An-Najah National University

Faculty of Graduate Studies

Nurses' Attitudes and Practices towards Inpatient Aggression in Dr. Kamal Mental Health Hospital

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الإهداء

إلى كل من أضاء بعلمه عقل غيره أو هدى بالجواب الصحيح حيرة سائليه فأظهر بسماحته تواضع العلماء وبرحابته سماحة العارفين.

أهدي هذا العمل المتواضع إلى أبي الذي لم يبخل علي يوماً بشيء.

إلى أمي التي ذودتني بالحنان والمحبة

أقول لهم: أنتم وهبتموني الحياة والأمل والنشأة على شغف الاطلاع والمعرفة

إلى زوجتي العزيزة

إلى فلذة كبدي وقرة عيني ولدي الحبيب

وإلى إخوتي وأسرتي جميعاً

إلى كل من علمني حرفاً أصبح سنا برقه يضيء الطريق أمامي

إلى فلسطين الجريحة

إلى روح الشهداء الأكرمين في عليين

إلى الأسرى رمز العزة

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الإقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل عنوان:

Nurses' Attitudes and Practices towards Inpatient Aggression in Dr. Kamal Mental Health Hospital

أقر بأن ما اشتملت عليه هذه الرسالة هو نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم لنيل أي درجة أو لقب علمي أو بحثي لدى أي مؤسسة تعليمية أو بحثية أخرى.

Declaration

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.

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ATAS	Attitude Toward Aggression Scale
MAVAS	Management Of Aggression and Violence Scale
ECT	Electro Convulsive Therapy
EEG	Electroencephalography
LSD	Least Significant difference

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Abstract

Background: Inpatient aggression can occur for many reasons and there are many factors that contribute to this occurrence such as patient factors, staff factors and environmental factors. There are strategies to prevent and manage aggression.

Aims: The aims of this study are to explore nurse's practices and attitudes of inpatient psychiatric aggression to identify the way the nurses handle aggression by patients and exploring the effects of patients, staff and environmental factors on the occurrence of aggression.

Participants and methods: The study was conducted at Dr. Kamal Adwan Psychiatric Hospital in Bethlehem. All nursing staff in the mental health hospital who had worked for at least one year at the time of the study were recruited (67 nurses). The participants ranged in age from 20-50 years with a mean age of (35.1) (±SD = ±7.8) and included 30 females and 37 males. A questionnaire was used which has three scales: Attitude Toward Aggression Scale (ATAS), Management Of Aggression and Violence Scale (MAVAS) and Demographic Scale.

Results: Nurses were inclined to perceive patient aggression as destructive, violent, intrusive and functional reactions. They were less inclined to view

aggression as protective, communicative or acceptable normal reactions. Female nurses in this study were more likely to view aggression as having an intrusive role whereas, on the contrary, male nurses were more likely to view aggression as having a communicative role and they believed that the aggression could be managed in general. Longer professional experience was significantly associated with a higher frequency of the management of aggression in general. Nurses from the admission ward (male and female) were in less agreement with the Protective and Communicative Attitudes scales than the nurses from the other inpatient wards. On the other hand, nurses from admission ward (particularly female) and recovery ward (male and female) had a higher rate of violent and offensive reaction to aggression than nurses from the other wards. The nurses from the chronic female ward had a higher intrusive scale than nurses from the other wards. The highest level of the scientific grade group is a Master of Mental Health with a high level mean regarding the attitudes to the acceptable normal reaction scale, violent reaction scale, functional reaction scale, offensive scale, communicative scale, destructive scale, external causative factors scale, situational/interactional causative factors scale, Management: general, and Management: use of medication.

The nurses agree that there are internal, external and interactional factors to inpatient aggression. Nurses believe that patients may be aggressive because of the environment of the psychiatric hospital. Nurses believe that aggression develops because staff do not listen to the patients, there is poor

interaction between staff and patients and other people make patients aggressive. Nurses believe in the use of medications, restraint and seclusion widely , on the contrary, they believe in the use of non-physical methods like negotiation and expression of anger.

Conclusion: This study demonstrate that there are different attitudes of nurses toward patient aggression in psychiatric inpatient settings. This study found that aggression is negatively viewed by Palestinian psychiatric nurses. These attitudes are reflective of the opinions of lay persons in our society. There is a need for training programs to reorient the opinions of nurses in relation to inpatient aggression. These programs should contribute to improved patient care and reduction in the frequency of aggressive acts within inpatient units.

Key words: Aggression; mental health nurses; ATAS; MAVAS

Chapter 1
Introduction

1.1 Introduction

Nurses are more likely to be involved in an aggressive incident with a patient than other professional health care providers because they have more interaction with the patients compare to the other members of the health team. In developing countries, there is a lack of knowledge and research about the perception of mental illness (Peluso&Blay 2004). The prevalence of violence between psychiatric inpatients ranges from 6.1% to 35% (Grassi, Peron, Marangoni, Zanchi, &Vanni, 2001; Haller &Deluty, 1988; Lee, Fan, & Tsai, 1987; Ruesch, Miserez, & Hell, 2003; Steinert, Wiebe, &Gebhardt, 1999; Walker & Seifert, 1994).Whittington (1994) found an average rate of reported assaults in psychiatric wards of about one every 11 days, while Gournay et al. (1998) found an average of two assaults per week per ward in a sample of inner-London adult acute wards and psychiatric intensive care units. Approximately two-thirds of the assaults recorded in this survey were directed at nursing staff. Professional skills and alternative methods are needed in dealing with aggressive patients in the right way to avoid the reflection of aggression from nurses to the patients. There are wrong and aggressive ways that the nurses may use to deal with patients. Thomas et al. (1995) interviewed inpatients about their direct experience of physically or sexually threatening situations

during admission and 71% of the sample (n=59) reported exposure to such incidents, of whom 23 patients (39%) had actually been hit.

Mental health disorders constitute one of the largest – and least acknowledged – health problems in Palestine. Patients with acute psychosis are often characterized by less insight and less tolerance of stress (Levy, Salagnik, Rabinowitz, & Neumann, 1989). This affects their judgment and anger reacton to reality,. Their behavior can cause anxiety in staff members who care for them, although the proportion of violent crimes committed by people suffering from severe mental disorders is small (Angermeyer, 2000).

This study will be done in a Palestinian psychiatric hospital, which is Dr. Kamal Adwan Hospital in Bethlehem, which has 207 beds and seven wards. The other psychiatric hospital is El Naser Psychiatric Hospital in Gaza, which will not be part of this study because access to Gaza is not possible. These two settings serve a population of approximately 4 million people. Most of the mental health workers are graduates of local Palestinian universities; there are five Palestinian universities and one college that offer bachelor degrees in nursing (An- Najah National University, Birzeit University, Bethlehem University, Al Quds University, Hebron University and Ibn Sena College). An- Najah National University also offers a Master of Community Mental Health Nursing and Al Quds University offers a Master of community Mental Health. Because there is a lack of studies on the attitude of nurses toward psychiatric inpatient

aggression in Palestine, the present study may provide new evidence of the actual attitudes of nurses toward psychiatric inpatient aggression.

The aim of this study is to explore the attitudes and practices of nurses toward inpatient aggression in a Palestinian psychiatric hospital.

1.2 Background

1.2.1 Dr. Kamal Adwan Psychiatric Hospital

Dr. Kamal Adwan Psychiatric Hospital is the only psychiatric hospital in the West bank of Palestine. It was opened in 1922, has seven wards, which are: Acute admission ward for males (33 beds), acute admission ward for females (16 beds), chronic ward for males (53 beds), chronic ward for females (42 beds), rehabilitation ward for males (30 beds) and rehabilitation ward for females (33 beds) with a total of 207 beds (Dr. Kamal hospital administration, 2012).

Admission wards have acute psychiatric cases and aggressive patients. Rehabilitation wards have the recovered patients who have a stable psychiatric condition. Chronic wards have chronic cases that have psychiatric disorders for a long time and have no shelter. These patients have no communications skills and a low level of functioning, so they need special care.

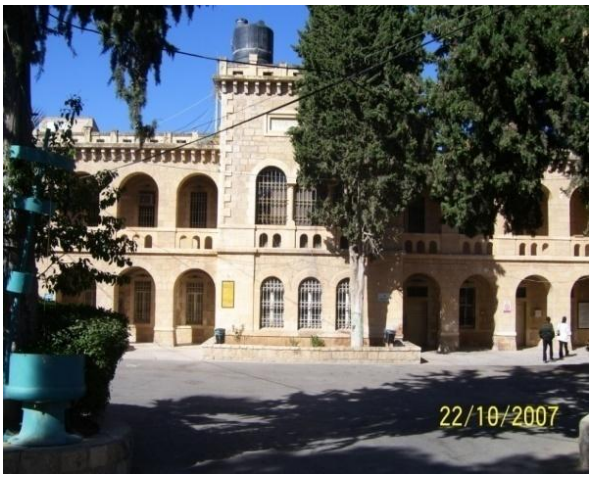

Figure 1. Bethlehem Psychiatric Hospital

The hospital offers inpatient treatment such as medication, observation, safety for the patient, isolation and restraint, electro convulsive therapy (ECT) for inpatients and outpatients, They use two types of ECT, which are modified ECT and simple ECT, as well as electroencephalography (EEG), and psychological tests which are done by one psychologist. They also have a recovery program, which is presented by occupational therapy.

1.2.2 Definition and Origins of Aggression

The Oxford Dictionary (1989) defines aggression as a "forceful action or procedure especially when intended to dominate or master and as hostile, injurious, or destructive behavioror outlook".

Geen (2001) introduced two characteristics that he considered should belong to a definition of aggression: firstly, there must be an intention to harm, and secondly the person towards whom the behaviour is directed must be motivated to avoid such interaction. Thus, he proposed the

following working definition of aggression: “the delivery of an aversive stimulus from one person to another, with intent to harm and with an expectation of causing such harm, when the other person is motivated to escape or avoid the stimulus” (Geen, 2001, p. 3).

According to Palmstierna (2002), aggression is a multidimensional construct. He proposed a three dimensional approach to define aggression:

• Inner experience versus outward behavior.

• Aggressor’s view versus observer’s view.

• Persistent versus episodically occurrence (trait or state).

1.2.3 Associated Factors of Aggression in Psychiatric Care

Researchers have attempted to understand the factors associated with the occurrence of aggression at the following three different levels: the patient level, the staff level and the environmental level. These levels are described below.

1.2.3.1 Patient Factors

Patient factors include biological factors such as gender, age, social and economic status, involuntary admission of patients and psychopathology.

Some researchers have found males to be more assaultive (Bornstein, 1985), but others have reported no relationship between gender and violence (Lam *et al.,* 2000; Craig, 1982; Durivage, 1989; Nijman*et al.,*

1997; Kay *et al.*, 1988). In fact some studies have reported higher rates of violence among female patients (Convey, 1986; Palmstierna and Wistedt, 1989; Way and Banks, 1990). A number of researchers have found that assaults are more often committed by younger inpatients (Bornstein, 1985; Pearson *et al.*, 1986; Karson and Bigelow, 1987; James *et al*,. 1990; Whittington *et al.*, 1996). Duxbury (2004) and Nijman (2002) suggest that severe psychopathology is still thought to be a major source of inpatient aggression. Steinert et al. (2000) found a strong association between thought disorders and violent behaviour during inpatient treatment.

Intoxication with alcohol is also believed to increase the potential for violence. Lanza et al. (1994) demonstrated that over one third of assaultive patients were alcohol-dependent. Morrison (1989) suggested that the particular combination of schizophrenia and substance abuse heightens the chance of aggression.

Mania, personality disorders, substance abuse and organic brain disease are thought to be associated with a heightened level of aggressive behaviour (Tardiff, 1992). Schizophrenia or schizoaffective disorders showed that 75% of the men and 53% of the women exhibited some type of aggressive behavior during the first or subsequent admissions (Steinert*et al.*, 1999).

1.2.3.2 Staff Factors

These factors pertain to inexperience or lack of training, low staff to patient ratios and a lack of a clear role. Most of the studies on the effects of staff education and training found that training staff in how to react to threatening situations can lead to a decline in the frequency or severity of

aggressive incidents (Infantino and Musingo, 1985; Paterson *et al.*, 1992; Rixtel, 1997; Phillips and Rudestam, 1995; Whittington and Wykes, 1996). There are three levels of nursing educational degrees in Palestine:

1- diploma degree: which is a nursing study for two years (diploma). This includes less skills and knowledge.

2- baccalaureate degree: which is a nursing study for four years.

   This includes more skills and knowledge than diploma certificate specialty.

3- master degree: which is a nursing study of specialty. This includes a high level of skills and knowledge of in nursing and mental health.

A number of studies support the view that negative staff and patient relationships lead to patient aggression (Nijman et al. 1999, Duxbury 2002). Sheriden et al. (1990) found that patients commonly saw conflicts with staff as contributory, while Whittington and Wykes (1994a) suggested that certain staff are prone to being assaulted, indicating problematic rather than therapeutic relationships (Harris & Morrison 1995). Limit-setting

styles, coupled with a lack of opportunity for negotiation, are also reported to be problematic (Lancee et al. 1995), and some nurses have been accused of ‘going in strong’ (Whittington &Wykes 1994b).

1.2.3.3 Environmental factors

The environmental stimuli of aggression can be divided into two categories: physical stimuli and stimuli in the social environment. Two examples of physical environmental stimuli as antecedents of aggression are high ambient temperature (Anderson *et al.,* 2000) and noise (Geen, 1978).Duxbury (2004) found that environmental factors contribute to the incidence of aggression. Issues that have been explored include provisions for privacy and space, location, type of regime and the impact of unit design (Nijman et al. 1999). Carmel and Hunter (1993) suggested that the location of an incident was generally the result of associated organizational routines such as medication rounds, handover periods or mealtimes (Vanderslott1998).it was found that assaults occur most frequently on Mondays and Tuesdays which be as a result of an increase in nursing and medical activities after the weekend such as ward rounds and group therapy (Flannery et al. 1994). Nijman (2002) suggested that assaults can also be triggered by the denial of services or liberty. Restrictions of this nature can, in turn, affect levels and quality of interaction between staff and patients (Flannery et al. 1994).

Three broad models of causation have been identified (Duxbury 2002):

• The internal model, in which aggression is seen as being due largely to factors within the aggressive person, such as mental illness or personality.

• The external model: in which aggression is regarded as being mainly caused by factors in the person's physical or social environment, such as the physical layout of the ward, or the way in which the ward is governed by the staff.

• The situational/interactional model: in which factors in the immediate situation, such as the interaction between the patient and others, especially staff members, are seen as the most important issues to be addressed.

1.2.4 Prevention and Management of Aggressiveness

Wright (2002) propones the interactive process in which a patient is directed towards a calmer 'personal space' through effective communication, identifying the patient's stressors, and providing functional alternatives to aggression. The following elements are described:

1. Self-awareness (of personal stress, anxiety, and knowledge of the patient).

2. Knowledge of the patient, particularly the patient's usual behavior and deviations from this which might signal agitation or hostility.

3. The use of verbal and non-verbal communication skills which convey non-threatening and attentive care.

4. Sensitivity to the need to give the patient adequate personal space (which tends to be greater than normal in angry or agitated people).

5. Use of a low-pitched and calm tone of voice to enable the patient to hear and understand what is said more easily.

6. Encouraging verbal responses by the use of open questions, which provide more information than closed questions and require mental engagement (thereby possibly distracting the patient away from more violent expression of feelings).

7. Appropriate investment of time for the task.

8. Conducting the process in a quiet environment.

9. Consideration of safety factors, such as wearing appropriate and safe clothing and jewelry, other staff being aware of what is happening and being available to intervene if necessary, placement of furniture, the avoidance of confrontation during the de-escalation process itself, and the judicious use of security staff.

Turnbull et al. (1990) describe a more dynamic model of de-escalation, where skills are used more flexibly, being continued or substituted by others depending on the evaluation of the patient's response. The following skills are presented:

1. The management of others in the environment (removing other patients from the area, enlisting help from colleagues, suggesting to the aggressor that he/she moves to another area).

2. Encouraging thought by use of open questions and inquiring about the reasons for the patient's anger (to encourage the patient to focus upon the problem rather than upon acting out).

3. Giving clear, brief, assertive instructions, and negotiating options, while avoiding threats, inviting assault (e.g. "You want to hit me? Go ahead and try, then!"), or making promises that cannot be kept.

4. Paying attention to non-verbal cues such as eye contact, allowing greater body space, using a posture that is orientated at 45o (rather than face-to-face),adopting an open posture with hands by the sides

with the palms facing outwards, and avoiding staring or provocative non-verbal behaviours such as folding the arms across one's chest or keeping the hands behind one's back or in one's pockets.

5. Personalizing oneself and emphasizing co-operation.

6. Showing concern and attentiveness through non-verbal and verbal prompts (e.g. head nodding, and phrases such as "Go on...", "I see...",etc.).

7. Mood matching (matching the person's level of arousal but not the emotion that is displayed).

1.2.5 Problem Statements

The incidence of psychiatric patient aggression is reportedly increasing and approaches used to manage patient aggression and violence are under-evaluated. Staff and particularly users' views on this matter are rarely explored.

The reported rise of patient aggression in mental health inpatient settings has been of interest to researchers for some time (Rippon 2000), and a number of theories have been developed that Endeavour to explain the causes. The case for the 'internal model' has been a strong one and numerous studies have explored an association between aggression and illness (Link &Stueve 1995). External model asserts that environmental factors contribute to the incidence of aggression. Issues that have been explored include provisions for privacy and space, location, type of regime and the impact of unit design (Nijman et al. 1999).

A number of studies support the view that negative staff and patient relationships lead to patient aggression (Nijman et al. 1999). Sheriden et al. (1990) found that patients commonly saw conflicts with staff as contributory. Whittington and Wykes (1994a) suggested that certain staff are prone to being assaulted, indicating problematic rather than therapeutic relationships (Harris & Morrison 1995).

Nurses who participated in this study have more interactions with patients without a clear role for nurses, no specialized psychiatric nurses and no

clear psychiatric policy to control nurse - patients' aggression. So it is important to investigate how they handle these patients and their attitude and practice against aggression of psychiatric patients. The current study might be the first study in Palestine that assess nurse-patient's aggression.

It is therefore important to conduct a study to examine the complex interplay of variables and address their impact when managing aggression in healthcare settings.

The aims of the current study are to assess nurse's practices and attitudes of inpatient psychiatric aggression.

Chapter 2
Literature Review

2.1 Frequency of Aggression

Aggression is a serious problem in society as well as in health care settings. Psychiatric patients need special care and treatment; to achieve this, patients need a positive health team attitude toward them to avoid feelings of inferiority and stigmatization, which lead to aggressiveness. Bjorkly (1996) estimated that 15% to 30% of hospitalized psychiatric patients have been involved in physical assaults. Another study performed in the Netherlands found prevalence rates of aggression ranging from 22.8 incidents per bed per year on locked admission wards to 17.6 incidents per bed per year on the long-stay wards (Broers and De Lange, 1996). Nijman (1999) reviewed a substantial number of descriptive studies on the epidemiology of the aggressive incidents and found a considerable range in the number of incidents, from 0.15 assaults per bed per year (Fottrell, 1980) to 88.8 incidents per bed per year (Brizer*et al.* 1987). Hou and Liao (1983)found that 18 of 19 Taiwanese nurses (94.7%) working in acute psychiatric wards had to use aggression management or had suffered from direct aggressive behaviors from inpatients and that 95% of them were physically injured. No national data bases are available to provide such data in Palestine.

2.2 Etiology of Aggression

Aggression of psychiatric patients has many causes, one of which is the psychiatric status itself. Lanza et al. (1994) demonstrated that over one third of assaultive patients were alcohol-dependent. Morrison (1989) suggested that the particular combination of schizophrenia and substance abuse heightens the chance of aggression. This was supported by the Royal College of Psychiatrists (RCP, 1998), who reported that young men with psychiatric illness and a history of substance abuse are most likely to be violent. Nijman (2002) suggested that assaults can also be triggered by a denial of services or liberty. A convenience sample of 80 patients and 82 nurses from three inpatient mental healthcare wards were surveyed using The Management of Aggression and Violence Attitude Scale. A further five patients and five nurses from the same sample participated in a number of follow-up interviews. They found that patients perceived environmental conditions and poor communication to be a significant precursor of aggressive behaviour. Nurses, in comparison, viewed the patients' mental illnesses to be the main reason for aggression, although the negative impact of the inpatient environment was recognized. From interview responses, it was evident that both sets of respondents were dissatisfied with a restrictive and under-resourced provision that leads to interpersonal tensions, (Duxbury, 2005). A study of the perception of aggression found that nurses working on wards where constraint measures were not applied proved to be more positive about the functional dimension of aggression than nurses on

wards where fixation and separation occurred. This finding could be explained by assuming that the nurses who worked on a ward where seclusion and fixation were applied intervened this way because aggression of patients manifested itself by violent behaviour. Nurses, however, who did not use constraint measures on their wards, because aggression was not manifested by the use of violence, perceived aggression as being more normal and functional.

So, if aggression is perceived as violent behaviour, nurses will report the occurrence of this aggressive incident. However, if aggression is perceived as normal or functional behaviour, the signs or symptoms of aggression will be observed by nurses, but probably they would be less encouraged to intervene and to report these types of 'aggressive' acts, (Jansen et al. 1997).

Theories of aggression

Social Learning Theory – Bandura

The potential for aggression is biological, but the expression of aggression is learnt. The social learning theory states that behaviours such as aggression can be learnt through observation. If a person observes aggressive behaviour in a model, they may imitate this behaviour. Imitation is more likely if they identify with or admire the model, or if the model is rewarded or succeeds. This is vicarious reinforcement. For social learning to take place, Bandura suggested that a child must form a mental

representation of the event. This includes the possible rewards or punishments for a behaviour. When a child imitates an aggressive behaviour, the outcome of this behaviour influences the value of aggression for the child. If they are rewarded, they are likely to repeat the behaviour. This is maintenance through direct experience. Children develop self-efficacy, which is confidence in their ability to carry out aggressive actions. If aggressive behaviours are unsuccessful, they will have a low sense of self-efficacy, so will not continue the behavior (Bandura, 1977)

Deindividuation Theory – Zimbardo

Fraser and Burchell define de-individuation as "a process whereby normal constraints on behaviour are weakened as persons lose their sense of individuality". De-individuation occurs when an individual joins a large crowd or group. Anonymity, e.g. uniforms, and drugs or alcohol also contribute to de-individuation. Individual behaviour is rational and conforms to social standards. De-individuated behaviour is based on primitive urges and doesn't conform to social norms. Anonymity leads to reduced inner restraints, and therefore an increase in behaviours that are usually inhibited, such as aggression. Originally, de-individuation was thought to be due to the lack of accountability that accompanies being in a large group of people. More recently, the theory has focused on the importance of reduced private self-awareness rather than public self-awareness. Prentice-Dunn and Rogers suggested that being in a crowd makes people less self-focused, so less able to regulate their behaviour

according to their internalized attitudes and moral standards (Zimbardo, 1969).

Biological theory

Temperature may be causally linked to other factors, which in turn are causally linked to aggression. Cohen and Felson's Routine Activity Theory states that opportunities for interpersonal aggression increase in summer as people change their routine activity pattern, e.g. they are more likely to be outside and so come into contact with more people, and there is an increase in alcohol consumption in summer. Biological psychologists offer alternative explanations of aggression to social and behaviourist psychologists. Instead of pointing towards the environment an individual is in as the cause for aggression, they instead claim that violence can stem from genes, hormonal mechanisms and neural mechanism. The neurotransmitters dopamine and serotonin in particular have been linked to aggression when levels of the former are high, and levels of the latter are low. Dopamine has been linked to aggression due to it's association with pleasure. It is the neurotransmitter stimulated after eating certain foods or sexual intercourse, and has been found to become more abundant after violent behaviour. Therefore, the 'reinforcing' nature of dopamine could cause violent behaviour. Increases in dopamine activity have also been shown to increase aggression, as evidenced in the use of amphetamines, which stimulate dopamine. Serotonin's function in the brain is to inhibit the firing of other neurons, especially in the prefrontal cortex, which is the area

in our neuro anatomy responsible for cognitive reasoning and social behaviour, among other things. It is the area where our morals are reasoned and the consequences of our actions are considered. Hormones such as testosterone and cortisol are also frequently linked with aggressive behavior (Ferrari et al., 2003).

2.3 Attitude and Practice of Nurses toward Aggression

In a study that assessed attitudes of health professionals towards patient aggression in psychiatry, the researchers analyze three types of attitudes toward aggression: the harming, the normal, and the functional evaluation of the behaviour. These attitudes were constructed by labeling three groups of statements taken mainly from interviews with psychiatric nurses (Finnema*et al.* 1994), together with some definitions of aggression found in the literature. The labels to denote the three types of attitudes were chosen in such a way that they would cover the underlying items best from a semantic point of view rather than from a theoretical perspective. In the literature, typologies of aggression are mentioned that match the labels developed in this study to a certain extent. Affective aggression is behaviour aimed primarily at injuring the provoking person, and it is accompanied by strong negative emotional states. This type of aggression comes close to what we called ‘the harming reaction’. What we labeled the functional reaction could be rephrased instrumental aggression, meaning a person is aggressive not in order to hurt another person but simply as a means to some other end. What we called the normal reaction could be

compared to what is called reactive aggression, i.e. reactive in the sense that it is enacted in response to provocation such as an attack or an insult (Geen, 2001).

Whichever label one prefers to choose, ‘normal’ or ‘reactive’, respondents appraised aggression not only as affective or instrumental aggressive behaviour with the intent to harm. The study found that the more often nurses used restraining interventions, and they evaluated aggression as harmful. On the other hand, the normal and functional attitudes were related to a more permissive strategy for managing aggression (Broers and De Lange, 1997). This could explain why an underestimate of the true prevalence of aggressive incidents is mentioned in many studies, since aggressive incidents perceived as normal or functional behaviour are not likely to be reported by nurses.

Significant differences were found between the mean factor scores of male and female nurses about the attitude towards aggression corresponding with the normal reaction. More male nurses than their female colleagues considered aggression to be a normal reaction. This is consistent with the findings of other studies which concluded that aggression is considered as inappropriate by females more often than males (Frodi*et al.,* 1977). However, female nurses approved of the functionality (instrumentality) of aggressive behaviour more than the males. The study showed that the most experienced nurses supported the attitude of aggression as a functional reaction less often than novice nurses (Jansen et

al. 2005). In a Nigerian study of patient aggression in psychiatric services it was found that nurses viewed aggression as offensive, destructive and intrusive. They were less likely to view it as a means of communication or serving protective functions. Verbal aggression was the most common type of aggression experienced while sexual intimidation and suicide attempts were least common. Male nurses were more likely to experience physical violence and aggressive 'splitting' behaviours, while nurses with over a decade of professional experience were more likely to experience verbal and humiliating aggressive behaviours. In contrast to previous studies, this study showed that fewer nurses required days off work due to aggressive behavior (James, et al. 2010). Ahmead et al**. (**2010)explores the attitudes of mental health staff working in the only psychiatric hospital in Palestine toward patients with mental illnesses. The majority of the respondents were nurses; most of the participants showed negative attitudes about psychiatric patients and their opinion was that members of society are at risk from those with mental illness (74.4%) and that people with mental illness have no control over their emotions (73%). Also, 79.5% of the respondents suggested that it is difficult to negotiate care plans with patients in acute inpatient mental health environments and that alcohol abusers have no self control. Previous studies have shown that 47% of mental health workers used medication, restraint or seclusion in the treatment of patients (Duxbury 2002) and they were comfortable with the use of seclusion as an adjunctive treatment in the management of patients considered to be 'out of control' (Eimear & Adult 1996). Eighty six of the participants agreed that

psychiatric drugs were used to control behavior, which is consistent with Foster's study (2008), in which 91.3% of mental health workers agreed with this statement.

3. Study Aims and Significance

Aim of the study

To assess nurses' practices and attitudes toward inpatient psychiatric aggression.

objectives

- To assess the way nurses handle aggression by patients.

- To assess the effects of patient, staff and environmental factors on the occurrence of aggression.

4. Significance of the study

1. This study is might be the first of its type in Palestine. Therefore, this study will give baseline data and information about the attitude of nurses toward aggressive psychiatric inpatients.

2. Exploration of the ways the nurses use to deal with aggressive patients and comparison to the right alternative methods.

3. This study may stimulates the administrators to make a change in psychiatric settings in Dr. Kamal Psychiatric Hospital.

Chapter 3
Methodology

3.1. Design: A cross sectional study to provide data on the entire population under study

3.2. Setting: Bethlehem (Kamal Adwan) Psychiatric Hospital in Palestine**.**

Justification for using this hospital because It is the only psychiatric hospital in Bethlehem, West Bank. This hospital provides treatment and care to patients with a variety of mental health problems .

3.3. Study period: August 2012 to May 2014

3.4. Study population*:* All nurses (n = 67) who work in Dr. Kamal Adwan psychiatric hospital in Bethlehem in Palestine.

3.5. Inclusion Criteria

- Nurses who work at Dr Kamal Adwan psychiatric hospital in Bethlehem

- Nurses who work at Dr. Kamal Adwan psychiatric hospital in Bethlehem for a year and more

3.6. Exclusion Criteria

- Nurses working in primary mental health centers

- Nurses who work with less than 1 year experience in hospital

3.7. Sample size and sampling

A convenience sampling method was adopted, all the mental health care nurses in Bethlehem psychiatric hospital who have worked at least one year at the time of the study were enrolled, n=67 nurses; 30 female nurses and 37 male nurses.

3.8. Study variables

Dependent variables

Nurses attitudes towards inpatients aggression

Independent variables: inpatients aggression

Independent variables: Characteristics of nurses: including age, sex, department, scientific level, job satisfaction and work shift.

3.9. Measurement tool

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, duration of experience in mental health nursing, work shift, job satisfaction, scientific level and work place.

Section B: Attitudes toward aggression scale (ATAS) which was developed by Collins (1994) which consist of 47 statements about aggression, This 47-item self report scale designed for the assessment of

staff attitudes toward in-patient aggression (appendix 1). The 47 statements on the ATAS comprise relevant themes on aggression with response options varying on a 5-point Likert scale from totally agree (5) to totally disagree (1). This scale comprises eight sub-scales: offensive attitude (seeing aggression as unpleasant, hurtful and an unacceptable behaviour); communicative attitude (aggression as a signal resulting from a patient's powerlessness aimed at enhancing a therapeutic relationship); destructive attitude (aggression as a threat or act of physical harm); protective attitude (aggression as shielding or defending of physical and emotional space), intrusive attitude (viewing aggression as the expression to damage or injure others), normal reaction (viewing aggression as a normal reaction from the patient because of his mental condition, functional attitude (considering aggression as an opportunity to focus on the patient conditions) and harmful attitude (viewing aggression as an assault reaction).

ATAS questionnaire was developed that intended to determine " Attitudes toward aggression scale ". The questionnaire consisted of 47-item self report scale designed for the assessment of staff attitudes toward in-patient aggression (i.e., 47 "items"). A total of 67 participants completed the questionnaire. Each question was measured using a 5-point Likert item from "strongly disagree" to "strongly agree". In order to understand whether the questions in this questionnaire were internally consistent, a Cronbach's alpha was run. In this study the ATAS was found to be a fairly reliable questionnaire with a Cronbach's alpha of 0.732. Also, factor

analysis was used showed that all the items have an extraction coefficient greater than 0.5. So, it is concluded that the questionnaire has a very high level of validity (see Appendix 3). The test-retest reliability of the items in the questionnaire used by Collins was 0.972 (Collins, 1994). The permission for the ATAS was obtained from the author through e-mail.

Section C: Management of Aggression and Violence Scale; MAVAS

The Management of Aggression and Violence Attitude Scale (MAVAS) was developed by Joy Duxbury (2005). It consists of 27 statements about the factors related to and management of aggression and violence according to the attitudes of nurses (appendix 2). It is divided into: Internal causative factors, External causative factors, Situational/interactional causative factors, Management: general, use of medication, use of seclusion, use of restraint, and non-physical methods. Test-retest reliability of the MAVAS revealed a correlation co-efficient of 0.894 using Pearson's r, indicating good reliability.

3.10. Validity and Reliability of the Two Questionnaires (Arabic language)

First , ATAS and MAVAS were translated by a fluent and expert English certificate translator and by a psychiatrist. The validity of the translation was checked by a committee of four experts in : clinical psychology, psychiatry and mental health nursing. The questionnaire was also back translated by an independent researchers as an additional check.

Secondly, for content validity the questionnaire was tested for its content by tenth professionals health team (four psychiatric doctors and four psychiatric nurses, one researcher and one statistician). They were asked to judge whether the questions were appropriate, understandable, reasonable and compatible to the English version. The questionnaire was pretested as a pilot study of tenth mental health nurses working in the governmental mental health centers, who completed the questionnaire twice at weekly intervals and the test-retest of the ATAS was 0.732 and the test-retest of the MAVAS was 0.869. These questionnaires were not included in the study.

3.11. Procedures and Data collection

The study used a cross-sectional survey sample approach. An institutional review board was approved by An-Najah National University specifying the aims, methods, and subjects involved in the research project. The Palestinian Ministry of Health and the administration of the psychiatric hospital were approached by the main researchers and agreed to the study. Data collection was carried out after informed consent from the nurses. Data were obtained by means of questionnaires (ATAS & MAVAS). The way the sample was accessed was a convenient sample. This was a group of nurses working on the wards in a psychiatric hospital where the member of the group was employed for at least one year. Sixty seven nurses from six different psychiatric wards were participated, The anonymous questionnaires were then individually hand delivered by the researcher in the hospital to all nurses working on the selected wards after taking their

consent to participate in the study. The questionnaires were accompanied by an information sheet explaining the purpose of the study and endorsing the right of the participants not to participate. After completing the questionnaire, the nurses were requested to return it to the contact person in the hospital. ATAS questionnaire was intended to determine " Attitudes toward aggression scale ". The questionnaire consisted of 47-item self report scale designed for the assessment of staff attitudes toward in-patient aggression (i.e., 47 "items"). A total of 67 participants completed the questionnaire. Each question was measured using a 5-point Likert item from "strongly disagree" to "strongly agree". In order to understand whether the questions in this questionnaire were internally consistent, a Cronbach's alpha was run. Also, MAVAS questionnaire was intended to determine "Management of Aggression and Violence Attitude Scale", which consisted of 27 items self reported scale designed for the assessment of nurses practices toward in-patient aggression. A total of 67 participants completed the questionnaire. Each question was measured using a 5-point Likert item from "strongly disagree" to "strongly agree". In order to understand whether the questions in this questionnaire were internally consistent, a Cronbach's alpha was run.

3.12 Analysis plan:

The data were analyzed using the Statistical Package for the Social Sciences (SPSS 17.0 for Windows). The level of significant was $p \leq 0.05$. Descriptive analyses, percentages, means and standard deviations were

calculated for socio demographic variables and attitude variables. After collecting questionnaires, the researcher entered the responses into the computer by recoding answers to numeric values, 5 degrees given for strongly agree answers, 4 degrees given for agree answers, 3 degrees given for neutral answers, 2 degrees given for disagree answers and 1 degree given for strongly disagree answers.

The Statistical methods used in answering questions:

1. Frequencies and Percentages to describe the personal variables.
2. Extraction Coefficients with Factor analysis method to measure the validity of ATAS and MAVAS.
3. Alpha (Cronbach) and Split-half reliability scales to measure the Reliability of MAVAS and ATAS.

One sample t- test was used to assess nurses attitudes and practices toward aggression management.

In order to study differences in attitudes by the nurses characteristics variables (age, the years of experience, the scientific degree, the wards of work and job satisfaction), One Way Analysis Of Variance (ANOVA) test was used.

In order to study differences in attitudes by the sex variable and work shifts, independent samples T-test was used.

3.13 Ethical Consideration

The study was approved by the Palestinian Ministry of Health, Dr. Kamal Psychiatric Hospital administration and An-Najah National University's the Institutional Review Board. Dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of the participants were considered. Participants were adequately informed of the aims, methods, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail.

Also participants were informed the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention was given to the specific information needs of participants as well as to the methods used to deliver the information. After ensuring that the participants understood the information, the researcher sought the participants' freely-given informed consent in writing. The participants who consented to participate signed an informed consent. Data was collected by using the questionnaire. In addition, Participants were informed that the data would be used only for research purposes. Considerations were based on the Helsinki Agreement (World Medical Association. Helsinki Declaration, 2008) on ethical guidelines for nursing research on volunteerism, to withdraw from the study, potential risks or discomfort, anonymity, confidentiality and contacts for any information needed.

Research questions

Q.1. What is the attitude of nurses toward inpatient aggression?

Q.2. What are the effects of: internal causative factors, external causative factors and situational/interactional factors on the attitude of nurses toward inpatient aggression? This question is from the MAVAS scale.

Q.3. How do nurses manage aggression by patients?

Q.4. What is the relationship between attitude of nurses toward inpatient aggression and their ages, their level of education, their gender, their ward of work, their scientific grade, their job satisfaction and their work shift?

Q.5. What is the relation between practice toward aggression management and nurses ages, and their level of education, gender, ward of work, scientific grade, job satisfaction and work shift?

Chapter 4
Results

Of a total of 67 questionnaires were sent out to the nurses in the mental hospital and 67 questionnaires were subsequently returned (100% response rate).

4.1 Socio-Demographic Characteristics

For gender, 44.8% (n=30) were females and 55.2% (n=37) were males, Their ages ranged between 20 and 50 years, with the mean age for males 35.2 and the mean age for females34.97, Also, the average duration of professional experience was 13.4 (±8.5) years and The duration of professional experience ranged from 1 to 30 years. The demographic and work-related data of the sample are presented in Table 1.

Regarding age, the percentage of the most common category is > 40, which is 50.7% (Table 1).

For years of experience in the psychiatric hospital, the proportion of the most common category is > 15 years, which is 32.8% (Table 1).

With regard to the ward of work, 25.4% of the participants were in the male admission unit, 16.4% were in the female admission unit, 13.4%were in the female rehabilitation unit, 17.9% were in the male rehabilitation unit, 13.4% in the male chronic unit and 13.4% were in the female chronic unit (Table 1).

67.2% of the participants were had a diploma degree, 28.4% were had baccalaureate degree, and 4.5% had Master of Mental Health (Table 1).

With regard to the job Satisfaction, 32.8% were satisfied, 26.9% were not satisfied, 7.5% did not like to work in this hospital and 32.8% were neutral (Table 1).

Finally, 13.4% of the participants had morning duty and 86.6% had all shifts (Table 1).

Table.1. Demographic data of the participants

	Variable category	Frequency	Percentages
Age	Less than 30	23	34.3
	30_40	10	14.9
	More than 40	34	50.7
	Total	67	100.0
Years of experience in the psychiatric hospital	1_3 years	12	17.9
	4_8 years	19	28.4
	9_15 years	14	20.9
	Over 15 years	22	32.8
	Total	67	100.0
Sex	Male	37	55.2
	Female	30	44.8
	Total	67	100.0
The ward of work	Male admission unit	17	25.4
	Female admission unit	11	16.4
	Female rehabilitation unit	9	13.4
	Male rehabilitation unit	12	17.9
	Male chronic unit	9	13.4
	Female chronic unit	9	13.4
	Total	67	100.0
Scientific degree	Diploma degree	45	67.2
	Baccalaureate degree	19	28.4
	Master of Mental	3	4.5

	Health		
	Total	67	100.0
Job Satisfaction	Satisfied	22	32.8
	Not satisfied	18	26.9
	Doesn't like to work in this hospital	5	7.5
	Neutral	22	32.8
	Total	67	100.0
Work Shift	Morning	9	13.4
	All Shifts	58	86.6
	Total	67	100.0

4.2 Results Based on ATAS:

4.2.1 Attitudes toward Inpatient Aggression

As shown in the table (2), The mean scores (± SD) for the sample on each of the eight subscales in the perception of aggression part of the ATAS indicated that they considered inpatient aggression to be: highly destructive; 4.12 (±0.7), offensive; 3.99 (± 0.87), violent reaction; 3.96 (± 80.85), intrusive 3.71 (±0.93), functional reaction ; 3.52 (±0.97). All the result of the one sample t- test were statistically significant except acceptable normal reaction (p=0.28).

Table 2: The means and standard deviations for ATA S subscales

Scale	N	Mean	Standard deviation	T	Df	Sig.
a) acceptable normal reaction	67	3.11	0.85	1.08	66	0.28
b) violent reaction scale	67	3.96	0.66	11.88	66	0.00
c) functional reaction scale	67	3.52	0.70	6.07	66	0.00
d) offensive	67	3.99	0.74	10.87	66	0.00
e) Communicative	67	2.63	1.01	-3.02	66	0.00
f) Destructive	67	4.12	0.68	13.61	66	0.00
g) Protective	67	3.28	0.95	2.45	66	0.02
h) Intrusive	67	3.71	0.75	7.75	66	0.00
Total degree of Perception of aggression	67	3.57	0.47	9.85	66	0.00

In order to study the perception of aggression as an acceptable normal reaction, one sample t-test was used and the results are as the following (Table 3): The following items have significant agreement($p< 0.05$):is all human energy necessary to attain one's end , reveals another problem the nurse can take up, is a normal reaction to feelings of anger, an adaptive reaction to anger, must be tolerated. Also, The following items have significant disagreement($p< 0.05$): improves the atmosphere on the ward; it is beneficial to the treatment

Table 3. Perception of aggression as an acceptable normal reaction

No	Item	mean	Standard deviation	t	p-value
1	has a positive impact on the treatment .	3.01	1.11	0.11	0.91
2	is constructive and consequently acceptable .	2.96	1.08	-0.34	0.74
3	is all human energy necessary to attain one's end .	3.33	1.20	2.24	0.03
4	is necessary and acceptable .	2.84	1.14	-1.18	0.24
5	reveals another problem the nurse can take up .	3.64	1.08	4.85	0.00
6	improves the atmosphere on the ward; it is beneficial to the treatment .	2.70	1.18	-2.07	0.04
7	is an acceptable ways to express feelings .	2.75	1.16	-1.79	0.08
8	is communicative and as such not destructive .	2.84	1.11	-1.21	0.23
9	is a normal reaction to feelings of anger .	3.51	1.16	3.58	0.00
10	is constructive behavior .	2.97	1.18	-0.21	0.84
11	an adaptive reaction to anger .	3.42	1.16	2.96	0.00
12	must be tolerated .	3.39	1.11	2.85	0.01
	Total	3.11	1.17	1.08	0.28

In order to study the perception of aggression as a violent reaction, one sample t-test was used and the results are as the following (Table 4)**:** All items in the table have significant agreement of aggression as a violent reaction($p<0.05$).

Table 4. Perception of aggression as a violent reaction.

No	Item	mean	Standard deviation	T	p-value
1	is violent behavior to others and self .	4.03	0.80	10.57	0.00
2	is directed at objects or self .	3.99	0.90	9.00	0.00
3	is to beat up another person through words or actions .	3.96	0.84	9.28	0.00
4	is threatening others .	4.27	0.66	15.62	0.00
5	is an inappropriate, non adaptive verbal/physical action .	3.99	0.83	9.77	0.00
6	is a disturbing interference to dominate others .	3.88	0.88	8.20	0.00
7	is to hurt others mentally or physically .	3.78	0.93	6.80	0.00
8	is a physical violent action .	3.87	0.97	7.32	0.00
9	is used as a means of power by the patient .	4.04	0.59	14.53	0.00
10	is every expression that makes someone else feel unsafe, threatened or hurt .	3.85	0.89	7.81	0.00
11	verbal aggression is calling names resulting in hurting .	3.87	0.95	7.44	0.00
	Total	3.96	0.85	11.88	0.00

In order to study the perception of aggression as a functional reaction, one sample t-test was used and the results are as the following (Table 5)**:** All items in the table have significant agreement($p< 0.05$).

Table 5. perception of aggression as a functional reaction.

No	Item	mean	Standard deviation	t	p-value
1	is an expression of emotions, just like laughing and crying .	3.43	0.97	3.64	0.00
2	is an emotional outlet .	3.40	0.99	3.35	0.00
3	offers new possibilities for the treatment .	3.69	0.91	6.19	0.00
4	is an opportunity to get a better understanding of the patient's situation .	3.46	0.93	4.09	0.00
5	a way to protect yourself .	3.64	0.92	5.73	0.00
6	will result in the patient quietening down .	3.48	1.08	3.63	0.00
	Total	3.52	0.97	6.07	0.00

In order to study the perception of aggression as an offensive reaction, one sample t-test was used and the results are as the following (Table 6)**:** All items in the table have significant agreement($p < 0.05$).

Table 6. Perception of aggression as an offensive reaction.

No	Item	Mean	Standard deviation	T	p-value
1	is destructive behavior and therefore unwanted	3.97	0.92	8.63	0.00
2	is unnecessary and unacceptable behavior	3.96	0.86	9.09	0.00
3	is unpleasant and repulsive behavior	4.12	0.77	11.91	0.00
4	is an example of a non-cooperative attitude	4.10	0.74	12.20	0.00
5	poisons the atmosphere on the ward and obstructs treatment	4.03	0.85	9.89	0.00
6	in any form is always negative and unacceptable	4.01	0.84	9.85	0.00
7	cannot be tolerated	3.70	1.04	5.50	0.00
	Total	3.99	0.87	10.87	0.00

In order to study the perception of aggression as a communicative reaction, one sample t-test was used and the results are as the following (Table 7)**:** The following items have significant disagreement($p<0.05$), offers new possibilities in nursing care and is the start of a more positive nurse relationship.

Table 7.Perception of aggression as a communicative reaction.

No	Item	Mean	Standard deviation	T	p-value
1	offers new possibilities in nursing care	2.64	1.14	-2.58	0.01
2	helps the nurse to see the patient from another point of view	2.79	1.25	-1.37	0.18
3	is the start of a more positive nurse relationship	2.45	1.03	-4.37	0.00
	Total	2.63	1.15	-3.02	0.00

In order to study the perception of aggression as a destructive reaction, one sample t-test was used and the results were as the following (Table 8)**:** All items in the table have significant agreement(p <0.05).

Table 8. Perception of aggression as a Destructive reaction.

No	Item	mean	Standard deviation	T	p-value
1	is when a patient has feelings that will result in physical harm to self or to others	4.15	0.70	13.40	0.00
2	is violent behavior to others or self	4.04	0.84	10.15	0.00
3	is threatening to damage others or objects	4.18	0.78	12.42	0.00
	Total	4.12	0.77	13.61	0.00

In order to study the perception of aggression as an offensive reaction, one sample t-test was used and the results were as the following (Table 9)**:** All items in the table have significant agreement(p <0.05).

Table 9. Perception of aggression as a protective reaction.

No	Item	mean	Standard deviation	t	p-value
1	is to protect oneself	3.30	1.04	2.34	0.02
2	is the protection of one's own territory and privacy	3.27	1.01	2.18	0.03
	Total	3.28	1.02	2.45	0.02

In order to study the perception of aggression as an intrusive reaction, one sample t-test was used and the results are as the following (Table 10)**:** All items in the table have significant agreement(p <0.05).

Table 10.Perception of aggression as an intrusive reaction.

No	Item	mean	Standard deviation	t	p-value
1	is a powerful, mistaken, non-adaptive, verbal and/or physical action done out of self-interest	3.66	0.96	5.59	0.00
2	is expressed deliberately, with the exception of aggressive behavior of someone who is psychotic	3.66	0.96	5.59	0.00
3	is an impulse to disturb and interfere in order to dominate or harm others	3.81	0.87	7.54	0.00
	Total	3.71	0.93	7.75	0.00

4.3 Results Based on MAVA Scale

After using t-test for MAVA result, the mean scores (± SD) for the sample on each of the eight subscales in the practice of aggression part of the MAVAS indicated inpatient aggression to be highly related to interactional causative factors 3.9 (0.77), external causative factors 3.89 (0.81) and internal causative factors 3.34 (1.18) (see table .11)and that nurses believe in management as the use of seclusion 3.64 (1.01), management as the use of medication 3.58 (1.08), management as the use of non-physical methods 3.5 (1.13), management as the use of restraint 3.37 (1.17) and management in general 3.36 (1.04)(see table.15).

4.3.1The effects of internal, external, situational causative factors on the attitude of nurses toward inpatient aggression? This question is from MAVAS scale.

As noted from the table (11) , this table show that the perception of nurses about the causative factors that increases the inpatient aggressivity.

Table 11.The number, means and standard deviation for the answers of respondents in the item of Internal , external and situational causative factors.

Scale	N	Mean	T	d.f	Sig.
i) Internal causative factors	67	3.34	5.02	66	0.00
j) External causative factors	67	3.98	12.37	66	0.00
k) Situational/interactional causative factors	67	3.90	12.31	66	0.00
Total degree of patient factors	67	3.70	12.53	66	0.00

In order to study the perception of the aggression's internal causative factors, one sample t-test was used and the results are as the following (Table 12)**:** All items have significant agreement (p-0.00) except the item(Aggressive patients will calm down if left alone) which has significant disagreement($p < 0.05$).

Table 12. Perception of aggression's internal causative factor.

No	Item	mean	Standard deviation	t	p-value
1	It is difficult to prevent patients from becoming aggressive	3.46	1.18	3.20	0.00
2	Patients are aggressive because they are ill	3.57	0.97	4.77	0.00
3	There are types of patient who are aggressive	3.93	0.88	8.65	0.00
4	Patients who are aggressive should try to control their feelings	3.40	1.06	3.11	0.00
5	Aggressive patients will calm down if left alone	2.33	1.17	-4.69	0.00
	Total	3.34	1.18	5.02	0.00

In order to study the perception of aggression's external causative factors, one sample t-test was used and the results were as the following (Table 13)**:** All items in the table have significant agreement($p < 0.05$).

Table 13.Perception of aggression's external causative factors.

No	Item	mean	Standard deviation	t	p-value
1	Patients are aggressive because of the environment they are in	3.85	0.91	7.66	0.00
2	Restrictive environments can contribute towards aggression	4.13	0.69	13.38	0.00
3	If the physical environment were different, patients would be less aggressive	3.96	0.81	9.70	0.00
	Total	3.98	0.81	12.37	0.00

In order to study the perception of aggression's situational causative factors, one sample t-test was used and the results were as the following (Table 14)**:** All items in the table have significant agreement($p < 0.05$).

Table 14. Perception of aggression's situational/interactional causative factors.

No	Item	mean	Standard deviation	t	p-value
1	Other people make patients aggressive or violent	3.97	0.70	11.42	0.00
2	Patients commonly become aggressive because staff do not listen to them	3.72	1.01	5.79	0.00
3	Poor communication between staff and patients leads to patient aggression	3.81	0.78	8.42	0.00
4	20. Improved one to one relationships between staff and patients can reduce the incidence of aggression	3.99	0.69	11.77	0.00
5	23. It is largely situations that can contribute towards the expression of aggression by patients	4.01	0.62	13.50	0.00
	Total	3.90	0.77	12.31	0.00

4.3.2. Nurses attitudes and practices toward aggression management

From Table (15), it is noted by the results of one sample t-test that the nurses were used different approaches to deal with aggrissivity, Also they use medications, seclusion, restraint and no-physical methods to deal with aggression.

Table 15. The number, means and standard deviation of Management: in general, use of medication, use of seclusion, restraint and non-physical methods.

Scale	N	Mean	Standard deviation	t	df	Sig.
l) Management: general	67	3.36	0.94	3.12	66	0.00
m) Management: use of medication	67	3.58	0.44	10.82	66	0.00
n) Management: use of seclusion	67	3.64	0.49	10.61	66	0.00
o) Management: restraint	67	3.37	0.53	5.69	66	0.00
p) Management: non-physical methods	67	3.50	0.44	9.22	66	0.00
Total degree of the nurses attitudes toward the aggression management	67	3.51	0.31	13.55	66	0.00

In order to study the perception of aggression's management: general, one sample t-test was used and the results were as the following (Table 16)**:** All items in the table have significant agreement($p < 0.05$).

Table 16. Perception of aggression's Management: general.

No	Item	mean	Standard deviation	t	p-value
1	Different approaches are used on the ward to manage aggression	3.45	1.02	3.60	0.00
2	Patient aggression could be handled more effectively on this ward	3.27	1.05	2.09	0.04
	Total	3.36	1.04	3.12	0.00

In order to study the perception of aggression's management: use of medications, one sample t-test was used and the results were as the following (Table 17)**:** The following items have significant agreement ($p < 0.05$): Medication is a valuable approach for treating aggressive and violent behavior and prescribed medication should be used more frequently

for aggressive patients. But the item (Prescribed medication can sometimes lead to aggression) has significant disagreement (p=0.00).

Table 17. Perception of aggression's Management: use of medication.

No	Item	mean	Standard deviation	t	p-value
1	Medication is a valuable approach for treating aggressive and violent behavior	4.04	0.88	9.74	0.00
2	Prescribed medication can sometimes lead to aggression	2.60	1.00	-3.30	0.00
3	Prescribed medication should be used more frequently for aggressive patients	4.09	0.54	16.42	0.00
	Total	3.58	1.08	10.82	0.00

In order to study the perception of aggression's management: use of seclusion, one sample t-test was used and the results were as the following (Table 18)**:** The following items have significant agreement($p< 0.05$): When a patient is violent seclusion is one of the most effective approaches and The practice of secluding violent patients should be discontinued.

Table 18. Perception of aggression's management: use of seclusion.

No	Item	mean	Standard deviation	t	p-value
1	When a patient is violent seclusion is one of the most effective approaches	4.09	0.85	10.52	0.00
2	The practice of secluding violent patients should be discontinued	3.91	0.69	10.79	0.00
3	Seclusion is sometimes used more than necessary	2.91	1.03	-0.71	0.48
	Total	3.64	1.01	10.61	0.00

In order to study the perception of aggression's management: restraint, one sample t-test was used and the results were as the following (Table 19)**:** The item (Patients who are violent are restrained for their own safety) have significant agreement (p=0.00), but the item(Physical restraint is sometimes used more than necessary) have significant disagreement ($p<0.05$).

Table 19. Perception of aggression's management: restraint.

No	Item	mean	Standard deviation	t	p-value
1	Patients who are violent are restrained for their own safety	4.24	0.63	16.10	0.00
2	Physical restraint is sometimes used more than necessary	2.49	0.89	-4.65	0.00
	Total	3.37	1.17	5.69	0.00

In order to study the perception of aggression's management: none-physical methods, one sample t-test was used and the results were as the following (Table 20)**:** These items have significant agreement($p< 0.05$), alternatives to the use of containment and sedation to manage physical violence could

be used more frequently, expressions of anger do not always require staff intervention and negotiation could be used more effectively when managing aggression and violence. Also, The following item have significant disagreement (p=0.03),The use of de-escalation is successful in preventing violence.

Table 20. Perception of aggression's Management: non-physical methods.

No	Item	mean	Standard deviation	t	p-value
1	Negotiation could be used more effectively when managing aggression and violence	3.30	1.19	2.05	0.04
2	Expressions of anger do not always require staff intervention	3.81	0.86	7.70	0.00
3	Alternatives to the use of containment and sedation to manage physical violence could be used more frequently	4.19	0.63	15.43	0.00
4	The use of de-escalation is successful in preventing violence	2.69	1.13	-2.27	0.03
	Total	3.50	1.13	9.22	0.00

4.4 Differences in attitudes of nurses towards inpatient aggression by the nurse's characteristics.

7.4.1. Differences in attitudes by the age variable for (ATAS) instruments:

In order to study differences in attitudes by the age variable, One Way Analysis Of Variance (ANOVA) test was used, and the results are as the following (table .21). From the table below, the differences by the age are not significant in nurses attitudes toward aggression. For description of age differences see appendix (4).

Table 21.Differences in Nurse's attitudes towards inpatient aggression by the age variable.

(ATAS) Scale	F	Sig.
a) acceptable normal reaction	1.674	0.196
b) violent reaction scale	2.811	0.068
c) functional reaction scale	0.851	0.432
d) offensive	0.316	0.730
e) Communicative	0.926	0.401
f) Destructive	0.976	0.382
g) Protective	1.934	0.153
h) Intrusive	0.833	0.439
Total degree of Perception of aggression	2.802	0.068

***The differences are significant at the 0.05 level.**

4.4.2 Differences in nursing attitudes toward aggression by the years of experience variable for ATAS:

In order to study differences in attitudes by the years of experience variable, One Way Analysis Of Variance (ANOVA) test was used and the results are, there are no significant differences in attitude toward aggression by the years of experience variable, for full description of differences in years of experience see Appendix (5).

Table 22.Differences in nurses' attitudes toward inpatient aggression by the years of experience variable.

(ATAS) Scale	F	Sig.
a) acceptable normal reaction	1.641	.189
b) violent reaction scale	1.602	.198
c) functional reaction scale	1.322	.275
d) offensive	.923	.435
e) Communicative	1.991	.124
f) Destructive	.400	.753
g) Protective	2.471	.070
h) Intrusive	.350	.789
Total degree of Perception of aggression	2.106	.108

***The differences are significant at the 0.05 level.**

4.4.3 Differences in nurses' attitudes toward aggression by sex variable for (ATAS):

In order to study differences in attitudes by the sex variable, independent samples T-test was used, and the results are as the following as noted from the table (23), it is noted that the differences by sex are significant only in attitudes toward the Communicative scale (p=0.016) and Intrusive scale (p=0.00), but the differences by sex are not significant in attitudes toward the other scales.

It is clear from the table that the attitudes toward the Communicative scale for males (mean=2.89) are higher than that for females (2.30). The attitudes toward the Intrusive scale for females (mean=4.07) are higher than that for males (3.41).

Table 23.Differences in nurses' attitudes toward inpatient aggression by the sex variable.

Scale	Sex	N	Mean	St.dev	T	Sig.	Mean level
a) acceptable normal reaction	Male	37	3.2027	.77493	.971	.335	medium
	Female	30	3.0000	.93490			medium
b) violent reaction scale	Male	37	3.8919	.48760	-.873	.386	high
	Female	30	4.0333	.82408			high
c) functional reaction scale	Male	37	3.4910	.68375	-.342	.734	high
	Female	30	3.5500	.72602			high
d) offensive	Male	37	3.9189	.73505	-.809	.422	high
	Female	30	4.0667	.75382			high
e) Communicative	Male	37	2.8919	1.00938	2.469	.016	medium
	Female	30	2.3000	.93198			low
f) Destructive	Male	37	3.9910	.68262	-1.824	.073	high
	Female	30	4.2889	.64168			very high
g) Protective	Male	37	3.3919	.87508	1.041	.302	medium
	Female	30	3.1500	1.02680			medium
h) Intrusive	Male	37	3.4144	.70011	-3.925	.000	high
	Female	30	4.0667	.64565			high
Total degree of Perception of aggression	Male	37	3.5595	.43236	-.200	.842	high
	Female	30	3.5830	.52726			high

***The differences are significant at the 0.05 level.**

4.4.4 Differences in nurses' attitudes toward aggression by the ward of work variable for (ATAS):

In order to study differences in attitudes by the ward of work variable, One Way Analysis Of Variance (ANOVA) test was used, and the results are as the following as noted from (Table 24). it is noted that the differences by the ward of work are significant in attitudes toward the following scales: violent reaction scale (p=0.026), offensive (p=0.020) ,

Communicative (p=0.005), and Intrusive (p=0.001), but the differences by the ward of work are not significant in attitudes toward the other scales.

Table 24.Differences in nurses' attitudes toward inpatient aggression by the ward of work variable.

Scale	F	Sig.
a) acceptable normal reaction	1.561	0.185
b) violent reaction scale	2.764	0.026*
c) functional reaction scale	1.134	0.352
d) offensive	2.920	0.020*
e) Communicative	3.756	0.005*
f) Destructive	1.906	0.106
g) Protective	1.744	0.138
h) Intrusive	4.711	0.001*
Total degree of Perception of aggression	2.149	0.072

***The differences are significant at the 0.05 level.**

In order to study these differences by the ward of work in these scales, LSD multiple comparisons test was used (Table 25), and the results are the following: The differences toward the violent reaction scale are between the ward (rehabilitation male) in comparison with the other groups, implying that the group (rehabilitation male) have higher agreement than the other groups. The differences toward the offensive scale are between the ward of work group (rehabilitation male)in comparison with the other groups implying that the group (recovery male) have higher agreement than the other groups. The differences toward the Communicative scale are between the ward of work group (admission male) in comparison with the other groups implying that the group (admission male) have higher

agreement than the other groups. The differences toward the Intrusive scale are between the ward of work group (rehabilitation male) in comparison with the other groups implying that the (rehabilitation male) have higher agreement than the other groups. Also, the differences toward the Intrusive scale are between the ward of work group (chronic female)in comparison with the group (admission female), implying that the group (chronic female) have higher agreement than only the group (admission female).

According to attitudes to acceptable normal reaction scale, the highest ward of work group is (rehabilitation female) with a high level mean (3.7) (see Appendix 6).According to attitudes to violent reaction scale, the highest ward of work group is (rehabilitation male) with a very high level mean (4.47) (Appendix 6).

According to attitudes to functional reaction scale, the highest ward of work group is (rehabilitation female) with a high level mean (3.91) (Appendix 6).

According to attitudes to offensive scale, the highest ward of work group is (rehabilitation male) with a very high level mean (4.54) (Appendix 6).

According to attitudes to Communicative scale, the highest ward of work group is (admission male) with a medium level mean (3.39) (Appendix 6).

According to attitudes to Destructive scale, the highest ward of work group is (rehabilitation male) with a very high level mean (4.61), (Appendix 6).

According to attitudes to Protective scale, the highest ward of work group is (admission male) with a high level mean (3.71), (Appendix 6).

According to attitudes to Intrusive scale, the highest ward of work group is (rehabilitation male) with a very high level mean (4.42), (Appendix 6).

According to attitudes to total degree of perception of aggression scale, the highest ward of work group is (rehabilitation female) with a high level mean (3.84), (Appendix 6).

Table 25. LSD multiple comparisons test for differences by the ward of work.

Dependent Variable	(I) The ward of work	(J) The ward of work	Mean Difference (I-J)	Sig.
violent reaction scale	rehabilitation male	admission male	.73173(*)	.003
		admission female	.53581(*)	.042
		rehabilitation female	.33838	.219
		chronic male	.83333(*)	.003
		chronic female	.62121(*)	.026
Offensive	rehabilitation male	admission male	.86345(*)	.002
		admission female	.49675	.091
		rehabilitation female	.29762	.334
		chronic male	.86905(*)	.006
		chronic female	.69444(*)	.027
Communicative	admission male	admission female	1.21034(*)	.001
		rehabilitation female	.57734	.134
		rehabilitation male	1.14216(*)	.002
		chronic male	1.16993(*)	.003
		chronic female	.94771(*)	.015
Intrusive	rehabilitation male	admission male	1.00490(*)	.000
		admission female	1.17424(*)	.000
		rehabilitation female	.78704(*)	.009
		chronic male	.60185(*)	.043
		chronic female	.56481	.057
		admission female	.60943(*)	.044
		rehabilitation female	.22222	.478
		rehabilitation male	-.56481	.057
		chronic male	.03704	.906

4.4.5 Differences in nurses' attitudes Toward aggression by Scientific degree variable for (ATAS):

In order to study differences in attitudes by the scientific degree variable, One Way Analysis Of Variance (ANOVA) test was used, and the results are as the following (table 26), there are no significant differences in attitudes toward all scales items by the scientific degree.

Table 26.Differences in nurses' attitudes toward inpatient aggression by the scientific degree variable.

Scale	F	Sig.
a) acceptable normal reaction	0.471	0.627
b) violent reaction scale	0.801	0.453
c) functional reaction scale	2.692	0.075
d) offensive	1.442	0.244
e) Communicative	1.190	0.311
f) Destructive	0.583	0.561
g) Protective	1.785	0.176
h) Intrusive	0.743	0.480
Total degree of Perception of aggression	1.393	0.256

***The differences are significant at the 0.05 level.**

For the attitudes to acceptable normal reaction, violent reaction, functional reaction, offensive, communicative, and destructive, the highest scientific grade group is master of mental health (Table 27).

For the attitudes to Protective and intrusive scale, the highest scientific grade group is Staff with a high level mean (3.60) and (3.87) respectively (Table 28).

Table 27. Number, mean, standard deviation and mean level of attitude toward aggression by the scientific degree.

Scale	Scientific grade	N	Mean	Std. Deviation	Mean level
acceptable normal reaction	Diploma	45	3.0519	.86407	medium
	Bachelorette	19	3.1974	.87762	medium
	master of mental health	3	3.4722	.34694	high
	Total	67	3.1119	.84966	medium
violent reaction scale	Diploma	45	3.8970	.67018	high
	bachelorette	19	4.0335	.64369	high
	master of mental health	3	4.3333	.57735	very high
	Total	67	3.9552	.65810	high
functional reaction scale	diploma	45	3.5630	.59701	high
	bachelorette	19	3.2982	.85089	medium
	master of mental health	3	4.2222	.69389	very high
	Total	67	3.5174	.69820	high
Offensive	diploma	45	4.0000	.71038	high
	bachelorette	19	3.8496	.80457	high
	master of mental health	3	4.6190	.65983	very high
	Total	67	3.9851	.74153	high
Communicative	diploma	45	2.5185	.95228	low
	bachelorette	19	2.7719	1.12246	medium
	master of mental health	3	3.3333	1.15470	medium
	Total	67	2.6269	1.01258	medium
Destructive	diploma	45	4.1778	.68387	high
	bachelorette	19	3.9825	.69809	high
	master of mental health	3	4.2222	.38490	very high
	Total	67	4.1244	.67628	high
Protective	diploma	45	3.1333	.92564	medium
	bachelorette	19	3.6053	.90644	high

	master of mental health	3	3.5000	1.32288	high
	Total	67	3.2836	.94638	medium
Intrusive	diploma	45	3.6296	.79208	high
	bachelorette	19	3.8772	.66861	high
	master of mental health	3	3.7778	.38490	high
	Total	67	3.7065	.74653	high
Total degree of Perception of aggression	diploma	45	3.5343	.40296	High
	bachelorette	19	3.5868	.60668	High
	master of mental health	3	4.0000	.45484	High
	Total	67	3.5700	.47356	High

4.4.6 Differences in nursing attitudes toward aggression by the Job Satisfaction variable for (ATAS) :

In order to study differences in attitudes by the job satisfaction , One Way Analysis Of Variance (ANOVA)-test was used and the results from the table (28), it is noted that the differences by the job satisfaction are not significant in the ATAS, for full description of job satisfaction see Appendix (7).

Table 28.Differences in nurses' attitudes toward inpatient aggression by the job satisfaction.

(ATAS) Scale	F	Sig.
a) acceptable normal reaction	0.442	0.723
b) violent reaction scale	0.781	0.509
c) functional reaction scale	0.912	0.440
d) offensive	1.451	0.236
e) Communicative	0.439	0.726
f) Destructive	1.124	0.346
g) Protective	1.065	0.371
h) Intrusive	0.849	0.472
Total degree of Perception of aggression	0.732	0.537

***The differences are significant at the 0.05 level.**

4.4.7 Differences in attitudes by work shift variable:

In order to study differences in attitudes by work shifts, independent samples T-test was used.

From the table (29), it is noted that there are no significant differences in attitudes toward all scales by the work shift.

Table 29. Differences in nursing attitudes toward aggression by the work shift variable.

Scale	work shift	N	Mean	St.dev	T	Sig.	Mean level
a) acceptable normal reaction	Morning	9	3.046	0.724	-0.247	0.805	medium
	All shifts	58	3.122	0.873			medium
b) violent reaction scale	Morning	9	3.859	0.774	-0.471	0.639	high
	All shifts	58	3.970	0.645			high
c) functional reaction scale	Morning	9	3.481	0.536	-0.165	0.870	high
	All shifts	58	3.523	0.724			high
d) offensive	Morning	9	4.206	0.506	0.962	0.340	very high
	All shifts	58	3.951	0.769			high
e) Communicative	Morning	9	2.593	0.760	-0.108	0.914	low
	All shifts	58	2.632	1.052			medium
f) Destructive	Morning	9	4.333	0.645	0.996	0.323	very high
	All shifts	58	4.092	0.681			high
g) Protective	Morning	9	2.889	0.741	-1.353	0.181	medium

	All shifts	58	3.345	0.965			medium
h) Intrusive	Morning	9	3.741	0.662	0.147	0.884	high
	All shifts	58	3.701	0.764			high
Total degree of Perception of aggression	Morning	9	3.556	0.499	-0.098	0.922	high
	All shifts	58	3.572	0.474			high

***The differences are significant at the 0.05 level.**

4.5 Differences in nurses' practices of management of inpatient aggression by the nurse's characteristics.

4.5.1 Differences in nurses' practice of aggression management by the age for (MAVAS) instruments:

In order to study differences in attitudes by the age variable, One Way Analysis Of Variance (ANOVA)-test was used and the results

from the table (30), there are no significant differences of nurse's practice of aggression management by the age variable, for full description see Appendix (8).

Table 30.Differences in nurses' practice of management of inpatient aggression by the age.

MAVAS Scale	F	Sig
i) Internal causative factors	0.139	0.870
j) External causative factors	0.759	0.472
k) Situational/interactional causative factors	0.311	0.734
Total degree of patient factors	0.301	0.741
l) Management: general	2.628	0.080
m) Management: use of medication	0.243	0.785
n) Management: use of seclusion	0.480	0.621
o) Management: restraint	1.195	0.309
p) Management: non-physical methods	1.169	0.317
Total degree of the nurses attitudes toward the aggression management	0.347	0.708

***The differences are significant at the 0.05 level.**

4.5.2 Differences in nursing practice by the years of experience variable for MAVAS:

In order to study differences in practice by the years of experience variable, One Way Analysis Of Variance (ANOVA)-test was used and the results are

from the table (31), it is noted that the differences by the years of experience are significant only in nurses' practices toward the Management in general (p=0.016).

Table 31.Differences in nurses' practices toward inpatient aggression by the years of experience.

MAVAS scale	F	Sig
i) Internal causative factors	.569	.637
j) External causative factors	1.115	.350
k) Situational/interactional causative factors	.070	.976
Total degree of patient factors	.032	.992
l) Management: general	3.694	.016*
m) Management: use of medication	.621	.604
n) Management: use of seclusion	2.001	.123
o) Management: restraint	.549	.651
p) Management: non-physical methods	.507	.679
Total degree of the nurses attitudes toward the aggression management	.632	.597

***The differences are significant at the 0.05 level.**

In order to study these differences by the years of experience in Management in general, LSD multiple comparisons test was used, and the results are: from the table (32) , it is noted that the differences toward the Management in General are between the years of experience groups (1-3 years),

(4-8 years) and (9-15 years) in comparison with the group (over 15 years), implying that the group (over 15 years) have higher agreement than the other years of experience groups.

Table 32. LSD multiple comparisons Test for differences by the years of experience in management in general.

(I) Years of experience	(J) Years of experience	Mean Difference (I-J)	Sig.
Over 15 years	1_3 years	.78030*	.017
	4_8 years	.65311*	.022
	9_15 years	.86364*	.006

***The differences are significant at the 0.05 level.**

According to attitudes to External causative factors scale and Situational/interactional causative factors, all nurses, regardless of their years of experience, consider attitudes towards aggression as based highly on external and interactional causative factors (see Appendix 9).

According to attitudes to Management: general scale, most of the nurses in the years of experience group in medium level except age group of (Over 15 years) with high level, see (appendix.9).

According to attitudes to Management: use of medication scale, seclusion, non physical methods and restraint, medication, restraint, non physical methods and seclusion are recommended by all nurses regardless years of experience (see Appendix 9).

4.5.3 Differences in nursing practice by sex variable for (ATAS):

In order to study differences in practice by sex variable, independent samples T-test was used and the results are as the following (table 34):

From the table (33), it is noted that the differences by sex are significant in Management in general (p=0.004) and management: non-physical methods (p=0.029).

The attitudes toward the Management in general for males (mean=3.65) are higher than that for females (3.00). The attitudes toward the Management: non-physical methods for males (mean=3.60) are higher than that for females (3.37). The attitudes toward the Total degree of the nurses attitudes toward the aggression management for males (mean=3.59) are higher than that for females (3.41).

Table 33.Differences in nurses' practice toward inpatient aggression by the sex.

MAVA Scale	Sex	N	Mean	St.dev	T	Sig	Mean level
i) Internal causative factors	Male	37	3.4216	.45162	1.405	.165	high
	Female	30	3.2333	.64345			medium
j) External causative factors	Male	37	3.8468	.66941	-1.905	.061	high
	Female	30	4.1444	.59166			high
k)Situational/interactional causative factors	Male	37	3.8865	.62812	-.182	.856	high
	Female	30	3.9133	.56735			high
Total degree of patient factors	Male	37	3.6985	.44831	-.058	.954	high
	Female	30	3.7051	.47808			high
l) Management: general	Male	37	3.6486	.74410	2.968	.004	high
	Female	30	3.0000	1.04221			medium
m) Management: use of medication	Male	37	3.5315	.46121	-.949	.346	high
	Female	30	3.6333	.40448			high
n) Management: use of seclusion	Male	37	3.6847	.52084	.884	.380	high
	Female	30	3.5778	.45430			high
o) Management: restraint	Male	37	3.4189	.46418	.918	.362	high
	Female	30	3.3000	.59596			medium
p) Management: non-physical methods	Male	37	3.6014	.45818	2.233	.029	high
	Female	30	3.3667	.38693			medium
Total degree of the nurses attitudes toward the aggression management	Male	37	3.5849	.28958	2.461	.017	high
	Female	30	3.4071	.29963			high

***The differences are significant at the 0.05 level.**

4.5.4 Differences in nursing practice by the ward of work for (MAVAS):

In order to study differences in practice by the ward of work variable, One Way Analysis Of Variance (ANOVA)-test was used, and the results are as the following as seen in the table (34), it is noted that the differences by the ward of work are significant for the following items: External causative factors(p=0.005), Situational/interactional causative factors (p=0.011), and Management in general (p=0.002), but the differences by the ward of work are not significant in attitudes toward the other remaining scales.

Table 34.Differences in nurses' practice toward inpatient aggression by the ward of work.

MAVA Scale	F	Sig
i) Internal causative factors	1.999	0.091
j) External causative factors	3.763	0.005*
k) Situational/interactional causative factors	3.300	0.011*
Total degree of patient factors	3.264	0.011*
l) Management: general	4.376	0.002*
m) Management: use of medication	0.796	0.557
n) Management: use of seclusion	1.947	0.099
o) Management: restraint	1.925	0.103
p) Management: non-physical methods	1.148	0.345
Total degree of the nurses attitudes toward the aggression management	2.308	0.055

***The differences are significant at the 0.05 level.**

In order to study these differences by the ward of work in these scales, LSD multiple comparisons test was used, and the results are as the following in (table35) of multiple comparisons it is noted that, the differences toward the External causative factors are between the ward (rehabilitation male)

corresponding to the other groups, implying that the group (rehabilitation male) have higher agreement than the other groups (table 35). Differences toward the Situational/interactional causative factors are between the ward of work group (rehabilitation male) corresponding to the other groups, implying that the group (rehabilitation male) have higher agreement than the other groups. Also, the differences toward the Situational/interactional causative factors are between the ward of work group (rehabilitation female) corresponding to the groups (admission female) and (chronic female), implying that the group (rehabilitation female) have higher agreement than the other two groups only. The differences toward the total degree of patient factors are between the ward of work group (rehabilitation male) corresponding to the other groups implying that the group (rehabilitation male) have higher agreement than the other groups. Also, the differences toward the total degree of patient factors are between the ward of work group (rehabilitation female) corresponding to the groups (admission female), (chronic male) and (chronic female), implying that the group (rehabilitation female) have higher agreement than the other three groups only. Finally, the differences toward the Management in general are between all the ward of work groups corresponding to the group (rehabilitation male), implying that the group (rehabilitation male) has less agreement than the other groups (table 35).

Table 35. LSD multiple comparisons Test for differences by the ward of work.

MAVA scale	(I) The ward of work	(J) The ward of work	Mean Difference(I-J)	Sig
External causative factors	rehabilitation male	admission male	.70098(*)	.003
		admission female	.97727(*)	.000
		rehabilitation female	.50926	.055
		chronic male	.65741(*)	.014
		chronic female	.80556(*)	.003
Situational/interactional causative factors	rehabilitation female	admission male	.29281	.202
		admission female	.67677(*)	.008
		rehabilitation male	-.04444	.856
		chronic male	.44444	.092
		chronic female	.64444(*)	.016
	rehabilitation male	admission male	.33725	.110
		admission female	.72121(*)	.003
		rehabilitation female	.04444	.856
		chronic male	.48889(*)	.049
		chronic female	.68889(*)	.006
Total degree of patient factors	rehabilitation female	admission male	.32328	.069
		admission female	.39938(*)	.040
		rehabilitation male	-.05342	.776
		chronic male	.41026(*)	.044
		chronic female	.52991(*)	.010
	Rehabilitation male	admission male	.37670(*)	.022
		admission female	.45280(*)	.013
		rehabilitation female	.05342	.776
		chronic male	.46368(*)	.016
		chronic female	.58333(*)	.003
Management: general	Rehabilitation female	admission male	-1.33088(*)	.000
		admission female	-1.07955(*)	.003
		rehabilitation female	-1.40278(*)	.000
		chronic male	-1.01389(*)	.008
		chronic female	-1.06944(*)	.005

*** The mean difference is significant at the .05 level.**

According to attitudes to Internal causative factors, the highest ward of work group is (rehabilitation female) with a high level mean (3.64), (see Appendix 10).

According to attitudes to External causative factors, the highest ward of work group is (rehabilitation male) with a very high level mean (4.58), (see Appendix 10).

According to attitudes to Situational/interactional causative factors, the highest ward of work group is (rehabilitation male) with a very high level mean (4.27), (see Appendix 10).

According to attitudes to total degree of patient factors, the highest ward of work group is (rehabilitation male) with a high level mean (4.02), (see Appendix 10).

According to attitudes to Management: general, the highest ward of work group is (rehabilitation female) with a high level mean (3.78), (see Appendix 10).

According to attitudes to Management: use of medication, the highest ward of work group is (chronic male) with a high level mean (3.78), (see Appendix 10).

According to attitudes to Management: use of seclusion scale, the highest ward of work group is (admission female) with a high level mean (3.88), (see Appendix 10).

According to attitudes to Management: restraint, the highest ward of work group is (chronic male) with a high level mean (3.56), (see Appendix 10).

According to attitudes to Management: non-physical methods, the highest ward of work group is (rehabilitation female) with a high level mean (3.61), (see Appendix 10).

According to attitudes to Total degree of the nurses' attitudes toward the aggression management, the highest ward of work group is (admission female) with a high level mean (3.61), (see Appendix 10).

4.5.5 Differences in nursing practice by Scientific degree for (MAVAS):

In order to study differences in attitudes by the scientific grade variable, One Way Analysis Of Variance (ANOVA)-test was used, and the results are as the following in (table 36), it is noted that there are no significant differences in attitudes toward all scales by the scientific degree.

Table 36.Differences in nurses' practice toward inpatient aggression by the scientific degree.

MAVA Scale	F	Sign
i) Internal causative factors	1.261	0.290
j) External causative factors	1.978	0.147
k) Situational/interactional causative factors	0.431	0.652
Total degree of patient factors	0.644	0.529
l) Management: general	0.036	0.965
m) Management: use of medication	0.328	0.722
n) Management: use of seclusion	2.186	0.121
o) Management: restraint	0.321	0.727
p) Management: non-physical methods	0.244	0.784
Total degree of the nurses attitudes toward the aggression management	0.382	0.684

***The differences are significant at the 0.05 level.**

As noted from the table (37) the master of mental health degree has a high agreement that external causative factors and interactional causative factors have an effect on patient's aggression. Also, they believe in management in general and medications more than the other scientific levels. According to nurses' practices to management: use of medications, restraint and non physical methods, the highest scientific degree group is staff with a high level mean (3.61). According to attitudes to the Internal causative factors scale, the highest scientific grade group is practical with a high level mean (3.41).

Table 37. Number, mean, standard deviation and mean level to describe nurses' practices toward aggression by the scientific grade level.

MAVA scale	Scientific grade	N	Mean	Std. Deviation	Mean level
Internal causative factors	Diploma	45	3.4089	.46506	high
	Bachelorette	19	3.2105	.71639	medium
	master of mental health	3	3.0667	.46188	medium
	Total	67	3.3373	.54961	medium
External causative factors	Diploma	45	3.9778	.62925	high
	Bachelorette	19	3.8772	.66861	high
	master of mental health	3	4.6667	.57735	very high
	Total	67	3.9801	.64844	high
Situational/interactional causative factors	Diploma	45	3.8978	.57307	high
	Bachelorette	19	3.8526	.65606	high
	master of mental health	3	4.2000	.72111	very high
	Total	67	3.8985	.59734	high
Total degree of patient factors	Diploma	45	3.7282	.41735	high
	Bachelorette	19	3.6113	.56786	high
	master of mental health	3	3.8718	.24727	high
	Total	67	3.7015	.45833	high
Management: general	Diploma	45	3.3556	.97481	medium
	Bachelorette	19	3.3421	.94358	medium
	master of mental health	3	3.5000	.50000	high
	Total	67	3.3582	.94069	medium
Management: use of medication	Diploma	45	3.5704	.45849	high
	Bachelorette	19	3.5614	.38574	high

	master of mental health	3	3.7778	.50918	high
	Total	67	3.5771	.43648	high
Management: use of seclusion	Diploma	45	3.6000	.41803	high
	Bachelorette	19	3.7895	.61071	high
	master of mental health	3	3.2222	.50918	medium
	Total	67	3.6368	.49145	high
Management: restraint	Diploma	45	3.3556	.53959	medium
	Bachelorette	19	3.4211	.53394	high
	master of mental health	3	3.1667	.28868	medium
	Total	67	3.3657	.52644	medium
Management: non-physical methods	Diploma	45	3.4944	.33915	high
	Bachelorette	19	3.5263	.65029	high
	master of mental health	3	3.3333	.14434	medium
	Total	67	3.4963	.44058	high
Total degree of the nurses attitudes toward the aggression management	Diploma	45	3.4937	.23681	high
	Bachelorette	19	3.5489	.44674	high
	master of mental health	3	3.4048	.08248	high
	Total	67	3.5053	.30516	high

4.5.6 Differences in nursing practice by the Job Satisfaction variable for (MAVAS):

In order to study differences in attitudes by the job satisfaction variable, One Way Analysis Of Variance (ANOVA)-test was used, and the results are as the following in(table 38), it is noted that the differences by the Job Satisfaction are significant only for attitudes toward the Management in general (p=0.001), but the differences by the Job Satisfaction are not significant in attitudes toward the other scales.

Table 38.Differences in nurses' practices toward inpatient aggression by the job satisfaction.

MAVAS Scale	F	sig
i) Internal causative factors	0.200	0.896
j) External causative factors	1.579	0.203
k) Situational/interactional causative factors	1.441	0.239
Total degree of patient factors	1.059	0.373
l) Management: general	6.382	0.001*
m) Management: use of medication	1.336	0.271
n) Management: use of seclusion	1.055	0.375
o) Management: restraint	0.780	0.510
p) Management: non-physical methods	0.609	0.611
Total degree of the nurses attitudes toward the aggression management	1.236	0.304

***The differences are significant at the 0.05 level.**

In order to study these differences by the Job Satisfaction in Management in general, LSD multiple comparisons test was used, and the results are as the

following in (table 39), of multiple comparisons, it is noted that the differences toward the Management in general scale are between all Job Satisfaction groups in comparison with the job satisfaction group (not satisfied) implying that the job satisfaction group (not satisfied) have less agreement than the other Job Satisfaction groups.

Table 39. LSD multiple comparisons Test for the differences by the job satisfaction in management in general.

(I) Job Satisfaction	(J) Job Satisfaction	Mean Difference (I-J)	Sig.
Not satisfied	Satisfied	-1.15152(*)	.000
	Doesn't like to work in this hospital	-.93333(*)	.032
	Neutral	-.74242(*)	.007

***The differences are significant at the 0.05 level.**

For the attitudes to Internal causative factors scale, the highest Job satisfaction group is (Not satisfied) with a medium level mean (3.38).

For the attitudes to the External causative factors scale, the highest Job Satisfaction group is (Not satisfied) with a very high level mean (4.22), see (appendix.11). For the attitudes to the Situational/interactional causative factors scale, the highest Job Satisfaction group is (Not satisfied) with a high level mean (4.06), see (appendix.11). For the attitudes to total degree of patient factors scale, the highest Job satisfaction group is (Not satisfied) with a high level mean (3.83), see (appendix.11). For the attitudes to Management: general scale, the highest Job satisfaction group is (Satisfied) with a high level mean

(3.82), see (appendix.11). For the attitudes to Management: use of medication scale, the highest Job satisfaction group is (Don’t like to work in this hospital) with a high level mean (3.93), see (appendix.11). For the attitude to management: use of seclusion scale, the highest job satisfaction group is (Don't like to work in this hospital) with a high level mean (3.87), see (appendix.11). For the attitudes to Management: restraint scale, the highest Job satisfaction group is (Not satisfied) with a high level mean (3.5), see (appendix.11). or the attitudes to Management: non-physical methods scale, the highest Job satisfaction group is (Neutral) with a high level mean (3.58), see (appendix.11).

For the attitudes to Total degree of the nurses attitudes toward the aggression management scale, the highest Job satisfaction group is (Don’t like to work in this hospital) with a high level mean (3.66), see (appendix.11).

4.5.7 Differences in nursing practice by the work shift variable:

In order to study differences in attitudes by the work shift, independent samples T-test was used, and the results are as the following From the table (40) above, it is noted that there are no significant differences in attitudes toward all scales by the work shift variable.

Table 40.Differences in nurses' practices toward inpatient aggression by the work shift.

MAVAS	Work shift	N	Mean	St.dev	T	Sig	Mean level
i) Internal causative factors	Morning	9	3.511	0.501	1.020	0.312	high
	All shifts	58	3.310	0.556			medium
j) External causative factors	Morning	9	4.074	0.813	0.465	0.644	high
	All shifts	58	3.966	0.627			high
k)Situational/interactional causative factors	Morning	9	4.000	0.436	0.545	0.588	high
	All shifts	58	3.883	0.620			high
Total degree of patient factors	Morning	9	3.829	0.368	0.896	0.374	high
	All shifts	58	3.682	0.470			high
l) Management: general	Morning	9	3.889	0.782	1.852	0.069	high
	All shifts	58	3.276	0.942			medium
m) Management: use of medication	Morning	9	3.519	0.294	-0.430	0.668	high
	All shifts	58	3.586	0.456			high
n) Management: use of seclusion	Morning	9	3.593	0.364	-0.288	0.774	high
	All shifts	58	3.644	0.511			high
o) Management: restraint	Morning	9	3.278	0.507	-0.535	0.594	medium
	All shifts	58	3.379	0.532			medium
p) Management: non-physical methods	Morning	9	3.417	0.280	-0.580	0.564	high
	All shifts	58	3.509	0.461			high
Total degree of the nurses attitudes toward the aggression management	Morning	9	3.524	0.220	0.194	0.847	high
	All shifts	58	3.502	0.318			high

***The differences are significant at the 0.05 level.**

Chapter 5
Discussion

To the knowledge of the authors, this is the first study to examine the attitudes of nurses towards aggression by psychiatric inpatients in Palestine.

This study found that nurses in Palestine perceived aggression as destructive, offensive, a violent reaction, intrusive and a functional reaction more than protective, acceptable normal reaction or as a communicative. This result is consistent with the studies by James et al. (2011) and Jonker and his colleagues (2008) in the Netherlands and in contrast with a study by Jansen et al. (2006) that showed aggression essentially communicative and protective.

Longer work experience was significantly associated with higher frequency of management of aggression in general ,it is noted that the differences toward the Management in General are between the years of experience groups (1-3 years), (4-8 years) and (9-15 years) in comparison with the group (over 15 years), implying that the group (over 15 years) have higher agreement than the other years of experience groups which is in contrast with the study of James et al. (2011) where it was shown that longer work experience was significantly accompanied with a higher frequency of physical violence as well as episodes of aggressive splitting behavior.

Whittington (2002) found that people with more than 15 years experience were significantly more tolerant of aggression than those with fewer years of experience. This result is in congruence in our results.

Nurses from admissions wards (male and female) agree less with the protective and communicative attitudes scales than nurses from other types of wards. On the other hand, nurses from the admissions department (especially women) and rehabilitation departments (male and female) had higher violent reactions and offensiveness than other types of wards and nurses from the chronic female department had a higher intrusive scale than other types of departments .Our results are congruent by a study by Katz and Kirkland (1990) which showed that admission departments more than the other departments are often the site of violence. This may be due to serious psychopathology and mental disorders of patients in the admissions department (Duxbury, 2004, et al. Steiner 2000).

There is wide agreement in the literature that ward culture (Katz and Kirkland, 1990), and wards with less "stable" patients (e.g admission and locked departments) are often the sites of violence (Fottrell, 1980;.Hodgkinson et al, 1985 ;Nijman et al, 1997;. Katz and Kirkland, 1990). Several studies reported that patients admitted involuntarily under mental health legislation proved significantly more likely to be engaged in acts of violence (James et al, 1990;. Powell et al, 1994).

In some studies, the conclusion is that the attacks often occurred when nurses administer drugs or leads or keep agitated patients (Soloff, 1983).According to sex, the findings indicate that female nurses more than their male colleagues, perceived aggression as an intrusive, offensive and violent reaction phenomenon. This result can be explained by the notion that, in general, female nurses feel more intimidated by the verbal and physical expressions of aggression than male nurses. In our opinion, the male nurses more than the female nurses experienced aggression as an attempt to communicate, which is related to our findings. It seems likely that men, more than women, had the option of perceiving the relational dimension of aggressive behavior because they felt less intimidated and afraid. From experimental cognitive psychology, when one experiences anxiety, memory, attention, and reasoning are affected. A person is overwhelmed by emotions and unable to attend to external events, and he or she is concentrated on his or her own feelings of distress (Eysenck, MacLeod, & Mathews, 1987).

Male nurses are more likely to be involved or called upon by their female counterparts to mediate in calming aggressive patients with the result that they are more exposed to violent acts. Though aggressive acts are likely to occur more frequently in closed wards, where a majority of patients are admitted involuntarily, the frequency of different types of aggression reported was higher in studies (Jonker et al. 2008; Oud et al. 2001; Nijman et al. 2005). Perhaps as declated in the paper by Jonker et al. (2008), aggressive acts now occur commonly such that about 40% of nursing staff, in their study had

become insensitive to the frequency of their occurrence and now see them as routine.

Several staff factors related to the occurrence of aggression on psychiatric wards are reported in the literature. Among them is gender. The conclusions about gender and its associated higher risk of assault are inconclusive. In a study by Carmel and Hunter (1989), male nursing staff were almost twice as likely as female staff to be injured and nearly three times as likely to receive containment-related injuries. In contrast, in two other studies no differences were found between male and female nurses and their assault rate (Whittington, 1994; Cunningham et al., 2003).

The impact of education was considered in our study. The highest scientific certificate group is Master of mental health with a high level mean of attitudes to acceptable normal reaction scale, violent reaction scale, functional reaction scale, offensive scale, communicative scale, destructive scale, total degree of perception of aggression scale, external causative factors scale, situational/interactional causative factors scale, management: general scale, management: use of medication scale. Our study is in agreement with Jansen et al. (2006) in which it was shown that a low level of qualification was found to be associated with higher rates of assault (Whittington and Wykes, 1994; Cunningham et al., 2003). In several studies it was found that the more inexperienced the staff were, the more they were exposed to assaults (Hodgkinson et al., 1985; Whittington et al., 1996; Cunningham et al., 2003). Cunningham et al. (2003) found that an increased number of hours of contact

between nurses and patients resulted in more injuries being sustained. Executive staff were most likely to be injured by patient violence (Carmel and Hunter, 1989) and charge nurses and staff nurses were assaulted more frequently than those in the non-assaulted control group (Whittington, 1994). Most of the studies on the effects of staff education and training found that training staff about how to react to threatening situations can lead to a decline in the frequency or severity of aggressive incidents (Infantino and Musingo, 1985; Paterson et al., 1992; Phillips and Rudestam, 1995; Whittington and Wykes, 1996; Rixtel, 1997).

Studies on the time of day and an increase of aggression showed that most incidents take place in the daytime, then in the evening, with the lowest rate found during the night. Some studies reported that most assaults occurred during mealtimes and early in the afternoon (Carmel and Hunter, 1989; Lanza et al., 1994; Nijman et al., 1995; Vanderslott, 1998; Bradley et al., 2001). Others found an increased rate in the morning (Fottrell, 1980; Hodgkinson et al., 1985; Cooper and Mendonca, 1991). According to our study we found that morning shift nurses consider aggression as a violent and destructive reaction and they always use medications, restraint and seclusion to control the patients.

Conclusion

This study demonstrated that there are different attitudes of nurses toward patient aggression in psychiatric inpatient settings. What is important is to gain a better understanding of the factors that account for the differences in attitudes. Another possibly effective way of addressing the issue would be to concentrate on the process of attitude formation within the work setting. Social learning is a powerful source of the socialization process through which nurses learn about which behavior and is not appropriate in their professional culture.

This study found that aggression is negatively viewed by Palestinian psychiatric nurses. These attitudes are reflective of the opinions of lay persons in our society. There is a need for training programs to reorient the opinions of nurses in relation to inpatient aggression. These programs should contribute towards improved patient care and reduction in the frequency of aggressive acts within inpatient units. To enable research in this direction, we first have to consider what important patient, client, and environmental effects there are on the social learning of nurses who deal with aggression.

Strengths &s of the Study

- Though the form of the ATAS showed fairly good reliability, testing the validity of the instruments in this cultural environment was undertaken. Another strength of this study is that it is the first study in Palestine of its kind.

- Our sample size is moderate and from the only psychiatric facility in the country. This might limit the ability to generalize the results. The nurses may feel restricted in the freedom of answering honestly because some how they can be easily identified by the nature of the sample. During the work the author felt a pressing need to ensure the diagnosis of the aggressiveness and to differentiate the circumstances of the aggressiveness events. Unfortunately, in Bethlehem Psychiatric Hospital the team considered every over-talkative and over-behavior as aggressiveness. This limited their correct understanding of aggression.

- With two self-administered questionnaires: Attitudes Towards Aggression Scale (ATAS) and the management of aggression and violence Attitude Scale (MAVAS) comprising 82 items were too complicated. Actually, we were guided by an expert in psychiatry when we give him ATAS Arabic version to validate, he suggested that it is not enough to study only the attitudes of nurses towards patients aggression, it will be interested if we study also the management of aggression, because of this, we choose these two surveys.

Nursing Implication

This study shows that psychiatric nurses differ in the way they evaluate aggressive behavior of psychiatric patients. This result is in contrast to the negative significance of the phenomenon of aggression primarily found in the literature.

Staff education and training found that training staff about how to react to threatening situations can lead to a decline in the frequency or severity of aggressive incidents .Educational programs to make and keep nurses aware of and sensitive to the positive attitudes to aggressive client behavior is recommended

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Appendix

Appendix.1.

The Attitude Towards Aggression Scale (ATAS)

Aggression as an: acceptable normal reaction

– has a positive impact on the treatment .
– is constructive and consequently acceptable .
– is all human energy necessary to attain one's end .
– is necessary and acceptable .
– reveals another problem the nurse can take up .
– improves the atmosphere on the ward; it is beneficial to the treatment .
– is an acceptable ways to express feelings .
– is communicative and as such not destructive .
– is a normal reaction to feelings of anger .
– is constructive behavior .
– an adaptive reaction to anger .
– must be tolerated .

violent reaction scale

– is violent behavior to others and self .
– is directed at objects or self .
– is to beat up another person through words or actions .
– is threatening others .
– is an inappropriate, non adaptive verbal/physical action .
– is a disturbing interference to dominate others .
– is to hurt others mentally or physically .
– is a physical violent action .
– is used as a means of power by the patient .
– is every expression that makes someone else feel unsafe, threatened or hurt .
– verbal aggression is calling names resulting in hurting .

functional reaction scale

– is an expression of emotions, just like laughing and crying .
– is an emotional outlet .
– offers new possibilities for the treatment .
– is an opportunity to get a better understanding of the patient's situation .

– a way to protect yourself .
– will result in the patient quietening down .

Offensive

-is destructive behaviour and therefore unwanted
-is unnecessary and unacceptable behavior
-is unpleasant and repulsive behavior
-is an example of a non-cooperative attitude
-poisons the atmosphere on the ward and obstructs treatment
-in any form is always negative and unacceptable
-cannot be tolerated

Communicative

-offers new possibilities in nursing care
-helps the nurse to see the patient from another point of view
-is the start of a more positive nurse relationship

Destructive

-is when a patient has feelings that will result in physical harm to self or to others
-is violent behaviour to others or self
-is threatening to damage others or objects

Protective

-is to protect oneself
-is the protection of one's own territory and privacy

Intrusive

-is a powerful, mistaken, non-adaptive, verbal and/or physical action done out of self-interest
-is expressed deliberately, with the exception of aggressive behaviour of someone who is psychotic
-is an impulse to disturb and interfere in order to dominate or harm others

Appendix.2.

Management of aggression and violence attitude scale Internal causative factors

. It is difficult to prevent patients from becoming aggressive
. Patients are aggressive because they are ill
. There are types of patient who are aggressive
. Patients who are aggressive should try to control their feelings
. Aggressive patients will calm down if left alone

External causative factors

. Patients are aggressive because of the environment they are in
. Restrictive environments can contribute towards aggression
. If the physical environment were different, patients would be less aggressive

Situational/interactional causative factors

. Other people make patients aggressive or violent
. Patients commonly become aggressive because staff do not listen to them
. Poor communication between staff and patients leads to patient aggression
. Improved one to one relationships between staff and patients can reduce the incidence of aggression
. It is largely situations that can contribute towards the expression of aggression by patients

Management: general

. Different approaches are used on the ward to manage aggression
. Patient aggression could be handled more effectively on this ward

Management: use of medication

. Medication is a valuable approach for treating aggressive and violent behaviour
. Prescribed medication can sometimes lead to aggression
. Prescribed medication should be used more frequently for aggressive patients

Management: use of seclusion

. When a patient is violent seclusion is one of the most effective approaches
. The practice of secluding violent patients should be discontinued
. Seclusion is sometimes used more than necessary

Management: restraint

. Patients who are violent are restrained for their own safety
. Physical restraint is sometimes used more than necessary

Management: non-physical methods

. Negotiation could be used more effectively when managing aggression and violence

. Expressions of anger do not always require staff intervention
. Alternatives to the use of containment and sedation to manage physical violence could be used more frequently
. The use of de-escalation is successful in preventing violence

Appendix .3

the validity of the ATAS questionnaire by using Factor Analysis to determine the Extraction coefficients of Principal Component Method, the results shown below :

Item	Extraction coefficient	Level of validity
has a positive impact on the treatment .	0.85	high
is constructive and consequently acceptable .	0.86	high
is all human energy necessary to attain one's end .	0.81	high
is necessary and acceptable .	0.84	high
reveals another problem the nurse can take up .	0.85	high
improves the atmosphere on the ward; it is beneficial to the treatment .	0.89	high
is an acceptable ways to express feelings .	0.78	high
is communicative and as such not destructive .	0.83	high
is a normal reaction to feelings of anger .	0.79	high
is constructive behavior .	0.75	high
an adaptive reaction to anger .	0.81	high
must be tolerated .	0.76	high
is violent behavior to others and self .	0.88	high
is directed at objects or self .	0.86	high
is to beat up another person through words or actions .	0.81	high
is threatening others .	0.82	high
is an inappropriate, non adaptive verbal/physical action .	0.85	high
is a disturbing interference to dominate others .	0.84	high
is to hurt others mentally or physically .	0.80	high

is a physical violent action .	0.79	high
is used as a means of power by the patient .	0.82	high
is every expression that makes someone else feel unsafe, threatened or hurt .	0.89	high
verbal aggression is calling names resulting in hurting .	0.93	high
is an expression of emotions, just like laughing and crying .	0.79	high
is an emotional outlet .	0.84	high
offers new possibilities for the treatment .	0.86	high
is an opportunity to get a better understanding of the patient's situation .	0.83	high
a way to protect yourself .	0.80	high
will result in the patient quieting down .	0.89	high
is destructive behavior and therefore unwanted	0.86	high
is unnecessary and unacceptable behavior	0.81	high
is unpleasant and repulsive behavior	0.94	high
is an example of a non-cooperative attitude	0.91	high
poisons the atmosphere on the ward and obstructs treatment	0.91	high
in any form is always negative and unacceptable	0.90	high
cannot be tolerated	0.87	high
offers new possibilities in nursing care	0.83	high
helps the nurse to see the patient from another point of view	0.87	high
is the start of a more positive nurse relationship	0.90	high
is when a patient has feelings that will result in physical harm to self or to others	0.84	high
is violent behavior to others or self	0.90	high
is threatening to damage others or objects	0.86	high
is to protect oneself	0.90	high
is the protection of one’s own territory and privacy	0.85	high

is a powerful, mistaken, non-adaptive, verbal and/or physical action done out of self-interest	0.80	high
is expressed deliberately, with the exception of aggressive behavior of someone who is psychotic	0.85	high
is an impulse to disturb and interfere in order to dominate or harm others	0.89	high
It is difficult to prevent patients from becoming aggressive	0.77	high
Patients are aggressive because they are ill	0.76	high
There are types of patient who are aggressive	0.85	high
Patients who are aggressive should try to control their feelings	0.88	high
Aggressive patients will calm down if left alone	0.86	high
Patients are aggressive because of the environment they are in	0.83	high
Restrictive environments can contribute towards aggression	0.72	high
If the physical environment were different, patients would be less aggressive	0.84	high
Other people make patients aggressive or violent	0.86	high
Patients commonly become aggressive because staff do not listen to them	0.84	high
Poor communication between staff and patients leads to patient aggression	0.72	high
20. Improved one to one relationships between staff and patients can reduce the incidence of aggression	0.81	high
23. It is largely situations that can contribute towards the expression of aggression by patients	0.83	high
Different approaches are used on the ward to manage aggression	0.88	high
Patient aggression could be handled more effectively on this ward	0.84	high
Medication is a valuable approach for treating aggressive and violent behavior	0.82	high
22. Prescribed medication can sometimes lead to aggression	0.85	high
25. Prescribed medication should be used more frequently for aggressive patients	0.79	high
When a patient is violent seclusion is one of the most effective approaches	0.81	high
The practice of secluding violent patients should be discontinued	0.81	high
Seclusion is sometimes used more than necessary	0.87	high

Patients who are violent are restrained for their own safety	0.84	high
Physical restraint is sometimes used more than necessary	0.86	high
Negotiation could be used more effectively when managing aggression and violence	0.79	high
Expressions of anger do not always require staff intervention	0.83	high
Alternatives to the use of containment and sedation to manage physical violence could be used more frequently	0.74	high
The use of de-escalation is successful in preventing violence	0.77	high

Appendix.4.

Differences of nursing attitudes toward aggression by the age variable

Scale	Age	N	Mean	Std. Deviation	Mean level
acceptable normal reaction	Less than 30	23	3.18	0.96	Medium
	30_40	10	3.49	0.68	High
	More than 40	34	2.96	0.80	Medium
	Total	67	3.11	0.85	Medium
violent reaction scale	Less than 30	23	4.15	0.64	High
	30_40	10	4.12	0.58	High
	More than 40	34	3.77	0.66	High
	Total	67	3.96	0.66	High
functional reaction scale	Less than 30	23	3.48	0.64	High
	30_40	10	3.78	0.56	High
	More than 40	34	3.47	0.77	High
	Total	67	3.52	0.70	High
Offensive	Less than 30	23	4.07	0.84	High
	30_40	10	4.01	0.80	High
	More than 40	34	3.92	0.67	High
	Total	67	3.99	0.74	High
Communicative	Less than 30	23	2.80	1.02	Medium
	30_40	10	2.80	1.39	Medium
	More than 40	34	2.46	0.88	Low
	Total	67	2.63	1.01	Medium
Destructive	Less than 30	23	4.07	0.83	High
	30_40	10	4.40	0.66	very high
	More than 40	34	4.08	0.55	High
	Total	67	4.12	0.68	High

Protective	Less than 30	23	3.57	0.95	High
	30_40	10	3.35	1.06	Medium
	More than 40	34	3.07	0.89	Medium
	Total	67	3.28	0.95	Medium
Intrusive	Less than 30	23	3.87	0.97	High
	30_40	10	3.63	0.79	High
	More than 40	34	3.62	0.53	High
	Total	67	3.71	0.75	High
Total degree of Perception of aggression	Less than 30	23	3.67	0.50	High
	30_40	10	3.77	0.35	High
	More than 40	34	3.44	0.46	High
	Total	67	3.57	0.47	High

Appendix.5.

Differences of nursing attitude toward aggression by the years of experience variable

Scale	Years of experience	N	Mean	Std. Deviation	Mean level
acceptable normal reaction	1_3 years	12	2.9722	1.11709	medium
	4_8 years	19	3.4693	.68167	high
	9_15 years	14	3.0238	.64337	medium
	Over 15 years	22	2.9356	.89233	medium
	Total	67	3.1119	.84966	medium
violent reaction scale	1_3 years	12	4.0152	.74244	high
	4_8 years	19	4.1483	.53458	high
	9_15 years	14	4.0130	.70224	high
	Over 15 years	22	3.7190	.65249	high
	Total	67	3.9552	.65810	high
functional reaction scale	1_3 years	12	3.4444	.64092	high
	4_8 years	19	3.6228	.57155	high
	9_15 years	14	3.7500	.70937	high
	Over 15 years	22	3.3182	.79667	medium
	Total	67	3.5174	.69820	high
Offensive	1_3 years	12	3.9524	1.01626	high
	4_8 years	19	4.0000	.68842	high
	9_15 years	14	4.2449	.59677	very high
	Over 15 years	22	3.8247	.69837	high
	Total	67	3.9851	.74153	high
Communicative	1_3 years	12	3.1389	1.14995	medium
	4_8 years	19	2.7719	1.02471	medium
	9_15 years	14	2.3095	1.01665	low
	Over 15 years	22	2.4242	.84316	low
	Total	67	2.6269	1.01258	medium
Destructive	1-_3 years	12	4.0000	.92113	high
	4_8 years	19	4.1053	.74579	high
	9_15 years	14	4.2857	.50395	very high
	Over 15 years	22	4.1061	.57631	high
	Total	67	4.1244	.67628	high

Protective	1_3 years	12	3.5833	.82112	high
	4_8 years	19	3.5789	.93189	high
	9_15 years	14	3.2500	1.10506	medium
	Over 15 years	22	2.8864	.81550	medium
	Total	67	3.2836	.94638	medium
Intrusive	1_3 years	12	3.8889	.96748	high
	4_8 years	19	3.6667	.95581	high
	9_15 years	14	3.7381	.69404	high
	Over 15 years	22	3.6212	.38894	high
	Total	67	3.7065	.74653	high
Total degree of Perception of aggression	1_3 years	12	3.5833	.59342	high
	4_8 years	19	3.7402	.38367	high
	9_15 years	14	3.6201	.41642	high
	Over 15 years	22	3.3839	.47178	medium
	Total	67	3.5700	.47356	high

Appendix.6.

Differences of nursing attitude toward aggression by the ward of work variable

Scale	The ward of work	N	Mean	Std. Deviation	Mean level
acceptable normal reaction	admission male	17	3.2157	.72412	medium
	admission female	11	2.7727	.76928	medium
	recovery female	9	3.7037	.61395	high
	recovery male	12	3.0208	1.28959	medium
	chronic male	9	3.1389	.70833	medium
	chronic female	9	2.8333	.57130	medium
	Total	67	3.1119	.84966	medium
violent reaction scale	admission male	17	3.7380	.63138	high
	admission female	11	3.9339	.18223	high
	recovery female	9	4.1313	.33744	high
	recovery male	12	4.4697	.69541	very high
	chronic male	9	3.6364	.96958	high
	chronic female	9	3.8485	.59613	high
	Total	67	3.9552	.65810	high
functional reaction scale	admission male	17	3.4412	.75678	high
	admission female	11	3.2273	.70818	medium
	recovery female	9	3.9074	.18840	high
	recovery male	12	3.6667	.90732	high
	chronic male	9	3.4259	.74587	high
	chronic female	9	3.5185	.42853	high
	Total	67	3.5174	.69820	high
Offensive	admission male	17	3.6723	.95800	high
	admission female	11	4.0390	.33861	high
	recovery female	9	4.2381	.43448	very high
	recovery male	12	4.5357	.59723	very high
	chronic male	9	3.6667	.58902	high
	chronic female	9	3.8413	.80952	high
	Total	67	3.9851	.74153	high
Communicative	admission male	17	3.3922	.93716	medium
	admission female	11	2.1818	.83485	low
	recovery female	9	2.8148	.85165	medium
	recovery male	12	2.2500	1.00629	low
	chronic male	9	2.2222	.83333	low
	chronic female	9	2.4444	1.01379	low
	Total	67	2.6269	1.01258	medium
Destructive	admission male	17	3.9216	.86224	high
	admission female	11	3.9697	.62280	high
	recovery female	9	4.1481	.29397	high
	recovery male	12	4.6111	.56557	very high

	chronic male	9	4.1852	.72860	high
	chronic female	9	3.9630	.48432	high
	Total	67	4.1244	.67628	high
Protective	admission male	17	3.7059	.93640	high
	admission female	11	3.2727	.68424	medium
	recovery female	9	2.9444	.80795	medium
	recovery male	12	3.2083	1.30486	medium
	chronic male	9	2.7222	.71200	medium
	chronic female	9	3.5000	.79057	high
	Total	67	3.2836	.94638	medium
Intrusive	admission male	17	3.4118	.93191	high
	admission female	11	3.2424	.44947	medium
	recovery female	9	3.6296	.35136	high
	recovery male	12	4.4167	.75378	very high
	chronic male	9	3.8148	.55556	high
	chronic female	9	3.8519	.33793	high
	Total	67	3.7065	.74653	high
Total degree of Perception of aggression	admission male	17	3.5244	.50780	high
	admission female	11	3.3810	.28537	medium
	recovery female	9	3.8440	.29366	high
	recovery male	12	3.8174	.61908	high
	chronic male	9	3.4043	.40691	high
	chronic female	9	3.4492	.42037	high
	Total	67	3.5700	.47356	high

Appendix.7.

Differences in nursing attitudes toward aggression by the job satisfaction

Scale	Job satisfaction	N	Mean	Std. Deviation	Mean level
acceptable normal reaction	Satisfy	22	2.9394	.83973	medium
	Not satisfy	18	3.1806	1.02671	medium
	Don't like to work in this hospital	5	3.2167	.73974	medium
	Neutral	22	3.2045	.74789	medium
	Total	67	3.1119	.84966	medium
violent reaction scale	Satisfy	22	3.9463	.46241	high
	Not satisfy	18	4.1263	.63302	high
	Don't like to work in this hospital	5	3.6727	.89211	high
	Neutral	22	3.8884	.78901	high
	Total	67	3.9552	.65810	high
functional reaction scale	Satisfy	22	3.3333	.85758	medium
	Not satisfy	18	3.6389	.59202	high
	Don't like to work in this hospital	5	3.7667	.32489	high
	Neutral	22	3.5455	.65502	high
	Total	67	3.5174	.69820	high
Offensive	Satisfy	22	4.0519	.71162	high
	Not satisfy	18	4.1825	.81523	high
	Don't like to work in this Hospital	5	4.1143	.56605	high
	Neutral	22	3.7273	.71484	high
	Total	67	3.9851	.74153	high
Communicative	Satisfy	22	2.7273	1.03196	medium
	Not satisfy	18	2.5370	1.04874	low
	Don't like to work in this hospital	5	2.2000	.73030	low
	Neutral	22	2.6970	1.04860	medium
	Total	67	2.6269	1.01258	medium
Destructive	Satisfy	22	4.1061	.74455	high
	Not satisfy	18	4.3519	.58825	very high
	Don't like to work in this hospital	5	3.8667	.29814	high
	Neutral	22	4.0152	.71623	high
	Total	67	4.1244	.67628	high
Protective	Satisfy	22	3.0909	.89491	medium
	Not satisfy	18	3.6111	1.00814	high

	Don’t like to work in this hospital	5	3.2000	.83666	medium
	Neutral	22	3.2273	.96025	medium
	Total	67	3.2836	.94638	medium
Intrusive	Satisfy	22	3.5909	.58129	high
	Not satisfy	18	3.9444	.99180	high
	Don’t like to work in this hospital	5	3.6667	.47140	high
	Neutral	22	3.6364	.71202	high
	Total	67	3.7065	.74653	high
Total degree of Perception of aggression	Satisfy	22	3.5000	.48437	high
	Not satisfy	18	3.7104	.39301	high
	Don’t like to work in this hospital	5	3.5319	.35122	high
	Neutral	22	3.5338	.54581	high
	Total	67	3.5700	.47356	high

Appendix.8.

Differences of nursing practice toward aggression by the age variable

Scale	Age	N	Mean	Std. Deviation	Mean level
Internal causative factors	Less than 30	23	3.38	0.55	Medium
	30_40	10	3.28	0.52	Medium
	More than 40	34	3.32	0.57	Medium
	Total	67	3.34	0.55	Medium
External causative factors	Less than 30	23	3.99	0.69	High
	30_40	10	4.20	0.59	very high
	More than 40	34	3.91	0.64	High
	Total	67	3.98	0.65	High
Situational/interactional causative factors	Less than 30	23	3.96	0.69	High
	30_40	10	3.96	0.49	High
	More than 40	34	3.84	0.57	High
	Total	67	3.90	0.60	High
Total degree of patient factors	Less than 30	23	3.74	0.54	High
	30_40	10	3.75	0.40	High
	More than 40	34	3.66	0.42	High
	Total	67	3.70	0.46	High
Management: general	Less than 30	23	3.04	1.10	Medium
	30_40	10	3.25	1.23	Medium
	More than 40	34	3.60	0.65	High
	Total	67	3.36	0.94	Medium
Management: use of medication	Less than 30	23	3.57	0.55	High
	30_40	10	3.50	0.36	High
	More than 40	34	3.61	0.38	High
	Total	67	3.58	0.44	High
Management: use of seclusion	Less than 30	23	3.70	0.57	High
	30_40	10	3.70	0.37	High
	More than 40	34	3.58	0.47	High
	Total	67	3.64	0.49	High
Management: restraint	Less than 30	23	3.50	0.50	High
	30_40	10	3.25	0.26	Medium
	More than 40	34	3.31	0.59	Medium
	Total	67	3.37	0.53	Medium
Management: non-physical	Less than 30	23	3.40	0.58	High

methods	30_40	10	3.65	0.52	High
	More than 40	34	3.51	0.27	High
	Total	67	3.50	0.44	High
Total degree of the nurses attitudes toward the aggression management	Less than 30	23	3.46	0.41	High
	30_40	10	3.51	0.25	High
	More than 40	34	3.53	0.24	High
	Total	67	3.51	0.31	High

Appendix.9.

Differences of nursing practice toward aggression by the years of experience variable

Scale	Years of experience	N	Mean	Std. Deviation	Mean level
Internal causative factors	1_3 years	12	3.3833	.65759	medium
	4_8 years	19	3.3474	.49370	medium
	9_15 years	14	3.1714	.44277	medium
	Over 15 years	22	3.4091	.60624	high
	Total	67	3.3373	.54961	medium
External causative factors	1_3 years	12	3.8889	1.00838	high
	4_8 years	19	4.0351	.49559	high
	9_15 years	14	4.2143	.54861	very high
	Over 15 years	22	3.8333	.57044	high
	Total	67	3.9801	.64844	high
Situational/interactional causative factors	1_3 years	12	3.9500	.87021	high
	4_8 years	19	3.8947	.43903	high
	9_15 years	14	3.8429	.71974	high
	Over 15 years	22	3.9091	.48492	high
	Total	67	3.8985	.59734	high
Total degree of patient factors	1_3 years	12	3.7179	.75107	high
	4_8 years	19	3.7166	.32236	high
	9_15 years	14	3.6703	.44284	high
	Over 15 years	22	3.6993	.39145	high
	Total	67	3.7015	.45833	high
Management: general	1_3 years	12	3.0833	1.14482	medium
	4_8 years	19	3.2105	.96200	medium
	9_15 years	14	3.0000	1.12660	medium
	Over 15 years	22	3.8636	.31554	high
	Total	67	3.3582	.94069	medium
Management: use of medication	1_3 years	12	3.5833	.35176	high
	4_8 years	19	3.5263	.59125	high
	9_15 years	14	3.7143	.36648	high
	Over 15 years	22	3.5303	.36600	high
	Total	67	3.5771	.43648	high

Management: use of seclusion	1_3 years	12	3.9444	.60022	high
	4_8 years	19	3.5789	.42806	high
	9_15 years	14	3.5714	.37958	high
	Over 15 years	22	3.5606	.50799	high
	Total	67	3.6368	.49145	high
Management: restraint	1_3 years	12	3.4583	.45017	high
	4_8 years	19	3.4211	.47910	high
	9_15 years	14	3.3929	.44629	medium
	Over 15 years	22	3.2500	.65009	medium
	Total	67	3.3657	.52644	medium
Management: non-physical methods	1_3 years	12	3.5625	.64071	high
	4_8 years	19	3.3947	.54209	medium
	9_15 years	14	3.5000	.29417	high
	Over 15 years	22	3.5455	.27426	high
	Total	67	3.4963	.44058	high
Total degree of the nurses attitudes toward the aggression management	1_3 years	12	3.5655	.42798	high
	4_8 years	19	3.4398	.34112	high
	9_15 years	14	3.4745	.19533	high
	Over 15 years	22	3.5487	.25459	high
	Total	67	3.5053	.30516	high

Appendix.10.

Differences of nursing practice toward aggression by the ward of work variable

Scale	The ward of work	N	Mean	Std. Deviation	Mean level
Internal causative factors	admission male	17	3.2118	.51706	medium
	admission female	11	3.5636	.25009	high
	recovery female	9	3.6444	.35746	high
	recovery male	12	3.4333	.71266	high
	chronic male	9	3.1111	.56667	medium
	chronic female	9	3.0889	.61734	medium
	Total	67	3.3373	.54961	medium
External causative factors	admission male	17	3.8824	.73542	high
	admission female	11	3.6061	.51247	high
	recovery female	9	4.0741	.68268	high
	recovery male	12	4.5833	.63763	very high
	chronic male	9	3.9259	.36430	high
	chronic female	9	3.7778	.28868	high
	Total	67	3.9801	.64844	high
Situational/interactional causative factors	admission male	17	3.9294	.72091	high
	admission female	11	3.5455	.44803	high
	recovery female	9	4.2222	.44096	very high
	recovery male	12	4.2667	.47737	very high
	chronic male	9	3.7778	.62004	high
	chronic female	9	3.5778	.36667	high
	Total	67	3.8985	.59734	high
Total degree of patient factors	admission male	17	3.6425	.53498	high
	admission female	11	3.5664	.28216	high
	recovery female	9	3.9658	.34852	high
	recovery male	12	4.0192	.44628	high
	chronic male	9	3.5556	.45472	high
	chronic female	9	3.4359	.30528	high
	Total	67	3.7015	.45833	high
Management: general	admission male	17	3.7059	.75122	high
	admission female	11	3.4545	.93420	high
	recovery female	9	3.7778	.44096	high
	recovery male	12	2.3750	1.08972	low

	chronic male	9	3.3889	.74068	medium
	chronic female	9	3.4444	.88192	high
	Total	67	3.3582	.94069	medium
Management: use of medication	admission male	17	3.4510	.62295	high
	admission female	11	3.5455	.16817	high
	recovery female	9	3.6667	.33333	high
	recovery male	12	3.5278	.43712	high
	chronic male	9	3.7778	.44096	high
	chronic female	9	3.6296	.30932	high
	Total	67	3.5771	.43648	high
Management: use of seclusion	admission male	17	3.7451	.64041	high
	admission female	11	3.8788	.26968	high
	recovery female	9	3.3333	.33333	medium
	recovery male	12	3.6111	.23925	high
	chronic male	9	3.7037	.45474	high
	chronic female	9	3.4074	.64070	high
	Total	67	3.6368	.49145	high
Management: restraint	admission male	17	3.5294	.54402	high
	admission female	11	3.5000	.38730	high
	recovery female	9	3.1111	.22048	medium
	recovery male	12	3.2917	.33428	medium
	chronic male	9	3.5556	.72648	high
	chronic female	9	3.0556	.68211	medium
	Total	67	3.3657	.52644	medium
Management: non-physical methods	admission male	17	3.6029	.49259	high
	admission female	11	3.5909	.42239	high
	recovery female	9	3.6111	.48591	high
	recovery male	12	3.3958	.27091	medium
	chronic male	9	3.4444	.20833	high
	chronic female	9	3.2500	.61237	medium
	Total	67	3.4963	.44058	high
Total degree of the nurses attitudes toward the aggression management	admission male	17	3.6050	.35003	high
	admission female	11	3.6104	.26985	high
	recovery female	9	3.5159	.18481	high
	recovery male	12	3.3095	.15629	medium
	chronic male	9	3.5794	.24076	high
	chronic female	9	3.3651	.42923	medium
	Total	67	3.5053	.30516	high

Appendix.11.

Differences in nursing practice toward aggression by the job satisfaction variable

Scale	Job satisfaction	N	Mean	Std. Deviation	Mean level
Internal causative factors	Satisfy	22	3.3364	.67721	medium
	Not satisfy	18	3.3778	.43866	medium
	Don't like to work in this hospital	5	3.1600	.29665	medium
	Neutral	22	3.3455	.55612	medium
	Total	67	3.3373	.54961	medium
External causative factors	Satisfy	22	4.0000	.72739	high
	Not satisfy	18	4.2222	.52394	very high
	Don't like to work in this hospital	5	3.8667	.29814	high
	Neutral	22	3.7879	.67882	high
	Total	67	3.9801	.64844	high
Situational/interactional causative factors	Satisfy	22	3.9545	.55868	High
	Not satisfy	18	4.0556	.55648	High
	Don't like to work in this hospital	5	4.0000	.00000	High
	Neutral	22	3.6909	.69755	High
	Total	67	3.8985	.59734	High
Total degree of patient factors	Satisfy	22	3.7273	.49325	High
	Not satisfy	18	3.8333	.38439	High
	Don't like to work in this hospital	5	3.6462	.12872	High
	Neutral	22	3.5804	.51230	High
	Total	67	3.7015	.45833	High
Management: general	Satisfy	22	3.8182	.60838	High
	Not satisfy	18	2.6667	.98518	Medium
	Don't like to work in this hospital	5	3.6000	.89443	High
	Neutral	22	3.4091	.90812	High
	Total	67	3.3582	.94069	Medium
Management: use of medication	Satisfy	22	3.5909	.36993	High
	Not satisfy	18	3.5370	.54997	High
	Don't like to work in this hospital	5	3.9333	.14907	High
	Neutral	22	3.5152	.42072	High
	Total	67	3.5771	.43648	High
Management: use of	Satisfy	22	3.5000	.49065	High

seclusion	Not satisfy	18	3.6852	.43495	High
	Don’t like to work in this hospital	5	3.8667	.38006	High
	Neutral	22	3.6818	.54895	High
	Total	67	3.6368	.49145	High
Management: restraint	Satisfy	22	3.2727	.55048	Medium
	Not satisfy	18	3.5000	.48507	High
	Don’t like to work in this hospital	5	3.5000	.50000	High
	Neutral	22	3.3182	.54654	Medium
	Total	67	3.3657	.52644	Medium
Management: non-physical methods	Satisfy	22	3.5114	.38942	High
	Not satisfy	18	3.4028	.39425	High
	Don’t like to work in this hospital	5	3.4000	.74162	High
	Neutral	22	3.5795	.45895	High
	Total	67	3.4963	.44058	High
Total degree of the nurses attitudes toward the aggression management	Satisfy	22	3.5357	.28121	High
	Not satisfy	18	3.4008	.33426	High
	Don’t like to work in this hospital	5	3.6571	.37253	High
	Neutral	22	3.5260	.28362	High
	Total	67	3.5053	.30516	High

Appendix.12.

جامعة النجاح الوطنية

كلية الطب والمهن الصحية\ كلية الدراسات العليا

استمارة بحثية بعنوان:

(موقف وسلوكيات التمريض تجاه عدوانية المريض المدخل بمستشفى بيت لحم للأمراض العقلية)

الزملاء التمريض الأعزاء\ السلام عليكم ورحمة الله وبركاته.

أنا الطالب حسين العواودة، ماجستير صحة نفسية ومجتمعية، جامعة النجاح الوطنية- كلية الطب والعلوم الصحية- دائرة التمريض والقبالة، سأقوم بدراسة مواقف و سلوكيات التمريض تجاه المريض النفسي العدواني المدخل بمستشفى بيت لحم للأمراض العقلية راجيا منكم التعاون وتعبئة هذه الاستمارة. لك الحق بالانسحاب في أي وقت من المشاركة بالبحث- مع العلم أننا سنحافظ لك على الاستقلالية و السرية الكاملة، هذه المعلومات ستستخدم فقط لأغراض البحث العلمي. أي استفسار حول الدراسة اتصل بي على الرقم (0597180005). شاكرين لكم حسن تعاونكم

الطالب: **حسين العواودة**
بإشراف
الدكتورة: **عايدة القيسي**
الدكتورة: **سابرينا روسو**

2014

هذه الاستمارة مكونة من ثلاثة أقسام، القسم الأول المعلومات الشخصية، القسم الثاني موقف التمريض تجاه عدوانية المريض العقلي، القسم الثالث يشمل سلوكيات التمريض تجاه عدوانية المريض العقلي.

الرجاء الإجابة على القسم الأول بوضع دائرة حول رمز الإجابة المناسبة.

القسم الأول: المعلومات الشخصية

1- العمر

أ- (20-24) ب- (25-29) ج- (30-34) د- (35- 39) ه- (40 فما فوق)

2- عدد سنوات الخبرة بمستشفى الأمراض العقلية

أ-سنة- 3 سنوات ب- 4سنوات- 8 سنوات ج- 9 سنوات 15 سنة د- أكثر من 15 سنة

3- الجنس

أ- ذكر ب- أنثى

4- مكان العمل\ القسم

أ- إدخال رجال ب- نقاهة رجال

ج- الأنسولين د- الفيلا(مزمنين رجال)

ه- إدخال نساء و- مزمنين نساء

ز- نقاهة نساء

5- المؤهل العلمي

أ- دبلوم ب- بكالوريوس

ج- ماجستير صحة نفسية د- ماجستير آخر

6- مدى الرضا الوظيفي

أ- راضي ب- غير راضي ج- لا أحب العمل بهذا المستشفى د- عادي

7- طبيعة الدوام

أ- صباحي ب- مسائي ج- ليلي د- جميع المناوبات

القسم الثاني: موقف التمريض تجاه العدوانية

يتكون هذا القسم من 47 سؤال مقسمة كالتالي، العدوانية كسلوك طبيعي ومقبول، مقياس ردة الفعل العدوانية،ردة الفعل الوظيفي تجاه العدوانية،العدوانية سلوك(هجومي، تواصلي، مدمر، وقائي وتطفلي).

العدوانية كرد فعل طبيعي	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- له تأثير ايجابي في العلاج					
2- هو بداية لعلاقة ايجابية قائمة على فهم أشمل					
3- هو طاقة يستخدمها الناس للوصول إلى الهدف					
4- ضروري ومقبول					
5- العدوانية تكشف عن مشكلة أخرى					
6- يحسن ويلطف الجو في القسم، وهو مفيد في العلاج					
7- هو طريقة مقبولة للتعبير عن المشاعر					
8- طريقة تواصل وعلى هذا النحو فهو ليس مدمر					
9- هو ردة فعل طبيعية للشعور بالغضب					
10- هو رد فعل صحي للشعور بالغضب					
11- هوردة فعل تكيفية مع الغضب					
12- هو تعبير عن المشاعر مثل الضحك أو البكاء					

هذا المقياس يقيس مدى ردة فعل الإنسان ووجهة نظره تجاه العدوانية

مقياس ردة الفعل العدوانية(مؤذي)	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- هو سلوك عدواني للنفس والآخرين					
2- عدواني اتجاه الأشخاص أو الأشياء					
3- يسمم أجواء القسم ويعيق العلاج					
4- هو تهديد الآخرين بالكلام أو الأفعال					
5- عمل لفظي أو جسدي غير مألوف وغير مناسب ويتميز بالقوة					
6- تدخل مزعج للسيطرة على الآخرين بالإكراه					
7- أي عمل عنف جسدي					
8- يستخدم كوسيلة سلطة وقوة من قبل المريض					
9- أي تعبير يشعر الآخرين بعدم الأمان والخوف والتهديد على الحياة					
10- أي تعبير لفظي يشعر الشخص باليذاء والتهديد					
11- إيذاءالآخرين نفسيا أو جسديا					

هذا المقياس يقيس مدى ردة فعل الإنسان ووجهة نظره من الناحية الوظيفية تجاه العدوانية

مقياس ردة الفعل الوظيفي	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- هو يأتي كتعبير عن الشعور بالعجز					
2- تنفيس و مخرج عاطفي					
3-إعطاء إشارة لطلب رد فعل					
4- يشبع حاجيات عنده أنه موجود					
5- صرخة للمساعدة					
6- يعطي الفرصة للحصول على معرفة أفضل عن وضع المريض					

مقياس وجهة النظر التي تقول أن العدوانية سلوك هجومي

هجومي	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- هو سلوك هدام وغير مطلوب أو مرغوب فيه					
2- غير ضروري وغير مقبول					
3- سلوك غير سار ومثير للاشمئزاز					
4- هو مثال لسلوك غير تعاوني					
5- يسمم الجو في القسم ويعيق العلاج					
6- بأي شكل من الأشكال هو دائما سلبي وغير مقبول					
7- لا يمكن استساغته أو التسامح معه					

مقياس وجهة النظر التي تقول أن العدوانية هي سلوك تواصلي

تواصلي	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- يوفر فرص و إمكانيات جديدة في الخدمة التمريضية					
2- يساعد الممرض أن يرى المريض من وجهة نظر أخرى أو بطريقة مختلفة					
3- نقطة البداية لعلاقة ايجابية بين الممرض والمريض					

مقياس وجهة النظر التي تقول ان العدوانية سلوك مدمر

مدمر	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- مدمر عندما يكون لدى المريض مشاعر عدائية من شأنها أن تتسبب في ضرر مادي للنفس أو على الآخرين					
2- سلوك عدواني تجاه النفس والآخرين					
3- خطير ومهدد لخراب وتدمير الأشياء وإيذاء الآخرين					

وجهة النظر أن ردة الفعل العدوانية هي إجراء وقائي

وقائي	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- هو لحماية النفس					
2- هو حماية شخص لخصوصيته وما يقع تحت سيطرته من ملكية أو بيئة محلية					

وجهة النظر أن العدوانية سلوك تطفلي

تطفلا	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- هو عمل لفظي أو جسدي خارج عن رغبة الشخص وهو غير مألوف وغير متناسب					
2- هو تعبير متعمد، أي ليس عفويا					
3- هو الدافع للتشويش ومقاطعة الآخرين للسيطرة عليهم وإيذائهم					

القسم الثالث: الجانب العملي/ سلوكيات التمريض تجاه العدوانية

هذا القسم متعلق بالسلوكيات اليومية التي يتعامل بها التمريض مع المريض العقلي

العوامل الداخلية المسببة	أوافق	أوافق بشدة	محايد	اعارض	أعارض بشدة
1- من الصعب وقاية ومنع المريض من ان يكون او يصبح عدائيا					
2- المرضى عدائيون لانهم يعانون من مرض					
3- هناك انواع من المرضى العدائيين					
4-المرضى العدائيين عليهم ان يحاولو ان يتحكمو بمشاعرهم					
5- المرضى العدائيين يهدئوون بسرعة اذا تركوا لوحدهم					

العوامل الخارجية المسببة	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- المرضى عدائيون بسبب البيئة التي يعيشون فيها					
2- البيئة المتزمتة او المضغوطة من الممكن ان تكون سببا في العدائية					
3- اذا تغيرت البيئة المادية من حول المرضى من الممكن ان يكونوا اقل عدائية					

العوامل الظرفية او الفاعلية المسببة	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- الاشخاص الاخرون ممكن ان يجعلوا المريض عدائيا او عنيفا					
2- المرضى يصبحون عدائيين في اغلب الحالات لان من حولهم لا يستمعون اليهم					
3-التواصل الضعيف بين المرضى ومن حولهم يؤدي الى العدائية					
4-العلاقات الفردية بين المرضى ومن حولهم من الممكن ان يقلل ويخفف حدوث العدائية					
5-الاحداث والظروف الكبيرة من الممكن ان تساهم في اخراج الالفاظ العدائية من المريض					

العلاج\ بشكل عام	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1-اساليب مختلفة تستخدم للتعمل مع وادارة العدائية					
2- عدائية المريض من الممكن ان تعامل وتدار بشكل اكبر تاثيرابهدا الاتجاه					

استخدام الادوية	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- الأدوية اسلوب قيم في علاج العدائيين والعنيفين					
2- الأدوية الموصوفة للمريض احيانا قد تؤدي الى العصبية					
3-العلاج المحدد او الموصوف يجب ان يستخدم بشكل متتابع للمرضى العدائيين					

العزل	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- عندما يكون المريض عدائيا فان العزلة من اكثر الاساليب فعالية					
2- عملية عزل المريض لا يجب ان تكون بشكل مستمر					
3- العزلة احيانا تستخدم بشكل اكبر من الضروري					

التقييد والربط	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- المرضى العنيفين يقيدون للحفاظ على سلامتهم الشخصية					
2- يستخدم الربط احيانا أكثر من اللزوم					

اساليب غير الجسمية	أوافق	أوافق بشدة	محايد	أعارض	أعارض بشدة
1- التفاوض يجب ان يستخدم بشكل فعال عند ادارة العدائية والعنف					
2- استخدام الالفاظ الغاضبة لا يجب ان تستخدم دائما من قبل من يعالج الحالة					
3- الاحتواء والتخدير يمكن ان تستخدم بشكل فعال ومنتظم للتعامل مع العنف الجسدي					
4- استخدام التصعيد اسلوب ناجح في منع العنف					

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بسم الله الرحمن الرحيم

An-Najah
National University
Faculty of Medicine

جامعة
النجاح الوطنية
كلية الطب

IRB Approval letter

Study title:
Nurses attitude toward inpatient aggression in a Palestinian psychiatric hospital.

Submitted by:
Hussein AL Awawdeh , Dr Aida Qaisi

Date Reviewed:
June 24, 2012

Date approved:
September 5, 2012

Your study titled " **Nurses attitude toward inpatient aggression in a Palestinian psychiatric hospital.**" Was reviewed by An-Najah National University IRB committee & approved on September 5, 2012

Samar Musmar,MD, FAAFP
IRB Committee Chairman
An-Najah National University

IRB

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جامعة النجاح الوطنية

كلية الدراسات العليا

موقف وسلوكيات طاقم التمريض اتجاه المريض المدخل لمستشفى الدكتور كمال للطب النفسي

إعداد

حسين العواودة

إشراف

د. عائدة القيسي

د. سابرينا روسو

قدمت هذه الأطروحة استكمالاً لمتطلبات الحصول على درجة الماجستير لتخصص تمريض الصحة النفسية المجتمعية ، بكلية الدراسات العليا في جامعة النجاح الوطنية ، في نابلس – فلسطين.

2014

موقف وسلوكيات طاقم التمريض اتجاه المريض المدخل لمستشفى الدكتور كمال للطب النفسي

إعداد

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الملخص

الهدف من البحث : يهدف هذا البحث لمعرفة وجهة نظر وسلوكيات التمريض تجاه المريض النفسي العدواني المدخل بمستشفى بيت لحم للأمراض العقلية، للعمل على تطوير برامج واستراتيجيات لكيفية التعامل مع عدوانية المريض العقلي.

طريقة البحث والمشاركين : عملت هذه الدراسة في مستشفى بيت لحم للأمراض العقلية والنفسية (مستشفى كمال عدوان) في فلسطين. العينة شملت كل التمريض الذين يعملون في المستشفى بخبرة سنة وأكثر وكانت العينة (67) ممرض وممرضة. تراوحت أعمارهم ما بين (20–50) بمتوسط حسابي (35.1)، 30 ممرضة و 37 ممرض. تم استخدام الاستبيان وقد اشتمل على ثلاثة مقاييس: المعلومات الشخصية، علاج العدوانية والعنف، السلوكيات تجاه العدوانية.

النتيجة: اتجهت وجهة نظر التمريض ميلا إلى أن عدوانية المريض مدمرة، عنيفة، تطفلية، و وظيفية، و أقل ميلا إلى العدوانية كردة فعل طبيعي و وقائية. وجهة نظر الممرضات كانت مع أن العدوانية شيء تطفلي، بينما الممرضين قالوا أن العدوانية إجراء تواصلي ويؤمنون أن علاج العدوانية يكون باستخدام أساليب مختلفة تتمكن من إدارة العدوانية وتوجيهها بالشكل الصحيح. عامل الخبرة له دور كبير في علاج العدوانية بالشكل الصحيح. تمريض قسم الإدخال رجال ونساء كانت لهم وجهة نظر تختلف عن تمريض الأقسام الآخرين حيث أنهم لا يوافقون على أن العدوانية إجراء وقائي وتواصلي بل هو عدواني ودفاعي. تمريض قسم المزمنين يؤمنون أن العدوانية إجراء تطفلي. التمريض الحامل لشهادة الماجستير وجهة نظره أن العدوانية سلوك طبيعي مقبول، وظيفي، تفاعلي تواصلي، عدواني، دفاعي، مدمر، كما يؤمنون أن للعوامل الخارجية والداخلية والتفاعلية

دور في حدوث العدوانية. وجهة نظر التمريض بشكل عام كانت أن للعوامل الخارجية والداخلية والبيئية دور في حدوث العدوانية. كما يؤمنون أن عدم سماعهم للمريض وسوء التواصل معهم له دور في حدوث العدوانية. يؤمن التمريض بدور الأدوية والتربيط والعزل في علاج المريض وعلى عكس ذلك يفضلون يؤمنون بدور الأساليب الغير جسمانية مثل التفاهم والتفاوض والتعبير عن الغضب.

الخلاصة: هذه الدراسة خلصت إلى أن هناك تباين في وجهات النظر لدى التمريض حول العدوانية وطرق التعامل معها، أشار التمريض الفلسطيني إلى العدوانية بالاتجاه السلبي لذلك لا بد من إيجاد برامج تعليمية تدريبية لإعادة صقل المفهوم الخاطئ لدى التمريض عن المريض وعدوانيته وذلك لتحسين الخدمة المقدمة للمريض لكي يتعافى سريعا ويعود لمجتمعه وحياته.