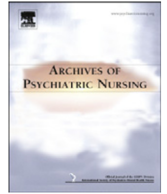
Archives of Psychiatric Nursing 29 (2015) 393–400

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu



Reducing or Increasing Violence in Forensic Care: A Qualitative Study of Inpatient Experiences

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ABSTRACT

Semi-structured interviews with 13 forensic psychiatric inpatients that had decreased their assessed risk of violence were analyzed using interpretive description. The main contribution from this study is a detailed description of patients' own strategies to avoid violence. Participants described having an ongoing inner dialog in which they encouraged themselves, thereby increasing their self-esteem and trying to accept their current situation. An unsafe and overcrowded ward with uninterested and nonchalant staff increased the risk of aggressive behavior. In the process of decreasing violence, the patients and the forensic psychiatric nursing staff interacted to create and maintain a safe environment.

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Violence and threats of violence are an everyday reality for patients and staff in forensic psychiatric hospitals (Dickens, Piccirillo, & Alderman, 2013). However, the prevalence of violence in forensic mental health hospitals is varied. In a study by Moyland and Cullinan (2011) which examined a sample of 110 psychiatric nurses, 80 percent of the nurses had been assaulted, 65 percent had been injured, and 26 percent had been seriously injured. Studies show that while serious incidents of aggression occur, the most common way for forensic patients to express their anger was through verbal aggression (Daffern et al., 2010; Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009).

According to Rippon (2000), it is difficult to define the nature of institutional aggression and violence because many definitions exist in the literature. However, he suggests that violence could be seen as synonymous with aggression, except that violence implies acts of aggression that are more intense and results in injuries. In line with Rippon (2000) we did not distinguish between the concept of aggression and violence in this study.

Aggression can be physical or verbal, and active or passive in nature. Passive aggression can be exerted through body language or by a refusal to conform or participate. Whittington and Richter (2006, p. 55) stated that the missing link in understanding and managing violence in mental health settings is that interpersonal violence between patients and nursing staff requires at least two parties, and both these parties influence the interaction.

Consequences of inpatient violence can include a feeling of being unsafe by both patients and staff (Delaney & Johnson, 2008). One of the few studies with a patient perspective has investigated the experience of being in a forensic ward where violence occurs. The patients were in continuous distress as they feared becoming a victim of violence (Hörberg et al., 2012). Another study revealed that the success of a forensic inpatients' recovery process depended on their experience of being in a safe environment (Olsson, Strand, & Kristiansen, 2014). Violence on a ward can start a vicious cycle in which staff members develop authoritarian and intimidating attitudes (Duxbury, 2002), which in turn escalates patient aggression (Meehan, McIntosh, & Bergen, 2006). Overall, research has identified various risk factors associated with inpatient aggression. A relationship between certain mental illnesses and violence is generally accepted in the literature (Daffern, Howells, Ogloff, & Lee, 2005; Douglas, Guy, & Hart, 2009). For example, Daffern et al. (2010) found that symptoms including delusions, unusual thoughts, and hallucinations were related to violence, and anxiety and depression seemed to be linked to aggression incidents. However, the question of why inpatient violence occurs is controversial. Violence in psychiatric hospitals is often explained with reference to the patients' diagnoses, but inpatient aggression is also a result of multiple interacting factors related to the individual patients, the staff, the context and circumstances on the ward (Björkdahl, 2010; Bowers, 2009; Daffern et al., 2010). Further, van Nieuwenhuize and Nijman (2009) found that low quality of life among forensic psychiatric inpatients were likely to increase the risk of institutional violence. Peplau (1952/1994) psychodynamic nursing theory can be used when describing the recovery process in a forensic setting. She claimed that the interpersonal relationship between nurse and patient must be based on a compassionate communication, in which both nurses and patients learn and develop skills. One of the fundaments of Peplau's theory is the belief that interpersonal relationships are affected by the surrounding environment.

In recent years, researchers have observed the limited representation of forensic psychiatric inpatients experience in research. However,

Funding: This study was supported by grants from the Swedish Research Council, the National Postgraduate School of Healthcare Science, Karolinska Institutet and Mid Sweden University.

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http://dx.doi.org/10.1016/j.apnu.2015.06.009
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during the last 5 years a few studies have been published in that topic. They aim to describe the experience of being a patient in forensic care (e.g. Dickens et al., 2013; Gildberg, Elverdam, & Hounsgaard, 2010; Hörberg et al., 2012; Meehan et al., 2006). The aim of the present paper was to specifically examine the experiences of forensic inpatients that have decreased their risk of becoming violent in forensic care. Further, it aimed to elucidate those patients' perceptions of factors believed to contribute to a decreased or increased risk of violent behavior in a forensic psychiatric ward.

METHOD

This study attempted to understand inpatients' experiences of decreased and increased risk of violence. Therefore, an inductive approach was chosen, i.e. interpretive description (Thorne, Kirkham, & O´Flynn-Magee, 2004), which was based on applied as well as theoretical nursing. Ethical approval was obtained from the Regional Ethical Review Board at Umeå University (Dnr. 07/164 M) and from each participating patient.

Setting, Characteristics, and Selection of Participants

Data collection was performed at a maximum security forensic psychiatric hospital in Sweden. The involuntary treatment setting is characterized by restrictions and a high safety and security approach, restricting the action of both staff and those receiving care.

According to Swedish law, compulsory psychiatric treatment can be ordered when an offense has been committed under the influence of a severe mental disorder. In Sweden, compulsory psychiatric treatment may also be required for individuals with serious psychiatric problems who become violent and unmanageable during imprisonment or arrest.

The sample in the present study was drawn from a larger study, described in detail in Olsson, Strand, Sjöling, and Asplund (2013). The inclusion criteria for participants were patients who had been admitted to forensic care and had been assessed as less violent according to the risk assessment instrument *Historical-Clinical-Risk Management-20* (HCR-20; Webster, Douglas, Eaves, & Hart, 1997). Further, the patients should have successfully been placed at a lower level of security (e.g. allowed to have short-term leaves or other outside privileges) and been assessed by staff as treatment-motivated. Treatment motivated in this context meant that patients were judged to be engaged in their treatment and interested in participating in everyday activities on the ward. The choice to include patients that had decreased their risk for violence was driven by the view that decreasing violence is a process and only people that have actually experienced the whole process were able to describe it. Thirteen participants met the criteria and were asked to participate. The participants were recruited from the same maximum security forensic psychiatric hospital, but they were in seven different wards. Most of the participants had a long history of attending different psychiatric care hospitals, and all of them had experienced forensic psychiatric hospitals in different parts of Sweden. Patient characteristics can be found in Table 1.

Data Collection

The 13 individual face-to-face interviews were conducted in a separate room in the patient's ward or in the patient's own room. The interviews were performed over a period of 2 months in 2011; they were tape-recorded and transcribed verbatim by the first author (HO). The interviews lasted between 22 and 66 minutes (median 46 minutes). None of the authors worked on the ward or had prior knowledge of the participants. In this study, we did not distinguish between the concepts of aggression and violence (Rippon, 2000), therefore the interviews began with a question about the concepts of aggression and violence. This approach was taken to ensure that the participants' understanding of the concepts did not differ from that of the interviewer. The semi-structured interview guide can be found in Table 2.

Table 1
Patient Characteristics (n = 13).

Demographic factors	*n*
Gender	
Female	2
Male	10
Age, *M (SD)*	37 years (R = 25–71 years)
Number of years in forensic psychiatric care, *M (SD)*[*]	7 years (R = 2–9 years)
Diagnosis/ICD-10	
Schizophrenia and other psychotic disorders	9
Personality disorders	1
Pervasive developmental disorders, such as autism	3
Index crimes	
Attempted murder	3
Assault	3
Arson	2
Unlawful threat	3
Admitted for involuntary treatment without being convicted of crimes	2

[*] As this time.

Data Analysis

Each transcript was analyzed using an interpretive description approach (Thorne, 2008; Thorne et al., 2004). Throughout the analytic process, questions regarding the contextual nature of the data were frequently explored to enrich the analytic process (Thorne et al., 2004). The data analysis was primarily performed by the first author (HO) and the second author (ÅA). Thereafter, all involved authors had frequent meetings to discuss the developing analysis and to determine the next steps. As Thorne et al. (2004) advocate, the analytic procedure was characterized by a process of five stages, namely: comprehending, synthesizing, decontextualization, theorizing, and recontextualization of data (see Fig. 1).

FINDINGS

The data analysis resulted in three themes: 1) staff's attitudes and actions, 2) patients' insight and actions, and 3) interactions in the health care environment. To describe the findings in further detail, all themes were divided into subthemes (see Table 3). All themes describe situations and issues that increased or decreased the likelihood of violence.

THEME 1: STAFF'S ATTITUDES AND ACTIONS

The attitudes and actions of the forensic nursing staff members (i.e. staff working with nursing care) were described by the participants on a continuum ranging from positive to negative. A majority of the participants described that nursing staff that held negative attitudes caused frustration on the ward. This frustration could sometimes lead to conflicts and subsequent violence. Meanwhile, positive staff attitudes typically led to good interactions between staff and patients. These positive

Table 2
Semi-Structured Interview Questions.

During a typical day, what do you do to feel good?
What is your relation to the other patients?
Please, tell me about how you experience safety at the hospital?
Please, tell me about a situation which could have ended in a violent act, but did not?
Please, tell me about a situation that became a violent act?
What do you think triggers respectively stop a violent act?
If you would be angry or upset or unfairly treated; how should staff respond so that you feel calm and safe again?
If you would be angry or upset or unfairly treated; what is a bad response from staff out on such an occasion? What would make you more upset?

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