



Comprehensive Strategies for Managing Aggression in Psychiatric Nursing Settings: Review of Contributing Factors and Effective Interventions

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Abstract

Background: Aggression in psychiatric settings is a critical concern, impacting both patient safety and staff well-being. It often leads to the use of seclusion and restraint, which patients frequently perceive as punitive rather than therapeutic. Understanding the multifactorial causes of aggression is essential for developing effective management strategies.

Methods: This systematic review synthesizes current literature on the incidence and contributing factors of aggression in psychiatric wards. A comprehensive search was conducted across multiple databases, applying explicit inclusion and exclusion criteria to identify relevant studies. The analysis focused on patient-related, staff-related, and ward-related factors influencing aggressive behavior.

Results: The review found a weighted mean prevalence of aggressive incidents at 54%, with significant variability across studies. Key patient-related risk factors included diagnoses of psychosis, personality disorders, and substance misuse. Staff-related factors such as job strain and inadequate communication skills also played a crucial role in the manifestation of aggression. Additionally, environmental variables, including ward design and patient occupancy rates, contributed to the likelihood of aggressive episodes. Notably, the first few days of admission were identified as a period of heightened risk for aggression.

Conclusion: Effective management of aggression in psychiatric settings requires a multifaceted approach that addresses patient, staff, and environmental factors. Implementing targeted training for staff, improving

communication, and modifying ward conditions can enhance safety and reduce the incidence of aggressive behavior. Future research should focus on prospective studies to further elucidate the dynamics of aggression in psychiatric care.

Keywords: Psychiatric aggression, patient safety, staff training, environmental factors, systematic review.

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1. Introduction

Aggression poses a significant issue in psychiatric wards, resulting in substantial repercussions for both patients and mental healthcare staff: aggressive behavior is a primary rationale for the seclusion or restraint of patients [1], yet patients perceive this as a form of control and punishment devoid of therapeutic benefit [2]. Healthcare professionals encounter emotions of wrath, worry, and guilt after an aggressive episode, as well as elevated levels of burnout [3,4].

The development and manifestation of aggression are typically elucidated as multifactorial, encompassing environmental factors (ward design, privacy, locked doors, ambiance, noise levels, over-stimulation), mental health care system factors (regional policy, hospital policy, ward regulations, patient attitudes, cultural influences), patient-related factors (demographics, cognitive and emotional states, malevolence, pathology), and clinician-related factors (communication proficiency, de-escalation skills, attitudes towards aggression, clinician stress levels) [5, 6]. Prior evaluations of violence in psychiatric wards mostly focused on patient-related criteria, such as the segregation of high-risk individuals predisposed to aggressive behavior [7–9]. From a preventive standpoint, ward and staff variables provide a compelling opportunity for mitigating aggressiveness, while the management of mental disorders is the only patient-related factor that diminishes the likelihood of aggression emergence [10]. Nonetheless, it remains ambiguous how the many elements that elucidate the development of aggressiveness interrelate.

The word aggressiveness is vague, having several connotations, and is often used interchangeably with agitation and violence [11]. Agitation is characterized in the DSM-5 as “a state of excessive psychomotor activity accompanied by heightened tension and irritability,” leading to non-productive and repetitive behavior.” It is often seen as a prelude to aggressiveness [12]. The WHO characterizes aggression and violence as synonymous, defining them as “the intentional use of physical force or power, threatened or actual, against oneself, another individual, or a group or community, that either result in or has a high probability of resulting in injury, death, psychological harm, maldevelopment, or deprivation” [13]. The British National Institute for Health and Care Excellence (NICE) guidelines characterize aggression as: “a spectrum of behaviors or actions that may lead to harm, injury, or distress to another individual, irrespective of whether the aggression is manifested physically or verbally, whether physical harm occurs, or whether the intent is evident” [14]. Agitation, aggressiveness, and violence may be seen as a continuum of intensity, with agitation progressing to aggression and finally culminating in violence. Violence is distinguished from aggressiveness by the degree of severity and the purpose of the behavior.

The extensive literature on aggressiveness may indicate the significance and relevance of the subject. Previous publications have addressed violence in emergency wards, hostility in forensic environments, and strategies aimed at minimizing confinement and constraint [15–17]. Previous reviews on the development of aggressiveness in mental institutions have mostly concentrated on certain aspects, such as patient characteristics while neglecting the contributions of staff and ward factors to aggression development. Dack's study offers a comprehensive examination of patient characteristics, however, it included only 34 publications, 11 of which pertain to forensic wards [18,19]. They considered just research that compared an aggressive cohort of patients to a non-aggressive cohort and omitted papers that reported the number of events rather than the number of aggressive patients [20]. Welsh's analysis focused only on environmental variables, while also including forensic and jail contexts [21].

Among the assessments that included all three characteristics, some examined research from 1983 to 2008 and need updating [16, 22, 23], while others incorporated just a limited number of studies [16, 23], or additionally included forensic wards [16]. Cutcliffe's essay offers a theoretical framework for synthesizing

and addressing several aspects relevant to our study; nevertheless, it is only descriptive and lacks statistical data and a defined search technique [24]. In 2015, Szabo performed a comprehensive evaluation including 120 papers; nonetheless, it had significant methodological deficiencies, including a lack of statistical support for its results and an absence of a search strategy [25]. This systematic review is the first to use a comprehensive search approach, explicit inclusion and exclusion criteria, and, importantly, to undertake a quality evaluation of the included articles. This systematic study aims to comprehensively examine the variables influencing the development of aggressiveness in closed psychiatric wards, building upon the integrative work of Cutcliffe.

This study is the first attempt to assemble a comprehensive overview of the elements related to patients, staff, and wards that lead to the emergence of aggressiveness in a general psychiatric admission ward, supported by statistical data when feasible. These findings may facilitate the development of enhanced preventive measures in the future.

2. Incidence of aggressiveness

Aggression is a significant challenge in mental health treatment, necessitating the safeguarding of both patients and staff. The weighted mean prevalence of aggressive episodes was 54%, exhibiting a broad prevalence range among studies (7.5% to 75.9%). This prevalence range differs from a prior study, which reported a range of 3–44% [18]. The rationale for this divergence lies in the notion of aggressiveness used in this review. Utilizing an expansive understanding of aggressiveness, including a spectrum from agitation to aggression to violence, results in a more extensive compilation of data that may indicate a broader occurrence range.

A minor fraction of admitted patients account for the bulk of hostile episodes: 0.5–33% of patients are responsible for 42–66% of the incidents. The first three days of admission seem to correlate with the greatest incidence rates, consistent with a prior analysis by Woods et al. (2007) [26]. This result may be attributed to several variables, including symptom intensity, drunkenness at the time of admission, admission without permission or comprehension, or the patient experiencing prolonged wait times, fatigue, or hunger. The incidence of aggressiveness seen by nurses in mental health treatment ranges from 25% to 80%. This aligns with prior research indicating that most personnel in acute psychiatric units had experienced violence at some stage in their careers [27]. The variability in aggressiveness rates highlights the magnitude and significance of the issue. Programs designed to mitigate aggressiveness should concentrate their efforts on the first day's post-admission and assist personnel in managing aggressive behavior.

3. Formation of aggressiveness

The present analysis identifies patient variables that elevate the chance of developing aggression: a diagnosis of a psychosis-spectrum disease, a personality disorder, or bipolar disorder, particularly during a manic episode. Paranoid delusions, impulsivity, and anger at the symptom level increase the likelihood of aggressiveness development. These results replicate other published evaluations of patient variables linked to violence [5, 7–10, 20, 22–24, 26, 28–30]. The studies included in previous evaluations have mostly been omitted from the present analysis due to their publication date before 1999 [8, 22, 23, 26, 28, 29], or because they pertained to outpatient clinics [20]. This study provides an update on the correlation between diagnosis and the incidence of aggressiveness in the inpatient ward.

A diagnosis of serious depression or high scores on feelings of sadness or gloom at the symptom level reduced the probability of violence. Dack [8] identified a reduction in the likelihood of aggressiveness associated with depression, bipolar disorder, adjustment disorder, and drug addiction. This review found no correlation between hallucinations and the development of aggression, contrasting with a prior review that identified contradictory evidence, revealing both significant associations and a lack thereof between hallucinations and aggression. However, that earlier review was based on studies conducted prior to 1999.

A minority of the research ($n = 13$) indicated that male gender is a factor affecting aggressiveness, whereas the majority ($n = 22$) found no correlation. Prior evaluations reached a similar conclusion [8, 10, 26],

although other earlier reviews determined that male gender is, in fact, a risk factor [9, 25]. Other investigations determined that hostility mostly transpired between same-sex victims and aggressors [7, 22]. The explanation for these disparities remains unclear, leading to the conclusion that male gender may constitute a risk factor. This requires further investigation.

Dack et al. found that younger age is a risk factor for aggressiveness [8], a finding previously documented by Aquilina, who noted that mostly patients under 40 exhibited violent behavior [22]. Nonetheless, this is not corroborated in the current study. A minority of research indicated that a younger age is a risk factor while an older age serves as a protective factor. This aligns with Cornaggia's analysis, which determined that there is only poor evidence supporting younger age as a risk factor [7]. Despite using various evaluation methodologies, all research demonstrated that a history of aggressiveness, broadly defined, forecasted the recurrence of aggressive behavior. This aligns with previous evaluations indicating that a history of violence is highly correlated with aggression during the present admission [8, 9, 23, 25, 26, 31, 32].

Substance misuse may contribute to aggressiveness, since the majority of research (18 out of 22) identified a correlating impact. This aligns with the previously published evaluations [8, 23, 25, 26]. This study concludes that cravings for alcohol or smoking and withdrawal symptoms are key contributors to the manifestation of violence. Despite homelessness and insight being identified as risk factors in Witt's 2018 review [9], only four research (2.7%) were identified that investigated these issues. The current research does not provide definitive results about the correlation of these parameters with aggressiveness.

The study by Dack et al. [8] identified involuntary admission as a significant factor; a finding corroborated by our present analysis across six research. Nevertheless, higher rates of involuntarily committed patients correlate with increased aggressiveness within the ward. The data does not allow for a conclusion about whether this outcome is causative or just a component of a multifactorial risk increase, since this aspect has not been examined. Involuntary admittance is more probable among patients exhibiting violent behavior since the loss of autonomy and independence compels individuals to struggle and exhibit aggression in an attempt to reclaim their liberty. Previous research confirms that a closed door seems to irritate patients [33], perhaps resulting in aggressiveness.

Clinical variables, including heightened symptom severity and treatment unresponsiveness, have proven to be superior predictors of aggression compared to demographic variables [23]. This assertion is corroborated by various assessment tools, notably the Brøset Violence Checklist (BVC) and the Violence Risk 10 (V-RISK-10), which have been identified as the most practical for application in acute mental health care environments [34]. This prediction is often used when a patient is disturbed to assess the likelihood of the patient exhibiting aggression. However, when aggressiveness is seen as a result of the interaction of patient, staff, and ward variables, the prediction of aggression becomes multivariate, and focusing just on patient factors becomes insufficient. Considering that some risk variables are dynamic and interactive in the present ward context, while others are fixed and unchanging constructions, such as prior hospitalizations or a history of violence. Administering medication alleviates some clinical variables; nonetheless, hostility mostly manifests during the first days of admission, prior to the treatment's efficacy. Consequently, staff and ward variables are more effective in mitigating aggressiveness inside the ward.

4. Personnel considerations

Personnel at mental hospitals are not only subjected to aggressiveness but also play a role in its manifestation since aggression is inherently interpersonal. The development of aggression in patients is strongly correlated with male staff, job strain, job discontent, overwork, unhappiness with leadership, fatigue, inadequate nurse orientation, poor cooperation among nurses, an increased presence of temporary staff, and heightened anxiety among nurses. This replicates the conclusions of previous assessments; however, none of them consolidated these criteria into a single study [10, 16, 21–23, 32]. Frequently, these characteristics have been examined in isolation, neglecting their interrelations, and have not been consistently repeated across several investigations. Consequently, the robustness of these data is dubious, and the clinical significance must be assessed with prudence. The findings on the staff characteristics of age and staffing level were ambiguous [10, 16, 22, 35].

Interactions between patients and staff trigger hostility in 40% of occurrences [5, 10, 16, 25, 26, 36]. These interactions encompass inadequate communication, absence of empathy or respect, lack of collaborative decision-making, patient restrictions, imposition of limits, denial of patient requests, assistance with activities of daily living (ADL), medication administration or discourse regarding medication, interactions with other patients, and discussions concerning tobacco use. This result, confirmed in past studies mostly including publications published before 1999, constitutes a definitive conclusion; nevertheless, the precise reasons for this link remain unknown due to the absence of prospective research. Future research should explicitly examine patient-staff interactions and the elements of job strain, job discontent, and overwork that affect this relationship. These criteria are vital for ensuring a secure environment on wards and are critical for management in directing ward personnel effectively.

The ward itself may also contribute to the development of increased aggressiveness, as stated by Welsh in their analysis of environmental variables related to aggression development. The most indisputable characteristics from this present research include elevated patient occupancy rates and an increase in admissions, particularly among males under the age of 36, which have also been noted in previous assessments [5, 10, 16, 21, 23, 25]. Moreover, high-traffic areas, including as hallways and communal spaces, characterized by increased interactions among patients and between patients and staff, seem to be more susceptible to violence, a finding corroborated by previous investigations [5, 10, 16, 23].

A variety of other characteristics have been analyzed, including the perceived lack of privacy for patients, personal space and mobility, imposed constraints, uneven adherence to regulations, feelings of insecurity, ward noise, and sensations of physical confinement. All of them are referenced in previous evaluations [5, 10, 23]. The present review contributes to this body of data by including research conducted after 1999, in contrast to past reviews that mostly focused on studies predating that year and addressed the prediction or treatment of aggressiveness. The data indicates a correlation between these parameters and the incidence of aggressiveness in the mental hospital; nevertheless, the study is just descriptive, necessitating more investigation to establish conclusive findings.

The locked doors of a closed ward may be seen by the patient as a kind of control, while also offering a sense of security. It reduces the need for vigilant monitoring by personnel and safeguards the ward from external influences [33, 37, 38]. Prior research could not reach a consensus on whether locking the doors results in increased aggressiveness [5, 33], and our current study similarly could not substantiate that a closed ward door correlates with heightened hostility.

The Highly Intensive Care (HIC) concept has been implemented in several mental facilities throughout Europe. The HIC approach emphasizes the establishment of an ideal healing environment, maximizing autonomy and privacy. The prevention of unnecessary escalation is achieved through a supportive environment, regular interactions between patients and nurses that emphasize patient strengths, consistent communication with ambulatory caregivers, collaboration among multidisciplinary staff, minimal reliance on coercive measures, and the option for individualized nursing in instances of agitation or aggression. The findings of this research emphasize the significance and practicality of implementing modifications in the ward environment and protocols that may aid in reducing the emergence of aggressiveness in the inpatient setting [39]. The results of this analysis are significant for both clinicians and management of inpatient psychiatric wards, providing valuable insights for enhancing ward conditions and staff practices to mitigate the emergence of violence. Effective leadership is essential for ensuring staff well-being, therefore mitigating job discontent, pressure, and fatigue resulting from excessive workloads. New nurses need a well-defined orientation program, and the employment of temporary personnel should be restricted.

Personnel need enough training in communication skills to engage with respect and empathy, allowing patients to participate in decision-making to the greatest extent feasible. It is essential to refrain from condescending interactions with a patient. Ward occupancy rates must not surpass the number of available beds; patients need sufficient room to navigate the ward, and crowding should be minimized to mitigate the increased risk of violence. Patients must be given enough privacy. Restrictions and regulations should

be minimized to the essential minimum, and if required, these constraints must be uniformly enforced by all personnel. Aggression is more likely to occur in the first days after admission. Consequently, personnel must monitor newly admitted patients more attentively during the first days for indications of agitation and respond promptly within the continuum of agitation–aggression–violence.

5. Constraints

The studies in this systematic review exhibit significant variability due to variations in methodological quality and diverse definitions of violence across the included research. The literature exhibits significant heterogeneity in the idea of aggressiveness, with most papers failing to provide a precise description or specify the term used. Agitation, aggressiveness, and violence are predominantly acknowledged as phases of hostility and are often used interchangeably, lacking unique and obvious underlying ideas and boundaries. Nonetheless, occurrences or attacks are examined without a precise description. The comparison of outcomes at various levels of agitation, hostility, and violence proved impracticable due to the inadequately defined terms. Consequently, this overview consolidates several definitions and ideas. It is recommended that research delineate the degree of hostility along the continuum of agitation, aggression, and violence.

A search period of 1999–2019 was selected, making this study a comprehensive survey of two decades of literature. Papers published before to 1999 were characterized in earlier research and reviews, and were likely of worse methodological quality (as inferred from the analysis of previous reviews and their critiques on quality), with hospital care being structured in a markedly different manner [18]. Consequently, these investigations would not have contributed more insight to the extensive data previously provided. This review includes only publications published in English. This constitutes a standard process. Consequently, significant information may have been overlooked. We selected only English papers to prevent selectivity based on our language proficiency, which might have resulted in selection bias. Translation systems that allow researchers to comprehend several languages are promising. Nonetheless, we contend that translation techniques remain inadequate for the translation of scientific literature.

Comparing variations in hospital settings is challenging, particularly if they are stated at all. The culture and structure of the wards are ambiguous, characterized by a heterogeneous mix of diagnoses, settings (acute admission wards, open versus closed admission wards, rehabilitation wards), bed capacity, patient-staff ratios, bed occupancy rates, and lengths of stay, all differing according to national or local standards. The disparity in ward configurations and regional cultures and policies results in significant diversity in outcomes. This is inescapable. A potential method to mitigate this bias might include stratifying by setting (open vs closed ward), diagnosis, and other variables. The significant difference would have resulted in extremely tiny sub-groups or several group comparisons (closed vs open ward, varied diagnoses, etc.). The efficacy of this approach in addressing the issue of heterogeneity and the associated comprehension of aggressive development is dubious, considering the small sample sizes. Notwithstanding these restrictions, the results of the current study remain valid. A clinician or management may identify elements relevant to their specific context and use strategies to mitigate the emergence of hostility in their ward.

Comparing prevalence rates across papers is challenging because to the many definitions of aggressiveness and methodological variations, such occurrences per patient, incidents per week or month, incidents per occupied bed, incidents per unit, per admission, or per institution.

The criteria for inclusion and exclusion are often inadequately articulated. Male patients with psychotic disorders are disproportionately represented in the trials, and the patients' IQ was never assessed as a variable. In the absence of severity ratings for symptoms, which are lacking in most research, the intensity of the psychopathology remains ambiguous. A significant bias has likely been introduced, suggesting that aggressiveness prevalence may be much higher, and many circumstances may assume more significance, since the most severely sick patients are often difficult to provide informed consent owing to their suspiciousness, but may exhibit the most violent behavior. Considering this constraint, the findings remain relevant for less unwell inpatients.

A further drawback is the scarcity of controlled prospective trials, comprising just 13%. Moreover, longitudinal or natural cohort studies that monitor patients during their hospital stay while considering patient, ward, and staff variables are lacking [8]. The prevailing retrospective research design obstructs the examination of aggressiveness development dynamics and results in recall bias. Nonetheless, the retrospective approach provides insights into the elements that may have led to the emergence of violence. In research using interviews to identify the elements affecting the development of aggressiveness, patients and staff exhibit divergent perspectives about the origins and reasons for hostility's emergence. Future research requires prospective designs to establish more definitive causation associations.

Numerous studies neglected to account for significant descriptive variables in their analyses (including the number of psychotic patients, the proportion of involuntarily admitted individuals, the percentage of patients with substance abuse issues, the security status of the ward, and the staff-patient ratio), potentially confounding the interpretation of the results (represented by odds ratios).

Despite these limitations, the findings elucidate the extent of aggressiveness in mental health care facilities and endorse the model including three primary elements (patient, staff, and ward) that contribute to the risk of violence. Future research needs a prospective design, accompanied by explicit descriptions of patient variables, including IQ. An IQ ranging from 50 to 84 is a risk factor for the use of coercive measures [40], however, it has not been examined as a direct contributor to aggressiveness. Additionally, ward culture and structure, occupancy rates, secured access, and staff metrics like as training, staff-to-patient ratio, communication methods, and patient interaction techniques should be examined prospectively. The data obtained from this research may be used to implement new policies aimed at reducing aggressiveness in diverse mental health care environments.

6. Summary

Aggression is a significant concern in mental inpatient wards, affecting both nurses and other patients. Aggression is most accurately characterized as a segment of a continuum including agitation, aggressiveness, and violence. The emergence of violence is attributed to a confluence of elements present in patients, personnel, and the ward environment. Most studies mostly emphasize patient variables in the emergence of aggressiveness, overlooking ward and staff characteristics that might serve as more effective targets for treatments aimed at mitigating or preventing violence in inpatient psychiatric settings. Future studies should concentrate on prospective naturalistic studies to enhance understanding of the dynamics of aggressiveness development in psychiatric wards, particularly regarding ward and staff characteristics. This may assist in identifying more accurate preventative and intervention measures.

References

1. Kaltiala-Heino R, Tuohimäki C, Korkeila J, Lehtinen V. Reasons for using seclusion and restraint in psychiatric inpatient care. *Int J Law Psychiat.* 2003;26(2):139–49.
2. Meehan T, Bergen H, Fjeldsoe K. Staff and patient perceptions of seclusion: has anything changed? *J Adv Nurs.* 2004;47(1):33–8.
3. Needham I, Abderhalden C, Halfens RJ, Fischer JE, Dassen T. Non-somatic effects of patient aggression on nurses: a systematic review. *J Adv Nurs.* 2005;49(3):283–96.
4. de Looff P, Didden R, Embregts P, Nijman H. Burnout symptoms in forensic mental health nurses: Results from a longitudinal study. *Int J Ment Health Nurs.* 2019;28(1):306–17.
5. Cutcliffe JR, Riahi S. Systemic perspective of violence and aggression in mental health care: towards a more comprehensive understanding and conceptualization: part 1. *Int J Ment Health Nurs.* 2013;22(6):558–67.
6. Nijman HL. A model of aggression in psychiatric hospitals. *Acta Psychiatr Scand Suppl.* 2002(412):142–3.
7. Cornaggia CM, Beghi M, Pavone F, Barale F. Aggression in psychiatry wards: a systematic review. *Psychiatry Res.* 2011;189(1):10–20.
8. Dack C, Ross J, Papadopoulos C, Stewart D, Bowers L. A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. *Acta Psychiatr Scand.* 2013;127(4):255–68.

9. Witt K, van Dorn R, Fazel S. Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. *PLoS One*. 2013;8(2):e55942.
10. Hamrin V, Iennaco J, Olsen D. A review of ecological factors affecting inpatient psychiatric unit violence: implications for relational and unit cultural improvements. *Issues Ment Health Nurs*. 2009;30(4):214–26.
11. Garriga M, Pacchiarotti I, Kasper S, Zeller SL, Allen MH, Vazquez G, et al. Assessment and management of agitation in psychiatry: Expert consensus. *World J Biol Psychiatry*. 2016;17(2):86–128.
12. Merriam Webster Dictionary. Merriam Webster US; 2008. Webster Dictionary.
13. 13.Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *Lancet*. 2002;360(9339):1083–8.
14. National Collaborating Centre for Mental Health U. London2015.
15. Stowell KR, Hughes NP, Rozel JS. Violence in the Emergency Department. *Psychiatr Clin North Am*. 2016;39(4):557–66.
16. Gadon L, Johnstone L, Cooke D. Situational variables and institutional violence: a systematic review of the literature. *Clin Psychol Rev*. 2006;26(5):515–34.
17. Steinert T, Lepping P, Bernhardsgrutter R, Conca A, Hatling T, Janssen W, et al. Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. *Soc Psychiatry Psychiatr Epidemiol*. 2010;45(9):889–97.
18. Iozzino L, Ferrari C, Large M, Nielssen O, de Girolamo G. Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis. *PLoS One*. 2015;10(6):e0128536.
19. Bjorkly S. Psychotic symptoms and violence toward others—a literature review of some preliminary findings Part 2. Hallucinations. *Aggress Violent Beh*. 2002;7(6):605–15.
20. Darrell-Berry H, Berry K, Bucci S. The relationship between paranoia and aggression in psychosis: A systematic review. *Schizophr Res*. 2016;172(1–3):169–76.
21. Welsh E, Bader S, Evans SE. Situational variables related to aggression in institutional settings. *Aggress Violent Beh*. 2013;18(6):792–6.
22. Aquilina C. Violence by psychiatric in-patients. *Med Sci Law*. 1991;31(4):306–12.
23. Johnson M. Violence on inpatient psychiatric units: State of the science. *Journal of the American psychiatric nurses*. 2004.
24. Cutcliffe JR, Riahi S. Systemic perspective of violence and aggression in mental health care: towards a more comprehensive understanding and conceptualization: part 2. *Int J Ment Health Nurs*. 2013;22(6):568–78.
25. Szabo KA, White CL, Cummings SE, Wang RS, Quanbeck CD. Inpatient aggression in community hospitals. *Cns Spectrums*. 2015;20(3):223–30.
26. Woods P, Ashley C. Violence and aggression: a literature review. *J Psychiatr Ment Health Nurs*. 2007;14(7):652–60.
27. d'Ettorre G, Pellicani V. Workplace Violence Toward Mental Healthcare Workers Employed in Psychiatric Wards. *Saf Health Work*. 2017;8(4):337–42.
28. Krakowski M, Volavka J, Brizer D. Psychopathology and violence: a review of literature. *Compr Psychiatry*. 1986;27(2):131–48.
29. Bjorkly S. A ten-year prospective study of aggression in a special secure unit for dangerous patients. *Scand J Psychol*. 1999;40(1):57–63.
30. Flannery RB Jr, Wyshak G, Tecce JJ, Flannery GJ. Characteristics of international assaultive psychiatric patients: review of published findings, 2000–2012. *Psychiatr Q*. 2014;85(3):303–17.
31. Flannery RB Jr, Characteristics of assaultive psychiatric inpatients: updated review of findings, 1995–2000. *American journal of Alzheimer's disease and other dementias*. 2001;16(3):153–6.
32. Erdos BZ, Hughes DH. A review of assaults by patients against staff at psychiatric emergency centers. *Psychiat Serv*. 2001;52(9):1175–7.
33. van der Merwe M, Bowers L, Jones J, Simpson A, Haglund K. Locked doors in acute inpatient psychiatry: a literature review. *J Psychiatr Ment Health Nurs*. 2009;16(3):293–9.

34. Anderson KK, Jenson CE. Violence risk-assessment screening tools for acute care mental health settings: Literature review. Archives of psychiatric nursing. 2019;33(1):112–9.
35. Edward KL, Stephenson J, Ousey K, Lui S, Warelow P, Giandinoto JA. A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff. J Clin Nurs. 2016;25(3–4):289–99.
36. Papadopoulos C, Ross J, Stewart D, Dack C, James K, Bowers L. The antecedents of violence and aggression within psychiatric in-patient settings. Acta Psychiatr Scand. 2012;125(6):425–39.
37. Bowers L, Haglund K, Muir-Cochrane E, Nijman H, Simpson A, Van Der Merwe M. Locked doors: a survey of patients, staff and visitors. J Psychiatr Ment Health Nurs. 2010;17(10):873–80.
38. Haglund K, von Knorring L, von Essen L. Psychiatric wards with locked doors—advantages and disadvantages according to nurses and mental health nurse assistants. J Clin Nurs. 2006;15(4):387–94.
39. van Mierlo T, Bovenberg F, Voskes Y, Mulder N. Werkboek HIC. High en intensive care in de psychiatrie. Utrecht: de Tijdstroom.; 2013
40. Nieuwenhuis JG, Noorthoorn EO, Nijman HL, Naarding P, Mulder CL. A Blind Spot? Screening for Mild Intellectual Disability and Borderline Intellectual Functioning in Admitted Psychiatric Patients: Prevalence and Associations with Coercive Measures. PloS one. 2017;12(2):e0168847.

استراتيجيات شاملة لإدارة العدوانية في إعدادات التمريض النفسي: مراجعة للعوامل المساهمة والتدخلات الفعالة

الملخص

الخلفية: تُعد العدوانية في البيئات النفسية قضية حرجية تؤثر على سلامة المرضى ورفاهية الموظفين. وغالبًا ما تؤدي إلى استخدام العزل والتقييد، وهو ما يدرسه المرضى في كثير من الأحيان كعقوبة بدلاً من كونه علاجًا. يُعد فهم الأسباب متعددة العوامل للعدوانية أمرًا أساسيًا لتطوير استراتيجيات إدارة فعالة.

المنهجيات: تستعرض هذه المراجعة المنهجية الأدبيات الحالية حول معدل انتشار العدوانية والعوامل المساهمة بها في الأجنحة النفسية. تم إجراء بحث شامل عبر قواعد بيانات متعددة، باستخدام معايير شاملة ودقيقة لتحديد الدراسات ذات الصلة. ركز التحليل على العوامل المتعلقة بالمرضى، والموظفين، والبيئة التي تؤثر على السلوك العدواني.

النتائج: أظهرت المراجعة متوسط معدل انتشار حوادث العدوانية بلغ 54% مع تباين ملحوظ بين الدراسات. ومن بين عوامل الخطر المرتبطة بالمرضى كان تشخيص الذهان، واضطرابات الشخصية، وإساءة استخدام المواد المخدرة. كما لعبت عوامل مرتبطة بالموظفين مثل ضغوط العمل وضعف مهارات الاتصال دورًا مهمًا في ظهور العدوانية. بالإضافة إلى ذلك، ساهمت المتغيرات البيئية، بما في ذلك تصميم الجناح ومعدلات إشغال المرضى، في احتمالية وقوع الحوادث العدوانية. وتم تحديد الأيام الأولى من الدخول على أنها فترة ذات مخاطر متزايدة للعدوانية.

الخلاصة: تتطلب الإدارة الفعالة للعدوانية في البيئات النفسية نهجًا متعدد الجوانب يعالج العوامل المرتبطة بالمرضى، والموظفين، والبيئة. يمكن أن يؤدي تنفيذ برامج تدريبية موجهة للموظفين، وتحسين التواصل، وتعديل ظروف الأجنحة إلى تعزيز السلامة وتقليل معدل حوادث العدوانية. يجب أن تركز الأبحاث المستقبلية على الدراسات الاستباقية لفهم ديناميكيات العدوانية بشكل أعمق في الرعاية النفسية.

الكلمات المفتاحية: العدوانية النفسية، سلامة المرضى، تدريب الموظفين، العوامل البيئية، مراجعة منهجية.