



**An-Najah National University**

**Faculty of Graduate Studies**

**THE EFFECT OF PSYCHIATRIC PATIENTS  
AGGRESSION AND VIOLENCE ON  
PSYCHIATRIC NURSES: A STUDY FROM  
BETHLEHEM PSYCHIATRIC HOSPITAL OF  
PALESTINIAN TERRITORIES**

**By**

**Saleh Ibrahim Abed Al Hadi Sayara**

**Supervisor**

**Dr. Adnan Sarhan**

**This Thesis is Submitted in Partial Fulfillment of the Requirements for the Degree of  
Master of Community of Mental Health Nursing, Faculty of Graduate Studies, An-Najah  
National University, Nablus - Palestine.**

**2023**

**THE EFFECT OF PSYCHIATRIC PATIENTS  
AGGRESSION AND VIOLENCE ON  
PSYCHIATRIC NURSES: A STUDY FROM  
BETHLEHEM PSYCHIATRIC HOSPITAL OF  
PALESTINIAN TERRITORIES**

By

Saleh Ibrahim Abed Al Hadi Sayara

This Thesis\Dissertation was Defended Successfully on //2023 and approved by

Dr. Adnan Sarhan  
Supervisor

  
Signature

Dr. Suheir Sabbah  
External Examiner

  
Signature

Dr. Fayez Mahamid  
Internal Examiner

  
Signature

## Dedication

أهدي هذا البحث إلى:

قدوتي ومثلي الأعلى - أبي الحنون - رحمه الله الذي غرس في حب العلم ورباني على العزة والكرامة. والله أسأل ان يكون هذا العمل خالصاً عن روحه، وأن يكون سبباً في رقيه وهناءه في الفردوس الأعلى من الجنة.

أمي الحنون، من علمتني العطاء، وسقنتني الحب والحنان منذ خلقت، سندي في هذه الدنيا.

زوجتي الغالية آيات التي أشرقت شمسها في سماء حياتي، وأصبحت نوراً تمدني بالحب والدعم، سندي ورفيقة

دربي التي تحملت عناء البيت عني خلال مرحلة دراستي وتحضيري لهذه الرسالة.

إلى إخوتي وأخواتي جميعاً فأنتم السند والعضد، ومن يشاطرنني أفراحي وأحزاني.

إلى بناتي فلذات كبدي.

إلى جميع الأصدقاء والزملاء والأساتذة، وكل من يحبني بصدق وإخلاص.

إلى كل من ساهم وشارك في انجاز هذا البحث.

والله أسأل أن يتقبل هذا العمل مني وان يكون في ميزان حسناتي.

## **Acknowledgements**

I would like to extend my sincere and heartfelt gratitude to all who have helped me with this endeavor. Without their active guidance, support, and encouragement, I would not have been successful with this project. I would like to dedicate this work to my supportive family especially and to my wife. I would also like to dedicate this work to my second family (my colleagues) for their supportive role from the beginning of this journey. I am indebted to Dr. Adnan Sarhan, my research adviser, for his conscientious guidance and direction throughout this entire process.

## **Declaration**

I, the undersigned, declare that I submitted the thesis entitled:

**THE EFFECT OF PSYCHIATRIC PATIENTS AGGRESSION AND VIOLENCE  
ON PSYCHIATRIC NURSES: A STUDY FROM BETHLEHEM PSYCHIATRIC  
HOSPITAL OF PALESTINIAN TERRITORIES**

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

**Student's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## List of Contents

Dedication.....	III
Acknowledgements.....	IV
Declaration.....	V
List of Contents.....	VI
List of Tables.....	IX
List of Figures.....	X
List of Appendices.....	XI
Abstract.....	XII
Chapter One: Introduction and Theoretical Background.....	1
1.1 Background.....	1
1.1.1 Bethlehem Psychiatric Hospital.....	1
1.1.2 Origins of Aggression.....	2
1.1.3 Associated Aggression Factors in Psychiatric Care.....	2
1.1.4 Clients' Factors.....	3
1.1.5 Staff Factors.....	4
1.1.6 Environmental factors.....	6
1.2 Aggression Management and Reduction.....	7
1.3 The steps performed to prevent violence within the workplace.....	8
1.4 Frequency of Aggression.....	9
1.5 Etiology of Aggression.....	9
1.6 Theories of aggression.....	10
1.7 Effects of Aggression and Violence in Mental Health Units.....	13
1.7.1 Physical harm.....	13
1.7.2 Emotional harm.....	14
1.7.3 Deteriorated therapeutic alliances.....	15
1.7.4 Cost to the organization financially.....	15
1.8 Nurses thoughts on aggression and violence.....	15
1.9 Psychiatric patient aggression among nurses in Psychiatric hospitals:.....	15
1.9.1 The effect of Psychiatric Patient Aggression on nurses in psychiatric hospitals... ..	16
1.10 The effect of Psychiatric patient violence on nurses in psychiatric hospitals.....	17
1.11 Literature Review Search Strategy.....	19
1.11.1 Theoretical review of psychiatric patient aggression on psychiatric nurses in psychiatric hospitals. ....	19

1.11.2 Theoretical Review of psychiatric patient violence on psychiatric nurses in mental hospitals .....	21
1.12 Significance of the Study .....	25
1.13 Aims of the Study .....	25
1.14 Research Objectives.....	25
1.15 Research Questions.....	25
1.16 Research Hypothesis.....	26
1.17 Problem Statement.....	26
1.18 Definition of Terms .....	27
1.18.1 Aggression .....	27
1.18.2 Violence .....	27
1.18.3 Psychiatric patient.....	27
1.18.4 Psychological state.....	27
1.18.5 Psychiatric nurse .....	27
1.18.6 Workplace violence .....	27
1.18.7 The nurses' role .....	28
1.18.8 Verbal Violence .....	28
1.18.9 Psychiatric facilities.....	29
Chapter Two: Methods .....	30
2.1 Study Design.....	30
2.2 Study Setting.....	31
2.3 Sample and Sampling Method.....	31
2.4 Inclusion Criteria .....	31
2.5 Exclusion Criteria .....	31
2.6 Instruments.....	31
2.6.1 Validity and Reliability of the Two Questionnaires (Arabic language) .....	32
2.6.1.1 Impact of Event Scale-Revised (IES-R).....	32
2.6.1.2 The Eysenck Personality Questionnaire-Revised (EPQ-R).....	33
2.7 Data Collection .....	33
2.8 Ethical Considerations .....	34
Chapter Three: Result .....	35
3.1 Socio-demographic characteristics .....	35
3.2 Distribution of PTSD among Psychiatric Nurses according to the level of Impact of Event Scale .....	37
3.3 Present versus absent of the component of PTSD; intrusion, avoidance, and hyperarousal.....	38

3.4 Association of PTSD with socio-demographic parameters .....	38
3.5 Types of Personality for Psychiatric Nurses according to Eysenck Personality Inventory (EPI) .....	40
3.6 Ordinal logistic regression for association of Personality type with PTSD among Psychiatric Nurses .....	40
Chapter Four: Discussion and Conclusions .....	42
4.1. Discussion .....	42
4.2 Limitations .....	46
4.3 Conclusions .....	46
4.4. Recommendations .....	47
References .....	48
Appendices .....	65
الملخص .....	ب

## List of Tables

Table 1: Distribution of participants according to socio-demographic characteristics ..	36
Table 2: Distribution of PTSD among Psychiatric Nurses according to the level of the Impact of Event Scale .....	37
Table 3: Present versus absent of the component of PTSD intrusion, avoidance, and hyperarousal.....	38
Table 4: Ordinal Logistic Regression for factors associated with PTSD among psychiatric nurses .....	39
Table 5: Types of Personality for Psychiatric Nurses according to Eysenck Personality Inventory (EPI) .....	40
Table 6: Ordinal logistic regression of the association of PTSD and Personality type among Psychiatric Nurses .....	41

## **List of Figures**

Figure 1: Bethlehem Psychiatric Hospital .....	1
Figure 2: Study variables.....	30
Figure 3: Distribution of PTSD among Psychiatric Nurses according to the level of the Impact of Event Scale.....	37

## **List of Appendices**

Appendix A: Facilitate The Search Task .....	65
Appendix B: IRB Aproval Letter.....	66
Appendix C: Questionnaire .....	67
Appendix D: Impact of Event Scale - Revised (IES-R) .....	68
Appendix E: Eysenck Personality Questionnaire .....	77

**THE EFFECT OF PSYCHIATRIC PATIENTS AGGRESSION AND VIOLENCE  
ON PSYCHIATRIC NURSES: A STUDY FROM BETHLEHEM PSYCHIATRIC  
HOSPITAL OF PALESTINIAN TERRITORIES**

**By**

**Saleh Ibrahim Abed Al Hadi Sayara**

**Supervisor**

**Dr. Adnan Sarhan**

**Abstract**

The nature of psychiatric nursing work is demanding and can be stressful, in comparison to other professions, psychiatric nurses suffer greater levels of stress. Related research has revealed that psychiatric nurses in work have a higher incidence of aggression and violence. According to evidence, the psychiatric nursing staff is often subjected to violence and aggressiveness, resulting in the affected nurses physical and mental well-being harmed.

The aim of the study is to evaluate the effect of psychiatric patients aggression and violence on psychiatric nurses in Bethlehem Psychiatric Hospital in Palestinian.

A descriptive quantitative cross-sectional study design was conveyed during November-December 2021 at Bethlehem Psychiatric Hospital in Palestine. The data was collected by using a questionnaire containing two sections (Demographic data, Impact of Event Scale-Revised, Eysenck Personality Questionnaire-Revised). The Data was analyzed by using SPSS version 26.

The results showed the prevalence of diagnosed PTSD nurses was (14.7%), and among participants who had partial PTSD and some symptoms was (20.0%). Furthermore, the number of people who outlived post-traumatic stress (enough to suppress the immune system) was (42.7%). Furthermore, it was clear that the impact of post-traumatic stress disorder on the personality among the nurses involved in the study, as the prevalence of neuroticism among the participating nurses was (48.0%), this means that participants are characterized by sadness, mood swings, and emotional instability. In addition, individuals with a high score for this trait tend to experience mood swings, anxiety, speed, and sadness, while the extroverted ratio reached (85.3%), and this degree

indicates that the person is social, loves parties, has many friends, needs many people around them, loves to talk a lot, does not like to read, and seeks excitement. They patient aims to do things they are not supposed to do, acts quickly without thought, is generally impulsive, is fond of making pranks for others, answer is insightful and quick witted, loves change, takes things, prefers to be always active and moving, does different actions and tends to aggression. In addition to being impatient easily, the patient cannot control their feelings and gets irritated quickly.

The study concluded that the aggressive and violent behaviors of the psychiatric patient on the nurses have negative impact on the psychological state of the nurses, and most of the participants suffer from PTSD. Furthermore, participants who are diagnosed with PTSD are more likely to suppress their immune system. Moreover, post-traumatic stress disorder was reflected on the personality state or personality dimensions of the nursing participants in the study. This reflection led to the emergence of neuroticism that manifests in the form of anxiety, difficulty sleeping, headaches, digestive disorders, back pain, and mood swings.

The Palestinian Ministry of Health must be aware of the difficulty of the work provided by these psychiatric nurses as well as to providing psychological supervision and counseling programs for these nurses.

**Keywords:** Psychiatric Patient, Psychiatric Nurse, Aggression, Violence, Psychological State, Bethlehem Psychiatric Hospital.

# Chapter One

## Introduction and Theoretical Background

This descriptive–correlational research study aimed to examine the effect of psychiatric patients aggression and violence on psychiatric nurses: A study from Bethlehem Psychiatric Hospital of Palestinian Territories. This chapter includes the background of the study, the problem statement, the significance of the study, study implications, study purpose, the research questions, hypotheses, and the definition of terms.

### 1.1 Background

#### 1.1.1 Bethlehem Psychiatric Hospital

##### Figure 1

*Bethlehem Psychiatric Hospital*



The only mental hospital in Palestine's West Bank is Bethlehem mental Hospital. It was built in 1922 and has seven wards, including an acute admission ward for men (33 beds), an acute admission ward for women (16 beds), a chronic admission ward for men (53 beds), and a chronic admission ward for women (16 beds. (207) beds altogether, including a rehabilitation ward for females (42 beds), a rehabilitation ward for males (30 beds), and a rehabilitation ward for females (33 beds). (Bethlehem psychiatric hospital administration, 2022)

Acute mental problems and aggressive individuals can be observed in the admissions wards. The recovered patients with stable psychiatric conditions stay in rehabilitation units. Patients with long-term psychological problems who need recovery are placed in chronic wards. These individuals require specialized care because they have poor functioning and no communication abilities.

The hospital provides inpatient treatment including medication, observation, patient safety, isolation and restraint, and electro convulsive therapy (ECT) for both inpatients and outpatients. They use modified ECT and simple ECT, as well as electroencephalography (EEG) and psychological tests that are administered by a single psychologist. Additionally, occupational therapy offers a recovery program there.

### **1.1.2 Origins of Aggression**

According to Anderson & Bushman, aggression: is any action taken against another person that is done with the express (immediate) intention of causing them damage (Anderson & Bushman, 2002, p. 28).

Geen (2001) suggested two elements that he believed should be included in a definition of aggression: first, there must be a desire to cause harm, and second, the target of the behavior must be a living being. must be inspired to steer clear of such interactions. The delivery of an aversive stimulus from one person to another, with purpose to damage and with an expectation of doing so, while the recipient is driven to flee or avoid the stimulus, is how he offered the following working definition of aggressiveness (Geen, 2001, p. 3).

According to Palmstierna et al., (2002), aggression is a multifaceted concept. He suggested using a three-dimensional definition of hostility:

- Internal versus external experience.
- The viewpoints of the aggressor and the spectator.
- A trait or state that occurs consistently as opposed to sporadically.

### **1.1.3 Associated Aggression Factors in Psychiatric Care**

Researchers have made an effort to comprehend the variables that contribute to the occurrence of aggression at the three levels listed below: the patient level, the level of the staff members and the atmosphere. The following explains these levels.

#### **1.1.4 Clients' Factors**

Patient factors include biological characteristics including gender, age, socioeconomic status, and psychopathology. They also include involuntary patient admission.

According to study on the biological causes of aggression by Dack et al. (2013), these factors include inheritance, the influence of hormones like testosterone, and the operation of brain processes such the limbic and cerebral cortices.

Studies on the subject of whether gender influences aggressive behavior are divided. Many researches have failed to find a connection between gender and violence. (Lam et al., 2000; Hojat et al., 2002), while some feel that men are more likely to be attacked (Hegney et al., 2003; Krakowski and Czobor, 2004; Cornaggia et al., 2011; Dack et al., 2013). Regarding age as a risk factor, younger patients are more prone to commit assaults (Cornaggia et al., 2011; Dack et al., 2013). Adolescent patients were the age range that (Kwok et al., 2006) focused on, although more research is still needed in this area before a firm conclusion can be drawn. Some studies have concentrated on how culture and economic position affect societal violence (Springer, 2011). Furthermore, there is no conclusive evidence linking demography to physical assaults, although (Esmaeilpour et al., 2011) found that there might be a link between physical aggression and poverty, broken marriages, and overcrowding. In addition to the aforementioned, there isn't any concrete evidence in the literature that aggression and psychopathology are related. According to recent research (Gaynes et al., 2017), there may be a connection between certain mental disorder symptoms and violence in some patient types. For instance, delusions, especially those with a persecutory theme, may have a significant and direct impact on violence (Nolan et al., 2005).

Other indicators could play a smaller role in setting off aggressive behavior. Though their effects will vary depending on the stage of the illness in question, these include thought disorder, increased physiological arousal, disordered behavior, and substance abuse (Gaynes et al., 2017). According to Daffern and Howells (2002), psychotic patients are most prone to act aggressively while they are in the acute stage of the illness. Walsh et al. (2002) conducted an analysis of the literature and presented evidence indicating a tight connection between schizophrenia and violence, but that fewer than 10% of societal violence can be directly attributable to schizophrenia.

Child abuse is one social component that has a substantial correlation with aggressive behavior in adults. In their analyses of family and non-familial violence, (Elliott et al., 2011) and Liu (2011) draw the conclusion that violent people were more likely to have experienced physical abuse as children.

In addition to the mentioned before, there is not any concrete evidence in the literature that aggression and psychopathology are related. According to recent research (Gaynes et al., 2017). There may be a connection between certain mental disease symptoms and violence in some patient types. For instance, delusions, especially those with a persecutory theme, may have a significant and direct impact on violence (Nolan et al., 2005). Additional signs might play a smaller role in setting off aggressive behavior. Though their effects will vary depending on the stage of the illness, these include thought disorder, increased physiological arousal, disorganized behavior, and substance abuse (Gaynes et al., 2017). According to Daffern and Howells (2002), psychotic patients are most prone to act aggressively while they are in the acute stage of the illness.

Fewer than 10% of societal violence can be directly attributed to schizophrenia, according to (Walsh et al.,2002) review of the literature, which shows that schizophrenia and violence are closely related. Child abuse is one social component that has a substantial correlation with aggressive behavior in adults. In their analyses of family and non-familial violence, Elliott et al. (2011) and Liu (2011) draw the conclusion that violent people were more likely to have experienced physical abuse as children blamed on schizophrenia.

### **1.1.5 Staff Factors**

Staff issues include a lack of experience, insufficient staff to patient ratios, unclear roles, and the reality that the majority of patients are compelled to be admitted to the hospital rather than choosing to do so (Wax et al., 2016). Several researchers, including Guay et al. (2016), have discovered that teaching employees how to deal with aggressive behavior reduces the frequency and severity of incidents. Low staff-to-patient ratios did not result in an increase in the number of violent episodes, according to (Ergün and Karadakovan's 2005), research. However, a different study (Jackson et al., 2002) discovered that there was an inverse correlation between the staff-to-patient

ratio and the frequency of assaults on staff. Studies linking staffing levels to aggressive occurrences should be viewed with caution since having patients who are violent in the study could lead to both high staffing levels and aggressive incidents. Unluckily, no randomised studies have been done to date to verify these findings. While Lorenzo et al. (2012) note that wards with clear staff roles, robust psychiatric leadership, regular and expected events resulted in a reduction in the level and frequency of violent events, (Ng et al., 2001) argued that high patient numbers on the ward could be a factor in precipitating assaults.

Furthermore, Violence can result from inadequate nurse-patient communication, and failure to comprehend the patients is also thought to play a role (Baby et al., 2014). Additionally, the majority of nurses believe that the challenging care of patients with drug and alcohol issues makes them feel stressed. Additionally, some violent mental health treatments can leave patients feeling depressed, anxious, uncontrollable, and uneasy (Baby et al., 2014). Despite differences in view, some nurses contend that professionals frequently use stereotypes to interpret potentially harmful circumstances. Professionals frequently have an impact on one another by talking negatively about patients (Baby et al., 2014). The working circumstances, including the ongoing lack of staff, increased duties, stress, and pressure, as well as the absence of nurses who were not replaced. In addition, the prolonged lack of staff may cause psychiatric nurses to act violently were also discussed in a study according to (Terkelsen & Larsen, 2016). Inadequate staffing, particularly at night, has a substantial effect on both people and professionals, according to several psychiatric nurses. Additionally, working alone as opposed to in groups increased their vulnerability to violence (Terkelsen & Larsen, 2016). Violence is also fueled by a lack of knowledge, which makes it difficult for nurses to manage their workload. Additionally, some attendance management systems still require improvement (Choiniere et al., 2013). Likewise some nurses worry about disappointing the team and could feel guilty, which lowers the standard of care. Violence occurs in the workplace as a result (Terkelsen & Larsen, 2016).

In Palestine, there are three stages of nursing education:

1. Diploma degree, which is a two-year nursing program.
2. Less knowledge and abilities are part of this.
3. Baccalaureate degree, which is a four-year nursing program
4. More knowledge and abilities are included here than in a diploma or certificate speciality.
5. A master's degree in nursing, a specialist field of study. This involves having a high level of expertise in nursing and mental health

### **1.1.6 Environmental factors**

Increased demand for employment at the psychiatry units and a lack of senior management support are two related factors. Fear of authority, responsibility, blame, and reliance on "outsiders" all contribute to a rise in workplace violence (Evans & Petter, 2012). In the wards, nurses are under a lot of stress, which makes it difficult for them to provide patient care. Additionally, the care of patients adds to the workload due to factors like unsupported involuntary admission, the design of a small workspace, inadequate personnel skills, and difficult patient diagnoses. And inexperienced workers are not suitable for their positions (Ward, 2013). Overworked nurses are less likely to provide high-quality care and are more likely to experience stress (Lantta et al., 2016). Nurses may become cynical if there is frequent workplace violence and a hostile environment. A person will alter after working in such a setting. Workplace violence has gotten worse since even physical violence is accepted as routine (Lantta et al., 2016). Having isolated locations and little room to move around can potentially increase workplace violence (Stevenson et al., 2015). In addition, the ambiance of the place also included the psychiatric nurses themselves. The ward may feel uneasy if the staff knows the patient was combative. Although restraint beds and isolation facilities seem like helpful tools for patient control, some patients may become paranoid when exposed to them (Terkelsen & Larsen, 2016). Another type of restraint is being forced to take medicine (Terkelsen & Larsen, 2016). In addition, Patients will experience discomfort in the isolation area because they perceive it to be unpleasant (Terkelsen & Larsen, 2016). In mental facilities, patients become aggressive because they refuse to take their medication or leave the ward. Some patients detest the sense of being confined to the

wards, and this emotion could act as a stressor and cause them to act violently (Nguluwe et al., 2014).

## **1.2 Aggression Management and Reduction**

According to Wright (2002), a patient can be guided toward a calmer "personal space" by efficient communication, the identification of their stresses, and the provision of practical alternatives to aggressiveness. The elements listed below are described:

1. Self-awareness (of one's own tension, anxiety, and patient knowledge).
2. Understanding the patient, particularly their typical behavior and any deviations that might indicate agitation or hostility.
3. The use of non-threatening, attentive nonverbal and vocal communication techniques.
4. Sensitivity to the patient's demand for enough personal space, which is typically larger than usual in agitated or furious people.
5. Speak in a low-pitched, calm tone to make it easier for the patient to hear and comprehend what is being stated.
6. Promoting verbal responses by using open-ended questions, which elicit more information than closed-ended inquiries and call for mental effort (perhaps diverting the patient from expressing more aggressive emotions).
7. Time spent on the work is appropriate.
8. Carrying out the procedure in a peaceful setting.
9. Taking into account safety factors like wearing appropriate and secure clothing and jewelry, having other staff members aware of what is happening and ready to step in if needed, placing furniture, avoiding conflict during the de-escalation process itself, and using security personnel sparingly.

Turnbull et al. (1990) outline a more dynamic de-escalation model in which skills are utilized more flexibly and are either continued or replaced by others depending on how the patient's behavior is judged. The following abilities are displayed:

1. Controlling other people around you (e.g., shifting patients out of the way, enlisting team support, suggesting the aggressor relocate somewhere else.)
2. Prompting thought by using open-ended inquiries and asking the patient why they are angry (to get them to think about the issue rather than acting out).

3. Ignoring threats and soliciting assault (e.g., "You want to hit me? "), while giving clear, succinct, and firm directives and negotiation options. Then go ahead and try!), or making unreachable promises.
4. Paying attention to nonverbal cues like eye contact, allowing more space between the body and the person in front of you, adopting a 45-degree posture (as opposed to standing face-to-face), adopting an open stance with your hands by your sides and palms facing outward, and refraining from staring or provocative nonverbal behaviors like folding your arms across your chest or keeping your hands behind your back or in your pockets.
5. Individualizing oneself and placing a focus on collaboration.
6. Using non-verbal and verbal cues to demonstrate concern and attention, such as head nodding and sayings like "Go on," "I see," etc.
7. Mood matching, which refers to emulating an individual's level of arousal but not their expressed mood.

### **1.3 The steps performed to prevent violence within the workplace**

#### **Increase understanding of the profession**

Psychiatric nurses believe that effective on-the-job training can facilitate the healing process (Lantta et al., 2016). Likewise, psychiatric nurses state that nurse-centered strategies should be prioritized and that a balance should be struck between the well-being and safety of patients and nurses and the pleasant clinical environment (Stevenson et al., 2015).

#### **Teaching on connecting and safety abilities**

Successful interaction between nurses and patients, in the opinion of psychiatric nurses, is essential (Ward, 2013). Psychiatric nurses need to focus on comprehensive control and logical choices while dealing with violence (Jeffery, & Fuller, 2016). At the same time, psychiatric nurses should advance their knowledge and skills in the field (Hylén et al., 2019). Additionally, it's important to strike a balance between force and impact. Beside, Psychiatric nurses claim that getting patients to adhere to treatment plans is an incentive. Contrarily, it may also result in violence (Hylén et al., 2019).

### **Improve teamwork**

Despite the fact that each mental nurse's experiences with workplace violence are unique, their following emotions are generally the same (Jeffery & Fuller, 2016). Therefore, psychiatric nurses are aware that providing post-incident support is a method for coping with emotions. And they believe that managers should start a support system (Jeffery & Fuller, 2016). Additionally, psychiatric nurses believe that the workplace culture requires to be one of love and care (Hylén et al., 2019).

### **Make the ward's setting secure**

Psychiatric nurses contend that a nurse-centered approach ought to be prioritized when thinking about how to cope with violence. And, it's important to maintain control over the patients' setting (Stevenson et al., 2015). Additionally, psychiatric nurses believe that the wards' physical layout needs to be improved in order to increase their safety (Lantta et al., 2016).

## **1.4 Frequency of Aggression**

Both in society and in medical settings, aggression is a major worry. Patients with mental illnesses require specialized care and therapy; in order to receive it, the medical staff must have a positive attitude toward them in order to prevent patients from feeling inferior and stigmatized, which might result in aggression. According to Bjorkly (1996) 15% to 30% of hospitalized psychiatric patients, have engaged in physical assaults. The number of events ranged from 0.15 attacks per bed per year (Fottrell, 1980) to 88.8 incidents per bed per year (Brizeret al. 1987), according to a review of descriptive research on the epidemiology of aggressive episodes by Nijman (1999).

In Palestine, there are no national databases available to offer such information.

## **1.5 Etiology of Aggression**

One of the many reasons why psychiatric patients act aggressively is their own psychiatric condition. According to Lanza et al. (1994), more than one-third of patients who were violent were alcohol dependent. Furthermore, according to Morrison (2002), aggressiveness is more likely when schizophrenia and substance addiction are combined. According to the Royal College of Psychiatrists (RCP, 1998), young males who have a history of substance misuse and psychiatric disease are more likely to be

violent. According to Nijman (2002), assaults may also result from the deprivation of rights or services.

## **1.6 Theories of aggression**

### **Social Learning Theory – Bandura**

Aggression is a biological characteristic, but how it manifests itself is learned. According to the social learning theory, aggressive behavior can be picked up through observation. If someone notices. When they see aggressive behavior in a model, they could copy it. If they identify with or appreciate the role model, or if the role model is rewarded or successful, imitation is more likely. This is reinforcement through proxies. Bandura proposed that a child must create a mental image of the experience for social learning to occur. This comprises potential incentives or penalties for a particular behavior. When a child imitates an aggressive behavior, the result of the behavior affects the child's perception of the worth of violence. If they receive a reward, they will probably repeat the behavior.

This is upkeep gained from firsthand experience. Children learn self-efficacy, which is assurance in one's capacity to engage in violent behavior. If aggressive action is unsuccessful, the person will feel less capable of succeeding and will stop doing it (Bandura, 1977).

### **Deindividuation Theory**

De-individuation, according to Fraser and Burchell, is the "process whereby normal restraints on behavior are weakened as persons lose their sense of individuality." When a person joins a sizable group, de-individuation takes place. throng or company. De-individuation is also facilitated by uniforms and other types of anonymity, as well as drugs and alcohol. Individual behavior is sensible and compliant with social norms. De-individuated behavior deviates from social norms and is motivated by primal drives. Since inner restraints are lessened when a person is anonymous, normally inhibited behaviors, like aggression, are more likely to be displayed. De-individuation was formerly believed to result from the lack of accountability that comes with being a part of a big group of individuals. The theory has recently concentrated on the decreased private self-awareness is more significant than increased public self-awareness. According to Prentice-Dunn and Rogers, being among others makes people less self-

focused and less able to control their behavior in accordance with their internalized beliefs and moral principles (Zimbardo,1969).

### **Biological theory**

Aggression may be causally related to other things, which may be causally related to temperature. According to Cohen and Felson's Routine Activity Theory, people's regular activity patterns change during the summer, increasing the likelihood that they will interact with more people and drink more alcohol. This leads to more opportunities for interpersonal aggression.

Biological psychologists provide an alternative to social and behaviorist psychologists' explanations of violence. They contend that violence might result from genes, hormonal processes, and neurological systems rather than blaming an individual's surroundings for their hostility. Particularly when dopamine levels are high and serotonin levels are low, aggression has been connected to these neurotransmitters. Due to dopamine's connection to pleasure, violence has been associated with it. It has been shown that this neurotransmitter increases in abundance following acts of violence and is triggered after consuming particular foods or engaging in sexual activity. Dopamine's "reinforcing" tendency may therefore lead to violent behavior.

The usage of amphetamines, which stimulate dopamine, has demonstrated that increases in dopamine activity also increase aggression. The role of serotonin in the brain is to prevent other neurons from firing, particularly in the prefrontal cortex, the region of the brain in charge of, among other things, social behavior and cognitive reasoning. It is the area where we use moral reasoning and weigh the effects of our choices. Additionally, there is a lot of evidence linking hormones like cortisol and testosterone to aggressive behavior (Ferrari, 2003).

### **Eysenck's Personality Theory**

Since the 18th century, personality tests have been around for a very long time. According to a personality test developed by Hans Eugen Eysenck, biological elements like genes and environmental cues have a significant role in determining personality. The so-called "Eysenck Personality" (sometimes referred to as Eysenck's personality), is described by the Eysenck theory of personality. According to this view, every human

has a core set of characteristics that make them distinct from other animals, and every person has a unique temperament or temperament type. How we act and react in daily life is a good way to describe our personalities. People who have a certain temperament type typically behave differently than people who have other temperament types. There are several theories explaining why some people's temperaments do not match those of others; this theory places a strong emphasis on genetic inheritance (Eysenck, 1975)

Additionally, this questionnaire included 57 Likert-type questions that focused on measuring the two main personality traits of extraversion and neuroticism.

Only two dimensions in Eysenck's personality theory measure the extraversion and neuroticism qualities of a person:

**Psychoticism-Normality:** A personality feature known as psychoticism is characterized by a lack of empathy, a difficult time forming bonds, and a lack of concern for others. High psychotic individuals are more prone to be violent, antisocial, and struggle with substance usage. People with low psychoticism, on the other hand, are more likely to be emotionally secure, empathic, and to form healthy relationships.

**Extraversion-Introversion:** The phrases "extraversion" and "introversion" in psychology refer to two distinct personality traits. People who are extraverted are outgoing and sociable; they enjoy being around other people and find solitude to be quickly boring. People who are introverted are more reserved, enjoy doing things alone, and are frequently more thoughtful and reflective than extroverts. Each personality type has advantages and disadvantages.

**Neuroticism-Emotional Stability:** Anxiety, worry, and insecurity are characteristics of neuroticism, a personality trait. People with high levels of neuroticism are often more animated and receptive to stress, as well as more prone to feeling sad, angry, and afraid. In contrast, emotional stability is the capacity to remain composed under pressure or misfortune. It is a quality that is valued in many professions and cultures and that may be developed (Eysenck, 1975).

## **1.7 Effects of Aggression and Violence in Mental Health Units**

Aggression and violence have a significant negative influence in mental health facilities. Physical harm, emotional or psychological suffering, impaired patient care, and cost to the organization financially are just a few of the effects that have been reported.

### **1.7.1 Physical harm**

Assault is defined as "attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives" by the NIOSH (2020). Webster's definition of "a violent physical... attack" and "a threat or attempt to inflict offensive physical contact or bodily harm on a person (as by lifting a fist in a threatening manner) that puts the person in immediate danger of or in the apprehension of such harm or contact" are additional definitions that have been used.

Other types of physical violence include physical harassment, mugging, and murder, all of which are defined separately. Physical harassment is defined as "to create an unpleasant or hostile situation, especially by uninvited and unwelcome physical conduct" by Webster (2020).

According to a study of the literature conducted by the Central Council for Nursing, Midwifery, and Health Visiting (2002), in the United Kingdom, inpatient mental health personnel appear to be more vulnerable to assault-related serious injury than the general population. Furthermore, it has been discovered that male employees are more than twice as likely to be assaulted as female employees (Carmel and Hunter, 1989; 1993). A report by Gournay et al. (1997) found that between 67% and 93% of assaults in surveys conducted between 1994 and 1997 resulted in no evident injury. Fortunately, rates of significant injury caused by patient aggression are thought to be rather uncommon.

Furthermore, a study in Jordan by (Al-Omari, 2015), founded that's about 26.5 % of nurses were physically violence in workplace. In addition to logistic regression study, female nurses were 1.5 times more likely than male nurses to report verbal abuse were and were 0.5 times less likely to report physical assault.

### **1.7.2 Emotional harm**

Despite the fact that most assaults in inpatient mental health wards leave no visible physical wounds, emotional harm has consistently been discovered. Workers who experienced verbal and physical assault have been found to have high levels of traumatic stress, anxiety, and tension (Caldwell, 1992; Whittington and Wykes; 1992). Whittington and Wykes (1992) discovered that nurses 19 reported substantial levels of worry and tension immediately after mild assaults, and that these symptoms were consistent with a PTSD diagnosis. After two and a half weeks, the levels of stress and anxiety had decreased, although they were still high. The authors note that their small sample size of 24 makes it difficult to draw broad conclusions, but they highlight the significance of the discovery that the emotional toll of an assault may be greater than the harm done physically. Similar outcomes were discovered by Caldwell (1992), albeit in a larger sample of 224 workers. According to the study's findings, 62% of the clinical staff in a private mental health facility had been involved in a significant event involving a danger to life or safety, and 61% of those people reported having PTSD symptoms, with 10% of those people reporting enough symptoms to meet the diagnostic criteria for the disorder. The authors draw the conclusion that a significant number of employees are emotionally impacted.

Furthermore, Abrasions, bruising, lacerations, hair tears, shoulder and knee joint injuries are some effects on physical health. After experiencing workplace violence, some nurses also had headaches, muscle tension, trouble sleeping, and nightmares (Stevenson et al., 2015). According to research on the effects of psychological health, people may experience frustration, a need to defend oneself, and a desire to exert control (Hammarström et al., 2019). In addition to that According to (Baby et al., 2014), it also encompasses pains, anger, dissatisfaction, vulnerability, fear, and anxiety. Among all types of influence, emotional influence frequently manifests first and has the greatest effect on nurses (Baby et al., 2014).

Furthermore. Abd Alhadi Hasan published a study among psychiatric nurses in Jordan to assess workplace stress levels in dealing with aggressive patients and found that 43% of nurses were emotionally stressed during working with aggressive psychiatric patients (Hasan & Tumah, 2018).

### **1.7.3 Deteriorated therapeutic alliances**

Staff who have experienced verbal and physical abuse have been found to have a negative impact on the quality of care that patients receive. It has been demonstrated that attitudes toward all patients, not just those who have been aggressive or violent, are damaged, and that these emotions, counterintuitively, enhance the likelihood of additional aggression and violence (Whittington and Wykes, 1994b). Briefly stated, Whittington and Wykes (1994a) provide a model that contends staff stress and anxiety are exacerbated by a patient's verbal and/or physical aggressiveness. This makes personnel avoid interacting with patients, act hostilely toward them, and behave in an excessively controlling manner, which in turn raises the patient's level of verbal and physical violence.

### **1.7.4 Cost to the organization financially**

Aggression and violence in mental health facilities have been studied in terms of their financial effects. (Hunter and Carmel, 1992; Lanza and Milner, 1989; Nijmane et al., 2005) Costs in terms of lost workdays, use of sick leave, compensation claims, medical costs, vocational rehabilitation, and preventative strategies such as educational programs have been identified and provide an indication of the enormous financial impact of aggression and violence. Job satisfaction, staff recruitment, retention, and turnover are some less obvious effects that have been linked to financial consequences (Alderman, 1997; Lanza, 1983; Poster and Ryan, 1994).

### **1.8 Nurses thoughts on aggression and violence**

"The nurse will render a change. "Accepting violence is "a component of the work" (Ward, 2013). It's crucial to highlight the emotions of patients and conduct thorough patient evaluations (Hammarström et al., 2019). "Violence is also fueled by fear" (Ward, 2013).

### **1.9 Psychiatric patient aggression among nurses in Psychiatric hospitals:**

In psychiatric hospitals, patient aggression can be a serious problem. According to studies, at least once assault occurred to 70% of nursing professionals in psychiatric hospitals in the United Kingdom (Needham et al., 2005). In addition to that, the documented increase in patient hostility inpatient psychiatric facilities has drawn the

attention of scientists for some years (Rippon, 2000). Because of its frequency, according to (Bowers et al., 2011), aggression in psychiatric hospitals is a significant issue with negative effects on healthcare (Arnetz & Arnetz, 2001).

One of the most common mental health indicators is an aggressive attitude, which can result in poor academic achievement, unemployment, isolation from society, violence, criminal behavior, and suicide. (Bor, 2004; Connor et al., 1998; Dean et al., 2007; Masters et al., 2002). Furthermore, aggression can take many different forms, and described for any action that causes injury to oneself, others, or possessions (Conner et al., 2006). The most prevalent kind of aggression in healthcare situations is impulsive and overt, characterized by acts like physical assaults, destruction of property, self-harm, and verbal harassment (Connor et al., 2006; Garrison et al., 1990; Farrell & Bobrowski, 2006). Young people's aggression may be a sign of their underdeveloped capacity to control their conduct, which has been connected to impulsivity and poor emotion regulation, according to (Hendren & Sugden, 2006) young people who are aggressive have higher mental health difficulties (Lyons & Schaefer, 2000), aggression has a substantial correlation with adult psychopathology, making it a significant indicator of adult psychiatric disorders (Kim-Cohen et al., 2003).

### **1.9.1 The effect of Psychiatric Patient Aggression on nurses in psychiatric hospitals**

Physical aggression has been documented at rates between 16 and 85 percent (Baxter et al., 1992; Inoue et al., 2006; Nijman et al., 2005; Poster, 1996; Soares et al., 2000). One in four nurses claim to have experienced workplace aggression (Liu et al., 2019).

Patient aggression can result in physical harm (Grainger & Whiteford, 1993) and it may have a number of detrimental physical and psychological effects (Needham et al., 2005). Anger, fear, and stress are widespread reactions to aggressive episodes, according to (Needham et al., 2005). Aggression can decrease job satisfaction and result in resignation (Tachimori & Yamada 2001; Needham et al., 2005), poor work performance has also been related to aggressive exposure (Jackson & Mannix, 2002), rates of substance addiction and sick days have also increased (Jackson et al., 2002; Nijman et al., 2005), trauma signs, too (Inoue et al., 2006; Needham et al., 2005).

From a practical standpoint, the emotions that nurses experience when dealing with psychiatric patients are essential because they influence clinical care. Anger, fear, and sadness are crucial and significantly impact the therapy relationship since it is dialogical and generated by both persons' feelings and reaction-response. Furthermore, in an acute clinical setting, patient care and treatment are the responsibility of psychiatric nurses team, therefore emotions and the duty of care are shared by the whole team. However, the emotions of one team member can often have an impact on the entire team's internal and exterior dynamics (Cleary et al., 2005).

### **1.10 The effect of Psychiatric patient violence on nurses in psychiatric hospitals**

As psychiatric nurses are exposed to aggression, they are also exposed to violence in the psychiatric hospital. According to (Iozzino et al., 2015) about one out of every five patients commits an act of violent behavior while being treated in acute psychiatric units. Also, he found that characteristics linked to violence in the particular clients, such as men's gender, schizophrenia disorder, addiction, and violent past, were similar to indications connected to levels of violence in psychiatric hospitals. Around the world, concern has grown as workplace violence has increased. The National Institute for Occupational Safety and Health defines it as "violent acts (includes physical harm and threats of harm)" that are "targeted at individuals who are employed or on job "and "range from insulting or affecting statements to homicidal." (CDC). According to the World Health Organization, incidences of workplace violence are "incidents where personnel is abused, intimidated, or attacked in conditions regarding their line of employment, including traveling to and from work, involving an explicit or implied a risk to their health, happiness, or safety " (WHO 2005). On a global scale, it has been discovered that the majority of these attacks are focused against clinical professionals (Federal Bureau of Investigation). According to Canadian research, there were 1.52 occurrences of patient aggressiveness overall for every 100,000 hours done over the course of a year (Kling RN et al., 2009). Studies show that healthy workplaces and well-being of healthcare professionals are essential elements of effective healthcare systems. This ought to be utilized by all healthcare-related sectors. Psychiatric nurses in particular may experience verbal, physical, emotional, and psychological abuse (CDC) (Chapman R et al., 2010).

In Turkey, occupational violence is viewed as a significant problem that negatively affects healthcare professionals' personal lives and leads to a high staff turnover rate (Aytac et al., 2011; St-Pierre et al., 2010). This study founded that psychiatric nurses are more likely than others to experience violence healthcare employees. Furthermore, according to (Fallahi et al., 2015) mental nurses were found to have the greatest rate of violence among Iranian healthcare workers, with 74.7 percent of the persons experiencing psychological violence. Moreover, work place violence has been researched in primary care in Saudi Arabia, with studies showing a wide range of violence incidence rate (28–67.5 percent in 12 months), particularly those nurses who are employed in primary care facilities for patients (Alghanim & Algwaizet, 2012; El-Gilany et al., 2010).

In addition, psychiatric nurses work in a unique setting with locked ward entrances, which increases the risk of patient conflict and the potential for physical and psychological harm from aggressive patients. They may also be required to seclude or restrain patients in order to prevent them from harming themselves or others, which may cause the stressor structures they encounter to be different from those encountered by other professions (Kane, 2012). Additionally, the aggressive or violent behavior of a psychiatric patient may have a psychological impact on psychiatric nurses on each day, which could affect the nurses.

Furthermore, a research by (Kerr et al., 2017), conducted in Australia among 50 nurses. To assess the prevalence of patient aggression among nurses used self-report questionnaire, resulted that 40% of them had suffered assaults and 82% had suffered emotional trauma. Despite the fact, only 12% of the staff looked for treatment. Verbal abuse and suffering psychological harm are associated ( $r=0.305$ ,  $p < 0.05$ ). It was more likely that someone will encounter the other types of hostility after experiencing one type. Physical aggressiveness and non-verbal aggression were connected with each other ( $r = 0.333$ ,  $p < 0.05$ ), while verbal aggression was correlated with both of them ( $r = 0.429$ ,  $p < 0.01$ ).

## **1.11 Literature Review Search Strategy**

This descriptive-correlational research study goal to examine the effect of psychiatric patients aggression and violence on psychiatric nurses: A study from Bethlehem Psychiatric Hospital of Palestinian Territories. The following search terms were used to review the literature from the fields of nursing, psychology, and behavioral and social sciences: psychiatric patient aggression and psychiatric nurses, psychiatric patient violence and psychiatric nurses. The following electronic databases were used to find the literature: PubMed, Science Direct, Google Scholar, APA PsycNet. Search results returned 300 titles. Searches were restricted to peer-reviewed, full-text, English-language research articles that had been published during the previous five years. Publications for pertinent, seminal research—particularly work involving concept analysis—were expanded. A variety of primary sources were discovered during this search. Manually examining the reference lists of pertinent papers yielded additional proof. Ten primary sources were found for this literature study after using precise search criteria and excluding irrelevant publications.

This literature review's objective was to clarify the ideas of psychiatric patient aggression and psychiatric patient violence. Furthermore, their significance in the effect on psychiatric nurses in their workplace. As a result, the literature review is split into two primary sections:

1. Theoretical review of psychiatric patient aggression on psychiatric nurses in mental health hospitals.
2. Theoretical review of violence of psychiatric patient on psychiatric nurses in mental health hospitals.

### **1.11.1 Theoretical review of psychiatric patient aggression on psychiatric nurses in psychiatric hospitals.**

There is increasing data that nurses in psychiatric facilities are likely to be victims of violence or aggression.

In Irish cross-sectional study conducted utilizing the Modified Overt Aggression Scale (MOAS) individuals in first psychosis in the study (n = 132) between the ages of 18 and 65, in those presenting with first-episode psychosis, it is crucial to determine the

frequency and clinical correlates of aggression and violence. Actual violence rates were found to be 29% among 38 nurses and verbal aggressiveness rates to be 36% among 74 nurses (Keane et al., 2018).

Furthermore, another study conducted in the southern region of Malawi among 490 psychiatric and non-psychiatric nurses in five facilities to examine and explain the types of violence experienced by nurses, additionally to the apparent effects on nurses, He claimed that all psychiatric institution had the greatest percentage of violence, at 70%. The most common forms of violence reported include physical attacks (22%), sexual harassment (16%), threats (73%), verbal abuse (95%), and others (3%). Patients (71%) were the most violent people (Banda et al., 2016)

In addition to that, a done about aggression against Spanish nurses and their effects on somatization of physical signs. A total of 1357 nurses from general and psychiatric hospitals were assessed. The aim of this report goal to investigate the outcomes of nursing staff hostility and the effect of stress in automatizing physical effects. According to the study, nurses who were exposed to patient aggression had a higher prevalence of somatic symptoms. Additionally, aggression had a significant effect on physical stigmatization, which served as an intermediary in the stress levels of nursing employee. Aggression raised nurses' stress levels due to the emergence of somatic symptoms (Pérez-Fuentes et al., 2020).

Pekurinen et al. (2017) conducted a study in psychiatric and non-psychiatric settings in Finland the incidence of inpatient aggression and the correlations between that behavior and wellbeing in order to estimate and compare both, a sample of (923 psychiatric nurses). Psychiatric nurses reported all forms of patient aggressiveness, and subjective measures were used to evaluate both the occurrence of patient aggression and the wellbeing of nurses. such as (negative self-rated wellbeing and reduced workability, emotional distress and sleep disturbances, physical assaults, and armed threats).

Another study examined staff nurses' experiences with inpatient aggressiveness in selected hospitals across all of Slovakia during the previous year of practice; the sample size was 1,042 nurses (medical, surgical, psychiatric wards, and emergency, and intensive care units). The Violence and Aggression of Patients Scale, a self-reference tool, was used to gather data (VAPS). The finding was that nurses working in acute care

and psychiatric wards had the most frequent experiences with verbal and physical patient hostility (Lepieová et al., 2015).

Also, a Cross-sectional study was conducted to determine the associations between the mental health nurses' experience to patient aggressiveness, their feelings, their thoughts about aggressive containment techniques, and their participation in instances involving isolation and restraint. In three secure psychiatric hospitals in England, the sample size was 68 mental health nurses who completed the study. They found high levels of anger, fatigue, and guilt (Jalil et al., 2017).

### **1.11.2 Theoretical Review of psychiatric patient violence on psychiatric nurses in mental hospitals**

Nurses during work in general hospitals have been subjected to workplace violence (Gignon et al., 2014; Spector PE et al., 2014), and in particular, in mental health hospitals, (Allen, 2013; Koukia & Zyga, 2013) has evolved into a major world difficulty. According to the World Health Organization (WHO, 2002), there are several different types of violence: Murder, psychological stress, physical assault, verbal harassment, bullying/mobbing, sexual and ethnic abuse, and are all examples of physical assault. In many workplaces, including hospitals and different healthcare facilities, violence has become a terrible reality. In a study, conducted by Al-Azzam et al., 2017. The goal of this investigation was to find out how mental health nurses felt about violence during their work. Nurses working in governmental hospital in Jordan completed self-reported questionnaires. The sample population included all nurses working in mental health treatment settings in Jordan. Results indicated that in the last two years, more than 75 percent (n= 110) of the sample reported violence while working in Jordan's mental health units, the finding demonstrates that 35% of the nurses had suffered verbal aggression. Furthermore, only seven physical assault instances were reported, despite the fact that 40% of the overall sample had felt both verbal and physical abuse. In addition, Grabbing, punishment, kicking, or shoving were the most common forms of physical violence (Al-Azzam et al., 2017).

In same context of violence against psychiatric nurses, between March and May 2017, cross-sectional research was carried at three major mental facilities in Saudi Arabia's Western area. These three hospitals employed a total of 938 nurses, and it was originally planned to include all nurses. The study's goal was to determine the prevalence of work place violence among professional nurses working in Saudi Arabian psychiatric facilities by a self-reported questionnaire. Concluded that 310 nurses. Work place violence was found to be present in 90.3 percent of nurses, and others have been subjected to both physical and verbal abuse. Patients were typically the ones that engaged in violent behavior (81.3%). in such events, more over half of the nurses needed medical care. after the incident, the majority of nurses (64.2%) felt tense or anxious (53.5%), and 34.2 percent felt sad. the prevalence of work place violent in psychiatric wards was substantially associated with time of violence (Basfr et al., 2019).

Patient violence is common among nurses in psychiatry hospitals, which has an effect on the nurses' outcomes. A study conducted by (Kelly et al., 2015). Aimed to know about the perceptions of nurses in acute care inpatient psychiatric settings with patient violence, this study which included 17 interviews with twelve Canadian nurses being assaulted by patients in acute care inpatient psychiatry, was guided by an interpretative descriptive design. The whole data interpretation was also structured using a problem, requirements, and practice analysis. Thirty-three unique patient violence exposures among nurses were examined as a result. Physical, emotional, and verbal violence were reported by nurses too. (Kelly et al., 2015)

Furthermore, a study by (Pelto-Piri et al., 2020) conducted to investigate the data which was collected using an open-ended questionnaire and recorded 283 occurrences reported by 181 staff members from 10 inpatient mental units in four distinct areas. The structural analysis began with extracts from significant episodes being organized into descriptions, which were then divided into three categories analysis: 1- ahead of the incident, 2- when the event occurred 3- following the incident they then divided all of the groups and subtypes of the descriptors, and major regions. Results: Employees frequently blamed inner patient reasons for anger and violence instead of situation - specific or organization variables. Violent threats, violent behavior, and verbal abuse were among the violent acts reported. The most significant consequences number of violent crimes there were emotional and psychological issues among the employees.

Such as: fear (n = 47) and increased stress/sleep issues (n = 72). a rise in caution (n = 19) was another impact of aggressive and violent episodes on the employees. Powerlessness, fatigue, and/or insulted feelings (n = 11), and concern for the patient (n = 10). Physical harm to employees and personal belongings Additionally reported: physiological discomfort (n = 29), physical injury (n = 25), and personal belongings/ shattered glasses (n = 2). In some cases, staff members occasionally needed surgery, which was followed by extended sick leave.

In addition to that, another cross-sectional study was carried out by among 429 nurses operating in acute mental facilities in northern Taiwan to examine the incidence of violence and the responses of several victims. The conclusion was that there was 55.7% both physical and emotional violence (82.1%). The majority of those who engaged in workplace violence were patients. Violence; of the violent episodes, verbal abuse accounted for 78.8% (n = 338), bullying/mobbing for 55.5% (n = 288), sexual harassment for 32.4% (n = 139), and threats for 24% (n = 103) of the instances. Only 5% (n = 12) among those who have endured physical abuse events asked for time off to rest at home following the events, although 25.1% (n = 60) of the victims were hurt. Eight victims out of those who asked for time off asked for a leave of 1-3 days (Niu et al, 2019).

Another Cross-sectional Survey aimed to look into the prevalence, nature, contributing factors, and repercussions of workplace violence on mental health nurses as well as come up with coping mechanisms The Maslach Burnout Inventory- General Survey and a researcher-designed questionnaire on workplace violence were given to nurses at a mental health institution in Wuhan, China. At a 950-bed mental health facility in china, data were gathered from 290 Chinese physicians among a number of 355 nurses employed there. The findings indicated that the majority of nurses (94.6%) reported experiencing violence in the previous year, which could have taken the form of physical assault, sexual assault, or verbal abuse. Significant correlation between the different types of violence was found ( $r > 0.5$ ,  $p=0.000$ ), (Yang, Stone, et al., 2018).

Also, an investigation was conducted to determine the frequency, causes, and effects of physical abuse committed by mentally ill persons towards psychiatric health workers. in a Nigerian Psychiatric Hospital. The sample size was 124 nurses who filled out a survey on their encounters with physical abuse. As a result, 38 (30.6%) of the 77 (62.1%) staff members who had experienced an assault in the previous year. Pushing was the most typical assault style (32.9%). The most frequent event that preceded an assault was calming a combative patient (44.1%). In their whole career, 22.1% of assaulted staff required medical attention for injuries, and 42.4% of assaulted staff occasionally, frequently, or always suffered symptoms of posttraumatic stress disorder. (Akanni et al., 2019).

In the same context, a research among professionals, the sample size was 201 mental health staff, completed a self-administered questionnaire. Results showed one hundred twenty-five respondents (69.8%) said they had ever encountered physical violence, and 44.1% said they had in the previous year, long duration of service was connected to lifetime encounters of physical violence, and employees who experienced being physically attacked expressed more job unhappiness than those who had never witnessed violence (Olashore et al., 2018).

Another study conducted in Jordan hospitals among 67 physicians and 96 nurses, by (Al Khatib et al., 2023), to evaluate the frequency of violence, both physical and verbal. Resulted that is physical violence was experienced by 33% and verbal aggression by 53% of the individuals, significantly. Males were abused verbally (61.3% vs. 29.5%, p-value 0.001) and physically (43.7% vs. 2.3%, p-value 0.001) more often than females.

These studies, however, indicate that aggressive behavior and violent behavior are riskier in other inpatient hospital settings, such as psychiatric care units, where patients are more mentally ill and more likely to act hostilely. In all healthcare settings, hospital staff safety is essential for maintaining consistency and providing high-quality care.

### **1.12 Significance of the Study**

1. This is the first study in Palestine investigating the effect of psychiatric patient aggression and violence on the psychological state of the psychiatric nurses in Bethlehem psychiatric hospital of Palestine.
2. This study may stimulate the government to modify mental services sittings in Bethlehem psychiatric hospital.

### **1.13 Aims of the Study**

The aims of this study were to:

Assess the effect of Psychiatric Patients Aggression and Violence on Psychiatric Nurses in Bethlehem Psychiatric Hospital in Palestinian.

### **1.14 Research Objectives**

1. To evaluate the impact of PTSD from psychiatric patients' aggression on psychiatric nurses.
2. To assess the effect of PTSD from psychiatric patient violence on psychiatric nurses.
3. To find if there is correlation between PTSD and Aggression and violence behaviors.
4. To explore any significant correlation between the demographics variables and the two dependent variables.
5. To investigate types of personalities for nurses affected by clients violence.

### **1.15 Research Questions**

The following research question guided this study:

1. What is the effect of PTSD on psychiatric nurses from psychiatric patient aggression?
2. What is the effect of PTSD on psychiatric nurses from psychiatric patient violence?
3. Is there any correlation between PTSD and Aggression and violence of patients among psychiatric nurses?
4. Is there any significant correlation between the demographic variables and the two dependent variables on psychiatric nurses?

### **1.16 Research Hypothesis**

1. There's a negative effect of PTSD on psychiatric nurses from psychiatric patient aggression on the psychological state of psychiatric nurses at the level of 0.05.
2. There's a negative effect of PTSD on psychiatric nurses from psychiatric patient violence on the psychological state of psychiatric nurses at the level of 0.05.
3. There's no significant correlation between aggression and violence of psychiatric nurses on the psychological state of psychiatric nurses at the level of 0.05.
4. There's no significant correlation between the demographic variables and the two dependent variables on the psychological state of psychiatric nurses at the level of 0.05.

### **1.17 Problem Statement**

In psychiatric facilities, acute instability, hostility, and violence among patients are frequent problems that can pose a significant challenge for the nursing staff (Richter & Whittington, 2006). Service users who are disturbed and troubled are those who are feeling emotions and acting in ways that are out of the ordinary as a result of mental illness, such as rage, aggression, agitation, physical violence, and anger (Evidence Based Medicine Working Group, National Institute for Clinical Excellence (NICE, 2001).

Aggressive and violent behavior of psychiatric patients in the workplace may attempt to cause injury to other service users, personnel, property, or themselves, the UK has one of the maximum average numbers of violent service user occurrences, according to an international literature evaluation of the prevalence, causes, repercussions, and conditions of violence and aggressiveness in mental institutions (Bowers et al., 2011). Approximately 70% of nurses in mental hospitals institutes having experienced at least one assault throughout their careers, according to estimates (Needham et al., 2005). Aggressive and violent behavior, on the other hand, can cause physical and psychological impairment to employees. (Abderhalden et al.; 2002; Bilgin, 2009; Duxbury et al., 2006; Maguire & Ryan 2007). Therefore, this research is important because it will help us in better understanding the effect of psychiatric patient aggression and violence on the psychological state of psychiatric nurses now and in the future, allowing us to intervene with appropriate interventions to reduce the psychological effect on nurses.

## **1.18 Definition of Terms**

### **1.18.1 Aggression**

Any action taken against another person that is done with the express (immediate) intention of causing them damage (Anderson & Bushman, 2002, p. 28).

### **1.18.2 Violence**

It is a severe sort of aggressiveness that causes more obvious harm (Anderson & Bushman, 2002).

### **1.18.3 Psychiatric patient**

Any person (male or female), aged between 20 and 70years, admitted because of a mental illness and who has spent at least six uninterrupted weeks in the mental healthcare institution (Bimenyimana, 2008).

### **1.18.4 Psychological state**

It is a condition in which how the mind works and affects behaviors. Also, it offers treatment for behaviors and focuses on their adaptations (Brazier Y et al., 2018).

### **1.18.5 Psychiatric nurse**

According to American Psychological Association (APA) psychiatric nurse is: "a specific area of nursing practice that entails providing care for people who have mental health disorders in order to aid in their recovery and enhance their quality of life." (APA Dictionary of Psychology, n.d.).

### **1.18.6 Workplace violence**

Workplace violence is described as any act of physical or verbal aggression towards the workplace or employees, including threats, stalking, and even murder (NIOSH, 2002). The interaction of employee actions has led to an increase in workplace violence. According to Shafran et al., (2017), other influences include waiting times, professional positions, hospital environments, and patient behaviors. Patients and their family members are the most frequent violators, followed by outside coworkers and managers (Pai & Lee, 2017).

### **1.18.7 The nurses' role**

Nursing professionals must assist patients emotionally and physically while upholding their dignity and health (Kozier et al., 2012). When dealing with patients, nurses should be proactive and work with multidisciplinary teams to deal with patients' aggressive and violent behaviors (Björkdahl et al., 2013).

To satisfy patients' medical requirements, nurses must be skilled in identifying patients' issues and communicating with other members of multidisciplinary teams in an effective and accurate manner, whether orally or in writing (Kozier et al., 2012). Patients should be able to communicate with nurses at any time and receive services from them. To establish a calm and secure environment on the wards, they should be adept in communicating with psychiatric patients (Olsson et al., 2015). Patient disputes should be resolved right away to prevent them from getting worse. After a disagreement, the nursing staff should speak with the patient if they need to communicate (Olsson et al., 2015).

Leaders in the nursing profession should have a good effect on others around them and collaborate to accomplish common objectives. Motivating people's needs and goals is a prerequisite for effective leadership. Additionally, nurses must develop intervention strategies to foster a pleasant workplace, lessen stress, and have zero tolerance for violence in the workplace (Al-Omari et al., 2019)

### **1.18.8 Verbal Violence**

Threats and verbal abuse are both considered forms of verbal violence but are also classified individually. Rippon (2000) defines verbal abuse as the act of swearing, intimidating, yelling, humiliating actions and verbal reprimands in public, including sexual shaming. In the meantime, the phrase "verbal threat" is defined by (NIOSH, 2020) as using language to four indicate the intention to be violent. This could be done by making threats out loud, using body language that suggests hazardous behavior, or by sending written threats.

### **1.18.9 Psychiatric facilities**

A psychiatric unit is a type of specialty ward that treats patients with serious mental health issues. On these units, a large number of specialists, including psychiatrists, physician specialists, psychiatric nurses, psychiatric social workers, occupational therapists, psychologists, and substance abuse teams, provide multidisciplinary care. The most prevalent mental disorders treated by nurses working in psychiatric units include those caused by addiction and substance abuse, Alzheimer's disease, anxiety disorders like phobias and panic attacks, psychotic disorders like schizophrenia, and mood disorders like depression and bipolar disorders.

## Chapter Two

### Methods

The primary aim of this study was to investigate the effect of psychiatric patients aggression and violence on psychiatric nurses in bethlehem psychiatric hospital. In this chapter, the methodology used to carry out the study is presented. Included are descriptions of the research design, setting, sample, procedures, instruments, data analysis, and ethical considerations.

#### 2.1 Study Design

A descriptive-correlational research study approach was used to carry out this research. A descriptive-correlational design is suitable for the examination's goals of the relationship among variables (Cheryl Tatano Beck & Polit, 2004). The correlation research design was selected for this study to provide answers to the research questions.

The variables included in the study are presented in Figure 1

#### Figure 2

*Study variables*

<b>Independent Variables:</b>	<b>Dependent Variables:</b>
Age, Gender, Social status, Years of experience at Bethlehem Psychiatric Hospital, Number of family members, what salary you or she gets, Academic qualification, The place of residence, The nature of the weekly work and shifts, Job title, The department you. work in	Aggression Violence

## **2.2 Study Setting**

Bethlehem Psychiatric Hospital in Bethlehem City-Palestine.

## **2.3 Sample and Sampling Method**

The participants who could be reached were 75 nurses working at the acute and chronic inpatient mental health care settings in the governmental Bethlehem psychiatric hospital in Palestine.

## **2.4 Inclusion Criteria**

1. Psychiatric nurses whom working in the psychiatric hospital.
2. Psychiatric nurses working in Bethlehem psychiatric hospital in the research area.
3. Any psychiatric nurse who having experience of at least one aggressive or violent event.

## **2.5 Exclusion Criteria**

1. Psychiatric nurses who do not reside in the research area.
2. Psychiatric nurses who refuse participation in this study.
3. Psychiatric nurse who was on treatment for mental disorders.
4. Psychiatric nurses who have been employed for 3 months because they may not have been subjected to aggression or violence by the psychiatric patient in the work area.

## **2.6 Instruments**

The questionnaire was used which is comprised of three sections:

**Section A:** A Socio-Demographic Questionnaire: designed by the author to

obtain variables such as age, gender, social status, years of expertise at Bethlehem psychiatric hospital, number of family members, salary you or she gets, academic qualification, the place of residence, the nature of the weekly work and shifts, job title, the department you work in.

**Section B:** Impact of Event Scale-Revised (IES-R).

It's a self-rating scale consisted of 22 questions created to assess the effect of psychological trauma of aggression and violence in the workplace. It was created by

Weiss (Marmer & Weiss, 1997). a more updated version of the Impact of Event Scale drawn up by Horowitz (Horovitz M 1979). The IES-R allows for measuring three subscales: intrusion, avoidance, and hyperarousal. The scale in its English version have been translated to Arabic Language and assessed by (Alharbi et al., 2020).

### **Section C: Eysenck Personality Questionnaire-Revised (EPQ-R).**

The Eysenck Personality Questionnaire-Revised (EPQ-R) designed by Eysenck et al., (1985) is a self-rating scale that evaluates personality characteristics. It is composed of 57 questions utilizing binary replies (yes or no), and there are 12 questions for each of four personality subscales (extraversion, neuroticism, psychoticism, and lie). Scores on each subscale between 0 and 12, with higher scores suggesting a stronger propensity to possess the personality trait represented by each subscale. I will use this scale to assess the personality of the individual in one way or another, and determining the behavioral patterns that the individual follows in his actions and his relations with others. The Eysenck Personality Questionnaire - Revised (EPQ-R) measures three major dimensions of personality: Extraversion/Introversion, Neuroticism, and Psychoticism or Tough-mindedness.

## **2.6.1 Validity and Reliability of the Two Questionnaires (Arabic language)**

### **2.6.1.1 Impact of Event Scale-Revised (IES-R).**

The Reliability and validity of the English and Arabic version of the scale (IES-R): to consistently evaluate the ability of the questionnaire, two tools were used, internal consistency through Cronbach's  $\alpha$  coefficient and test-retest reliability. The Cronbach's  $\alpha$  coefficients for 3-factors were 0.85, 0.75 and 0.74 for intrusion, avoidance and hyperarousal respectively, Cronbach's  $\alpha$  coefficient of total IES-R score is 0.88, according these values a good internal consistency was improved. Furthermore, test-retest reliability was used with a period of 2 weeks between each sitting, intra-class correlation is 0.885 for Intrusion, 0.846 for Avoidance, 0.873 for Hyperarousal, and 0.886 for the total IES-R score, demonstrating an excellent consistency between the two sittings (Fleiss, 1999). The scale will be used in the Arabic language; the Arabic scale was requested by the primary investigator from the author and was sent in the Arabic language by the E-mail. Refer to Annex 1.

### **2.6.1.2 The Eysenck Personality Questionnaire-Revised (EPQ-R)**

The reliability and validity of the English version have been translated to Arabic and assessed by (Abdel-Khalek, 2012), according that the Arabic scale was requested by the primary investigator from the author and was sent in the Arabic language by the E-mail. The Reliability and validity of the English and Arabic version of the scale (EPQ-R), to assessment the validity of the English and Arabic version of the scale (EPQ-R), construct validity through factor analysis was used by essential elements analysis with Varimax rotation, six elements labeled Self-confidence, Satisfaction, Meaningful life, Enjoyment, optimism, and stability, these factors forced solution explains 72.1% of the variance, items 6, 13, 18, 21, 22, 24, 30, 38, 45, and 49 had a factor load with  $<0.5$  for all of the factors (Hair et al., 2011).

On other hand, two tools were used to assessment the questionnaire, Cronbach's  $\alpha$  coefficients and test-retest reliability. Cronbach's  $\alpha$  coefficients ranged from 0.94 to 0.96, and the correlation of test-retest was between 0.84 and 0.94 (over 7–10 days), that's indicating a good internal consistency

## **2.7 Data Collection**

After receiving the nurses' informed consent, data collection was done.

Data were collected via questionnaires (IES-R & EPQ-R). The sample was easy to get in this manner. This was a team of nurses that worked on the wards of a mental health facility and had each been there for at least three months. 75 nurses from five different psychiatric wards took part in the study, and after receiving their consent, the researcher hand-delivered the anonymous questionnaires to every nurse working on the chosen wards at the hospital. An information leaflet outlining the study's goals and endorsing the participants' right to decline participation was included with each questionnaire. The nurses were instructed to complete the questionnaire and submit it to the hospital's person of contact. the Impact of Event Scale-Revised (IES-R) is a self-rating scale consisting of 22 items created to assess the effect of the psychological trauma of aggression and violence in the workplace. A total of 75 persons finished the questionnaire. Each question was assessed utilizing a 5-point Likert content from "No never, rarely, sometimes, often, and always ". A Cronbach's alpha was performed to see whether the questionnaire's questions were internally consistent. Also, (EPQ-R) is a

self-rating scale that assesses personality characteristics. A total of 75 participants completed the questionnaire. There are 12 items for each of the four personality subscales among the 57 questions that can only have a yes or no response (extraversion, neuroticism, psychoticism, and lie). Each subscale has a score range from 0 to 12, with higher scores suggesting a stronger propensity to have the personality trait that each subscale represents. A Cronbach's alpha was performed to see whether the questionnaire's questions were internally consistent.

## **2.8 Ethical Considerations**

The research was permitted by the Palestinian Ministry of Health, Bethlehem Psychiatric Hospital administration (Appendix A), and An-najah National University Institutional Review Board (Ref. Mas, Jan.2022/5). Dignity, integrity, self-determination, privacy, and secrecy of the participants' personal data were taken into consideration (Appendix B). Participants received enough information about the study's objectives, methodology, potential conflicts of interest, institutional affiliations of the researcher, expected benefits and hazards, and any potential discomfort. Additionally, participants have been made aware of their freedom to decline study participation or to withdraw consent at any moment without facing consequences. Both the techniques utilized to transmit the information and the participants' particular information needs received special consideration. The researcher requested the participants' "freely-given informed consent in writing" after making sure they comprehended the information. The participants who consented to participate signed informed consent. A questionnaire was used to gather data. Participants were also made aware that the data would only be utilized for study.

## Chapter Three

### Result

This chapter points out the results of the study, including: Part one presents socio-demographic data, part two Distribution of PTSD among Psychiatric Nurses according to the Impact of Event Scale, and part three the findings of Present versus absent of the component of PTSD -intrusion, avoidance, and hyperarousal. Furthermore, this chapter including types of Personality for Psychiatric Nurses according to Eysenck Personality Inventory (EPI).

The present study included 75 samples from the study area. In this chapter, the data collected were edited, tabulated, analysed, and interpreted. The researcher used appropriate statistical tests, including frequencies and percentages. Characteristics of study participants are demonstrated below.

#### 3.1 Socio-demographic characteristics

Table 1 shows the results of demographic characteristic distribution. Which, most of the employees ages ranged from 31-40 years, constituted (38.7%) of the study sample, while 19 participants were between 20-30 years, which represents (25.3%); in addition to 10 participants between 41-50 years, and means (13.3%). Also, 17 participants aged more than 51 years, and means (22.7%) of the study sample. Also, male participants outnumbered females by 48 (64.0%) versus 27 (36.0%) respectively.

Regarding marital status, most of the participants (n=64) were married (85.3 %), while 11 participants (14.7%) were single. Moreover, most of the participants (n=43) have 1-4 kids (57.3%), while 20 participants (26.7%) have more than 4 kids and 12 participants (16.0%) have no kids. In addition, 10 participants (13.3%) they're a monthly income is less than 500\$, while 34 participants (45.3%) they're a monthly income from 501\$ to 700\$.

Also, the results showed that 31 participants (41.3%) have monthly income of more than 700\$. With regard to educational level, most of the participants 37 (49.3%); while 28 (37.3%) have Bachelor's degree; in addition, 10 (13.3%) had a master's degree. Furthermore, most of the participants (n=52) have experienced more than eight years of working at Bethlehem psychiatric hospital (56.0%), while 8 participants (10.7%)

worked for less than one year, and 12 participants (16.0%) experienced one to three years. In addition, 13 participants (17.3%) experienced four to eight years.

Finally, most of the participants (n=40) in the admission wards (53.3%), while 25 participants (33.3%) worked in recovery wards, in addition, 10 participants (13.3%) worked in the chronic ward.

**Table 1**

*Distribution of participants according to socio-demographic characteristics*

Variables		Frequency (n)	Percentage (%)
Age group	20-30	19	25.3%
	31-40	29	38.7%
	41-50	10	13.3%
	More than 51	17	22.7%
Gender	Male	48	64.0%
	Female	27	36.0%
Marital status	Single	11	14.7%
	Married.	64	85.3%
Number of kids	Have no kids	12	16.0%
	1 to 4 kids.	43	57.3%
	More than 4 kids	20	26.7%
Monthly income:	Less than 500\$.	10	13.3%
	From 501 to 700 \$.	34	45.3%
	More than 700\$	31	41.3%
Experience by years for working at Bethlehem Psychiatric Hospital:	Less than one year.	8	10.7%
	One to three years.	12	16.0%
	Four to eight years.	13	17.3%
	More than eight years.	42	56.0%
Level of education:	Diploma.	37	49.3%
	Bachelor degree.	28	37.3%
	Master degree or more.	10	13.3%
Nature of work shift:	Morning shift.	11	14.7%
	All shifts alternately.	64	85.3%
Job title	Head of a department	9	12.0%
	Practical nurse	34	45.3%
	Staff nurse.	32	42.7
The ward you work in:	Admission ward	40	53.3%
	Recovery ward	25	33.3%
	Chronic ward	10	13.3

### 3.2 Distribution of PTSD among Psychiatric Nurses according to the level of Impact of Event Scale

Table 2 and figure 1 Show that (22.7%) of the participants in the study have no PTSD. (20.0%) have partial PTSD and some symptoms, (14.7%) Probable diagnosis of PTSD, and (42.7%) enough to suppress the immune system.

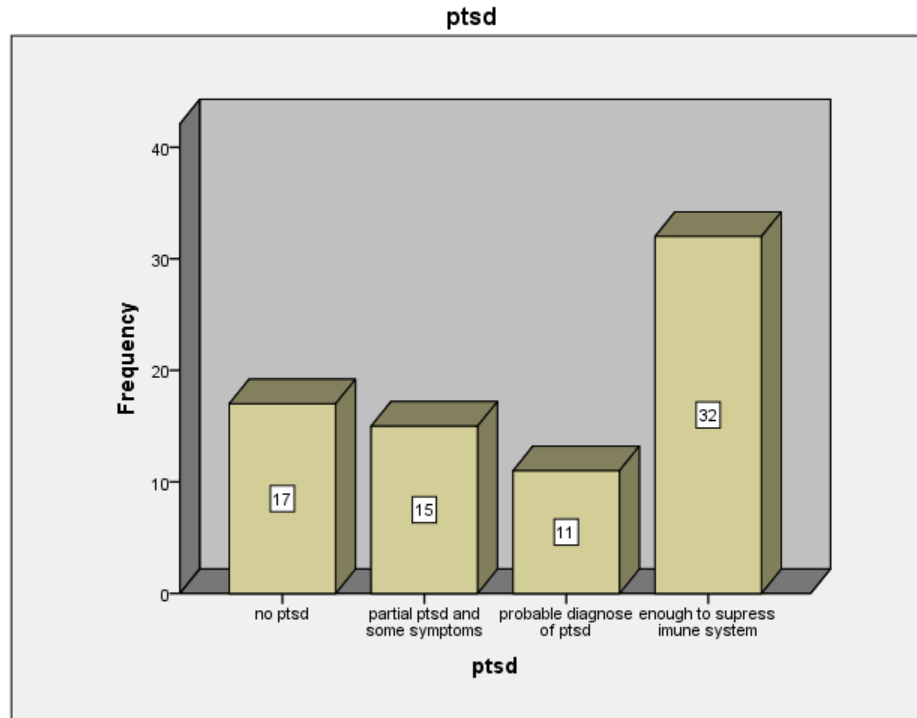
**Table 2**

*Distribution of PTSD among Psychiatric Nurses according to the level of the Impact of Event Scale*

Level	The Impact of Event Scale–Revised (IES-R)	Frequency (n)	Percentage (%)
No PTSD		17	22.7 %
Partial PTSD and some symptoms		15	20.0 %
Probable diagnosis of PTSD		11	14.7%
Enough to suppress immune system		32	42.7%

**Figure 3**

*Distribution of PTSD among Psychiatric Nurses according to the level of the Impact of Event Scale*



### **3.3 Present versus absent of the component of PTSD; intrusion, avoidance, and hyperarousal**

Table 3, shows that (70.7%) of the participants have no intrusion, (29.3%) intrusion present, (40.0%) no intrusion, (60.0%) intrusion present, (68.0%) no hyperarousal, in addition (32.0%) present hyperarousal.

**Table 3**

*Present versus absent of the component of PTSD intrusion, avoidance, and hyperarousal*

Level	The Impact of Event Scale–Revised (IES-R)	Frequency (n)	Percentage (%)
No intrusion		53	70.7 %
Intrusion present		22	29.3 %
No avoidance		30	40.0%
Avoidance present		45	60.0%
No hyperarousal		51	68.0%
Hyperarousal present		24	32.0%

### **3.4 Association of PTSD with socio-demographic parameters**

Table 4 showed the results of an ordinal logistic regression analysis of the factors associated with partial PTSD and some symptoms, Probable diagnosis of PTSD, and Enough PTSD to suppress the immune system among psychiatric nurses. The results showed a significant association between the Job title and Probable diagnoses of PTSD. The practical Nurses were 0.15 expectation of being diagnosed with PTSD (95% CI 0.03-0.96). Other socio-demographic parameters have no significant correlation with PTSD.

**Table 4***Ordinal Logistic Regression for factors associated with PTSD among psychiatric nurses*

Variables	B	SE	OR	(95% C. I for OR)		P
				Lower	Upper	
No PTSD	-1.79	1.50	0.168	0.009	3.13	0.23
Partial PTSD and some symptoms	-0.44	1.47	0.65	0.04	11.48	0.77
Probable diagnose of PTSD Enough to suppress immune system	0.38 0a	1.47	1.46	0.09	25.86	0.80
Age.						
20-30	0.71	1.46	2.03	0.12	35.32	0.63
31-40	1.80	0.94	6.02	0.96	37.89	0.06
41-50.	1.04	0.93	2.81	0.46	17.33	0.27
More than 50.	0a	-	1	-	-	-
Gender.						
Male	-0.51	0.57	0.61	0.21	1.82	0.37
Female.	0a	-	-	-	-	-
Marital status.						
Single.	0.92	0.60	2.50	0.771	8.11	0.127
Married.	0a	-	-	-	-	-
Number of kids.						
No kids.	0.77	0.68	2.15	0.56	8.200	0.99
1-4 kids.	0.49	0.70	0.62	0.16	2.43	0.49
More than 4 kids.	0a	0.70	0.62	0.16	2.43	0.49
Work experience.						
Less than 1 year	1.24	1.07	0.30	0.04	2.34	0.25
1 to 3 year.	1.50	1.06	0.23	0.29	1.80	0.16
4 to 8 years	-0.67	1.10	0.52	0.06	4.37	0.55
More than 8 year.	0a	-	-	-	-	-
Monthly income.						
Less than 500\$.	1.21	1.40	3.34	0.22	51.12	0.39
From 501 to 700\$.	1.21	0.66	3.35	0.93	12.09	0.07
More than 700\$.	0a	-	-	-	-	-
Level of education.						
Diploma.	-0.27	1.27	0.77	0.07	9.12	0.14
Bachelors.	-1.54	1.04	0.22	0.29	1.62	0.14
Master.	0a	-	-	-	-	-
Nature of work shift.						
Morning shift.	-0.58	1.33	0.57	0.05	7.50	0.67
All shifts.	0a	-	-	-	-	-
Job title.						
Head of department.	-2.19	1.44	0.12	0.01	1.88	0.13
Practical nurse.	-1.92	0.96	0.15	0.03	0.96	0.05
Staff nurse.	0a	-	-	-	-	-
The world you work in.						
Admission words.	1.31	0.88	3.69	0.67	20.47	0.14
Recovery words.	1.03	0.93	2.80	0.46	17.19	0.27
Chronic words.	0a	-	1	-	-	-

**B:** coefficient; **SE:** standard error; \*statistically significant difference at  $p \leq 0.05$ ; **OR:** odds ratio.

### 3.5 Types of Personality for Psychiatric Nurses according to Eysenck Personality Inventory (EPI)

Table 5, shows that most of the participants (85.3%) have extroverted personality, (14.7%) introverted, (52.0%) stability, (48.0%) neuroticism, and (78.7%) believable, in addition (21.3%) lie.

**Table 5**

*Types of Personality for Psychiatric Nurses according to Eysenck Personality Inventory (EPI)*

Level	Eysenck Personality Inventory (EPI)	Frequency (n)	Percentage (%)
Introverted		11	14.7 %
Extroverted		64	85.3 %
Stability		39	52.0%
Neuroticism		36	48.0%
Believable		59	78.7%
Lie		16	21.3%

### 3.6 Ordinal logistic regression for association of Personality type with PTSD among Psychiatric Nurses

Table 6 showed the results of an ordinal logistic regression analysis of the factors associated with partial PTSD and some symptoms, Probable diagnosis of PTSD, and Enough PTSD to suppress the immune system among psychiatric nurses. Nurses with Stable personality were at lower potential of increased PTSD categories than neuroticism personality nurses by 0.09 times (95% CI 0.032-0.256). In other words, Nurses who have neuriticism personality have a high probability to get PTSD. Otherwise, the results revealed considering that there is no a significant relationship between introverted versus extroverted personalities in relation with the increase or decrease in the PTSD prevalence among psychiatric nurses.

**Table 6**

*Ordinal logistic regression of the association of PTSD and Personality type among Psychiatric Nurses*

Variables	B	SE	OR	(95% C. I for OR)		P
				Lower	Upper	
No PTSD	-3.44	0.76	0.032	0.007	0.141	0.001
Partial PTSD or some symptoms	-2.26	0.71	0.105	0.026	0.421	0.001
Probable diagnose of PTSD	-1.39	0.67	0.248	0.067	0.914	0.036
Enough to suppress immune system	0a					
Introverted	0.149	0.67	1.161	0.315	4.271	0.823
Extroverted	0a					
Stability	-2.407	0.533	0.090	0.032	0.256	0.001
Neuroticism	0a					
Believable	-0.646	0.712	0.524	0.130	2.114	0.364
Lie	0a					

**B:** coefficient; **SE:** standard error; \*statistically significant difference at  $p \leq 0.05$ ; **OR:** odds ratio.

## Chapter Four

### Discussion and Conclusions

#### 4.1. Discussion

The goal of this chapter is to compare and contrast the findings represented in Chapter one with existing literatures.

Violence and aggression adverse to nurses in mental health facilities have become a major global problem (Allen 2013), (Koukia & Zyga 2013). Occupational violence is regarded as one of the most serious workplace risks in the health sector. Furthermore, compared to other healthcare professionals, nurses have a higher chance of experiencing workplace violence because of the nature of their employment, which necessitates frequent and lengthy interaction with patients or close family members (Lipscomb & McPhaul 2013). In fact, in a literature review researched by Nowrouzi and Huynh on the 50 most cited aggressive and violent psychiatric patient-related articles, it was reported that psychiatric nurses made up 46.4% of the sampling population in these top publications (Huynh & Nowrouzi, 2016).

Additionally, the presence of violence in the nursing field surely affects job performance, hiring decisions, and nursing as a career aspirations (Farrell et al., 2006), (Jackson et al., 2002), and the overall professional quality of life (ProQOL) (Choi & Lee, 2017), (Hooper et al., 2010), (Choi & Kim, 2012). ProQOL, A model put forth by Stamm includes both good and negative elements that have an impact on the lives of paid caregivers. Compassion satisfaction (CS), a measure of the happy emotions attained by helping others, is one of the positive aspects. Burnout (BO), which reflects emotional exhaustion, frustration, hopelessness, and difficulties coping with the job, and secondary traumatic stress (STS), which is the result of work-related secondary exposure to people who have experienced a traumatic event, are further classified as the negative aspects of compassion fatigue (CF) (Stamm ,2010). Furthermore, a Korean study analyzing the impact of violence and aggression against nurses on professional quality of life, and staff turnover, among 358 nurses 95.5% originating from three hospitals in Seoul, discovered that nurses on the psychiatric unit experienced the greatest rates of all three categories of violence (verbal abuse, physical threats, and physical assault). The rate of secondary trauma and degree of professional quality of life

was highest among nurses who had been subjected to all three forms of violence. For nurses who experienced verbal abuse or physical threats, staff turnover increased (Choi & Lee, 2017).

Moreover, a review of violence over the past 20 years revealed that inquiries of violence have mostly focused on its frequency, risk assessment, and risk management; few studies have evaluated the physical and psychological effects of violence (d'Ettoire & Pellicani, 2017). In addition to that, work place violence of psychiatric patient among psychiatric nurses may have psychological effects in addition to physical ones, increasing the likelihood of dread or anxiety, rage, insecurity, sadness, emotional fatigue, suicidal thoughts, post-traumatic stress symptoms, guilt, self-blame, and shame (d'Ettoire & Pellicani, 2017; Mento et al., 2020). Furthermore, Lower health-related quality of life, higher intent to leave the job, and lower job satisfaction are all effects of WPV (d'Ettoire & Pellicani, 2017).

Also, another study indicating that 80.3% of the respondents in the total sample (n = 110) reported that they were subjected to verbal and physical violence in mental hospitals in Jordan in the last two years. On the other hand, this result is higher than what was found in our study, our study showed that's (42.7%) of the PTSD participants having aggressive and violent events in (n=75). Which sufficient to suppress the immune system according to the IES scale (Al-Azzam et al. 2017).

Furthermore, a study in japan among (n=63) psychiatric nurse, founded that 40% of respondents were experienced to (verbal abuse), two (6%) of the 34 individuals who took the IES-R had a very high risk of developing PTSD, and 28 of them (83%) showed some lingering psychological distress. While our study is higher in the result, that's 15 nurses had Partial PTSD and some symptoms (20.0%), and 11 nurses' Probable diagnosis of PTSD (14.7%). The elevated percentage among our sample may refers to that our sample is more than that mentioned among Japanese nurses (Fujimoto et al.2017).

Moreover, a study conducted among 394 psychiatric nurses in Australia indicated that verbal abuse was the most common form of violence (80%), followed by physical violence (34%), and bullying (30%). Nearly one in three victims of violence reported experiencing psychological stress (n=101, 33%), with 54, 54% of them indicating severe psychological distress (Tonso et al., 2016).

These results are consistent with our study results, approximately participants (n=32, 42.7%) were psychologically distressed according to (IES, Reserved) in our study, in addition to that, this is enough to suppress the immune system. While Neuroticism nurses in our study (n=36, 48.0%) according to Eysenck scale

Furthermore, in the same country in Australia, a study among 196 psychiatric nurses, to investigate the prevalence of inpatient aggressiveness, determine what causes general distress and post-traumatic stress reactions, as well as workplace stress, discovered that's (14-17%) of nurses satisfied the PTSD diagnosis criteria, and 36% achieved a psychiatric caseness score that was over the cutoff. In comparison to our study, the findings of Lee study are less than the finding of our study for PTSD criteria, as well as those in our study (42.7 %) exceeded PTSD criteria, which enough to suppress the immune system (Lee et al.,2014).

Furthermore, in the same context of psychiatric patient aggression and violence among nurses, a result of a study in Canada (province of Newfoundland and Labrador), among 84 psychiatric workers to examine violence, and physical threats in the workplace, found that the prevalence of PTSD symptoms among them was (14 %) (Hilton et al.2021). That means the result of this study (Hilton) agreed with our study results, (14.7%) probable diagnosis of PTSD. Although the number of survey respondents exceeds the number of people in our study by nine participants. Additionally, (Seto et al.,2020), published a research among 761 psychiatric nurses in Canada (Ontario), to ascertain whether PTSD symptoms are common among psychiatric staff whom exposed to workplace aggression. Found that's (16%) had a probable diagnosis of PTSD, which was congruent with our study results. While, a study conducted in Greece among 174 psychiatric nurses, to investigate the prevalence of PTSD in psychiatric nurses due to psychiatric patient aggression in the workplace. Found that (44.8%) of the participants nurses were at risk of PTSD (Mangoulia et al.,2015). Mangoulia study agreed with our study result on the prevalence of PTSD (42.7 %) among our nurses.

In addition, a study conducted in Bern (Switzerland) among 82 psychiatric nurses in two acute psychiatric hospital, to investigate PTSD among psychiatric nurses, found that (22%) of psychiatric nurses had the greatest prevalence of PTSD symptoms, Also, when compared to our study, PTSD symptoms among our nurses was found to be (20.0%), that's mean that the study of Soravia was agreed to our study results (Soravia et al., 2021).

According to our findings, there is a strong association between violence and PTSD regarding the psychological effect on psychiatric nurses, which was higher than a study (Fugimoto et al.,2017), among Twenty-eight of the 34 psychiatric nurses (83%) in Japan (in the Kinki area) two (6%) of the nurses who completed the (IES-R) had a potentially high risk of developing posttraumatic stress disorder. While the prevalence of diagnosed PTSD (14.7%) among our nurses, maybe the words of the closed admissions in our hospital increased the violence of psychiatric patients among our nurses.

On the other hand, a research study was carried out in Sbrana Psychiatric Hospital by (Olashore et al., 2018). To find out how common PTSD was among the 201 mental health nurses working in a tertiary mental health facility in Botswana. The average participant age was 32 years, and the most were female (n = 122, 60.7%). Besides that, they revealed that 37 participants (18.4%) matched the criteria for PTSD, and that PTSD diagnoses were substantially correlated with high neuroticism scores (AOR = 2.72; 95% CI: 1.19-6.24) (Olashore et al., 2018). Furthermore, our result agreed with Olashore, when found that (14.7%) of the participants aged (31-40) years met the diagnoses of PTSD, and (20.0%) had partial PTSD and some symptoms. In addition, (48.0%) had neuroticism.

Besides, one study founded that's nurses who have been in contact with patients aggression and violence high degree of anxiety, which are consistent with our study results (Pérez-Fuentes et al., 2020).

Basfr et al. (2019), conducted a study in Saudi Arabia's among psychiatric nurses (n=310) founded that's (64.2%) felt tense or anxious (53.5%), and 34.2 percent felt sad after the aggressive or violence behavior from psychiatric patient. Besides that's our study founded Neuroticism (48.0%), n=38) between our nurses, so our study was consistent with Basfr study.

Moreover, a study carried out in a Nigerian Psychiatric Hospital among 124 nurses realized that most of those employees (42.4%) experienced PTSD symptoms (Akanni et al., 2019). These results are consistent with our study results.

Finally, this study's objective was to evaluate the effect of psychiatric patients aggression and violence on psychiatric nurses in Bethlehem psychiatric hospital in Palestinian. Furthermore, in this study, the researcher did not find a relationship between the prevalence of PTSD among nurses and gender, age, marital status, location, income each month, work, and educational level. In addition, this study found that PTSD among psychiatric nurses in Bethlehem psychiatric hospital who were diagnosed with PTSD is higher or equal to nurses mentioned in the previous studies above. From the perspective of the researcher, this is maybe due to the nature of closed units worlds in Bethlehem psychiatric hospital increasing the aggressive or violent behavior of psychiatric patients.

#### **4.2 Limitations**

- Movement restrictions and isolation during the COVID-19 epidemic.
- lack of research into the effect of Psychiatric Patients Aggression and Violence on Psychiatric Nurses, particularly in Palestine.
- Despite the privacy offered, some participants might be embarrassed to answer some questions honestly owing to social barriers.
- Bethlehem Mental Hospital is the only psychiatric hospital in Palestine, making it impossible to include any others.

#### **4.3 Conclusions**

The aggressive and violent behavior of the psychiatric patient on the nurses has a negative impact on the psychological state of the nurses, and most of the participants suffer from PTSD. In addition, Participants who are diagnosed with PTSD are more likely to suppress their immune system.

And therefore, Post-traumatic stress disorder was reflected on the personality traits or personality dimensions of the nursing participants in the study, this reflection led to the emergence of neuroticism that manifests in the form of anxiety, difficulty sleeping, headaches, digestive disorders, back pain, and mood swings.

The Palestinian Ministry of Health must understand the difficulty of the work provided by these psychiatric nurses. In addition to providing psychological supervision and counseling programs for these nurses.

#### **4.4. Recommendations**

The Palestinian Ministry of Health should understand the nature and difficulty of the work provided by these psychiatric nurses. In addition to providing psychological supervision and counseling programs for these nurses to relieve them of the psychological burdens, they face from the violent and aggressive psychiatric patient.

## References

- [1] Abdel-Khalek, Ahmed M. "Personality and Mental Health: Arabic Scale of Mental Health, Eysenck Personality Questionnaire, and NEO Five Factor Inventory." *Psychological Reports*, vol. 111, no. 1, Aug. 2012, pp. 75–82, 10.2466/09.02.08.pr0.111.4.75-82. Accessed 8 Oct. 2021.
- [2] Abderhalden C., Needham I., Friedli T.K., et al. (2002) Perception of aggression among psychiatric nurses in Switzerland. *Acta Psychiatrica Scandinavica* 106, 110–117.
- [3] Akanni, O. O., Osundina, A. F., Olotu, S. O., Agbonile, I. O., Otakpor, A. N., & Fela-Thomas, A. L. (2019). Prevalence, Factors, and Outcome of Physical Violence against Mental Health Professionals at a Nigerian Psychiatric Hospital. *East Asian Archives of Psychiatry*, 29(1), 15–19. <https://doi.org/10.12809/eaap1727>
- [4] Al Khatib, O., Taha, H., Al Omari, L., Al-Sabbagh, M. Q., Al-Ani, A., Massad, F., & Berggren, V. (2023). Workplace Violence against Health Care Providers in Emergency Departments of Public Hospitals in Jordan: A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, 20(4), 3675. <https://doi.org/10.3390/ijerph20043675>
- [5] Al-Azzam, Manar, et al. "Mental Health Nurses' Perspective of Workplace Violence in Jordanian Mental Health Hospitals." *Perspectives in Psychiatric Care*, vol. 54, no. 4, 27 Oct. 2017, pp. 477–487, 10.1111/ppc.12250. Accessed 5 Oct. 2021.
- [6] Alderman, C. (1997). Bullying in the workplace: a survey. *Nursing Standard*, 11 (35), 22-25.
- [7] Algwaiz WM, Alghanim SA. Violence exposure among health care professionals in Saudi public hospitals. A preliminary investigation. *Saudi Med J* 2012; 33:76–82.
- [8] Alharbi, Hatim, et al. "ARTICLE Reliability and Validity of Arabic Translation of the Impact of Event Scale-Revised for COVID-19 Pandemic Medical Science." Oct. 2020.

- [9] Allen DE. Staying safe: re-examining workplace violence in acute psychiatric settings. *J Psychosoc Nurs Mental Health Serv.* 2013;51(9):37–41.
- [10] Al-Omari, H. (2015). Physical and verbal workplace violence against nurses in Jordan. *International Nursing Review*, 62(1), 111–118. <https://doi.org/10.1111/inr.12170>
- [11] Al-Omari, H., Abu Khait, A., Al-Modallal, H., Al-Awabdeh, E., & Hamaideh, S. (2019). Workplace violence against nurses working in psychiatric hospitals in Jordan. *Archives of psychiatric nursing*, 33(5), 58–62. <https://doi.org/10.1016/j.apnu.2019.08.002>
- [12] Anderson, C. A., & Bushman, B. J. (2002). Human aggression. *Annual Review of Psychology*, 53, 27–51. <http://dx.doi.org/10.1146/annurev.psych.53.100901.135231>.
- [13] APA Dictionary of Psychology. (n.d.). [Dictionary.apa.org](https://dictionary.apa.org/psychiatric-nursing). <https://dictionary.apa.org/psychiatric-nursing>
- [14] Arnetz, J. E., & Arnetz, B. B. (2001). Violence towards health care staff and possible effects on the quality of patient care. *Social Science & Medicine* (1982), 52(3), 417–427 (doi:S0277953600001465).
- [15] Aytac S, Bozkurt V, Bayram N, Yildiz S, Aytac M, Akinci FS, et al. Workplace violence: A study of Turkish workers. *Int J Occup Saf Ergon* 2011; 17:385–402. <https://doi.org/10.1080/10803548.2011.11076902>.
- [16] Baby, M., Glue, P., & Carlyle, D. (2014). 'Violence is not part of our job': a thematic analysis of psychiatric mental health nurses' experiences of patient assaults from a New Zealand perspective. *Issues in mental health nursing*, 35(9), 647–655. <https://doi.org/10.3109/01612840.2014.892552>
- [17] Banda, C. K., Mayers, P., & Duma, S. (2016). Violence against nurses in the southern region of Malawi. *Health SA Gesondheid*, 21, 415–421. <https://doi.org/10.1016/j.hsag.2016.01.002>
- [18] Bandura, A. (1977). *Social learning theory*. London, Englewood Cliffs.

- [19] Basfr, Wafa, et al. "Workplace Violence against Nurses in Psychiatric Hospital Settings: Perspectives from Saudi Arabia." *Sultan Qaboos University Medical Journal [SQUMJ]*, vol. 19, no. 1, 30 May 2019, p. 19, 10.18295/squmj.2019.19.01.005. Accessed 5 Oct. 2021.
- [20] Baxter, E., Hafner, R. J., & Holme, G. (1992). Assaults by patients: The experience and attitudes of psychiatric hospital nurses. *Australian and New Zealand Journal of Psychiatry*, 26(4), 567-573.
- [21] Björkdahl, A., Hansebo, G., & Palmstierna, T. (2013). The influence of staff training on the violence prevention and management climate in psychiatric inpatient units. *Journal of psychiatric and mental health nursing*, 20(5), 396–404. <https://doi.org/10.1111/j.1365-2850.2012.01930.x>
- [22] Bjorkly, S. (1996). Report form for aggressive episodes: preliminary Report. *Perceptual and Motor Skills*. 83, 1139-1152.
- [23] Bilgin H. (2009) An evaluation of nurses' interpersonal styles and their experiences of violence. *Issues in Mental Health Nursing* 30, 252–259.
- [24] Bimenyimana, E 2008: The Lived Experience of Aggression and Violence in a Gauteng Psychiatric Institution. Unpublished MCur Psychiatric Nursing Mini-dissertation. Johannesburg: University of Johannesburg
- [25] Bowers L., Stewart D., Papadopoulos C., et al. (2011) Inpatient violence and aggression: a literature review. Report from the Conflict and Containment Reduction Research Programme. Available at: [http://www.academia.edu/727659/Inpatient\\_violence\\_and\\_aggression\\_a\\_literature](http://www.academia.edu/727659/Inpatient_violence_and_aggression_a_literature)
- [26] Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H., & Jeffery, D.(2011). Inpatient violence and aggression: A literature review. London: Institute of Psychiatry, Kings College London.
- [27] Bradley, N., Kumar, S., Ranclaud, M., & Robinson, E. (2001). Ward crowding and incidents of violence on an acute psychiatric inpatient unit. *Psychiatric Services*, 52, 521–525.

- [28] Brazier, Y. (2018). Psychology: Definitions, branches, history, and how to become one. Retrieved 14 October 2021, from <https://www.medicalnewstoday.com/articles/154874>
- [29] Briere, J. (1997). Psychological assessment of adult posttraumatic states. Washington D.C.: American Psychological Association.
- [30] Caldwell, M.F. (1992). Incidence of PTSD among staff victims of patient violence. *Hospital & Community Psychiatry*, 43, 838-839.
- [31] Carmel, H., & Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 40, 41–46.
- [32] Centers for Disease Control and Prevention. Violence occupational hazards in hospitals. From: <https://www.cdc.gov/niosh/docs/2002-101/default.html>
- [33] Chapman R, Styles I, Perry L, Combs S. Nurses' experience of adjusting to workplace violence: A theory of adaptation. *Int J Ment Health Nurs* 2010; 19:186–94. <https://doi.org/10.1111/j.1447-0349.2009.00663.x>.
- [34] Choi, S.-H., & Lee, H. (2017). Workplace violence against nurses in Korea and its impact on professional quality of life and turnover intention. *Journal of Nursing Management*, 25(7), 508–518. <https://doi.org/10.1111/jonm.12488>
- [35] Choiniere, J. A., MacDonnell, J. A., Campbell, A. L., & Smele, S. (2013). Conceptualizing structural violence in the context of mental health nursing. *Nursing Inquiry*, 21(1), 39–50. doi:10.1111/nin.12028
- [36] Cleary M., Walter G. & Hunt G. (2005) The experience and views of mental health nurses regarding nursing care delivery in an integrated, inpatient setting. *International Journal of Mental Health Nursing* 14, 72–77.
- [37] Connor, D. F., Carlson, G. A., Chang, K. D., Daniolos, P. T., Ferziger, R., Findling, R. L., et al. (2006). Juvenile maladaptive aggression: A review of prevention, treatment, and service configuration and a proposed research agenda. *Journal of Clinical Psychiatry*, 67(5), 808–820.

- [38] ConvePalmstierna, T. and Wistedt, B. (1989).Risk factors for aggressive behaviour are of limited value in predicting the violent behavior of acute involuntarily admitted patients". *ActaPsychiatricaScandinavica*.81,152-155.y, J. (1986).A record of violence. *Nursing Time*, Nov. 12, 36-38.
- [39] Cooper AJ, Mendonca JD. 1991. A prospective study of patients assaults on nurses in a provincial psychiatric hospital in Canada. *Acta PsychiatrScand* 84:163–166.
- [40] Cornaggia, C.M., Beghi, M., Pavone, F. and Barale, F. (2011) 'Aggression in psychiatry wards: a systematic review', *Psychiatry research*, 189(1), pp. 10-20.
- [41] d'Ettorre, G., & Pellicani, V. (2017). Workplace Violence Toward Mental Healthcare Workers Employed in Psychiatric Wards. *Safety and Health at Work*, 8(4), 337–342. <https://doi.org/10.1016/j.shaw.2017.01.004>
- [42] Dack, C., Ross, J., Papadopoulos, C., Stewart, D. and Bowers, L. (2013) 'A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression', *Acta Psychiatrica Scandinavica*, 127(4), pp. 255-268.
- [43] Daffern, M. and Howells, K. (2002) 'Psychiatric inpatient aggression: A review of structural and functional assessment approaches', *Aggression and violent behavior*, 7(5),pp. 477-497.
- [44] Di Lorenzo, R., Baraldi, S., Ferrara, M., Mimmi, S. and Rigatelli, M. (2012) 'Physical restraints in an Italian psychiatric ward: clinical reasons and staff organization problems,'*Perspectives in psychiatric care*, 48(2), pp. 95-107.
- Durivage, A. (1989).Assaultive Behavior. *Canadian Journal of Psychiatry*.34, 397.
- [45] Duxbury J.A., Bjorkdahl A. & Johnson S. (2006) Ward culture and atmosphere. In: *Violence in Mental Health Settings: Causes, Consequences, Management* (eds Richter, D. & Whittington,R.), pp. 273–291. Springer Science-Business Media, New York.
- [46] El-Gilany AH, El-Wehady A, Amr M. Violence against primary health care workers in Al Hassa, Saudi Arabia. *J Interpers Violence* 2010; 25:716–34. <https://doi.org/10.1177/0886260509334395>.

- [47] Elliott, G.C., Cunningham, S.M., Colangelo, M. and Gelles, R.J. (2011) 'Perceived mattering to the family and physical violence within the family by adolescents', *Journal of Family Issues*, 32(8), pp. 1007-1029.
- [48] Ergün, F. and Karadakovan, A. (2005) 'Violence towards nursing staff in emergency departments in one Turkish city', *International nursing review*, 52(2), pp. 154- 160.
- [49] Esmailpour, M., Salsali, M. and Ahmadi, F. (2011) 'Workplace violence against Iranian nurses working in emergency departments', *International nursing review*, 58(1), pp. 130-137.
- [51] Evans, R. E., & Petter, S. (2012). Identifying mitigating and challenging beliefs in dealing with threatening patients: an analysis of experiences of clinicians working in a psychiatric intensive care unit. *Journal of Psychiatric Intensive Care*, 8(02), 113–119. <https://doi.org/10.1017/s1742646411000318>
- [52] Eysenck SBG, Eysenck HJ, Barrett P. A revised version of the psychoticism scale. *Person Individ Diff*. 1985; 6: 21–29.
- [53] Eysenck, H. J., & Eysenck, S. B. G. (1975). *Manual of the Eysenck Personality Questionnaire (Junior and Adult)*. London: Hodder & Stoughton.
- [54] Fallahi Khoshknab M, Oskouie F, Najafi F, Ghazanfari N, Tamizi Z, Ahmadvand H. Psychological violence in the health care settings in Iran: A cross-sectional study. *Nurs Midwifery Stud* 2015; 4:e24320. <https://doi.org/10.17795/nmsjournal 24320>.
- [55] Farrell, G. A., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: findings from an Australian study. *Journal of Advanced Nursing*, 55(6), 778–787. <https://doi.org/10.1111/j.1365-2648.2006.03956.x>
- [56] Federal Bureau of Investigation, U.S. Department of Justice. Workplace violence: Issues in response. From: <https://www.fbi.gov/sta ts-services/publications/workplace-violence>
- [57] Ferrari. (2003). Biological explanation of aggression. Retrieved from <http://www.autismodiario.org/wp.../biologicalexplanationsof aggression>.

- [58] Fottrell, E. (1980). A study of violent behaviour among patients in psychiatric hospitals. *British Journal of Psychiatry*, 136, 216–221.
- [59] Fujimoto, H., Hirota, M., Kodama, T., Greiner, C., & Hashimoto, T. (2017). Violence exposure and resulting psychological effects suffered by psychiatric visiting nurses in Japan. *Journal of Psychiatric and Mental Health Nursing*, 24(8), 638–647. <https://doi.org/10.1111/jpm.12412>
- [60] Garrison, W. T., Ecker, B., Friedman, M., Davidoff, R., Haeberle, K., & Wagner, M. (1990). Aggression and counter-aggression during child psychiatric hospitalization. *Journal of the American Academy of Child Adolescent Psychiatry*, 29(2), 242–250.
- [61] Gaynes, B.N., Brown, C.L., Lux, L.J., Brownley, K.A., Van Dorn, R.A., Edlund, M.J., Coker-Schwimmer, E., Weber, R.P., Sheitman, B. and Zarzar, T. (2017) 'Preventing and de-escalating aggressive behavior among adult psychiatric patients: a systematic review of the evidence', *Psychiatric services*, 68(8), pp. 819-831.
- [62] Gignon M, Verheye JC, Manaouil C, Ammirati C, Turban-Castel E, Ganry O. Fighting violence against health workers: a way to improve quality of care. *Workplace Health Safety*. 2014;62(6):220–222.
- [63] Gournay, K., Gray, R., Wright, S., and Thornicroft, G. (1997). Mental health nursing in inpatient care: a review of literature and an overview of current service issues. A report to the Standing Nursing and Midwifery Advisory Committee. London: Institute of Psychiatry.
- [64] Grainger, C., & Whiteford, H. (1993). Assault on staff in psychiatric hospitals: A safety issue. *Australian and New Zealand Journal of Psychiatry*, 27(2), 324–328.
- [65] Guay, S., Goncalves, J. and Boyer, R. (2016) Healthcare. Multidisciplinary Digital Publishing Institute.
- [66] Hair, Joe F., Ringle, C. M., & Sarstedt, M. (2011). PLS-SEM: Indeed a Silver Bullet. *The Journal of Marketing Theory and Practice*, 19(2), 139–152.

- [67] Hammarström, L., Häggström, M., Devik, S. A., & Hellzen, O. (2019). Controlling emotions-nurses' lived experiences caring for patients in forensic psychiatry. *International journal of qualitative studies on health and well-being*, 14(1),1-11. <https://doi.org/10.1080/17482631.2019.1682911>
- [68] Hasan, A. A., & Tumah, H. (2018). The correlation between occupational stress, coping strategies, and the levels of psychological distress among nurses working in mental health hospital in Jordan. *Perspectives in Psychiatric Care*, 55(2), 153–160. <https://doi.org/10.1111/ppc.12292>
- [69] Hegney, D., Plank, A. and Parker, V. (2003) 'Workplace violence in nursing in Queensland, Australia: A self-reported study', *International journal of nursing practice*, 9(4), pp. 261-268.
- [70] Hilton, N. Z., Ricciardelli, R., Shewmake, J., Rodrigues, N. C., Seto, M. C., & Ham, E. (2021). Perceptions of Workplace Violence and Workplace Stress: A Mixed Methods Study of Trauma among Psychiatric Workers. *Issues in Mental Health Nursing*, 1–21. <https://doi.org/10.1080/01612840.2021.1899350>
- [71] Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., & Reimels, E. (2010). Compassion Satisfaction, Burnout, and Compassion Fatigue Among Emergency Nurses Compared With Nurses in Other Selected Inpatient Specialties. *Journal of Emergency Nursing*, 36(5), 420–427. <https://doi.org/10.1016/j.jen.2009.11.027>
- [72] Hojat, M., Gonnella, J.S., Nasca, T.J., Mangione, S., Vergare, M. and Magee, M. (2002)
- [73] 'Physician empathy: definition, components, measurement, and relationship to gender and
- [74] specialty', *American Journal of Psychiatry*, 159(9), pp. 1563-1569.
- [75] Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A Measure of Subjective Stress. *Psychosomatic Medicine*, 41(3), 209–218. <https://doi.org/10.1097/00006842-197905000-00004>
- [76] Hunter, M., and Carmel, H. (1992). The cost of staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 43, 586-588.

- [77] Hylén, U., Engström, I., Engström, K., Pelto-Piri, V., & Anderzen-Carlsson, A. (2019). Providing Good Care in the Shadow of Violence - An Interview Study with Nursing Staff and Ward Managers in Psychiatric Inpatient Care in Sweden. *Issues in mental health nursing*, 40(2), 148–157. <https://doi.org/10.1080/01612840.2018.1496207>
- [78] Inoue, M., Tsukano, K., Muraoka, M., Kaneko, F., & Okamura, H. (2006). Psychological impact of verbal abuse and violence by patients on nurses working in psychiatric departments. *Psychiatry and Clinical Neurosciences*, 60(1), 29–36.
- [79] Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & de Girolamo, G. (2015). Prevalence and Ito, H., Eisen, S. V., Sederer, L. I., Yamada, O., & Tachimori, H. (2001). Factors affecting psychiatric nurses' intention to leave their current job. *Psychiatric Services*, 52(2), 232–234.
- [80] Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace—a factor in recruitment and retention. *Journal of Nursing Management*, 10(1), 13–20. <https://doi.org/10.1046/j.0966-0429.2001.00262.x>
- [81] Jalil, R., Huber, J. W., Sixsmith, J., & Dickens, G. L. (2017). Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: Cross sectional questionnaire survey. *International Journal of Nursing Studies*, 75, 130–138. <https://doi.org/10.1016/j.ijnurstu.2017.07.018>
- [82] Jeffery, D., & Fuller, P. (2016). Witnessing violence: what are the experiences of mental health nurses? *Mental Health Practice*, 20(2), 15–21. <https://doi.org/10.7748/mhp.2016.e1100>
- [83] Kane, P.(2012): stress causing psychiatric illness among nurses. *j occup envnt med* ;13(1).available from [www.ijoem.com](http://www.ijoem.com)
- [84] Kerr, K., Oram, J., Tinson, H., & Shum, D. (2017). Health Care Workers' Experiences of Aggression. *Archives of Psychiatric Nursing*, 31(5), 457–462. <https://doi.org/10.1016/j.apnu.2017.06.011>

- [85] Keane, S., Szigeti, A., Fanning, F., & Clarke, M. (2018). Are patterns of violence and aggression at presentation in patients with first-episode psychosis temporally stable? A comparison of 2 cohorts. *Early Intervention in Psychiatry*, 13(4), 888–894. <https://doi.org/10.1111/eip.12694>
- [86] Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, 60(7), 709–717.
- [87] Kling RN, Yassi A, Smailes E, Lovato CY, Koehoorn M. Characterizing violence in health care in British Columbia. *J Adv Nurs* 2009; 65:1655–63. <https://doi.org/10.1111/j.1365-2648.2009.05020.x>.
- [88] Koukia E, Zyga S. Critical cases faced by mental health nurses and assistant nurses in psychiatric hospitals in Greece. *Int J Caring Sci*. 2013;6:465–471.
- [89] Kozier, B., Erb, G., Berman, A., Snyder, S., Harvey, S. & Morgan-Samuel, H. (2012). *Fundamentals of Nursing, concepts, process and practice* 2nd ed Harlow: Person Education Limited, chapter 1.
- [90] Krakowski, M. and Czobor, P. (2004) 'Gender differences in violent behaviors: relationship to clinical symptoms and psychosocial factors', *American Journal of Psychiatry*, 161(3),pp. 459-465.
- [91] Kwok, R., Law, Y., Li, K., Ng, Y., Cheung, M., Fung, V., Kwok, K., Tong, J., Yen, P. and Leung, W.-C. (2006) 'Prevalence of workplace violence against nurses in Hong Kong', *Hong Kong Medical Journal*.
- [92] Lantta, T., Anttila, M., Kontio, R., Adams, C. E., & Välimäki, M. (2016). Violent events, ward climate and ideas for violence prevention among nurses in psychiatric wards: a focus group study. *International journal of mental health systems*, 10,1-10. <https://doi.org/10.1186/s13033-016-0059-5>
- [93] Lam, J.N., McNiel, D.E. and Binder, R.L. (2000) 'The relationship between patients' gender and violence leading to staff injuries', *Psychiatric Services*, 51(9), pp. 1167-1170.
- [94] Lanza, M.L. (1983). The reactions of nursing staff to physical assault by a patient. *Hospital & Community Psychiatry*, 34, 44-47.

- [95] Lee, J., Daffern, M., Ogloff, J. R. P., & Martin, T. (2014). Towards a model for understanding the development of post-traumatic stress and general distress in mental health nurses. *International Journal of Mental Health Nursing*, 24(1), 49–58. <https://doi.org/10.1111/inm.12097>
- [96] Lepiešová, M., Tomagová, M., Bóriková, I., Farský, I., Žiaková, K., & Kuručová, R. (2015). Experience of nurses with in-patient aggression in the Slovak Republic. *Central European Journal of Nursing and Midwifery*, 6(3), 306–312. <https://doi.org/10.15452/cejnm.2015.06.0020>
- [97] Liu, J. (2011) 'Early health risk factors for violence: Conceptualization, evidence, and implications', *Aggression and violent behavior*, 16(1), pp. 63-73.
- [98] Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occupational and Environmental Medicine*, 76(12), 927–937. <https://doi.org/10.1136/oemed-2019-105849>
- [99] Lyons, J. S., & Schaefer, K. (2000). Mental health and dangerousness: Characteristics and outcomes of children and adolescents in residential placements. *Journal of Child and Family Studies*, 9(1), 67–73.
- [100] Maercker A, Schützwohl M. Erfassung von psychischen belastungsfolgen: Die Impact of Event Skala-revidierte Version (IES-R). *Diagnostica* 1998; 44(3):130-141. DOI: 10.1037/t55092-000
- [101] MAGUIRE, J., and D. RYAN. “Aggression and Violence in Mental Health Services: Categorizing the Experiences of Irish Nurses.” *Journal of Psychiatric and Mental Health Nursing*, vol. 14, no. 2, Apr. 2007, pp. 120–127, 10.1111/j.1365-2850.2007.01051.x. Accessed 5 Oct. 2021.
- [102] Mangoulia, P., Koukia, E., Alevizopoulos, G., Fildissis, G., & Katostaras, T. (2015). Prevalence of Secondary Traumatic Stress Among Psychiatric Nurses in Greece. *Archives of Psychiatric Nursing*, 29(5), 333–338. <https://doi.org/10.1016/j.apnu.2015.06.001>

- [103] McPhaul KM, London M, Lipscomb JA. A framework for translating workplace violence intervention research into evidence-based programs. *Online J. Issues Nurs.* 2013;18:4–6.
- [104] Mento, C., Silvestri, M. C., Bruno, A., Muscatello, M. R. A., Cedro, C., Pandolfo, G., & Zoccali, R. A. (2020). Workplace violence against healthcare professionals: A systematic review. *Aggression and Violent Behavior, 51*(1), 101381. <https://doi.org/10.1016/j.avb.2020.101381>
- [105] Morrison, E., Morman, G., Bonner, G., Taylor, C., Abraham, I., & Lathan, L. (2002). Reducing staff injuries and violence in a forensic psychiatric setting. *Archives of Psychiatric Nursing, 16*, 108–117.
- [106] Needham, I., Abderhalden, C., Halfens, R. J., Fischer, J. E., & Dassen, T. (2005). Non-somatic effects of patient aggression on nurses: A systematic review. *Journal of Advanced Nursing, 49*(3), 283–296.
- [107] Ng, B., Kumar, S., Ranclaud, M. and Robinson, E. (2001) 'Ward crowding and incidents of violence on an acute psychiatric inpatient unit', *Psychiatric Services, 52*(4), pp. 521-525.
- [108] Nguluwe, B., Havenga, Y. & Sengane, M. (2014). Violence experienced by nurses working in acute care psychiatric wards at a gauteng hospital. *Africa Journal of Nursing and Midwifery, 16*(1), 60-74. <https://doi.org/10.25159/2520-5293/1488>
- [109] Nijman, H., Bowers, L., Oud, N., & Jansen, G. J. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive behavior, 31*, 217–227. *Nursing 31*, 452–460.
- [110] Nijman, H., Bowers, L., Oud, N., and Jansen, G. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive Behavior. 31*(3), 217-227.
- [111] Nijman, H., Merckelbach, H., Evers, C., Palmstierna, T., Campo, J., 2002. Prediction of aggression on a locked psychiatric admissions ward. *Scandinavia, Volume 105, Issue 5*, pages 390–395.
- [112] NIOSH (2020) Violence Occupational Hazards in Hospitals. Available at: <https://www.cdc.gov/niosh/docs/2006-144/default.html>.

- [113] NIOSH, National Institute for Occupational Safety and Health, (2002). Violence in the workplace: Risk factors and prevention strategies (DHHS (NIOSH) Publication No. 2002–101).
- [114] Niu, S.-F., Kuo, S.-F., Tsai, H.-T., Kao, C.-C., Traynor, V., & Chou, K.-R. (2019). Prevalence of workplace violent episodes experienced by nurses in acute psychiatric settings. *PLOS ONE*, *14*(1), e0211183. <https://doi.org/10.1371/journal.pone.0211183>
- [115] Nolan, K.A., Volavka, J., Czobor, P., Sheitman, B., Lindenmayer, J.-P., Citrome, L.L.,
- [116] McEvoy, J. and Lieberman, J.A. (2005) 'Aggression and psychopathology in treatment-resistant inpatients with schizophrenia and schizoaffective disorder', *Journal of psychiatric research*, *39*(1), pp. 109-115.
- [117] Nolan, P., Dallender, J., Soares, J., Thomsen, S. and Arnetz, B. (2000) 'Violence in mental
- [118] health care: the experiences of mental health nurses and psychiatrists', *Journal of Advanced Nursing*, *30*(4), pp. 934-941.
- [119] Nowrouzi, B., & Huynh, V. (2016). Citation analysis of workplace violence: A review of the top 50 annual and lifetime cited articles. *Aggression and Violent Behavior*, *28*, 21–28. <https://doi.org/10.1016/j.avb.2016.03.014>
- [120] Olashore, A. A., Akanni, O. O., & Ogundipe, R. M. (2018). Physical violence against health staff by mentally ill patients at a psychiatric hospital in Botswana. *BMC Health Services Research*, *18*(1). <https://doi.org/10.1186/s12913-018-3187-6>
- [121] Olsson, H., Auduly, Å., Strand, S., & Kristiansen, L. (2015). Reducing or increasing violence in forensic care: a qualitative study of inpatient experiences. *Archives of psychiatric nursing*, *29*(6), 393–400. <https://doi.org/10.1016/j.apnu.2015.06.009>
- [122] Pai, H. C., & Lee, S. (2011). Risk factors for workplace violence in clinical registered nurses in Taiwan. *Journal of clinical nursing*, *20*(9-10), 1405–1412. <https://doi.org/10.1111/j.1365-2702.2010.03650.x>

- [123] Palmstierna, T., L., Nijman, H., Bowers and Crowhurst, N. (2002). (Issues in the measurement of violent incidents and the introduction of a new scale: the 'attacks' (attempted and actual assault scale). (Acta Psychiatrica Scandinavica suppl. 412, 106-109.
- [124] Panaghi L, Hakim shoostari M, Atari Mogadam J. Tehran University Medical Journal TUMS Publications, 2006.
- [125] Pekurinen, V., Willman, L., Virtanen, M., Kivimäki, M., Vahtera, J., & Välimäki, M. (2017). Patient Aggression and the Wellbeing of Nurses: A Cross-Sectional Survey Study in Psychiatric and Non-Psychiatric Settings. *International Journal of Environmental Research and Public Health*, 14(10), 1245. <https://doi.org/10.3390/ijerph14101245>
- [126] Pérez-Fuentes, María del Carmen, et al. "Cross-Sectional Study of Aggression against Spanish Nursing Personnel and Effects on Somatisation of Physical Symptoms." *BMJ Open*, vol. 10, no. 3, Mar. 2020, p. e034143, 10.1136/bmjopen-2019-034143. Accessed 5 Oct. 2021.
- [127] Pett M. Lackey N, Sullivan J, Making Sense of Factor Analysis: The use of factor analysis for instrument development in health care research. 2003; 368 P, USA
- [128] PLoS One, 10(6), e0128536. <http://dx.doi.org/10.1371/journal.pone.0128536>.
- [129] Poster, E. C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10 (6), 365–373.
- [130] Poster, E.C., and Ryan, J. (1994). A multiregional study of nurses' beliefs & attitudes about work safety & patient assault. *Hospital & Community Psychiatry*, 45, 1104-1108.
- [131] Rippon T.J. (2000) Aggression and violence in health care professions. *Journal of Advanced risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis*.
- [132] Rippon, T.J. (2000) 'Aggression and violence in health care professions', *Journal of advanced nursing*, 31(2), pp. 452-460.

- [133] Seto, M. C., Rodrigues, N. C., Ham, E., Kirsh, B., & Hilton, N. Z. (2020). Post-traumatic Stress Disorder, Depression, Anxiety Symptoms and Help Seeking in Psychiatric Staff: Trouble de stress post-traumatique, dépression, symptômes d'anxiété et recherche d'aide chez le personnel psychiatrique. *The Canadian Journal of Psychiatry*, 65(8), 577–583. <https://doi.org/10.1177/0706743720916356>
- [134] Shafran-Tikva, S., Chinitz, D., Stern, Z., & Feder-Bubis, P. (2017). Violence against physicians and nurses in a hospital: How does it happen? A mixed-methods study. *Israel journal of health policy research*, 6(1), 59. <https://doi.org/10.1186/s13584-017-0183-y>
- [135] Soares, J. F., Lawoko, S., & Nolan, P. (2000). The nature, extent and determinants of violence against psychiatric personnel. *Work and stress*, 14(2), 105–120.
- [136] Soravia, L. M., Schwab, S., Walther, S., & Müller, T. (2021). Rescuers at Risk: Posttraumatic Stress Symptoms Among Police Officers, Fire Fighters, Ambulance Personnel, and Emergency and Psychiatric Nurses. *Frontiers in Psychiatry*, 11. <https://doi.org/10.3389/fpsy.2020.602064>
- [137] Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying and sexual harassment: a quantitative review. *Int J Nurs Stud*. 2014;51:72–84.
- [138] Springer, S. (2011) 'Violence sits in places? Cultural practice, neoliberal rationalism, and virulent imaginative geographies', *Political Geography*, 30(2), pp. 90-98.
- [139] Stamm BH. *The Concise ProQOL Manual*. Pocatello, ID: ProQOL.org (2010).
- [140] Stevenson, Kelly N., et al. "Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric Inpatient Units: An Interpretive Descriptive Study." *BMC Nursing*, vol. 14, no. 1, 17 May 2015, 10.1186/s12912-015-0079-5.
- [141] St-Pierre I, Holmes D. The relationship between organizational justice and workplace aggression. *J Adv Nurs* 2010; 66:1169–82. <https://doi.org/10.1111/j.1365-2648.2010.05281.x>.

- [142] Sugden, S. G., Kile, S. J., & Hendren, R. L. (2006). Neurodevelopmental pathways to aggression: A model to understand and target treatment in youth. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 18(3), 302–317.
- [143] Terkelsen, T. B., & Larsen, I. B. (2016). Fear, danger and aggression in a Norwegian locked psychiatric ward: Dialogue and ethics of care as contributions to combating difficult situations. *Nursing ethics*, 23(3), 308–317. <https://doi.org/10.1177/0969733014564104>
- [144] Tonso, M. A., Prematunga, R. K., Norris, S. J., Williams, L., Sands, N., & Elsom, S. J. (2016a). Workplace Violence in Mental Health: A Victorian Mental Health Workforce Survey. *International Journal of Mental Health Nursing*, 25(5), 444–451. <https://doi.org/10.1111/inm.12232>
- [145] Turnbull, J., Aitken, I., Black, L., & Paterson, B. (1990). Turn it around: short-term management for aggression and anger. *Journal of Psychosocial Nursing*, 28(6), 7–13.
- [146] United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. (2002). *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*. London, England: UKCC.
- [147] Walsh, E., Buchanan, A. and Fahy, T. (2002) 'Violence and schizophrenia: examining the evidence', *The British Journal of Psychiatry*, 180(6), pp. 490-495.
- [148] Ward L. (2013). Ready, aim fire! Mental health nurses under siege in acute inpatient facilities. *Issues in mental health nursing*, 34(4), 281–287. <https://doi.org/10.3109/01612840.2012.742603>
- [149] Wax, J.R., Pinette, M.G. and Cartin, A. (2016) 'Workplace Violence in Health Care—It's Not “Part of the Job”', *Obstetrical & gynecological survey*, 71(7), pp. 427-434.
- [150] Webster, M. (2020) Merriam-Webster online dictionary.
- [151] Weir, J. P. (2005). Quantifying Test-Retest Reliability Using the Intraclass Correlation Coefficient and the SEM. *The Journal of Strength and Conditioning Research*, 19(1), 231. <https://doi.org/10.1519/15184.1>

- [152] Weiss DS, Marmar CR. The Impact of Event Scale-Revised. In: Wilson JP, Keane TM (eds). *Assessing Psychological Trauma and PTSD*. Guilford Press, New York, 1997; 399–411.
- [153] Weiss, D. & Marmar, C. (1997). The Impact of Event Scale -Revised. In J. Wilson & T. Keane (Eds), *Assessing psychological trauma and PTSD*. New York: Guildford.
- [154] Whittington R, Wykes T. 1994. Violence in psychiatric hospitals: Are certain staff prone to being assaulted? *J AdvNurs* 19: 219–225.
- [155] Whittington R. & Richter D. (2006) From the individual to the interpersonal: environment and interaction in the escalation of violence in mental health settings, Chapter 3. In: *Violence in Mental Health Settings* (eds Richter, D. & Whittington, R.), pp. 47–68. Springer, New York.
- [156] Whittington, R. (1994). Violence in psychiatric hospitals. In T. Wykes Ed.), *Violence and Health Care Professionals* (pp. 22-43). London: Chapman & Hall.
- [157] Whittington, R., Shuttleworth, S., and Hill, L. (1996). Violence to staff in a general hospital setting. *J AdvNurs* 24, 326-333.
- [158] World Health Organization. Workplace violence: World Health Organisation 2005 From: [prevention/injury/work9/en/index2.html](http://www.who.int/prevention/injury/work9/en/index2.html).
- [159] Wright, S., Gray, R., Parkers, J., & Gournay, K. (2002). The recognition, prevention and therapeutic management of violence in acute in-patient psychiatry.
- [160] Yang, B. X., Stone, T. E., Petrini, M. A., & Morris, D. L. (2018). Incidence, Type, Related Factors, and Effect of Workplace Violence on Mental Health Nurses: A Cross-sectional Survey. *Archives of Psychiatric Nursing*, 32(1), 31–38. <https://doi.org/10.1016/j.apnu.2017.09.013>
- [161] Zombard. (1969). Theories of aggression and violence. retrieved from <http://www.vle.ccs.northants.sch.uk/.../UNIT%20ONE%20AGGRES>.

**Appendices**  
**Appendix A**  
**Facilitate The Search Task**

State of Palestine  
Ministry of Health  
Education in Health and Scientific  
Research Unit



دولة فلسطين  
وزارة الصحة  
وحدة التعليم الصحي  
والبحث العلمي

Ref.: .....  
Date:.....

الرقم: ٠٠٤٩٤/١٦٤  
التاريخ: ٠٠٤٩/١١/١٤

الأخ مدير عام الإدارة العامة للمستشفيات المحترم،،،  
تحية واحترام،،،

**الموضوع: تسهيل مهمة بحث**

يرجى التكرم بتسهيل مهمة الطالب: صالح ابراهيم عبد الهادي سياجرة- ماجستير ترميز صحة نفسية - جامعة النجاح، لعمل بحث بعنوان:

مدى تاثير السلوك العنيف والعدواني للمريض النفسي على الحالة النفسية لمرضى الصحة النفسية:

دراسه في مستشفى الامراض العقلية في بيت لحم -فلسطين

حيث سيقوم الطالب بجمع معلومات عن طريق تعبئة استبانة من قبل الممرضين/ات في مستشفى بيت لحم، بدون استخدام المعلومات الشخصية للمرضى، وذلك في:

- مستشفى بيت لحم للأمراض العقلية

مع العلم أن مشرف الدراسة: د. عدنان سرحان.

على ان يتم الالتزام بالمحافظة على اخلاقيات البحث العلمي وسرية المعلومات.  
على ان يتم الالتزام بجميع تعليمات واجراءات الوقاية والسلامة الصادرة عن وزارة الصحة بخصوص جائحة كورونا، وتحت طائلة المسؤولية. وابرار شهادة التطعيم قبل دخول مرافق وزارة الصحة.  
على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر لحين الحصول على موافقة وزارة الصحة.

مع الاحترام،،،

د. عبد الله القواسمي

رئيس وحدة التعليم الصحي والبحث العلمي



نسخة: منسقة برنامج ماجستير ترميز الصحة النفسية المجتمعية المحترمة/ جامعة النجاح

P.O .Box: 14  
Telfax.:09-2333901

[scientificresearch.dep@gmail.com](mailto:scientificresearch.dep@gmail.com)

ص.ب. 14  
تلفاكس: 09-2333901

## Appendix B

### IRB Approval Letter

1/16/22, 1:02 PM

12\_0001.jpg

An-Najah National University  
Faculty of Medicine & Health  
Sciences  
Institutional Review Board



جامعة النجاح الوطنية  
كلية الطب وعلوم الصحة  
لجنة الأخلاقيات البحث العلمي

Ref.: Mas, Jan, 2022/5

#### IRB Approval Letter

**Title of Research:**

**The effect of Psychiatric Patients Aggression and Violence on Psychiatric Nurses: A study from Bethlehem Psychiatric Hospital ,Palestine"**

**Submitted by:**

Saleh Sayareh

**Supervisor:**

Adnan Sarhan

**Approved:**

9<sup>th</sup> Jan. 2022

Your Study Title "**The effect of Psychiatric Patients Aggression and Violence on Psychiatric Nurses: A study from Bethlehem Psychiatric Hospital ,Palestine"** reviewed by An-Najah National University IRB committee and was approved on 9<sup>th</sup> Jan. 2022

  
Hasan Fitian, MD

IRB Committee Chairman



Nablus - P.O Box :7 or 707 | Tel (970) (09) 2342902/4/7/8/14 | Faximile (970) (09) 2342910 | E-mail :  
[IRB@najah.edu](mailto:IRB@najah.edu)

<https://mail.google.com/mail/u/0/#inbox/FMfgzGmtXCRLtvSpgLjBwgrpxDBFTm?projector=1&messagePartId=0.1>

**Appendix C**  
**Questionnaire**  
**الاستبيان**

المعلومات الشخصية:

1. الجنس:  
أ. ذكر  
ب. أنثى
2. العمر:  
أ. (20-30) ب. (31-40) ج. (41-50) د. (51 فما فوق)
3. الحالة الاجتماعية:  
أ. أعزب/ عذباء  
ب. متزوج/ة  
ج. مطلق/ة  
د. أرمل/ة
4. عدد أفراد الأسرة:  
أ. لا يوجد ب 1-4  
ب. أكثر من 4
5. عدد سنوات الخبرة بمستشفى بيت لحم للأمراض النفسية:  
أ. أقل من سنة  
ب. سنة واحدة- 3 سنوات  
ج. 3 سنوات – 8 سنوات  
د. أكثر من 8 سنوات
6. الراتب الذي تتقاضاه/ تتقاضينه ما بين:  
أ. 1880-2999 شيكل  
ب. 3000 فأكثر شيكل
7. المؤهل العلمي:  
أ. دبلوم  
ب. بكالوريوس (أربع سنوات) او اعلى
8. مكان السكن:  
أ. مدينه  
ب. قرية  
ج. مخيم
9. طبيعة الدوام:  
أ. صباحي (7ص- 2 م)  
ب. مسائي(2م-9م)  
ج. ليلي( 9م-7ص)  
د. جميع الورديات
10. المسمى الوظيفي:  
أ. رئيس قسم  
ب. ممرض مؤهل  
ج. ممرض قانوني
11. القسم الذي تعمل/ تعملين به:  
أ. ادخال رجال/ إدخال نساء  
ب. نقاهة رجال/ نقاهة نساء  
ج. - مزمنين رجال

## Appendix D

### Impact of Event Scale - Revised (IES-R)

(Weiss & Marmar, 1997)

**Devised By:** The IES-R was developed by Daniel S. Weiss and Charles R. Marmar in 1997 to parallel the DSM-IV criteria for PTSD. The original IES was developed prior to the adoption of Posttraumatic Stress Disorder as a legitimate diagnosis in the DSM-III published in 1980, and only tap 2 of the 4 criteria set out for PTSD in the DSM-IV: intrusion and avoidance (Weiss & Marmar, 1997). IES-R was intended to tap hyperarousal cluster of symptoms, the 4th criterion for PTSD.

**Type of Instrument:** The IES-R is similar to IES in that it is a self-report measure designed to assess current subjective distress for any specific life event. The IES-R has 22 items, 7 items having being added to the original 15-item IES (Weiss & Marmar, 1997). The 7 items comprise 6 that tap hyperarousal symptoms such as: anger and irritability, heightened startle response, difficulty concentrating, hypervigilance; and 1 new intrusion item that taps the dissociative-like re-experiencing when experiencing true flash-back. The hyperarousal subscale and the new intrusion item along with the existing intrusion and avoidance subscales parallel the DSM-IV criteria for PTSD.

The 7 items were randomly interspersed with the existing 7 intrusion and 8 avoidance items. The only modification to the IES items was the bifurcation of the item "I had trouble falling asleep or staying asleep" into "I had trouble falling asleep" (assigned to the hyperarousal subscale), and "I had trouble staying asleep" (retained in the intrusion subscale).

Respondents are asked to rate each item in the IES-R on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely) according to the past 7 days.

**Reliability:** In their study of 4 different population samples, Weiss and Marmar (1997) reported that the internal consistency of the 3 subscales was found to be very high, with intrusion alphas ranging from .87 to .92, avoidance alphas ranging from .84 to .86, and hyperarousal alphas ranging from .79 to .90 (Briere, 1997).

**Split-half/Cronbach's Alpha:** NA

**Test-Retest Reliability:** Test-retest data were available for 2 of the samples in the Weiss and Marmar (1997) study. Data from sample 1 (n = 429) yielded the following test-retest correlation co-efficients for the subscales: intrusion = .57, avoidance = .51, hyperarousal = .59. From sample 2 (n = 197) the correlation coefficients were considerably higher: intrusion = .94, avoidance = .89, hyperarousal = .92. It is believed that the shorter interval between assessments and the greater recency of the traumatic event for Sample 2 contributed to the higher coefficients of stability.

**Alternate Form Reliability:** NA

**Inter-rater Reliability:** NA

**Validity:**

**Criterion (or Predictive) Validity:** Weiss and Marmar noted that the hyperarousal subscale has good predictive validity with regard to trauma (Briere, 1997). The intrusion and avoidance subscales, which are original IES components, have been shown to detect change in respondents' clinical status over time and detect relevant differences in the response to traumatic events of varying severity (Weiss and Marmar, 1997, Horowitz et al, 1979).

**Content Validity:** Not available for the hyperarousal subscale. The intrusion and avoidance subscales which are originally IES items had high endorsements of up to 85% (Horowitz, et al. 1979).

**Construct Validity:** Weiss and Marmar (1997) utilised the item-to-subscale correlation with that item removed from the subscale generated by the standard alpha coefficient analyses. These were then compared to the cross-subscale Pearson correlations. The results showed that only 1 item ("I had trouble falling asleep") showed a stronger relationship between it and a different subscale. The corrected correlation of this item with its assigned hyperarousal subscale was .71, and its correlation with the intrusion subscale was .79. Nineteen items showed a correlation with their assigned subscale that was higher than with the other subscales; and 2 items ("I had trouble

staying asleep" and " I avoided letting myself get upset when I thought about it or was reminded of it") showed a correlation that was equal.

The explanations given by Weiss and Marmar (1997) for these results are that the 2 sleep items are very highly correlated, driving a relationship between them in terms of intrusion and hyperarousal; and as to the equal relationship of the avoidance item with the avoidance and intrusion subscales, this may have occurred because the presentation of the thought or the reminder invokes intrusion, and the not dealing with it invokes avoidance.

**Convergent Validity:** NA

**Discriminant Validity:** NA

**Scoring Method:**

Avoidance Subscale: Mean of items 5, 7, 8 11, 12, 13, 17, 22

Intrusions Subscale: Mean of items 1, 2, 3, 6, 9, 14, 16, 20

Hyperarousal subscale: Mean of items 4, 10, 15, 18, 19, 21

IES-R score: Sum of the above 3 clinical scales.

For valid comparisons with scores from the IES, use just the sum of the Avoidance and Intrusion subscales.

## The Impact of Event Scale - Revised

Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to, how much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Any reminder brought back feelings about it	0	1	2	3	4
I had trouble staying asleep	0	1	2	3	4
Other things kept making me think about it	0	1	2	3	4
I felt irritable and angry	0	1	2	3	4
I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
I thought about it when I didn't mean to	0	1	2	3	4
I felt as if it hadn't happened or wasn't real	0	1	2	3	4

I stayed away from reminders about it	0	1	2	3	4
Pictures about it popped into my mind	0	1	2	3	4
I was jumpy and easily startled	0	1	2	3	4
I tried not to think about it	0	1	2	3	4
I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
My feelings about it were kind of numb	0	1	2	3	4
I found myself acting or feeling as though I was back at that time	0	1	2	3	4
I had trouble falling asleep	0	1	2	3	4
I had waves of strong feelings about it	0	1	2	3	4

I tried to remove it from my memory	0	1	2	3	4
I had trouble concentrating	0	1	2	3	4
Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
I had dreams about it	0	1	2	3	4
I felt watchful or on-guard	0	1	2	3	4
I tried not to talk about it	0	1	2	3	4

**Scoring:**

Avoidance Subscale = mean of items 5, 7, 8, 11, 12, 13, 17, 22

Intrusion Subscale = mean of items 1, 2, 3, 6, 9, 14, 16, 20

Hyperarousal Subscale = mean of items 4, 10, 15, 18, 19, 21

أثر مقياس الحدث:

فيما يلي قائمة بالصعوبات التي يواجهها الأشخاص أحياناً بعد أحداث الحياة المجهدة. يرجى قراءة كل عنصر، ثم الإشارة إلى مدى إزعاجك لكل صعوبة خلال الأيام السبعة الماضية فيما يتعلق بـ ، إلى أي مدى كنت متضايقاً أو منزعجاً من هذه الصعوبات؟

	لا إطلاقاً	نادراً	أحياناً	غالباً	دائماً
1.	0	1	2	3	4
	أي شيء ذكرني بالحدث أعاد لي المشاعر مرة أخرى				
2.	0	1	2	3	4
	كان لدي صعوبة بالبقاء نائماً				
3.	0	1	2	3	4
	أشياء أخرى ذكرتني دوماً بالحدث.				
4.	0	1	2	3	4
	شعرت بانني منفعل وغاضب				
5.	0	1	2	3	4
	حاولت تجنب الانزعاج عندما فكرت أو تذكرت ذلك الحدث.				
6.	0	1	2	3	4
	تذكرت الحدث عن غير قصد				
7.	0	1	2	3	4
	شعرت كأن الحدث لم يحدث أو كأنه غير حقيقي				
8.	0	1	2	3	4
	أبعدت نفسي عن ذكريات الحدث.				
9.	0	1	2	3	4
	ظهرت الصورة المتعلقة بالحدث بذهني بشكل مفاجئ				
10.	0	1	2	3	4
	كنت سريع الانفعال وعصبياً				
11.	0	1	2	3	4
	حاولت عدم التفكير في				

					الحدث.	
4	3	2	1	0	كنت مدركا بأنني لازلت أملك الكثير من المشاعر حول الحدث ولكني لم أكثر لها	.12
4	3	2	1	0	كنت أشعر بنوبات من الخدر تجاه الحدث.	.13
4	3	2	1	0	وجدت نفسي أتصرف وأشعر كما لو أنني أعيش حينها وقت الحدث.	.14
4	3	2	1	0	كانت لدي صعوبة في بداية النوم	.15
4	3	2	1	0	حصل لدي موجات من مشاعر قوية تتعلق بالحدث.	.16
4	3	2	1	0	حاولت إزالة هذا الحدث من ذاكرتي	.17
4	3	2	1	0	كان لدي صعوبة في التركيز	.18
4	3	2	1	0	تذكرني للحدث أثار عندي انتكاسات جسدية، مثل التعرق، أو صعوبة في التنفس، أو الغثيان، أو تسارع في ضربات القلب	.19
4	3	2	1	0	راودتني أحلام حول الحدث.	.20

4	3	2	1	0	شعرت انني حذر جدا أو مترقب	.21
4	3	2	1	0	حاولت عدم التحدث حول ذلك الحدث.	.22

التهديف:

مقياس التجنب الفرعي = متوسط العناصر 5 ، 7 ، 8 ، 11 ، 12 ، 13 ، 17 ، 22

مقياس التطفل الفرعي = متوسط العناصر 1 ، 2 ، 3 ، 6 ، 9 ، 14 ، 16 ، 20

المقياس الفرعي Hyperarousal = متوسط العناصر 4 ، 10 ، 15 ، 18 ، 19 ، 21

## Appendix E

### Eysenck Personality Questionnaire

The Eysenck Personality Inventory (EPI) measures two broad and independent dimensions of personality, introversion-introversion, and neurotic stability, which account for most of the variance in the personality domain. Each form contains 57 "yes-no" items.

To assess the personality traits of a person.

Number	Test Items	Yes	No
1.	Do you often long for excitement?		
2.	Do you often need understanding friends to cheer you up?		
3.	Are you usually carefree?		
4.	Do you find it very hard to take no for an answer?		
5.	Do you stop and think things over before doing anything?		
6.	If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so?		
7.	Do your moods go up and down?		
8.	Do you generally do and say things quickly without stopping to think?		
9.	Do you ever feel 'just miserable' for no good reason?		
10.	Would you do almost anything for a dare?		
11.	Do you suddenly feel shy when you want to talk to an attractive stranger?		
12.	Once in a while do you lose your temper and get angry?		
13.	Do you often do things on the spur of the moment?		

14. Do you often worry about things you should have done or said?
15. Generally, do you prefer reading to meeting people?
16. Are your feelings rather easily hurt?
17. Do you like going out a lot?
18. Do you occasionally have thoughts and ideas that you would not like other people to know about?
19. Are you sometimes bubbling over with energy and sometimes very sluggish?
20. Do you prefer to have few but special friends?
21. Do you daydream a lot?
22. When people shout at you do you shout back?
23. Are you often troubled about feelings of guilt?
24. Are all your habits good and desirable ones?
25. Can you usually let yourself go and enjoy yourself a lot at a lively party?
26. Would you call yourself tense or 'highly strung'?
27. Do other people think of you as being very lively?
28. After you have done something important, do you come away feeling you could have done better?
29. Are you mostly quiet when you are with other people?
30. Do you sometimes gossip?
31. Do ideas run through your head so that you cannot sleep?
32. If there is something you want to know about, would you rather look it up in a book than talk to someone about it?

33. Do you get palpitations or thumping in your heart?
34. Do you like the kind of work that you need to pay close attention to?
35. Do you get attacks of shaking or trembling?
36. Would you always declare everything at customs, even if you knew you could never be found out?
37. Do you hate being with a crowd who play jokes on one another?
38. Are you an irritable person?
39. Do you like doing things in which you have to act quickly?
40. Do you worry about awful things that might happen?
41. Are you slow and unhurried in the way you move?
42. Have you ever been late for an appointment or work?
43. Do you have many nightmares?
44. Do you like talking to people so much that you never miss a chance of talking to a stranger?
45. Are you troubled by aches and pains?
46. Would you be very unhappy if you could not see lots of people most of the time?
47. Would you call yourself a nervous person?
48. Of all the people you know, are there some whom you definitely do not like?
49. Would you say that you were fairly self-confident?
50. Are you easily hurt when people find fault with you or your work?

- 51. Do you find it hard to really enjoy yourself at a lively party?**
- 52. Are you troubled by feelings of inferiority?**
- 53. Can you easily get some life into a dull party?**
- 54. Do you sometimes talk about things you know nothing about?**
- 55. Do you worry about your health?**
- 56. Do you like playing pranks on others?**
- 57. Do you suffer from sleeplessness?**

## مقياس ايزنك للشخصية

### الصورة (أ)

#### عزيزي الممرض/ الممرضة

إليك بعض الأسئلة على الطريقة التي تسلك بها وتشعر حاول أن تحدد الإجابة التي تتفق مع طريقتك المعتادة في التصرف والشعور هل هي (نعم) أم (لا) ثم ضع علامة (صح) في المستطيل تحت عمود نعم أو لا

يقيس مخزون شخصية (EPI) Eysenck بعدين عريضين ومستقلين للشخصية، الانطواء-الانطواء، والاستقرار العصبي، والتي تمثل معظم التباين في مجال الشخصية. يحتوي كل نموذج على 57 عنصرًا "نعم لا".

لتقييم السمات الشخصية للشخص.

شاكرًا لكم حسن تعاونكم

الرقم	فقرات الاختبار	نعم	لا
1	هل تتوق إلى الأشياء المثيرة في معظم الأحيان ؟		
2	هل تحتاج إلى أصدقاء يفهمونك لكي تشعر بالارتياح والابتهاج ؟		
3	هل أنت سعيد وتعالج الأمور ببساطة ودون تدقيق وتصحيح ؟		
4	هل تنزعج إلى حد كبير لو رفض لك طلب ؟		
5	هل تتمهل وتفكر مليا قبل الإقدام على عمل أي شيء ؟		
6	هل تفي دائما بوعد قطعتة على نفسك بغض النظر عما قد يكلف من تعب أو عناء ؟		
7	هل يثور مزاجك ويهدأ في بعض أحيان كثيرة ؟		
8	هل من عادتك أن تقوم بعمل وقل أشياء على نحو متسرع ودون تأمل أو تفكير ؟		
9	هل حدث أن شعرت بالتعاسة دون سبب كافٍ لذلك ؟		
10	هل تعمل أي شيء تقريبا من أجل الجراءة ؟		
11	هل تشعر بالخجل فجأة عندما تريد التحدث إلى شخص غريب جذاب ؟		
12	هل يحدث أن تفقد السيطرة على نفسك وتغدو غاضبا أحيانا ؟		
13	هل تقوم بالأشياء على نحو ارتجالي في معظم الأحيان ؟		
14	هل تشعر غالبا بالقلق حيال أشياء كان ينبغي لك أن لا تفعلها أو تقولها ؟		
15	هل تفضل المطالعة على التحدث أمام الآخرين بصفة عامة ؟		
16	هل يسهل جرح مشاعرك نوعا ما ؟		
17	هل ترغب في الخروج كثيرا من المنزل ؟		
18	هل تراودك أحيانا أفكار وخواطر لا ترغب أن يعرفها الآخرين ؟		

19	هل تشعر بنشاط شديد أحيانا و بالبلادة أحيانا أخرى ؟
20	هل تفضل أن يكون لديك عدد قليل من الأصدقاء شريطة أن يكونوا من المقربين ؟
21	هل تستغرق في أحلام اليقظة ؟
22	هل تجيب الناس بالصراخ عندما يصرخون في وجهك ؟
23	هل يضايك الشعور بالذنب في كثير من الأحيان ؟
24	هل عاداتك جميعها حسنة ومرغوب فيها ؟
25	هل يمكنك أن تترك نفسك على سجيتها وتتمتع كثيرا في حفل مرح ؟
26	هل تعتبر نفسك متوتر الأعصاب ؟
27	هل يعتقد الآخرون أنك حيوي ونشط ؟

28	هل قمت بعمل شيء هام ثم شعرت غالبا بان باستطاعتك القيام به على نحو أفضل ؟
29	هل يغلب عليك طابع الهدوء عندما تكون مع الآخرين ؟
30	هل تنهمك في القيل والقال أو نشر الإشاعات أحيانا ؟
31	هل تلازمك الأفكار لدرجة لا تستطيع معها النوم ؟
32	إذا كنت تريد معرفة شيء ما , فهل تفضل معرفته من خلال اللجوء إلى الكتاب بدلا من اللجوء إلى شخص آخر تحدثه عنه ؟
33	هل يحدث خفقان قلب أو تسارع في دقاته ؟
34	هل تحب نوع العمل الذي يتطلب منك انتباها شديدا أو دقيقا ؟
35	هل تنتابك نوبات من الارتجاف و الارتعاش أحيانا ؟
36	هل تصرح للجمارك عن كل شيء لديك حتى لو علمت انه يستحيل اكتشافه ؟
37	هل تكره أن تكون في مجموعة يتكل الواحد على الآخر ؟
38	هل أنت شخص سريع الاستثارة أو الانفعال ؟
39	هل ترغب القيام بأشياء ينبغي لك أن تتصرف حيالها بسرعة ؟
40	هل تقلق بصدد أشياء مخيفة قد تحدث لك ؟
41	هل يمتاز أسلوب حركتك بالبطء وعدم السرعة ؟
42	هل حدث أن تأخرت عن تنفيذ موعد أو عمل ما ؟
43	هل تنتابك كوابيس أو أحلام مزعجة كثيرة ؟
44	هل ترغب في التحدث مع الناس إلى حد كبير بحيث لم تضع فرصة الحديث إلى شخص غريب ؟
45	هل تزعجك الآلام والأوجاع ؟

		هل تشعر بتعاسة شديدة إن لم تر من الناس في بعض الأحيان ؟	46
		هل تعتبر نفسك عصبيا ؟	47
		هل هناك أشخاص ممن تعرفهم لا تحبهم على نحو قاطع ؟	48
		هل تستطيع القول بأنك شخص واثق من نفسك تماما ؟	49
		هل يولمك الآخرون بسهولة لدى اكتشافهم الخطايا فيك أو في عملك ؟	50
		هل يصعب عليك أن تتمتع فعلا في حفل مرح ؟	51
		هل تنزعج من الشعور بالنقص ؟	52
		هل يسهل عليك إضفاء جو من الحيوية على حفل ممل إلى حد ما ؟	53
		هل تتحدث أحيانا عن أمور لا تعرف عنها شيئا ؟	54
		هل أنت قلق على صحتك ؟	55
		هل تحب إيقاع الآخرين في " مقالب " بقصد المرح ؟	56
		هل تعاني من الأرق ؟	57



جامعة النجاح الوطنية  
كلية الدراسات العليا

مدى تاثير السلوك العنيف والعدواني للمريض النفسي على الحالة  
النفسية لمرضى الصحة النفسية: دراسته في مستشفى الامراض  
العقلية في بيت لحم - فلسطين

إعداد

صالح ابراهيم عبد الهادي سباعرة

إشراف

د. عدنان سرحان

قدمت هذه الرسالة استكمالاً لمتطلبات الحصول على درجة الماجستير في ترميض المجتمع للصحة النفسية، من  
كلية الدراسات العليا، في جامعة النجاح الوطنية، نابلس - فلسطين.

2023

## مدى تأثير السلوك العنيف والعدواني للمريض النفسي على الحالة النفسية لمرضى

الصحة النفسية: دراسته في مستشفى الامراض العقلية في بيت لحم -فلسطين

اعداد

صالح ابراهيم عبد الهادي سباعرة

إشراف

د. عدنان سرحان

### الملخص

طبيعة العمل التمريضي النفسي متطلبة ويمكن أن تكون مرهقة، والمرضى النفسيين يواجهون مستويات أعلى من التوتر من تلك الموجودة في التخصصات الأخرى. أظهرت الدراسات السابقة ارتفاع معدل العنف والعنف بين المرضى النفسيين العاملين. في الآونة الأخيرة، بذلت جهود لفهم طبيعة العدوانية والعنف من المرضى النفسيين ضد المرضى في مستشفيات الأمراض النفسية. يمكن اعتبار أي نوع من أنواع العنف اللفظي والجسدي والعدواني، وكذلك العنف الفعلي، عنفًا في هذا السياق.

وفقًا للأدلة، غالبًا ما يتعرض طاقم التمريض النفسي للعنف والعدوانية، مما يؤدي إلى إصابة المرضى المتضررين بدنيًا ونفسيًا. علاوة على ذلك، تظهر الأبحاث أن تداعيات ذلك على المرضى والمنظمة ككل كبيرة. يمكن أن يكون للعنف والعدوانية، على سبيل المثال، تأثير سلبي على جودة الرعاية والعلاج المقدمين، فضلاً عن التسبب في فترات أطول من التغيب عن العمل وانخفاض جودة العمل. لذلك، تهدف هذه الدراسة إلى استكشاف تأثير عدوانية وعنف المرضى النفسيين على الحالة النفسية لمرضى الطب النفسي في مستشفى بيت لحم للأمراض النفسية في فلسطين.

تهدف هذه الدراسة الى تقييم أثر عدوان وعنف المرضى النفسيين على المرضى النفسيين في مستشفى بيت لحم للأمراض النفسية في فلسطين.

تم تقديم تصميم دراسة مقطعية وصفية كمية خلال الفترة من تشرين الثاني (نوفمبر) إلى كانون الأول (ديسمبر) 2021 في مستشفى بيت لحم للأمراض النفسية في فلسطين. تم جمع البيانات باستخدام استبيان يحتوي على قسمين (البيانات الديموغرافية، تأثير مقياس الأحداث المنقح، استبيان شخصية Eysenck المنقح) وإجراء مقابلات مع الممرضين النفسيين. تم تحليل البيانات باستخدام الإصدار 26 من SPSS.

كانت نسبة انتشار اضطراب ما بعد الصدمة بين الممرضين المشخصين (14.7%) وبين المشاركين الذين يعانون من اضطراب ما بعد الصدمة الجزئي وبعض الأعراض (20.0%). علاوة على ذلك، بلغ عدد الأشخاص الذين تجاوزوا فترة الإجهاد اللاحق للصدمة (بما يكفي لقمع جهاز المناعة) (42.7%).

بالإضافة إلى ذلك. كان واضحاً أن تأثير اضطراب ما بعد الصدمة على شخصية الممرضين المشاركين في الدراسة، حيث بلغ انتشار العصابية بين الممرضين المشاركين (48.0%)، أي أن هؤلاء المشاركين يتميزون بالحزن وتقلب المزاج، وعدم الاستقرار العاطفي. بالإضافة إلى أن الأفراد الحاصلين على درجة عالية في هذه السمة يميلون إلى الشعور بتقلبات مزاجية وقلق وحزن.

بينما بلغت نسبة المنفتحين (85.3%)، وهذه الدرجة تشير إلى أن الشخص اجتماعي، يحب الحفلات، لديه أصدقاء كثيرون، يحتاج للكثير من حوله، يحب الحديث كثيراً، لا يحب القراءة، ويسعى للإثارة. يهدف إلى القيام بأشياء لا يفترض أن يفعلها، يتصرف بسرعة دون تفكير، متسرع بشكل عام، مغرم بعمل المزاح للآخرين، عندهم سرعة البديهة، يحب التغيير، يأخذ الأشياء، يفضل أن يكون نشطاً ومتحركاً دائماً، يفعل مختلف الأفعال ويميل إلى العدوان. بالإضافة إلى عدم صبره بسهولة، فإنه لا يستطيع التحكم في مشاعره ويغضب بسرعة.

أظهرت الدراسة أن السلوك العدواني والعنيف للمريض النفسي على الممرضين له تأثير سلبي على الحالة النفسية للممرضين، ومعظم المشاركين يعانون من اضطراب ما بعد الصدمة. بالإضافة إلى ذلك، فإن المشاركين الذين تم تشخيصهم باضطراب ما بعد الصدمة هم أكثر عرضة لتثبيط جهاز المناعة لديهم.

وبالتالي انعكس اضطراب ما بعد الصدمة على السمات الشخصية أو أبعاد الشخصية للمرضات المشاركين في الدراسة، وأدى هذا الانعكاس إلى ظهور عصابية تتجلى في شكل القلق، وصعوبة النوم، والصداع، واضطرابات الجهاز الهضمي، وآلام الظهر، وتقلب المزاج.

يجب أن تفهم وزارة الصحة الفلسطينية صعوبة العمل الذي يقدمه هؤلاء الممرضون النفسيون. بالإضافة إلى توفير برامج الإشراف والإرشاد النفسي لهؤلاء الممرضين.

**الكلمات المفتاحية:** حالة نفسية، مريض نفسي، مستشفى بيت لحم للطب النفسي، ممرض نفسي، عنف وعدوان.