NURSES' KNOWLEDGE AND TRAINING ON THE MANAGEMENT OF AGGRESSION IN MENTAL HEALTH CARE SETTINGS: A LITERATURE REVIEW

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ABSTRACT

Aggression is a public health issue, irrespective of age, class, level of education and place. Its attribution to mental health care setting makes focus in mental health paramount. Aggression is eminent in mental health care settings and professionals have been accused of poor method of aggression management. Study shows that nurses have the highest risk of being prone to aggression and are three times more likely to experience aggression than any other healthcare worker hence the need for knowledge and training. The cause of aggression in mental health care settings is unknown but some authors believed that the level of knowledge on the mode of aggression management in relation to controlling the patients among nurses is low. Studies have also established the need for specialized training for psychiatric nurses on aggression management and a change in approach that will result in reduction of the high rates of aggression. Thus, this review discusses the nurses' knowledge and training about the concept of aggression and its management in mental health care settings.

Keywords: Knowledge, Aggression, Mental Health Care.

Introduction

Anger can be framed as a conscious or wilful decision to commit an aggressive act, seen as violation of an accepted social norm (Berkowitz, 2012). The progression of anger leads to aggression and can become an attitude (Large and Nielssen, 2011; Berkowitz, 2012). It is an emotional reaction (Franz, Zeh, Schablon, Kuhnert, and Nienhaus, 2010) and rarely is this an autonomic response, but develop in intensity over a period of time. (Berkowitz, 2012) and might extend to the intent of inflicting injury or causing death to an innocent person – the victim (Berkowitz, 2012). This might be cyclical in nature involving offense and retaliation, termed as "aggression breeds aggression" (DeWall, Anderson, and Bushman, 2011). This is supported by findings of Franz, et al. (2010) who describe anger as one of the emotional reactions that arise in a victim of aggression which leads to fight or flight responses.

History reveals that aggression was used as a socially adaptive method to maintain boundaries (DeWall, et al., 2011). As social integration occurred, aggression becomes unacceptable and the skill of negotiation developed until ultimately in 1945, when it was legislated internationally as a crime, described as unlawful actions of discrimination, intimidation and excommunication ((DeWall, et al.,2011; Sayapin, 2014). Aggression, as stipulated in the global decree, is a crime, irrespective of where, when, how, why, and by whom it is perpetrated (Sayapin, 2014). Despite the declaration of criminality of aggression, unresolved expressions of anger results in violation of law by the offender or the offended in form of gender-based aggression, social aggression, self-directed aggression (Sayapin, 2014; Vives-Cases, Ruiz-Cantero, Escribà-Agüir, and Miralles, 2011).

The Concept of Anger and Aggression in Mental Health Care Setting

National surveys portray the public's perception of aggression being a defining characteristic of mental illness (Ünsal Atan, Baysan Arabaci, Sirin, Isler, Donmez, Unsal Guler, and Tasbasi, 2013; Corrigan, Watson, Warpinski and Gracia, 2014; Nestor, 2014). This perception is seen to extend into the work setting where, despite aggression not being accepted internationally, psychiatric nurses consider it part of the job where anger and aggression have become more of a norm than an anomaly (Child and Mentes, 2010; Moylan and Cullinan, 2011; James, Isa and Oud, 2011; Ukpong, Owoeye, Udofia, Abasiubong, and Ukpong, 2011; Steinman, 2013). It is therefore not a surprise to discover anger as a form of emotional reaction mental health care professionals' display in face of aggression (Franz, et al., 2010). The perception of mental health professionals about aggression can constitute stigma and affect the mode of management (Ünsal, et al., 2013; Nestor, 2014,). This leads to fight or flight responses exhibited in form of forceful detention, restrain, force medication, use of armed responses- police and, or withdrawal (Franz, et al., 2010). The

tendency to retaliate aggression by aggression leads to continuous circle of aggression and retaliation (DeWall, et al., 2011). However, therapeutic communication is effective and evidence-based approach of aggression resolution, but less utilized by mental health care professionals (Björkdahl, Hansebo, and Palmstierna, 2013; Cleary, Hunt, Horsfall and Deacon, 2012).

Therapeutic communication is also required to develop insight in mentally ill patients (Stenhouse, 2011; Cleary, et al., 2012; Mcandrew, Chambers, Nolan, Thomas and Watts, 2013), but psychiatric nurses have been criticized for their lack of interaction and therapeutic engagement with patients both in terms of quality time and use of standard psychological interventions (Thibeault, Trudeau, D'entremont, and Brown, 2010; Sharac, McCrone, Sabes-Figuera, Csipke, Wood, & Wykes, 2010; McAndrew, et al., 2013). From patients' view, this is regarded to have developed from the culture of a busy schedule and time constraints of nurses (Stenhouse, 2011). While on the other hand, nurses view such accusation from angle of lack of knowledge of therapeutic communication (McAndrew, et al., 2013).

However, McAndrew, et al. (2013) declare the need to address barriers preventing nurses from engaging with patient, either by training or removal of non- nursing duty that consume nurses' time.

Psychiatric Nurses' Knowledge and Training on Aggression Management

Aggression is a significant global problem in health care settings, specifically mental health care settings (WHO, 2002; Child and Mentes, 2010). Linguistically and hence conceptually aggression is often used interchangeably with aggression (Child and Mentes, 2010; Franz, et al., 2010; DeWall, Anderson and Bushman, 2011). The World Health Organization (WHO) (2002) definition of aggression is inclusive of concepts denoting physical force / aggression, purposeful intent, direction of intent and the possibility of actual physical or psychological harm. Aggression, and the risk of aggression, has attracted attention from the WHO and has become an increasing focus of public health research (WHO, 2002; Child and Mentes, 2010; Franz, et al., 2010; Gates, Gillespie and Succop, 2011; Reingle, Jennings, Piquero, and Maldonado-Molina, 2014). Aggression in healthcare settings can include several forms namely: patient to fellow patient, objects, patients' relative or to health care worker (Rasmussen, Hogh and Andersen, 2013).Current research indicates that nurses have the highest risk of being prone to aggression (Anderson and West, 2011; Hahn, Müller, Hantikainen, Kok, Dassen, and Halfens, 2013; Pompeii, Dement, Schoenfisch, Lavery, Souder, Smith and Lipscomb, 2013; Steinman, 2013; Bader, Evans and Welsh, 2014).While Mitchell, Ahmed and Szabo (2014) specify that nurses are three times more likely to experience aggression than any other healthcare worker. This pattern of the direction of aggression is particularly evident in mental health care settings (Large and Nielssen, 2011).

Literature provides research reports, not only on incident rates of aggression but also about the extent and nature of injury (Jennings, Piquero and Reingle, 2012; Yang, Spector, Chang, Gallant-Roman, and Powell, 2012). International literature categorizes the nature of injury to range from minor to disabling (Anderson and West, 2011). Briefly, a workplace injury is deemed as disabling when an employee cannot cope with work as a result of the emotional or physical injury sustained from aggression (Yang, Spector, Chang, Gallant-Roman, and Powell, 2012; Bader, Evans, and Welsh, E2014). These injuries can lead to either temporary loss of psychological wellbeing or hyper psycho-somatic reactions and have frequently necessitate time off duty or resignation form the job (Child and Mentes, 2010; Yang, et al., 2012). As stated previously prevalence rates of aggression, and disabling injuries, against PNs is suggested to differ between LMIC countries and upper income countries (Franz, et al., 2010, 3; Moylan and Cullinan, 2011; Ukpong, et al., 2011; Steinman, 2013). However, the difference is suggested to be within the range of reporting (Large and Nielssen, 2011). These vary from 80% - 100% in upper income countries, while the prevalence range in LMIC countries is 50% to 85% (Franz, et al., 2010; Gates, et al., 2011; Moylan and Cullinan, 2011; Ukpong, et al., 2011).

There appears to be no single reported cause of aggression in mental health care settings (Amoo and Fatoye, 2010; Child and Mentes, 2010; Franz, et al., 2010; Chukwujekwu and Stanley, 2011; Virtanen, Vahtera, Batty, Tuisku, Pentti, Oksanen, and Kivimäki, 2011;

Papadopoulos, Ross, Stewart, Dack, James, and Bowers, 2012; Bader, et al., 2014). These authors described causes that are interrelated and summarized as including; environmental adversity (specifically increased noise leading to perceived chaos), high stress levels, and time of the day, with Amoo and Fatoye (2010) reporting increased risk at night attributed to hallucinatory tendencies which are considered higher in the dark. In addition, the relationship between certain psychiatric labels or conditions and the risk of aggression is well documented (Child and Mentes, 2010; Gray, Taylor and Snowden, 2011; Large and Nielssen, 2011; Bader, et al., 2014; Nestor, 2014; Swartz, Swanson, Hiday, Borum, Wagner, and Burns, 2014). Specifically, a history of, or current, substance abuse (Child and Mentes, 2010; Vaidyanathan, Patrick and Iacono, 2011; Swartz, et al., 2014) is noted as increasing the risk of aggression, and schizophrenic illnesses have been linked to the highest predisposition to aggression irrespective of any substance abuse history (Volavka and Swanson, 2010; Gray, et al.,, 2011; Soyka, 2011; Van Dorn, Volavka and Johnson, 2012; Bader, et al., 2014).

Swanson, et al. (2015) suggests that within the mental health care setting causes of violent behaviour have their origin within mental health care legislation and policy, or lack thereof. Firstly, mental health care legislation has the purpose of determining safe and ethical care of the mental health patient. Legislation, such as the South African Mental Health Care Act (no 17 of 2002), is frequently supported by provincial or regional treatment protocols related to the assessment of risk for aggression and practitioner's response (KZN DoH, 2007). The absence of national legislation, and provincial / regional protocols to support national legislation, results in a lack of risk assessment and treatment guidelines for the prevention of aggression. 64% of LMIC, has no mental health legislation (Westbrook, 2011).

Studies suggest that the actual practices of mental health professionals, specifically the nurse, are directly linked to incidents of violent behaviour (Jonker, et al., 2008; Bader, et al., 2014). Firstly, authors argue that within nurse-patient interactions confidence, knowledge and skills, obtained through experience, are necessary to manage, assess for, and prevent aggression (Papadopoulos et al., 2012; Björkdahl, Hansebo and Palmstierna, 2013; Mitchell, et al., 2014). This focus on practitioner knowledge and skill derived through experience is supported by research that reports increased aggression rates associated with the reduction in the number of experienced nurses and the use of casual and agency nurses rather than specialized professionals (Child and Mentes, 2010). However, aggression against PNs in Nigeria is reported to be higher among older nurses (James, et al., 2011). Thus, experience may not be as relevant as specific content received in training. Jonker, Goossens, Steenhuis, and Oud, (2008) suggested direct links between training of psychiatric nurses and work place violent incidence. These authors stated that the occurrence of aggression is highly dependent on the type of training psychiatric nurses receive, specifically related to preparedness for practise of assessment, prevention and management of aggression (Jonker, et al., 2008). It is suggested that this specific training be inclusive of regular risk assessment involving structured professional judgement and de-escalation techniques (Björkdahl, et al., 2013; Yao, Li, Arthur, Hu, and Cheng, 2014).

Psychiatric nurses in both high- and low-income countries have reported lack of educational preparation and knowledge of aggression management (Liu, Hou, Tian, Hu, and Li, 2011; Koukia, Mangoulia, Stathopoulos, and Madianos, 2013; Coban Arguvanli, Karata□, Ba□er, and Zararsiz, 2015).

Studies have established the need for specialized training for psychiatric nurses on aggression management (McAndrew, et al., 2013; Björkdahl, Hansebo and Palmstierna, 2013; IIkiw-Lavalle and Grenyer, 2014). De-escalation techniques was embraced in the U.K in 2002 after the United Kingdom Central Council for Nursing, UKCC, (2002) conducted a study on the knowledge of psychiatric nurses on aggression management and discovered that nurses have no formal training that prepares them to prevent aggression. UK psychiatric / mental health nursing curriculum addressed the use of restraint but provided no information on aggression management (UKCC, 2002). The U.K report is similar to Nigeria where the nursing curriculum does not include aggression management but provides extensive information on the use of restrain (NMCN, 2006). In the UKCC (2002), 61% of the psychiatric nurses reported that they were trained to inflict pain on patients to achieve compliance with restraint. This is similar to the

report of Nigeria mental health legislation in which some of the procedural element give room for abuse (Westbrook, 2011). However, training of psychiatric nurses on verbal de-escalation techniques has been widely embraced and found effective by psychiatric nurses in U.K unlike Nigeria where the concept is still alien and abuse persists (Committee of Public Accounts, 2003; Inglis and Clifton, 2013; Westbrook, 2011).

A Greek study examining aggression against psychiatric nurses, reported that nurses consider overpowering and restraining patients to be wrong and unhealthy for both the nurse and the patient, but know no alternative means to curtail aggression (Koukia, et al., 2013). In another study conducted to elicit the knowledge and training need of psychiatric nurses on aggression management in China, 76% of the psychiatric nurses reported never to have had any form of training on aggression management while 97% requested to be trained (Liu, et al., 2011). Also in Turkey,

Coban, et al. (2015) highlighted that the level of knowledge of a non-punitive mode of aggression management among nurses is low with a very high rate of dysfunctional reactions which serve as a means of controlling the patient, but with corresponding high rates of aggression that showed a reduction after training and a change in approach. Though studies have established the need for specialized training for psychiatric nurses on aggression management, the decision to accept or reject the approach is still largely vented in the nurse (Mc Andrew, et al., 2013; Björkdahl, Hansebo and Palmstierna, 2013). Cleary, et al. (2012) argue that attributes of a caring nurse originates primarily from intrinsic characteristics and not as a product of training. Further to this, the structure of the practice setting can make implementation of therapeutic strategies gained in any training challenging if the willingness of nurses does not coincide with supportive structures (Laker, Callard, Flach, Williams, Sayer, and Wykes, 2014). These supportive structures are; Legislation/institutional policy, managers directive, occupational hazard/job satisfaction (Laker, et al., 2014).

Lack of mental health legislation in majority of low-income countries (64%) have constituted major barrier to effective mental health care as against the minority (8%) of high-income country that have no standardized mental health legislation (WHO, 2013). Legislation being a major determinant of mode of practice, lack of it will invariably affect the mode of care and the therapeutic milieu of a psychiatric unit (Alhasnawi, Sadik, Rasheed, Broadhead, Blazer, and George, 2012; Laker, 2014; Swanson, et al., 2015).

Further to legislation, the direction of the flow of care is from the managers – key change agents - to their subordinates (Letlape, Koen, Coetzee, and Koen, 2014). Letlape, et al. (2014) also note the need for updating psychiatric nurses' knowledge on new research, laying emphasis on the recognition of ward managers' input in training needs and hindrances before decision making on the commencement of training. Therefore, success of any training programme may depend on the opinion of nurse leaders before and after training. The significance of this participative relationship between researcher and nurse leaders is seen in a study conducted in Turkey by Coban, et al. (2015) during which aggression management training led to change in nurses' attitudes and practise which resulted into reduction in the aggression incidence. This positive result was in contradiction to the initial subjective bias expressed by Coban, et al. (2015) that nurses will be resistance towards change.

De-Escalation Techniques of Aggression Management

One such training that can be conducted to manage aggression is de-escalation. De-escalation has been declared an evidence-based approach of aggression management (Price and Baker, 2012; Richmond, Berlin, Fishkind, Holloman, Zeller, Wilson, and Ng, 2012; Inglis and Clifton, 2013). These techniques offer a communication approach that emphasizes the expression of an understanding and respect for each other's' opinion in the face of anger (Price and Baker, 2012). It emphasizes the need for the respect for human dignity and also serves as an evidence-based approach for a desirable outcome in aggression management (Price and Baker, 2012; Richmond, et al., 2012; Inglis and Clifton, 2013). Furthermore, it serves as a rehabilitative approach through therapeutic nurse-patient communication, the lack of which has been emphasized as a causative factor of aggression (Cleary, et al., 2012; Mc Andrew, et al., 2013). Aggression management through de-

escalation techniques is considered essential to achieve a therapeutic milieu in the mental health setting (Björkdahl, Hansebo and Palmstierna, 2013). Loewenstein and McManus (2014) identified the importance of verbal de-escalation techniques above the punitive and restrictive approaches and declared the need to update nurse's knowledge. A punitive approach, and the failure of nursing staff to engage early with de-escalation to prevent aggression progression can trigger further incidences of aggression (Franz, et al., 2010; Moylan and Cullinan, 2011; McAndrew, Chambers, Nolan, 2013; Loewenstein and McManus, 2014).

Richmond, et al. (2012) provides a detailed description of de-escalation techniques as involving; therapeutic communication skill, respect for human right, maintaining situational and self-control. Therapeutic communication, besides being an aggression de-escalation technique, is also an essential skill every nurse must acquire to maintain professionalism and quality of service delivery (Arnold and Boggs, 2015). This is because the mode of information dissemination does not only affect the reception and response to the information, it also says a lot about the knowledge and character of the disseminator (Arnold and Boggs, 2015). In the management of aggression, the way messages are conveyed to the angry person can either aggravate or calm the anger (Richmond, et al., 2012).

Psychiatric nurses' mode of communication has been declared a contributory factor to incidents of aggression in mental health care settings (Ilkiw-Lavalle and Grenyer, 2014). Communication techniques required in de-escalation involve initiating discussion and establishing the verbal contact in a friendly rather than an accusation manner (Richmond, et al., 2012). The ability to listen carefully, understand the needs of an individual and provide suggestions on the way forward is not only a quality psychiatric nurses should develop to be able to de-escalate aggression; it has also been declared as the hallmark of professionalism (Richmond, et al., 2012; Arnold and Boggs, 2015).

Similarly, dissemination of information by verbal briefing and accurate report writing concisely is regarded as an essential communication skill in aggression management (Richmond, et al., 2012). Communication cannot be effective if the nurse is unable to achieve self and situational control (Richmond, et al., 2012). Self-control is the ability to maintain a calm disposition in case of threat and displeasure (Inzlicht and Schmeichel, 2012). This is important because aggression will naturally breed aggression, but a professional will remain focused if able to achieve self-control in case of provocation (DeWall, et al., 2011; Richmond, et al., 2012). Situational control can be regarded as the ability to put disruptive behaviour under control without inflicting physical or emotional injury on another person (Schmidt and Diestel, 2015). A psychiatric nurse needs to engage with situational control to be able to prevent aggression and this can be achieved by determining the level of control and setting clear limits in a respectful manner (Richmond, et al., 2012). According to Richmond, et al. (2012) it is important to let the person know the limit to which they can act in response to ventilation of their anger, example of such is, stating the non-allowance for destruction of life or property of self or others.

Conclusion

The WHO (2012) quality right tool kit recognizes lack of respect for human dignity as the cause of aggression in mental health care setting. Respect for human dignity, besides being an aggression de-escalation technique, is also an essential human quality, the lack of which can show the perpetrator as being inhumane (Richmond, et al., 2012). This requires; respecting the opinion and personality of others by consenting to their view or disagreement in a non-provocative manner, admitting one's fault; a sign of respect for the self-dignity and the dignity of another person. It is important for psychiatric nurses to agree with the truth as opposed to defend the institution and its policy as a sign of respect for the mentally ill individual (Richmond, et al., 2012). It is of interest to note that older Nigerian nurses are greater victims of aggression as compared to other international health care settings (James, et al., 2011). Thus, the need for concerted effort on aggression management in mental health settings requires concerted effort for improved practice.

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