VIOLENCE EXPERIENCED BY NURSES WORKING IN ACUTE CARE PSYCHIATRIC WARDS AT A GAUTENG HOSPITAL

B.C.J. Nguluwe, M Cur
Department of Nursing science
University of Limpopo (Medunsa)

Y. Havenga, D Cur
Department of Nursing Science,
University of Limpopo (Medunsa) and
Adelaide Tambo School of Nursing Science,
Tshwane University of Technology
HavengaY@tut.ac.za

M.L.M. Sengane, D Cur
Department of Nursing Sciences
University of Limpopo (Medunsa)

ABSTRACT

Of all hospital staff, nurses are the most exposed to violence in the workplace that can cause long-term negative effects. The purpose of this study is to increase the understanding of violence against nurses in acute care psychiatric wards in a Gauteng hospital to promote the nurses' mental health. A qualitative, explorative, descriptive and contextual research design was used by purposively sampling nurses who had experienced violence. Semi-structured individual interviews were conducted. Nurses had experienced physical, sexual and psychological violence and perceived the risk factors of violence to be mental health care user-related. They described the physical and emotional effects of the violence they experienced. Recommendations are made to prevent violence and manage incidents after their occurrence to promote nurses mental health.

KEYWORDS: acute care psychiatric wards, mental health care user, nurses, physical, psychological and sexual violence

INTRODUCTION AND BACKGROUND INFORMATION

The growing epidemic of violence against nurses in the workplace is of great concern globally (Hinchberger, 2009:37). Among all hospital staff, nurses are most exposed to violence in the workplace (International Council of Nurses (ICN), 2006:3). The most

vulnerable nurses are those working in emergency departments and psychiatric wards (Howerthorn Child & Mentes, 2010:89).

In a study by Stein (2003:21) conducted in the greater Johannesburg Metropolitan Region, 61.9% of all health care workers experienced at least one incident of violence in the year prior to the study. However, an accurate account of violence against nurses is unavailable, as violence is defined inconsistently, inadequately documented, under-reported and normalised (Cowman & Bowers, 2008:1346; Howerthorn Child & Mentes, 2010:89; ICN, 2006:3; Kennedy & Julie, 2013:5; Stein, 2003:7). These shortcomings have been reflected in inconsistent prevalence figures and research reports that isolate the most vulnerable nursing groups. Despite these inconsistencies, violence perpetrated by patients in health care settings show a considerable and significant increase (Irwin, 2006:310; Kennedy & Julie, 2013:2).

Various risk factors for violence in hospital settings pertain to the patient and his/her family, the nurse, the environment, culture and management (Howerthorn Child & Mentes, 2010:90; Pich, Hazelton, Sundin & Kable, 2010:269–271). Workplace violence in health care facilities can be expressed as physical assault and psychological violence expressed as verbal abuse, bullying, mobbing, sexual or racial harassment and threats (International Labour Office, International Council of Nurses, World Health Organization & Public Service International, 2002:3–4), of which verbal abuse is the most prevalent (Pich et al., 2010:269). Violence negatively impacts nurses' physical and mental health, the therapeutic environment, the quality of patient care, productivity and health costs (Bowers, Allen, Simpson, Jones & Van der Merwe, 2009:260; Gates, Gillespie & Succop, 2011:65; Irwin, 2006:310; MacKinnon & Cross, 2008:11; Pich et al., 2010:271–272).

STATEMENT OF THE RESEARCH PROBLEM

More than half of the nurses in South Africa are exposed to at least one incident of physical or psychological violence from patients in health care facilities per year (Fagin, Maraldo & Mason, 2005:1). This violates their rights to dignity, freedom from harm and physical and psychological integrity (ICN, 2006:1). Nurses working in inpatient psychiatric settings and emergency departments are particularly vulnerable to patient violence (Howerthorn Child & Mentes, 2010:89). Violence perpetrated by mental health care users is often passively accepted (ICN, 2006:3), because their behaviour is more unpredictable and not always fully under their control (MacKinnon & Cross, 2008:10).

Violence impacts nurses' day to day work as it negatively affects their physical and mental health, work satisfaction, productivity and the quality of patient care (Gates, Gillespie & Succop, 2011:65). These harmful consequences have led to the urgency in providing safer working environments for nurses (Cowman & Bowers, 2008:1346) by

eliminating all forms of violence (ICN, 2006:1). If safer working environments are to be created in psychiatric inpatient settings, the phenomenon of violence perpetrated by mental health care users has to be uncovered and openly discussed. Discussions with the public and the nursing community can serve as a first step toward taking a "zero tolerance" approach to violence (ICN, 2006:1).

Research about violence against nurses often focuses on emergency care departments and psychiatric wards, but this phenomenon is yet to be explored and described in the acute care psychiatric wards of this specific hospital in Gauteng. This study would allow nurses to recount their stories of violence and its effects to bring it into the open in an attempt to address it. The following research questions were posed:

- What are nurses' experiences of violence working in acute care psychiatric wards in a Gauteng hospital?
- What are the perceived effects of violence against nurses working in acute care psychiatric wards in this Gauteng hospital?

PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to increase the understanding of violence against nurses in acute care psychiatric wards in a Gauteng hospital to address it and thereby promote the nurses' mental health. The objectives were: firstly, to explore and describe the nurses' experiences of violence; and secondly, to explore and describe the perceived effects when working in acute care psychiatric wards at a specific hospital in Gauteng.

THEORETICAL FRAMEWORK

The theoretical framework in this study is the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:4). This theory aims to promote the mental health of individuals, groups, families and communities through the mobilisation of resources. The aim of this study relates to the goal of the Theory for Health Promotion in Nursing to promote the mental health of nurses working in acute care psychiatric wards (University of Johannesburg, 2009:4).

OPERATIONAL DEFINITIONS

The operational definitions of the study were as follows:

Acute care psychiatric wards refer to wards where newly diagnosed mental health care users are admitted in a specific hospital in Gauteng.

A mental health care user is a person who receives care, treatment and rehabilitation at the specific hospital in order to enhance his/her mental health status (Republic of South Africa, Mental Health Care Act, No 17 of 2002:6).

A nurse signifies a person who is registered as a professional nurse, staff nurse or auxiliary nurse as specified in Section 31(1) of the Nursing Act, No. 33 of 2005 (South African Nursing Council [SANC], 2005:34).

Violence refers to incidences where nurses working in acute care psychiatric wards are physically, sexually, verbally and psychologically abused, threatened or assaulted (International Labour Office, International Council of Nurses, World Health Organization & Public Service International, 2002:3) by mental health care users admitted to those wards.

RESEARCH METHODOLOGY

A qualitative, explorative, descriptive and contextual research design was used in this study. The setting was two acute care psychiatric wards, one male and one female, at a hospital in Gauteng. Both psychiatric wards have an average of 20 mental health care users admitted daily per ward. The common mental health conditions include substance-induced psychoses, schizophrenia and mood disorders. The average length of stay for mental health care users is one month and if there is no improvement, they are referred to another level hospital for further management.

The population in the study includes all the nurses working in the two acute care psychiatric wards at the identified hospital. The total population size was 25 nurses, which included one operational manager with a post basic psychiatric specialisation, ten professional nurses, one community role service professional nurse, three staff nurses and ten nursing auxiliaries. A purposive sampling method was used that involved the selection of participants with experience of violence in this setting (Polit & Beck, 2012:517). The inclusion criteria of participants were as follows:

- all nurses who had experienced violence while working in acute care psychiatric wards, regardless of how long they had worked in the environment;
- all categories of nurses;
- nurses permanently employed at the study site; and
- nurses who consented to participate in the study.

The sample size for this study was thirteen nurses. After ten interviews, new data led to redundant information, however, three more interviews were done, at which point

data saturation was confirmed by the researcher, supervisors and the independent coder (Polit & Beck, 2012:742).

Data were collected during February and March 2012. Semi-structured individual interviews were conducted using a single question followed by probes. The central question was: "What experiences of violence have you had while working in the acute care psychiatric ward at this hospital?" Two pilot interviews were conducted in order to ensure in-depth probing by the researcher. The information from these interviews was not included in the data.

Interviews were done in English, the official language of service provision in the hospital, and on average lasted 45 minutes to allow the researcher to get a thick description of participants' experiences of violence. Interviews were audio-recorded and descriptive, methodological, theoretical, reflective and personal field notes were kept (Polit & Beck, 2012:548–549).

Data analysis was done concurrently with data collection. Prior to analysis of the data, field notes were added to verbatim transcriptions. Content analysis was done based on the two research questions as the two main themes. Each interview was read and patterns among the data were identified under each of the two themes forming units of analysis. Each unit of analysis was named and formed the categories and subcategories (Polit & Beck, 2012:564).

To enhance the trustworthiness of this study, the researcher used Guba and Lincoln's (1989, in Polit & Beck, 2012:584) framework of trustworthiness that included criteria of credibility, dependability, confirmability, transferability and authenticity. Dependability was enhanced through data triangulation by involving nurses from different categories. Credibility was enhanced by prolonged engagement and persistent observation, whereby the researcher initially spent time working with the potential participants to get to know them and the work context, as well as spending sufficient time with them during data collection. To enhance confirmability, the interviews were audio-recorded and transcribed verbatim. Transferability was enhanced by collecting complete data such as biographical and in-depth accounts of their experience of violence in order to provide a concentrated description of rich data. The research methodology was also explained clearly. To enhance authenticity, the researcher kept a reflective journal in which he wrote personal thoughts, feelings and values related to the research study that could have an impact on the data collection, as he had personal experience of violence as a psychiatric nurse. It was necessary to write and reflect about these experiences in order to bracket his own experiences from those of the participants (Burns & Grove, 2009:545–546). Verbatim quotes were also included.

Before commencement, approval was obtained from the Medunsa Research and Ethics Committee (MREC), the Regional Director of the Department of Health's Research

and Ethics Committee, as well as the Chief Executive Officer (CEO) of the hospital where the study was conducted. Autonomy was ensured by explaining the purpose and objectives of the study to the participants and providing them with an information leaflet. Beneficence/non-maleficence was guaranteed by ensuring that the interviewer was skilled and by supporting participants if they experienced distress. Anonymity and confidentiality were ensured by omitting the participants' names on any documents. Justice was ensured by respecting participants' beliefs, habits and lifestyles regardless of their backgrounds and cultures. All nurses were given an opportunity to participate if they wished to do so by extending an open invitation during a ward meeting. Sound research was ensured by the involvement of two supervisors with doctoral degrees and honest reporting of the findings.

FINDINGS AND DISCUSSION

The demographic data will be discussed first. Next, the findings of the study will be discussed based on the two objectives of the study.

Demographic data

Table 1 summarises the participants' demographic information.

Table 1: Demographic data

Characteristic	Number
Nursing categories (n)	
Professional nurses	7
Staff and auxiliary nurses	6
Age (years)	
Range	23-64
Mean	43.5
Median	42
Sex (n)	
Female	10
Male	3
Period of work in a psychiatric nursing setting	
Range	2 weeks – 30 years
Mean	16.5 years

The majority of the participants were females, which is a reflection of the fact that nursing is a female-dominated profession in South Africa. The 2013 mid-year population estimates in South Africa indicated that there were 22 698 male nurses versus 238 000 female nurses working in different South African health facilities (SANC, 2014:1). The shortest period of experience in the acute care psychiatric ward by a nurse was two weeks; this person was included as s/he was purposively selected because of experiencing violence over this short period. The researcher deemed any experience of violence as relevant, despite the length of period employed in the environment.

Themes, categories and subcategories identified in the data

The two themes were "experiences of violence" and "the effects of violence". These themes were (sub)categorised as outlined in Table 2.

Table 2: Themes and (sub) categories reflecting violence experienced by nurses

Theme: Nurses' experience of violence	
Category	Subcategory
Category 1: Forms of violence nurses experienced	Physical violence
	Sexual violence
	Psychological violence
Category 2: Perceived risk factors contributing to violence	Substance abuse during admission
	Mental illness
	Resistance to ward structure
	Habitual violent behaviour
Theme: The effects of violence	
Category	Subcategory
Category 3: Physical and emotional effects	Physical pain
	Emotional distress

Theme: Nurses' experience of violence

Nurses expressed their experiences of violence by explaining the forms of violence they experienced. Next, they attempted to make sense of the experiences by discussing their perceptions of the risk factors that contributed to the violence.

Category 1: Forms of violence nurses experienced

In response to a question about nurses' experience of violence, they elaborated on the various forms of violence experienced, namely, physical, sexual and psychological.

Physical violence

Various forms of physical violence were experienced, namely beating, slapping, biting, grabbing and pushing. One of the participants who was beaten and slapped while working in an acute care psychiatric ward said the following:

> *"The patient came in the room where we were doing a ward round ... while looking at the door … he started hitting my back. I could not run away because there was no space."*

Another participant who was bitten by a mental health care user explained:

> *"I had a patient bite from a female patient when I was working in the female psychiatric ward. I went to stop her from fighting with other patients and the patient turned around to fight with me."*

The findings regarding the forms of physical violence experienced concur with a study conducted by Gacki-Smith, Jauarez, Boyett, Homeyer, Robinson and Maclean (2009:342) on violence against nurses working in US Emergency Departments that revealed some of the most common types of physical violence experienced included hitting, slapping, being pushed or shoved, scratching, biting, spitting and kicking.

Sexual violence

The sexual violence experienced by nurses included sexual harassment with verbal content and sexual harassment with physical contact. One participant who had experienced this explained:

> *"There was this patient who was … sexual[ly] attracted to me. I was not aware of it until … I was away from the others [nurses]. He followed me and he was having an erect penis. He came near me and then said to me 'I love you.'"*

Another participant who experienced sexual harassment with physical contact reported the following:

> *"A patient wanted to rape me in this ward when I was on duty. He grabbed me and pushed me down on the floor and he was saying 'I want to rape you.' After he grabbed me, I fell down and I was rolling and he was saying 'I am going to rape you.' I was fighting him as he was on top of me."*

A study conducted by Shiao, Tseng, Hsieh, Hou, Cheng and Guo (2009:824) on assaults against nurses in general and psychiatric hospitals revealed high rates of assault, with nurses in psychiatric hospitals reporting a higher rate of sexual assault, which included verbal harassment with sexual content and sexual harassment with physical contact. A study conducted by Kwok, Law, Li, Ng, Cheung, Fung, Kwok, Tong and Yen (2006:6) on the prevalence of workplace violence against nurses in Hong Kong revealed 18% of the participants were sexually harassed in the workplace.

Psychological violence

The findings in this study revealed that psychological violence, usually in the form of verbal threats and insults, was common when working in acute care psychiatric wards. One participant who experienced verbal threats said:

> *"There was this one patient who talked [said] to me that 'I am going to beat you, I am going to kill you' while I was working in this ward. Sometimes the patient tells me 'I hate you' on several occasions and when the patient says that, you must be on the alert."*

Another participant said:

> *"There was a certain patient who insulted me and later he wanted to beat me. He was telling me things like 'voetsek' [go away], you can't do anything to me, you are here because of me, I will deal with you."*

Pich et al. (2010:268) report that verbal abuse is the most common form of violence experienced by nurses, but the effects are similar to physical assault (ICN, 2006:3). Other forms of violence such as self-directed and object-directed violence (Bowers, Stewart, Papadopoulos, Dack, Ross, Khanom & Jeffery, 2011:4) were not mentioned by participants in this study.

Category 2: Perceived risk factors contributing to violence

In recounting their experiences of violence, nurses listed the factors that they perceived to be risk factors for violent behaviour by mental health care users: substance abuse during admission, mental illness, resistance to ward structure and habitual violent behaviour.

According to participants, mental health care users abused substances before and during admission and then became aggressive. When asked what triggered violence, a participant thought cannabis abuse was a likely factor:

> *"He went out and started smoking. I am sure he smoked ganja (cannabis) with his friends outside in their bathroom. It was the time when he came and started beating me."*

According to Hamrin, Iennaco and Olsen (2009:216), factors that are mental health care user related include the person's age, gender, psychiatric diagnosis, symptoms, prior violence and difficulties in interpersonal relationships. Pich et al. (2010:269) report that substance and alcohol use and/or abuse is associated with an increased risk of patient-related violence against emergency department nurses.

Reasons for aggression included mental illness and associated symptomatology. Nurses used these risk factors to normalise violent behaviour by mental health care users, as one participant explained:

> *"You see this patient was psychotic and when somebody is psychotic he doesn't know or doesn't understand his condition and that particular patient can do anything at any time to you."*

Hamrin et al. (2009:221) explain that symptoms such as psychosis are great risks for violence, as communication with nurses is misinterpreted and delusions and hallucinations could instruct mental health care users to harm others. Pich et al. (2010:270) report on studies that confirmed patients with a serious mental health condition are more likely to display violence.

In addition, nurses were of the opinion that mental health care users were not willing to accept the ward structure such as the rules about discharge or taking medication. Nurses expressed this resistance to ward structure as mental health care users being unwilling to "take orders from nurses". Not being allowed to leave the ward when they wished to do so also triggered aggressive behaviour. A participant explained:

> *"He wanted to come out of the gate and go home because he was near the gate. He was also refusing to take the medication. When I called him to come and take medication that was when he said 'I will beat you and I will kill you'."*

Regarding resistance to ward structure, Trenoweth (2003:282) proposes that mental health care users become violent in psychiatric institutions because they refuse to take medication, or because they are refused permission to leave the ward. The controlled nature of a psychiatric ward and restrictions such as locked doors could be a stressor that contributes to violent behaviour (Bowers et al., 2009:266; 269; McKenna, Poole, Smith, Coverdale & Gale, 2003:61). It is, however, important to mention that nurse/patient power struggles trigger violent encounters and nurses who are more authoritative and detached are more inclined to experience violent encounters (Hamrin et al., 2009:219).

Nurses also explained that violent behaviour was a habit. One of the participants who experienced sexual violence with physical contact said:

> *"I think it was because he was used to this behaviour of rape. As I said he once raped his grandmother before he came to hospital so I think he is used to that habit of wanting to rape females."*

In support of nurses' perceptions that habitual violent behaviour was related to violence in the ward, Pich et al. (2010:269) and Trenoweth (2003:281) assert the greatest risk factor in health facilities is a recent and past history of violence.

Theme 2: The effect of violence

Te effects of violence on nurses related to the physical pain and emotional distress they experienced after violent episodes by mental health care users against them.

Category 3: Physical and emotional effects

Participants described the pain they experienced after physical violence. One participant explained:

> *"I felt pain from the muscles of my left hand. I started feeling pain and when I looked at myself and saw that she had bitten me."*

A frequent theme in the data was emotional distress including emotions such as anger, depression, anxiety and fear of future violence. Emotions such as frustration, confusion and disappointment were expressed by the following participants:

> *"… I was scared and I felt angry. It was the first time that something like this happened to me and I was thinking if he caught me what could happen to me?"*

> *"Yesterday when I left here [the psychiatric ward] I felt depressed after work. I just wanted to sleep. If I am feeling like that I just want to sleep…."*

> *"I felt very sorry [sad] and I was anxious about what happened to me that time …"*

> *"I was confused, frustrated and disappointed, because the following day I had to come to work. I was thinking should I resign and what if it happens again?"*

A study by Lau, Magarey and McCutheon (2004:30) explain that violence against nurses could lead to pain, anger, fear, loss of confidence and depression. In their study on occupational violence and assault in mental health nursing in Australia, MacKinnon and Cross (2008:11) found that nurses who had been subjected to violence could suffer long-term negative emotional effects that included depression, disappointment, loss

of self-confidence and health, self-dissatisfaction and anxiety. Kindy, Peterson and Parkhurst (2005:173) confirmed the finding that nurses who experience violence in psychiatric units fear future injuries and others have a desire to leave after weighing the risks and benefits of continuing with their work.

CONCLUSIONS

The demographic characteristics of the study sample described violence against nurses regardless of their age, sex, or period of work. This study has shown that nurses experienced physical, sexual and psychological violence. Nurses tried to make sense of the cause of the violence from mental health care users by focusing mainly on mental health care user-related intrinsic factors such as substance abuse, being mentally ill, resistance to ward structure ("refusal to take orders") and habitual violent behaviour. Nurse-related environmental factors such as experience, interaction with staff members and fellow patients, the ward structure and ward culture were not mentioned (Lau et al., 2004:31; Jansen, Dassen, Burgerhof & Middel, 2006:45–46). Furthermore, the risk factor, "take orders" from nurses, could point to nurses expecting mental health care users to obey their commands, a potentially directive and instructing form of interaction with mental health care users that negatively affects the therapeutic nurse-mental health care user relationship.

Nurses explained the effects of the violence as physical pain and emotional distress. It can be concluded that these experiences of violence could have a negative effect on their mental health and influence the quality of care provided to mental health care users. Even though this study did not yield unexpected findings, it confirmed that violence perpetrated by mental health care users is present in this setting and affects nurses' mental health. This effect underscores the importance of implementing measures to prevent and manage it effectively.

RECOMMENDATIONS

Prevention measures should include the implementation of violence prevention education and nurse training. These measures would improve and reinforce clinical skills in risk assessment, measures to prevent violence (McKenna et al., 2003:62; Pich et al., 2010:272; Shiao et al., 2010: 829), managing conflict and aggression (Stein, 2003:46) and enhancing nurses' and mental health care users' relationships and interactions (Bowers et al., 2011:160). Education and training should also focus on developing nurses' facilitative communication skills in order to show empathy and caring (Bowers et al., 2011:160). To mitigate rules and structure as a trigger for aggression, nurses should listen to mental health care users' requests and be transparent about ward rules (Bowers et al., 2011:161). The structure of physical facilities should be safe with

appropriate security systems and adequate staffing levels (ICN 2006:1–2; Pich et al., 2010:272). Clear context specific guidelines should be available for the management of violence (Shiao et al., 2010:829) and a friendly and confidential reporting mechanism and post-incident support and counselling should be offered (ICN, 2006:1–2; McKenna et al., 2003:62; Pich et al., 2010:272; Stein, 2003:48).

LIMITATIONS

The researcher did not establish the number of participating nurses with a qualification in psychiatric nursing. This information would assist in contextualising the findings as relevant to psychiatrically trained nurses, which in turn would influence the recommendations made.

ACKNOWLEDGEMENTS

We express our gratitude to the nurses who participated in the study and all persons and institutions who granted permission for conducting this study. We also thank the University Nursing Education South Africa (UNEDSA) for the scholarship awarded for this study.

REFERENCES

Bowers, L., Allen, T., Simpson, A., Jones, J. & Van der Merwe, M. 2009. Identifying key factors associated with aggression on acute inpatient psychiatric wards. *Issues in Mental Health Nursing*, 30:260–271.

Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H. & Jeffery, D. 2011. Inpatient violence and aggression: A literature review. Report from the *Conflict and containment reduction research programme*. Section of Mental Health Nursing, Health Service and Population Research. London: Institute of Psychiatry, Kings College.

Burns, N. & Grove, S.K. 2009. *The practice of nursing research*. 6th Edition. St Louis: Saunders Elsevier.

Cowman, S. & Bowers, L. 2008. Safety and security in acute admission psychiatric wards in Ireland and London: a comparative study. *Journal of Clinical Nursing*, 18:1346–1353.

Fagin, C., Maraldo, P. & Mason, D. 2005. *A short history of violence.* Cape Town: Cape Argus Available from: http://nursingadvocacy.org/news/2005nov/10-cape-argus.html (accessed 5 June 2011).

Gacki-Smith, J., Juarez, A.M., Boyett, L., Homeyer, C., Robinson, L. & Maclean, S.L. 2009. Violence against nurses working in US emergency departments. *The Journal of Nursing Administration*, 39(7/8):340–349.

Gates, D.M., Gillespie, G.L. & Succop, R. 2011. Violence against nurses and its impact on stress and productivity. *Nursing Economics*, 29(2): 59–67.

Hamrin, V., Iennaco, J. & Olsen, D. 2009. A review of ecological factors affecting inpatient psychiatric unit violence: Implications for relational and unit cultural improvements. *Issues in Mental Health Nursing*, 30:214–226.

Hinchberger, P.A. 2009. Violence against female student nurses in the workplace. *Nursing Forum*, 44 (1):37–46.

Howerthorn Child, R.J. & Mentes, J.C. 2010. Violence against women: The phenomenon of workplace violence against nurses. *Issues in Mental Health Nursing*, 31:89–95.

International Council of Nurses. 2006. Position statement: Abuse and violence against nursing personnel. Available from: http://www.icn.ch/images/stories/documents/publications/position_statements/C01_Abuse_Violence_Nsg_Personnel.pdf (accessed 16 January 2013).

International Labour Office, International Council of Nurses, World Health Organisation, Public Service International. 2002. Framework guidelines for addressing workplace violence. Geneva: ILO, ICN, WHO, PSI. Available at: http://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf (accessed on 1 February 2014).

Irwin, A. 2006. The nurse's role in the management of aggression. *Journal of Psychiatric and Mental Health Nursing,* 13:309–318.

Jansen, G.J., Dassen, T., Burgerhof, G.M. & Middel, B. (2006). Psychiatric nurses' attitudes towards inpatient aggression: preliminary report on the development of Attitude Towards Aggression Scale (ATAS). *Aggressive behaviour*, 32:44–53.

Kennedy, M. & Julie, H. 2013. Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. *HealthSAGesondheid*, 18(1):1–9.

Kindy, D., Petersen, S. & Parkhurst, D. 2005. Perilous work: Nurses' experiences in psychiatric units with high risk of assault. *Archives of Psychiatric Nursing*, 19(4): 169–179.

Kwok, R.P.W., Law, Y.K., Li, K.E., Ng, Y.C., Cheung, M.H., Fung, V.K.P., Kwok, K.T.T., Tong, J.M.K. & Yen, P.F. 2006. Prevalence of workplace violence against nurses in Hong Kong. *Hong Kong Medical Journal*, 12(1):6–9.

Lau, B.C.J., Magarey, J. & McCutheon, J. 2004. Violence in the emergency department: a literature review. *Australia Emergency Journal*, 7(2):27–37.

MacKinnon, B. & Cross, W. 2008. Occupational violence and assault in mental health nursing: a scope project for a Victorian mental health service. *International Journal of Mental Health Nursing*, 17(1):9–17.

McKenna, B.G., Poole, S.J., Smith, N.A., Coverdale, J.H. & Gale, C.K. 2003. A survey of threats and violent behaviour by patients against registered nurses in their first year of practice. *International Journal of Mental Health Nursing*, 12:56–63.

Nursing Act see South African Nursing Council.

Pich, J., Hazelton, M., Sundin, D. & Kable, A. 2010. Patient-related violence against emergency department nurses. *Nursing and Health Sciences*, 12(2):268–274. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1442-2018.2010.00525.x/abstract (accessed 12 August 2012).

Polit, D.F. & Beck, C.T. 2012. *Nursing research: generating and assessing evidence for nursing practice.* Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Republic of South Africa. 2002. *Mental Health Care Act no 17 of 2002*. Pretoria: Government Printer.

Shiao, J.S.C., Tseng, Y., Hsieh, Y.T., Hou, J.Y., Cheng, Y. & Guo, Y.L. (2009). Assaults against nurses of general and psychiatric hospitals in Taiwan. *International Archive of Occupational Environmental Health*, 83(1):823–832.

South African Nursing Council. 2005. *Nursing Act, No 33 of 2005*. Pretoria: Government Printer.

South African Nursing Council. 2014. SANC Geographical Distribution 2013. Available at: http://www.sanc.co.za/stats/stat2013/Distribution%202013.htm (Accessed 2 February 2014).

Stein, S. 2003. Workplace violence in the health sector: Country Case Study: South Africa. Geneva: Joint Programme on Workplace Violence in the Health Sector. Available at: http://www.who.

int/violence_injury_prevention/violence/interpersonal/en/WVcountrystudysouthafrica.pdf (Accessed on 1 February 2013).

Trenoweth, S. 2003. Perceiving risk in dangerous situations*:* Risks of violence among mental health inpatients. *Journal of Advanced Nursing*, 42(3):278-287.

University of Johannesburg, Department of Nursing Science. 2009. *Theory for Health Promotion.* Johannesburg: University of Johannesburg, Department of Nursing Science*.*