabbed me and kept on pulling me; I shouted for help. They came to help me..."

Morrison (1993:54) identified three types of aggression and violence through grounded theory research among eleven nurses, viz. (1) violence towards the self, (2) violence towards others, and (3) violence to property. In this research, most violent attacks were directed at others (e.g. nurses and other patients). Whittington & Wykes (1992:482) and Castledine (1993:187) found that attacks by patients are acknowledged as an important source of stress for psychiatric staff, with serious ramifications for patients and the nurses' employers as well.

Feelings experienced by nurses

Professional nurses expressed the following two feelings with regard to the care of mentally ill people in general hospital settings:

Fear associated with lack of safety

Almost all the participants reported a fear of mentally ill patients in their wards. Fear is an unpleasant, excited, activating affect with psychological and physiologic components elicited by a specific threatening person, object, or event (Sideleau, 1992:60). Fear may be divided into four sub-categories as revealed in this research:

- Deep-seated fear due to a lack of understanding of the condition of the patient *"...cannot differentiate between someone who is violent and someone who is not..."*
- irrational fear *"...he might jump on me..." "...he might remove my eye...".*
- fear of the unknown *"...any thing might happen..." "...may assault nurses or patients...". "...he might be out of his senses..."*
- fear associated with the unlikelihood of compensation in the event of injury *"...it is said one will not be paid if injured by a patient...".*

Most participants confirmed their vulnerability to danger and felt responsible for the safety of other patients in the ward. These findings are supported by Dolinar (1993:16), who found that medical-surgical staff, unaccustomed to impulsive patients, may fear for their safety. McHanon (1992:164) asserts that fear of physically aggressive or verbally abusive

patients is common among nurses. She is also of the opinion that stereotyped images of violent patients further contribute to this fear.

A feeling of despair

Due to fear of violence or the loss of a patient in a medical-surgical-orthopaedic ward, nurses either approached the security guards or the matrons for help, usually in vain. As a result, they felt nothing was being done for them in such cases.

"...Even if you report to the matron's office, nobody will do anything about it..." "...you phone the guards at Casualty and they ask: why don't you call the guards at the main gate..." "...Doctors want proof that the patient is aggressive before referral to the psychiatrist..."

Need for support from security staff, superiors and doctors

Due to fear of physical violence, nurses were constantly in need of support from other nurses in the ward, security staff, their nursing superiors and doctors. They gave the following verbal statements:

"...when we don't see the patient, we normally phone the security staff, and also report to the matron's office..." "...when we find the patient we hold him down. If at times we feel we can't, we phone the police to come and help us..." "...fortunately, the police from the security department came in, otherwise this nurse was going to be raped..." "...usually we cannot handle the psychiatric patient alone..." "...we phone the security staff for help and the doctor will come and order something..." "...so we phone the guards to come and help us..." "...the doctor accompanied me to the patient..."

This need for support compelled nurses to phone the matrons' offices time and again to report incidences of violence in the ward that might have involved patients or other nurses. The matrons offered no support, instead blaming the nurses for problems that occurred in their wards or units. Support from managers is acknowledged as contributing greatly to staff morale (Parahoo & Barr, 1994:1046). In order to cope, nurses used certain strategies to deal with violent patients in their units or wards.

Strategies used by nurses for coping with violent patients

Strategies of this nature entail physical restraint and physical contact (Standford & Elzinga, 1990:47). The present research study correlates with the study mentioned above in that both physical restrainers and sedation were used.

Physical restrainers

This involved nurses teaming up in groups of four to eight to hold the patient down. They then applied physical restrainers in order to protect treatment given to patients, and generally to protect patients and themselves. Restraint refers to measures designed to confine and restrict a patient's bodily movements (Kaplan & Sadock, 1992:2118).

"...at times the relatives feel we are cruel by restraining the patient..." "...the first thing that we do is to restrain...". "...these people have to be restrained..." "... whether ordered to or not, we restrain the patient...".

Before one can use restraints, it is important to consider the patient's rights to freedom (Brown, 1991:64-65 and Klop, van Wijmen & Philipsen, 1991:408-412). Consequently, Feutz-Harter (1990:8-9) argues, decisions to restrain patients must be made on the basis of appropriate medical and nursing judgements.

Chemical measures

Nurses also gave medication in order to sedate patients during times of crisis in the ward. The following verbal statements were made:

"...they've got to be sedated...". "...to avoid trouble once he starts to be violent, we ask for sedation...". "...doctors have decided that we should administer etomine (our drug of choice) so that we can calm the patient down...". "...The doctor would order the sedation on a six-hourly basis and we would comply ...".

Decisions involving the administration of medications, and the manner in which they are arrived at, give rise to important considerations that can significantly affect patient responses (Blair & Ramones, 1994:50).

In this study, nurses verbalised the use of the above-mentioned two strategies to calm patients. Again, due to the fact that nurses verbalised a feeling of fear, which may be due to ignorance, the above-mentioned strategies indicate that nurses lacked the appropriate communication skills to deal with mentally ill people. Instead, they used physical and chemical measures, which are not therapeutic to the patient.

Lack of protocols or policies for dealing with emergency situations

The major problem identified in this research was the lack of protocols or policies to be followed in the event of a crisis or emergency situation in wards tasked with the care of the mentally ill. It also became clear that some aspects of existing protocol were inappropriate for the actual problems experienced by nurses in this institution.

"...You use your own discretion as a nurse...". "...Well there is no protocol, no guidelines concerning the nursing care of mentally ill people whilst they are in the ward...". "...if a psychiatric patient is being admitted he/she has to stay more than 5 hours due to tests that are carried out...".

These findings also correlate with those of Dolinar (1993:16), who found that detention, seclusion, and restraint policies are often poorly co-ordinated in general hospitals which lack emergency procedures. Dolinar adds that medical-surgical staff is unfamiliar with involuntary treatment guidelines such as forced treatments.

Victim blaming of nurses by their superiors

In this study, nurses reported victimisation when reporting incidents involving injuries inflicted by patients, or patients absconding from the wards.

"...Now if you are injured by the patient, they say it's your own carelessness because you are not supposed to hold the patient...". "...It is so difficult because they assume we are irresponsible...". "...Superiors ask why you failed to take precautions when it became evident that the patient was capable of behaviour...".

Khanyile (1992:26) describes the nursing hierarchy as rather authoritarian in nature, exerting more pressure on the nurse and often quoted as being one of the most frustrating aspects of nursing. She bases her argument on victimisation of nurses by the strict nursing hierarchy and misinterpretation of assertiveness as aggression.

Incidentation or writing of statements in the ward

Whenever there was an incidence of violence or when a patient had absconded from the ward, nurses were asked by the hospital authorities to write a statement about the event.

"...In fact, we do write an incident report of what took place in the ward: 'so-and-so' was involved, and this-and-this happened and after that I don't know what happened...". "...you can imagine we were going mad writing statements while the patient was at home...".

Consequences of violence for nurses

Due to violence, nurses experienced further serious health problems; some patients also suffered similarly.

"...one nurse in this ward is now HIV-positive after being bitten by a confused and violent patient...". "...one of the nurses was attacked by a male psychiatric patient who stabbed her in the chest and back during lunch at the hospital...". "...restrainers do cause gangrene in patients when applied for longer periods, meaning that a protective foam should be applied...". "...a patient next door was killed by a very violent patient...".

LIMITATIONS

This research was conducted at a single institution, among KwaZulu-Natal general hospital professional nurses only. In keeping with self-prescribed criteria for inclusion in this research study at the beginning of fieldwork, it did not include other race groups found in the area. Another limiting fact is the absence of male nurses from the sample. Therefore the research findings are contextualised within the general hospital setting where research fieldwork was conducted, since the results of qualitative research are not value-free.

CONCLUSION

The results in this study are discussed in the light of relevant literature with the aim of contextualising them. It became clear that the experience of nursing violent mentally ill people in general hospital settings was predominantly negative. Nurses therefore constantly seek support from various members of hospital personnel. These results affected the external (social) environment of professional nurses. It was recommended that a model of facilitative communication be developed to equip these nurses with appropriate knowledge and skills that will improve the care they render to violent mentally ill people in these settings.

REFERENCES

Blair, DT & Ramones, VR 1994: Psychopharmacologic treatment of anxiety. **Journal of Psychosocial Nursing**, 32 (7), 1994:49-53.

Bornstein, A 1985: The use of restraints on a general psychiatric units. **Journal of Clinical Psychiatry**, 46, 1985:175-178.

Brown, M 1991: Watching the detentions. **Nursing Times**, 87(27), 3 July 1991:64-66.

Burns, N & Grove, SK 1993: The practice of nursing research: conduct, critique and utilization. Philadelphia: Saunders.

Castledine, G 1993: Violent attacks: Nurses at risk. British **Journal of Nursing**, 2(3), 1993:187-188.

Chenitz, WC & Swanson, JM 1986: From practice to grounded theory: Qualitative research in nursing. Ontario: Addison-Wesley Publishing Company.

Dolinar, LJ 1993: Obstacles to the care of patients with medical-psychiatric illness in general hospital psychiatric units. **General Hospital Psychiatry**, 15, 1993:14-20.

Feutz-Harter, SA 1990: Legal implications of restraints. **Journal of Nursing Administration**, 20(10), 1990:8-9.

Giorgi, A **ed**. 1985: Phenomenology and Psychological Research. Pittsburgh, PA: Duquesne University Press.

Kaplan, H & Sadock, BJ 1992: Seclusion and Restrainers. Synopsis of Psychiatry; sixth edition Baltimore: Williams & Wilkins.

Khanyile, C 1992: Where is team-work in psychiatric hospital? **Nursing RSA Verpleging**, 7(9), 1992:26-27.

Klop, R; van Wijmen, FCB & Philipsen, H 1991: Patients' rights and the admission and discharge process. **Journal of**

Advanced Nursing, 16, 1991:408-412.

Kvale, S 1983: The qualitative research interview: a phenomenological and a hermeneutical mode of understanding. **Journal of Phenomenological Psychology**, 14, 1983:171-196.

Lincoln, YS & Guba, EG 1985: Naturalistic Inquiry. Beverly Hills: Sage.

Mavundla, TR 1982: Categorizing aggression and violence for the purpose of accurate management. An unpublished paper read at a seminar. Department of Psychiatry, King Edward VIII Hospital: Durban.

Mavundla, TR 1997: A model of facilitative communication for support of general hospital nurses nursing mentally ill people. Auckland Park: Rand Afrikaans University. (Doctoral Thesis).

McHanon, AL 1992: Nurse Client Relationship. (**In**: Haber, J; McHanon, AL; Price-Hoskins, P & Sideleau, BF **eds**. 1992: Comprehensive Psychiatric Nursing; fourth edition. St Louis: Mosby Year Book.)

Monahan, J 1984: The prediction of violent behaviour: Toward second generation of theory and policy. **American Journal of Psychiatry**, 141, 1984:10-15.

Morrison, EF 1993: The measurement of aggression and violence in hospitalized psychiatric patients. **International Journal of Nursing Studies**, 30(1), 1993:51-54.

Morse, JM 1995: The significance of saturation. **Qualitative Health Research**, 24, 1995:385-390.

Oral Roberts University: Anna Vaughn School of Nursing 1990: The Nursing For The Whole Person Theory. Baccalaureate and Higher Degree Programs, National League for Nursing, August 1990. Volume I - Narrative by Criteria. Tulsa, Oklahoma: Oral Roberts School of Nursing, pp. 13, 136-139, 142.

Parahoo, K & Barr, O 1994: Job satisfaction of communication health nurses working with people with a mental handicap. **Journal of Advanced Nursing**, 20, 1994:1046-1055.

Poggenpoel, M; Nolte, A; Dôrfling, C; Greeff, M; Gross, E; Muller, M; Nel, E & Roos, S 1994: Community views on informal housing environment: implications for health promotion. **South African Journal of Sociology**, 25(4), 1994:131-136.

Polit, DF & Hungler, BJ 1991: Nursing Research: Principles and Methods; fourth edition. Philadelphia: JB Lippincott Company.

Rand Afrikaans University, Department of Nursing Science 1992: Nursing for the Whole Person Theory. Auckland Park: Rand Afrikaans University.

Reid, W; Bollinger, M & Edwards, J 1989: Serious assaults by inpatients. **Hospital and Community Psychiatry**, 1989:54-56.

Roper, JM & Anderson, NLR 1991: The international dynamics of violence, Part I: An acute psychiatric ward. **Archives of Psychiatric Nursing**, 4, 1991:209-215.

Sideleau, BF 1992: Person-environment interaction. (**In**: Haber, J; Mc Mahon, AL; Price-Hoskins, P & Sideleau, BF **eds.** 1992: Comprehensive Psychiatric Nursing; fourth edition. St Louis: Mosby Year Book.)

Standford, DA & Elzinga, RH 1990: A quantitative study of nursing staff interaction in psychiatric wards. **Acta Psychiatrica Scandanavica**, 81, 1990:46-51.

Taylor, PJ 1989: A survey of treatment strategies for aggressive, acute psychiatric patients. (**In**: Wiestedt, B **ed.** 1989: Proceeding of VIII world congress of psychiatry on new strategies in the treatment of aggressive acute psychiatric patients. Amsterdam: Excerpta Medica.)

Whittington, R & Wykes, T 1992: Staff strain and social support in a psychiatric hospital following assault by a patient. **Journal of Advanced Nursing**, 17, 1992:480-486.

Wiestedt, B **ed.** 1989: Aggression and violence within psychiatric care and new treatment strategies - An introductory review. VIII World Congress of Psychiatry: New Strategies in the treatment of aggressive, acutely psychotic patients. Proceedings of the symposium, 14 October 1989. Amsterdam: Excerpta Medica.

Wilson, HS 1989: Research in Nursing; second edition. Redwood City: Addison-Wesley Publishing Company.