Culturally safe management of aggression and violence in mental health care institutions

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DECLARATION

By submitting this research assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date December 2015

Signature

Theresa M. Bock

DEDICATION

To the memory of all the Health Care Users I have nursed over the past 30 years.

The potency of a lifelong initiative

This research project is a sub-project of the Seboka research Team. The African academic is firstly the child of mother Africa and secondly the creator of knowledge in the primary context of Africa and secondarily in the global sphere. The configuration of an African scholar's identity necessarily entails accepting a bundle of responsibilities shaped by mother Africa's potent imperatives. Etymologically defined, 'Seboka' denotes a 'group,' a 'team,' a 'community' and a phenomenal 'coming together' of sorts. The term of necessity subsumes one's ephemeral individuality under the value-generating ethos of 'communitarian' solidarity. A signifier of the shared benefits of synergy, the Seboka emblem - depicting a pride of lions on a mission under the supreme guidance of collective vision - is a celebration of the invaluable wealth of sharing and reciprocal engagement which lies at the heart of Africa's philosophy. As such, the Seboka concept was born out of respect for the imperatives of mother Africa, whose breast has availed the milk of human kindness moulding the African children into a team of valiant warriors in legitimate defence of their priceless heritage.

The Seboka logo summons to memory the telling axiom, 'A lion that goes on a hunt by itself, without co-existing in a pride, will always fail to catch even a limping deer.' In the same communitarian spirit, Seboka uses the claypot as a key emblem, symbolising sharing and communal solidarity. The Seboka team perceptively unpacks this definitive element of African life and essence, the profound *Ubuntu* philosophy, potently encapsulated in the dictum 'I am, because we are,' hence placing community and group care above the focus of the self. This Seboka team is a rich confluence of various tributaries, but the Community is their first consideration.

The hallmark of Seboka's invaluable research output has been the endeavour to strike signature partnerships with the community, the very custodians of the forests, mountains and rivers which are the abode of nature's healing essence and strength. Quite enlightening is the Khoi-chief's statement made recently in an open platform, *'The veld is our chemist'* (Kok V, 2013). The wisdom enshrined in this statement is a telling testimony of how conventional medical practice has always tapped into the resourcefulness of medicinal plants and other curative phenomena in Africa's rich forests. Notwithstanding the research on medicinal plants, the Seboka team predominantly re-engineer the broader practices of the African child

Seboka Greeting

The activities of the Seboka project is predominantly funded by the National Research Foundation (RSA); The Department of Science and technology (RSA) and the North-West University (Mafikeng Campus)

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"a Solitary lion is incapable of even catching a limping deer."

The pride came through after all!

Kea le boha ntate!

ABSTRACT

(*Key words: Cultural safety; aggression; violence; mental health care facilities.)*

Aggression and violence in Health Care is common course in mental health care facilities. Literature informs that staff finds it difficult to managing aggression and violence. This is exacerbated in the South African context where we deal with diverse cultures despite the fact that the majority of our mental health care users rely heavily on care from their own indigenous healers according to their Indigenous Knowledge System. This adherence to a Western Based Knowledge System often makes care not culturally safe or appropriate.

Most of the research done in this regard focusses on pure management of aggression and violence and the effect of training programmes in the European context. This research project, however explored the methods used by indigenous healers and combining that knowledge and practices with additional training in cultural sensitivity and awareness, to determine the effect of a treatment interventions which includes *inter alia* with understanding the phenomenon of aggression and violence, de-escalation techniques, safe restraint and dignified break away techniques. The research objectives addressed aspects such as Indigenous Knowledge and skills, attitudes of staff with regards to the management of aggression and violence, cultural sensitivity of staff, refinement of a training programme on the management of aggression and violence to include skills and knowledge used by indigenous healers which is applicable to the management of aggression and violence and determining the effect of the training programme on the above.

An exploratory sequential mixed method was followed, with a qualitative phase which used *makgotla* as novel data collection method, the information generated during this data analysis was utilised to augment current literature and refine an existing training programme. The indigenous healers used in this study were from the same geographical area where the participants in the experimental groups are employed, as they would be dealing with mental health care users from the same cultural group their respective mental health care institutions would serve.

The quantitative phase consisted of a pretest and posttest after a training programme (the refined training course). The researcher primarily made use of purposive sampling, based on findings in the literature study and, thereafter, proceeded to perform randomised cluster sampling. In the latter, the researcher randomly selected which hospitals will fall into which experimental group. Participants completed the MAVAS (management of aggression and violence attitude scale) and the Intercultural sensitivity questionnaires for both the pretest

and the posttest, after the administration of the training programme. Questionnaires for the posttest were administered after the presentation of different parts of the training programme in the different mental health care institutions, these pretests and posttest results were compared both within the groups and between the experimental groups.

Descriptive statistics were used to describe the demography of the participants and inferential statistics were used to determine the effect of the training programme.

The findings revealed that the experimental group constituted of participants with the least amount of experience in mental health care had the most significant attitudinal change with regards to the management of aggression and violence. All the experimental groups showed a significantly improved understanding of how the environment in the mental health care facility can contribute to mental health care user related violence and aggression and that improved communications between mental health care providers and mental health care users can contribute to a decrease in aggression and violence.

The most remarkable result was however the group who only received training on cultural sensitivity and awareness had the most significant change in attitude in the management of aggression and violence. This experimental group was coincidentally the least experienced in mental health care. Therefore it can be concluded training programme which included cultural sensitivity and awareness showed the most significant effect on the attitudes towards the management of aggression and violence and the youngest least experienced group were more influenced by the training.

These findings have implications for nursing curricula in foundational programmes with reference to cultural sensitivity and awareness and the management of mental health care user related aggression and violence. Mental health care facilities and management must be made aware of the benefit of such a training programme when orientating the neophyte to the services and also for continuous professional development of permanent employees to improve their ability to deal with aggression and violence and to render cultural safe care. The community can also benefit from this research through equipping them with the skills to deal with aggression and to avoid harmful practices as identified during the *makgotla*.

Finally this study suggests avenues for further research, namely determining the perception of mental health care users with reference to whether they render the care received to be culturally sensitive and appropriate, exploration of the culturally safe mental health care

environment and research focused on "unlearning" destructive attitudes in mental health care providers.

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List of abbreviations

AIKS	African Indigenous Knowledge Systems
DSM 5	Diagnostic and Statistic Manual 5
IKS	Indigenous Knowledge System
MAVAS	Management of Aggression and Violence Scale
WBKS	Western Based Knowledge Systems
MHCU	Mental Health Care User

Definitions

Concept	Conceptual definition	Researcher's operational definition
Aggression	The Penguin Dictionary of Psychology (1995:18) describes aggression as "a desire to produce fear or flight in others". Aggression is a motivation to harm another individual (Geen & Donnerstein, 1998:Loc.105) and Farlex Partner Medical Dictionary © Farlex(2012).Bock (2013:105) supports the definition of aggression as mentioned in (Uys & Middleton, 2013:255) where aggression is uttered threats as opposed to physical harm.	Emotional, psychological reaction used to create fear or to intimidate others. Aggression must not be confused with violence, because violence is the behavioral component.
Attitude	Attitude was defined in 1860 by Herbert Spencer and Alexander Bain as referenced by Cacioppo *et al.* (1994:261) and was used to explain an internal state of readiness for action which includes affect. In further elaboration the researcher concurred with the following definition of attitude being "a general enduring evaluative perception of a stimulus or set of stimuli" (Cacioppo *et al.*, 1994:261 and Lakkaraju & Speed, 2010:76).	Attitude is therefore an intangible, persistent/bold stance towards something; such as an idea or a phenomenon.
Cultural awareness	Health care providers understand there are cultural differences to overcome between them and their patients (Tjale & de Villiers, 2004:24) and Hogg. A person becomes aware of the existence of cultural differences between groups and can stand back to reflect upon those cultural differences	Noticing one culture differs from the next and the ability to identify these differences, without doing anything about these differences.
Culturally acceptable	The online dictionary defines culturally acceptable to be a behavior accepted by the majority of a culture, McIntyre (2016:1996) agrees with	Culturally acceptable is anything accepted as normal for a particular culture.

Concept	Conceptual definition	Researcher's operational definition
	this definition.	
Cultural safety	Cultural safety was defined by Ramsden as cited in Tjale and De Villiers (2004:24), to be the ability to evaluate a persons' own cultural mind-set and recognise, respect and nurture the culture of another person. For the purpose of this research project the researcher concurs with the definition of Ramsden and Spoonley (1994:163), namely that cultural safety means the nurse is open minded and flexible in her attitude towards other cultures. The researcher will include Leininger's definition of Culture-congruent care as augmentation of the definition by Ramsden wherein Leininger refers to culture-congruent care as service which fits in with the beliefs and way of life of the client. Cultural safety is "recognising the position of another culture in society" as stipulated by Polascheck (1998:452)	Rendering care that the MHCU observes as safe.
Cultural sensitivity	"The nurse understands and respects the legitimacy of cultural differences and reflects on the impact of their own cultural beliefs and values on the therapeutic relationship" (Tjale & de Villiers, 2004:25). According to Sublette and Trappler (200:133) and Portalla and Chen (2010:21) cultural sensitivity is the affective aspect which represents the ability of a person to appreciate the differences of another culture and to also respect it. Fritz *et al.* (2002:167) continues to explain that cultural sensitivity includes cultural awareness and self-awareness.	A person considers how their behavior may affect another culture
Mental Health Care	Hospital or facility approved in terms of the Mental Health Care Act (17 0f 2002) to provide health care and rehabilitation services to mental health	A hospital or care facility accredited to provide mental health care.

Concept	Conceptual definition	Researcher's operational definition
Institution	care user	
Violence	Uys and Middleton (2013:255) reports violence to be; the infliction of physical injury to self, or others. Moreover, the Collins Pocket English Thesaurus (2012:601) defines violence as follows: "Use of brute force or rough handling of another person or property." Kaliski (2006:118), confirms that there are various forms of violence and that violence is associated with posing a danger to others	The physical/behavioral component of aggression.

CHAPTER 1

OVERVIEW OF THE RESEARCH

1.1 TITLE

Culturally safe management of aggression and violence in mental health care facilities
(Key words: Cultural safety; aggression; violence; mental health care facilities.)

1.2 INTRODUCTION AND RATIONALE FOR THE RESEARCH

As a Mental Health Care Practitioner, the researcher witnessed many incidents of mental health care user related violence and aggression. The researcher also experienced situations where she doubted the practice of secluding a person who is deemed aggressive to be the best option to manage the MHCU. The researcher acknowledges self-perceived difficulty in establishing a therapeutic relationship with persons who could not converse in English or Afrikaans (the Mother tongue of the researcher). The use of an interpreter often left the researcher with the impression that there is better rapport between the interpreter and the mental health care user than with the rest of the therapeutic team. The interpreter would refrain from translating back what the MHCU said as they deem it to be non-sensical. Often this left the researcher in a position where she felt as though she does not understand the patient's perception about his situation, and some of the cultural practices seemed to be alien as is reflected upon in the following paragraph.

Through the literature, the researcher established that amongst some cultural groups there is a practice where some people will consume small amounts of Jeyes Fluid ® (a powerful disinfectant containing amongst things tar acids) to rid themselves of what is considered possession by an evil spirit. Due to Jeyes Fluid ® being a toxic irritant with the inducement of vomiting being contra-indicated, this practice is frowned upon in medical circles, despite being used by western medicine during the 1870's to treat conditions such as scarlet fever.

Subsequently, due to the toxicity of Jeyes Fluid ®, substances such as these are confiscated upon admission of the patient to the psychiatric hospitals as it is deemed to be contraband. It is, however, common course that routine searches for possible contraband and confiscation thereof are part of hospital policy. However, this often results in aggressive reactions by MHCU. Unfortunately, practices such as ingestion of and often bathing in Jeyes Fluid forms part of the IKS of some cultures.

Therefore, the researcher is of the belief that due to a lack of understanding of the perspective of persons from a culture different to that of the mental health care provider, the therapeutic relationship is compromised as the mental health care user is forced to adapt to a WBKS in terms of the "way things are done here".

One particular incident which springs to mind is when the researcher witnessed an extremely anxious mental health care user in his bewilderment grabbing a bottle of mineral turpentine and attempting to take a sip out of the bottle. Obviously the researcher grabbed the bottle away from him before he could actually swallow it; the highly flammable turpentine which spilled over him was promptly cleaned off by the researcher. During a follow-up debriefing interview, the researcher established that he (the mental health care user) believed that as turpentine is used to strip away paint and clean objects; the ingestion of this turpentine would have stripped away the evil spirit which he believed possessed him.

Aggression and violence are accepted as the "norm" in psychiatry. Health care providers are constantly faced with violence and aggression, as concluded in several studies (Needham, 2004:2; Chen *et al.,* 2005:141; Lewis-Lanza *et al.,* 2006:71; Bock, 2013:105).

The researcher, through a study (Bock, 2010:55), confirmed that the majority of mental health care practitioners experience difficulty in the management of aggression and violence in mental health care users, and had not received training to capacitate them. This perception by the researcher, of aggression and violence being difficult to manage, is confirmed through a study by Mavundla (2000:1575), wherein he observed that staff found it difficult to deal with aggression and that psychiatric patients are difficult to manage.

Complicating the situation within the South African context is the fact that South Africa is a country with 11 official languages nestled in their own cultures (Joyce, 2009:7), and within this multi-cultural context each culture has their perspectives around mental illness and the treatment thereof. In an attempt to develop an understanding of the status quo in South Africa, the researcher consulted literature and noted that there are two opposing knowledge systems in South Africa, namely the Indigenous Knowledge System (IKS) and the Western based knowledge system (WBKS). These two systems each have their own vantage points in terms of illness and disease, which perspectives the researcher will elaborate in the following section.

1.3 BRIEF LITERATURE REVIEW

African Indigenous Knowledge Systems (AIKS) is deemed to be a collection of knowledge, skills and practices within a specific frame of reference and a specific geographical area, which allows people to make sense of; and live and survive in their environment (Naidoo, 1985:2; Quiroz, 1994:12; Okpako, 1999:482; Viljoen & Van der Walt, 2003:15; Raphesu, 2010:3). Almost contrary to this definition, the Western-based knowledge health care system is based on scientific measurement and scientific reasoning whereas the Indigenous Health Knowledge System is based on understanding referred to as magico-religious perspective (Tjale & de Villiers, 2004:4). Within this AIKS, the term African Primal Health care coined by Dr Mbulawa in 2012 as cited by Taaka *et. al.* (2013:128) refers to the health care rendered in this knowledge system, unique to the African community. This African Primal Health care is more than mere magico-religion as assumed by Tjale and De Villiers (2004:4), because it in essence refers to the continent "Mother Africa" who provides all components to allow for health of her "children," the African community.

The different views of health care systems are defined to be pluralistic and reported to exist parallel to one another. Based on this report, and estimation by authors such as Robertson *et al.* (2001:87) and Abbo (2011) - that as much as 70% of South Africans use traditional healers as primary health care providers - it is important that this source of health care provision be recognised within the current health care system as it has stood the test of time

The recognition of the indigenous healing practices used by indigenous healers has led to a quest to legalise the IKS practices to ensure safety to the user. As such, the Traditional Health Practitioners Act (22 of 2007) was promulgated to regulate the profession. Through this Traditional Health Practitioners Act (22 of 2007) the practices, training and registration of these health providers are regulated (Janse van Rensburg, 2009:157).

Both Indigenous knowledge Systems and WBKS have their unique conviction regarding the phenomenon and causes of mental illness. Possible causes of mental illness within IKS are reportedly through supernatural causes, witchcraft, breaking of taboos, especially in cases where a disease is of a chronic nature as pointed out by Tjale and De Villiers (2004:147-149). These causes are linked with the frame of reference and often cultural norms of the person attempting to explain mental illness (Kabir *et al.,* 2004:2; Teferra Shibre, 2012:1). The diametrically opposite view of mental illness within WBKS is explained by means of a scientific approach. Teferra and Shibre (2012:1) also notice that WBKS focuses more on biological, genetic and social causes for mental illness as opposed to Indigenous Knowledge Systems which focusses on supernatural and religious factors as influential in the cause of mental illness.

The phenomenon of mental illness is explained through a plethora of signs and symptoms as depicted in the Diagnostic and Statistic Manual 5, established through research (Robertson *et al.,* 2001:9). The DSM 5 allows for what is deemed reliable diagnosis and is objective in establishing differential diagnoses. There are definite medical, genetic, social and psychological causes for mental illness (Robertson *et al.,* 2001:16). Robertson *et al.* (2001:16) continue to explain the phenomenon of mental illness from a bio-psychosocial model with an emphasis on an allopathic explanation.

In view of these different causes for mental illness, the logical deduction is that treatment of mental illness will differ between IKS and WBKS's.

Several authors touched on the topic of how mental illness is treated in the different Indigenous Knowledge Systems; a commonality is that the treatment is directly related to what is considered to be the ethiology of the disease (Mzimkulu *et al.,* 2006:425; Shankar *et al.,* 2006:230). Similarly, in WBKS's the allopathic treatment of mental illness commences with a diagnosis of the illness by means of a Mental Status Examination, where all the signs and symptoms of the illness are confirmed (Robertson *et al.,* 2001:39-50). Thereafter, psychotropics or allopathic medicine are administered to treat the symptoms identified (Robertson *et al.,* 2001:417).

Due to a link between mental illness and aggression, it is necessary to explore both the IKS and WBKS's perceptions of this mental illness related aggression and the subsequent proposed treatment strategies as both IKS and WBKS have methods which they feel is best, and perhaps safest to deal with this aggression and violence.

Aggression was cited to be the most common feature associated with the presence of a confirmed mental illness in a study performed by Kabir, *et al.* (2004:3). Several authors are in agreement that extreme forms of behaviour such as violence might be indicative of an underlying mental illness (Shankar *et al.,* 2006:231; Ewhirudjakpor, 2009:24; Sorsdahl *et al.,* 2010:286). In terms of the WBKS, the phenomenon of aggression in persons with recognised mental illness has been well researched and accordingly documented by numerous researchers. This has allowed mental health care providers to make certain predictions with regards to the clientele more prone to aggression and violence. Koen *et al.* (2003:254) proved a link between substance abuse and violence in male mental healthcare users with schizophrenia, as supported by similar findings by Milton *et al.* (2001:439) and McDougall (2000:98), who noted the presence of severe psychosis and conduct disorders in adolescence who exhibit aggression.

In South Africa the Mental Health Care Act (17 of 2002) makes allowance for a person who is mentally ill and a danger to himself, other persons or their property; to be admitted to a hospital for observation. Furthermore, if the person resists treatment and is not prepared to undergo any form of treatment, the Mental Health Care Act (17 of 2002) informs practitioners that such a person can be forced to undergo treatment involuntarily.

As observed and reported by the researcher, mental health care users in WBKS are often secluded in single rooms and sedated with psychotropics when aggressive. Similarly, within IKS, it was revealed that some of the indigenous healers managed aggression associated with mental illness by physical means such as tying the person up with ropes and occasionally chains, to prevent harm or injury to others (Sorsdahl *et al.*, 2010:286). The pharmacological management of aggression revolved around the use of "muti". *"Umuti"* stems from the isiZulu language and literally means "medicine" (Labuschagne, 2004:192). This can be in the form of a liquid, ointment or powder. This medicine, "muti" can be administered to the patient via different routes and applications such as sniffing, drinking, inhalation of vapours when burned, topical application in incisions made by the indigenous healer and baths with "muti" in it. The administration of "muti" is only one part of the treatment regimen and it is further followed up with rituals to complete the healing process (Sorsdahl *et al.* 2010:287).

1.4 CONTEXT

As a mental health care practitioner, the researcher has witnessed numerous incidents of violence and aggression as associated with mental illness. The researcher observed both effective and less effective attempts to deal with the management of aggression and violence. Difficulty in the management of aggression and violence was particularly exacerbated during dealings with MHCU's from a culture vastly different from that of the health care provider and more so if the MHCU's could not converse in English or Afrikaans. This observation led the researcher to deduce that it is possible that a lack of understanding and appreciation of cultural differences might affect the ability to therapeutically deal with aggression as encountered in mental health care users from diverse cultures.

It is noteworthy that the researcher has experienced several incidents where MHCU's who became aggressive were treated by means of what is referred to as traditional psychiatric methods to contain this aggression and violence. Such traditional methods, as referred to by Duxbury (2002:325), include the use of mechanical restraint and seclusion in a single room.

The researcher is of the belief that there is no valid "one cure fits all" regime to manage mental health care user related violence, considering that people differ in terms of their culture and

knowledge system, and any degree of insensitivity and indifference to these cultural differences leads to unsafe care.

1.5 PROBLEM STATEMENT

Health care practitioners find it difficult to manage aggression and violence. Adding to this problem is the cultural diversity of mental health care users, especially in a country such as South Africa with its 11 different official languages. Mental health care practitioners are trained to use what Duxbury (2002:325) refers to as traditional western based methods in the management of aggression and violence. Due to the cultural diversity of mental health care users, the methods used by mental health care practitioners do not acknowledge the multi-cultural sphere within which care is to be rendered.

In light of the previous discussions, the researcher is in agreement with the finding of Breidlid (2009:142), who warns that the exclusion of IKS will hinder the development of a scientific understanding of natural phenomena, including natural methods of delivering culturally-competent health care. Therefore, the researcher promotes the inclusion of IKS in the education and training of health care providers. Ignoring IKS will ignore the cultural, beliefs and spirituality of a MHCU.

From the problem statement, a question arises:

> *Could a training programme which includes cultural safety and awareness training, with a focus on the management of aggression, within a multi-cultural context; effect attitudinal changes in the cultural awareness, sensitivity, and safety with reference to the attitudes of mental health care practitioners, towards the management of aggression and violence?*

To answer this broad question, the following exploratory research questions needed to be addressed:

- What are the attitudes of mental health care practitioners towards the management of aggression and violence?
- How culturally safe and aware are mental health care practitioners?

- How effective is a proposed training programme on management of aggression and violence, in combination with cultural sensitivity and awareness, to bring about attitudinal changes in Mental Health Care Practitioners?

1.6 AIMS AND OBJECTIVES OF THE RESEARCH

The aim of this research is to establish whether a training programme (which includes training in cultural sensitivity and awareness) aimed at capacitating mental health care practitioners to manage aggression and violence, within a multicultural context would affect attitudinal changes in the cultural sensitivity and awareness and changes in attitudes towards the management of aggression and violence of MHCU.

Further objectives in this study include the following:

- An exploration of African Indigenous Knowledge Systems used to manage mental health care user related aggression. The data generated through *makgotla* is found in chapter 4 and incorporated into training programme as presented in Annexure 2 and discussed in section 6.1.2.
- The establishment of base-line data on the level of cultural awareness and sensitivity of mental health care practitioners. Baseline data was established during 2010 (Bock & Pienaar 2013) and during 2015 for this study.
- An assessment of the attitudes of mental health care providers towards the management of aggression and violence and cultural sensitivity and awareness A discussion of the observed attitudes is concluded in section 6.1.1 in chapter 6.
- The implementation of a training programme that will capacitate mental health care practitioners to manage aggression and violence in a culturally diverse sphere. See section 6.2.2.
- To influence nursing curricula to include IKS with regards to the management of MHCU related violence. This recommendation is explained in section 6.2.3.

With the aims and objectives of this research in mind, the researcher subsequently developed the central theoretical argument and hypothesis for this research.

1.6.1 Central theoretical argument

The conduct of *makgotla* (focusing on how aggression and violence in persons known to be mentally ill is managed), with indigenous healers will augment current knowledge in terms of

how aggression is being managed within an African IKS, and will further guide the content for a curriculum/training programme for the culturally safe management of aggression and violence.

1.6.2 Hypothesis

The researcher proposed a complex non-directional hypothesis, namely: "Implementation of a training programme in the management of aggression and violence with a focus on cultural sensitivity, awareness and cultural safety, will lead to a change in attitude towards the management of aggression and violence in mental health care practitioners".

1.7 RESEARCHER'S ASSUMPTIONS

A philosophical stance is explained to be a philosophical view held by a group or persons, and forms an integral part of conceptual models; one example of such a model would be Madeleine Leininger's theory of cultural care, diversity and universality (Burns & Grove, 2011:229; George, 2002:497) and Irihapeti Ramsden's Cultural safety theory (Ramsden, 2000). Noting the existence of such assumptions the researcher's assumptions that training could impact on attitudes towards the management of aggression and violence and cultural safety and awareness, were tested during the quasi experimental phase of this research. The researcher will elaborate on these assumptions further in this chapter.

1.8 PHILOSOPHICAL GROUNDING OF THIS RESEARCH

The researcher is in agreement with Leininger who describes human beings to be capable of caring and being concerned about the needs of others (George, 2002:494). This statement by Leininger is supported by Pienaar (2013:10) where he explains the concept of *Ubuntu,* where one only becomes through the group or others. The researcher hence deems this care to be focussed on the need of others and a person getting better through care by others. In Africa especially, the full spectrum of care includes spiritual care, which cardinal dimension is ignored in Western care. Because the African is characteristically a deep spiritual being, his health seeking behaviour includes the spiritual dimension (Pienaar, 2013:1). This emphasises the urgent need for cultural awareness and sensitivity in mental health care practitioners in order to render culturally safe care.

Care and health are universal concepts to all cultures; however the method of rendering care and the application of IKS in the rendering of care is not universal, as emphasised by Leininger (George, 2002:492). In Africa the care rendered within AIKS refers to Primal Care which was in

existence since time immemorial, long before the existence of WBKS (Taaka *et al.* 2013:128). WBKS challenges this concept, as will be elaborated on during the literature review.

The researcher therefore assumes that one can only truly care for another person if you have an understanding of the perspective and the culture of such a person. This assumption is supported by Fulcher (2002:702) where the author indicates that the only person who could inform the nurse that care is culturally safe is the recipient of the care. Therefore the *"makgotla"* will inform the researcher on culturally safe and acceptable care; this knowledge could influence the training programme.

1.9 THEORETICAL ASSUMPTIONS

1.9.1 Cultural awareness and sensitivity

Cultural awareness refers more to the cognitive reaction or functioning in a person where he or she becomes aware of the differences in the cultural norms and values of different groups (Hardy & Laszoffy 1995: 227; Tjale & De Villiers, 2004:37; Leppert & Howard, 2011:1). Being culturally aware does not imply that one is culturally sensitive. It merely indicates a beginning to perform duties ritualistically appropriate without the presence of the emotional and spiritual component appropriate to the "other" culture (Koptie, 2009:31).

Cultural sensitivity in addition is described as being aware of cultural differences between people, respecting those differences and noticing and accepting that the perceptions of people will differ from one's own perception. Additionally, it implies that a person will refrain from making a value judgement on another person's cultural perception, and will adapt their own skills to become more sensitive towards others. Therefore, cultural sensitivity implies the affective functioning or reaction in a person. (Hardy & Laszoffy, 1995:227; Seibert, *et al.* 2002:143; Tjale & De Villiers, 2004:27, 38; Leppert & Howard, 2011:3). Koptie (2009:31) elaborates further and states that in cultural sensitivity, the nurse is aware of her own culture and she is aware that she brings her own culture into the nurse-patient relationship and that her own culture will impact on the cultures of others.

The above-mentioned description of cultural sensitivity leaves the researcher with the impression that this cultural sensitivity in the individual is observable or measurable on a continuum. This motivated the researcher to further explore this through the use of a cultural sensitivity scale as designed by Chen and Starosta (2000).

It is unknown how culturally aware and sensitive mental health care practitioners in psychiatric hospitals in Southern Africa are in the execution of their duties.

1.9.2 Cultural safety

It is generally assumed that health care users can have input in their own treatment. The Mental Health Care Act (17 of 2002) also advocates for the right of the patient. Ramsden and Spoonley (1994:164) refer to this as cultural safety. Contrary to the quest for cultural safety, the researcher has experienced that the patient admitted as involuntary have very limited input into his treatment plan, if any. Ramsden and Spoonley (1994:165) reiterate this quest for cultural safety through pointing out the effect that culture has on the effectiveness of health care.

Therefore, the sunrise model of Leininger and a combination of Ramsden's cultural safety models is applicable to this research project and the researcher will apply and use these proposed models in combination with the information collected during the *makgotla* with the indigenous healers, to influence training programmes aimed at improving the ability of mental health care practitioners to manage aggression and violence in a multi-cultural milieu.

1.10 METHODOLOGICAL ASSUMPTIONS

This research project being an exploratory sequential mixed methodology is anchored in both the post-positivist and interpretivist paradigm due to the sequential qualitative and quantitative phases of this research.

The interpretivist paradigm is observed where the researcher interviewed indigenous healers in order to get an understanding of how they manage violence and aggression in mentally ill persons. The researcher used this information obtained during the qualitative phase of the research to adapt a training programme on the management of aggression and violence to include AIKS with regards to the management of aggression and violence. The Phenomenon under investigation are indigenous healers in their own social reality and according to Loiselle and Profetto-McGrath (2011:1179) this encompasses trying to understand how the healers manage aggression and violence in their own environment with the aim of describing this phenomenon after analysis, roots the qualitative phase of this research solidly in the interpretivist paradigm.

Creswell (2014:7) explains Post-positivism clearly as being "deterministic", where any cause will have an effect. This maxim correlates with the assumption of the researcher that "treatment" (the proposed training programme for the culturally safe management of aggression and

violence) will have an effect on the attitudes of mental health care users towards the management of aggression and violence in a culturally safe manner.

The post-positivist framework is further identifiable through the researcher's quasi-experimental design (Andrew & Halcomb, 2009:122). In the event where the researcher attempts to control variables and conditions, and to investigate cause and effect, the study falls within the perspective of positivism as stipulated by Henning *et al.* (2011:17). Within the post positivist research the aim is to understand the underlying causes of a natural phenomenon as per Loiselle and Profetto-McGrath (2011:10). This assumption by the post positvism and post-post positivism underpins the aim of what the researcher wishes to accomplish, namely researching the cause and effect and attempting to obtain objectivity whilst recognising the impossibility of total objectivity (Loiselle & Profetto-McGrath, 2011:11). The post positivism has been very prominent in nursing research according to Loiselle and Profetto-McGrath (2011:10). Hence, in this research project the researcher attempted to explore attitudes and investigated the effect of a treatment through a cross-sectional design with treatment partitioning (Burns & Grove, 2011:284). As this research project is not aimed at generalising to a general population, this proposed research project which is a mixed methodology falls within the perspective of post-positivism (Maree, 2007:65), as opposed to the positivism which seeks to establish generalisability.

1.11 RESEARCH DESIGN AND RESEARCH METHOD

A mixed methodology design is more than a mere combination of qualitative and quantitative data in a single study. It requires integration of data at some point (Creswell, 2012:14, Polit & Beck, 2012:603; Andrew & Halcomb, 2009:3). With this mixed methodological approach, the researcher was able to explore the knowledge of indigenous healers and the IKS used to manage mental health care user related violence, augmented current literature and tested the implementation of a training programme aimed at the management of aggression and violence in a culturally safe manner.

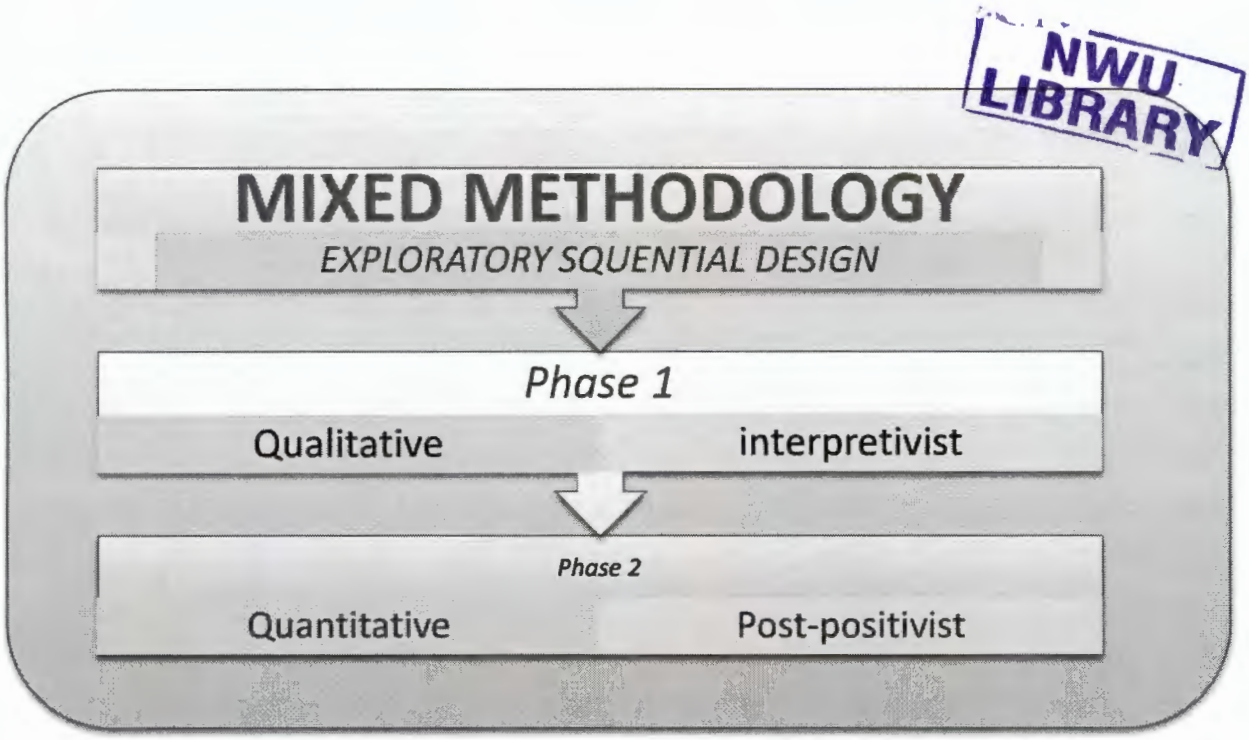


Figure 1.1: Schematic design of the research project (designed by T M Bock)

1.11.1 Overview of the research design and research method

The *qualitative phase* of the research consisted of *makgotla* with indigenous healers. Information obtained during this phase was used to adapt the structured MAVAS questionnaire to include components of IKS. The *makgotla* will be further explained in Chapter (3) three of this thesis.

The aim of the qualitative component was to describe how indigenous healers treat aggression and violence in mentally ill persons, focusing on why they propose the specific form of treatment and how effective they consider this treatment to be. Henning *et al.* (2011:3) recommend a qualitative approach to investigate "how and why" a phenomenon takes place. Social reality is explained by Henning *et al.* (2011:13) to be an attempt at understanding from the perspective of the role players, hence the decision to conduct *makgotla* with indigenous healers.

The *quantitative phase* of this research project consisted of the utilisation and application of the adapted MAVAS questionnaire and the Inter Cultural Sensitivity Scale in the form of a pre- and post-test to determine changes in attitudes towards the management of aggression and violence and cultural sensitivity in the subjects chosen for the study after the administration of a training programme aimed at the management of aggression and violence in a culturally safe manner.

In Chapter (3) three the researcher will elaborate further on the processes which were followed during this research.

1.12 STUDY OUTLAY

Chapter 1: Overview of the research
Chapter 2: Literature review
Chapter 3: Research methodology
Chapter 4: Qualitative phase of this research and the discussion of the findings
Chapter 5: Quantitative phase of this research and the discussion of the findings.
Chapter 6: Recommendations and conclusion of the research

1.13 CONCLUSION

The WHO (2004) encourages a utilisation of skill mix to deal with staffing problems in mental health care. The researcher as previously stated recognises the role of Indigenous healers in the mental health care of 70% of South Africans. This is echoed in Pienaar (2013:151), who explains that unique primal health care practices have outlived the Western health care practices and continue to dominate in rural areas.

Therefore the researcher feels these skills could possibly be utilised in the rendition of health care to the diverse population of South Africa. Not only can these skills be used, but cross-pollination should take place between WBKS and AIKS as this would encourage the provision of culturally safe care.

The lack of scientifically generated evidence depicting staff's attitudes of the management of mental healthcare user related violence and aggression and cultural sensitivity in the four psychiatric hospitals chosen for this study necessitated further investigation to collect data to evaluate the current status of the management of aggression in a culturally safe manner and to test if the proposed training programme has an effect on the aforementioned attitudes.

In subsequent chapters, the researcher will discuss the findings from the literature review, the research methodology followed during this study, the research outcomes, the training programme curriculum designed and final conclusions made.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

This literature review chapter will further discuss the literature consulted by the researcher in search of the conceptualisation of topics such as aggression and violence, IKS and attitudes of staff. The literature review will also elaborate on the attitudes of staff and indigenous healers towards mental health care and aggression as sometimes found in mental illnesses.

Through consultation of the literature, the management of aggression and violence associated with mental illness will be investigated. A comparison will be made between the perceptions of the above-mentioned within the AIKS and Western based medicine also known as Allopathic or Western biomedicine system (Andrews & Boyle, 2003:282).

This chapter continues to provide an overview of AIKS and the WBKS to create an understanding of the two concepts. The researcher elaborates further on the attitudes of health care practitioners in the WBKS towards AIKS and vice versa, in order to establish whether the two opposing knowledge systems are both acknowledged in terms of the provision of care to MHCU. The different perceptions of mental illness and the management of mental illness are explored with reference to the way in which the two opposing world views deal with mental illness.

Through a comparison the researcher additionally explored the tolerance of the opposing knowledge systems to each other and how it is utilised in the Southern African countries. The aim of this approach is to provide the reader with an overview of the differences between the knowledge systems and how these differences impact on the quality of care MHCU still receive today.

2.2 AFRICAN INDIGENOUS KNOWLEDGE SYSTEMS (AIKS) AND WESTERN-BASED KNOWLEDGE SYSTEMS (WBKS)

> *"He who speculates from the shore about the ocean shall know only its surface, but he who would know its depths must be willing to Plunge into it."*
> *Anonymous*

One can only truly understand a culture different from their own if they are prepared to delve into the culture in order to understand the perspective of the said culture (Naidoo, 1985:1).

2.2.1 Introducing the status quo with regards to cultural differences as evident in health care institutions

Each cultural group has its own cultural norms, beliefs and traditions. These traditions include health care practices, building styles, clothes, dietary beliefs, the existence of a higher spiritual being responsible for the creation of all life on earth and beliefs about causative factors (Andrews and Boyle, 2003:274; Helman, 2001:2; Tjale & De Villiers, 2004:161). Giddy (2012:19) reported some cultures which believe that there are incidences where an evil external force accidentally gains power over humans and this can cause illness or death, these beliefs are frowned upon by WBKS.

In terms of the co-existence of the Western Based Knowledge Systems (WBKS), the researcher has experienced situations where the culture and knowledge systems of MHCU are not always recognised or where staff are insensitive towards a culture. One such example is during celebration of Christmas. The wards in the hospital where the researcher used to work are decorated very festively with Christmas trees; gifts are given to MHCU on Christmas morning, regardless of the cultural and religious beliefs of the person. However, the researcher noticed that *Chanukah,* a Jewish festivity which coincides with Christmas, is ignored. Similarly, other religious celebrations such as *Eid* for the Muslim patients and *Diwali* for the Hindu patients, went by without an acknowledgement by the staff.

The researcher assumes that through acknowledgement of these beliefs, the mental health care practitioners might contribute to a positive mental health care user experience, and hence begin to provide culturally safe care.

Attempts geared at collaboration between WBKS and AIKS are further explored and the researcher elaborates on the intended professionalisation of indigenous healers.

In conclusion, the similarities and differences between the two diametrically opposed knowledge systems will be illustrated; with a further exploration of the current training provided to assist mental health care providers to manage the aggression and violence associated with mental illness in a culturally safe manner. The researcher will continue to elaborate on how cultural awareness and sensitivity is addressed as part of the proposed curriculum.

In order to facilitate further discussions, it is necessary to provide an overview of AIKS as described in this work.

2.2.2 Broad overview of African Indigenous Knowledge Systems (AIKS)

South-Africa, a country on the most Southern tip of the African continent, has eleven (11) official languages, each of which is nestled in its own culture (Joyce, 2009:7). It is common course that along with the different cultures come unique perceptions of the world and practices by which the members of the different cultures make sense of their environment and lived experiences.

An explanation of Indigenous Knowledge Systems (IKS) can be found in a definition by Quiroz (1994:14) wherein he defines (IKS) to be the totality of the knowledge and skills of a group of people, which knowledge and skills make it possible for them to live in and off their specific geographical area. Raphesu (2010:3) elaborates further through citing Quiroz (1994), expanding the definition to indicate that each new generation adapts this knowledge to suit changes in their environment. This definition is supported by Maila and Loubser (2003:276) and Ngomane and Mulaudzi (2010:30), who reiterate that it is inherited knowledge, customs used to advance themselves and it is quite unique to each culture. IKS is sometimes referred to as *Traditional African Medicine* (TAM) when treatment of illness is discussed (Okpako, 1999:482). Okpako (1999:482) continues further and refers to IKS as the more than mere medicine, referring broadly to the: "accumulated experience of ancient Africans".

Therefore, based on the findings of the authors cited above, the researcher establishes that African Indigenous Knowledge Systems (AIKS) is a collection of knowledge, skills and practices within a specific frame of reference and a specific geographical area, which allows people to make sense of; and live and survive in, their environment on the African continent. AIKS is thus not a static phenomenon but evolves as people evolve, and this flexibility allows people to adapt to changes.

This AIKS is deeply embedded in the culture of all people and forms part of their worldview (Maila & Loubser, 2003:276; Higgs, 2010:2414). Both the metaphysical aspects as well as the technology, social, economic and philosophical learning and educational systems should be a part of the definition of AIKS, as stated in a study done by Hoppers and Makhale-Mahlangu (1998) in Breidlid (2009:141).

The AIKS is sometimes explained to be based on understanding from a magico-religious perspective (Tjale & De Villiers, 2004:4; Holland, 2001:3). This magico-religious perspective is explained by Tjale and De Villiers (2004:4) through a holistic explanatory model. This model

refers to the body being in harmony with the physical world, social world and other people. Illness would stem from disharmony between these afore-mentioned systems. How the person would interpret the illness will depend on their unique cultural beliefs and knowledge systems. Because many Africans believe and are one with their ancestors, they would often find the cause of illness through reference to this world of contact with the Ancestors. WBKS would refer to this form of belief as being magico-religious (Edwards *et al.*, 1983:213).

The magico-religious perspective becomes more evident where Indigenous healing systems include the practice of the indigenous healers' use of spiritual forces to determine "the cause of ill health and misfortune" (Ensink *et al.,* 1999:26; Shankar, Saravanan & Jacob, 2006:222). A further definition of indigenous healing explains indigenous healing to be, "the sum total of knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve, or treat physical healing and mental illness" (WHO, 2002).

In elaboration on the concept of the magico-religious perspective, notably one category of healers within AIKS is referred to as diviners, who are reported to possess the ability to "divine the cause of illness and misfortune". Divining the cause of illness refers to the practice where the diviner enters into a state of trance in order to communicate with the ancestors who will then indicate the cause of illness. (Joyce, 2009:47).

In further explanation, diviners reportedly have power over life and death and can use this power for either good or evil purposes, as alluded to in a study by Ngubane (1977) in Ensink *et al.* (1999:25).

Equally important is to note that religious healing systems are commonly found in the Eastern African regions and developed under the influences of Islam and Christianity (Teuton, Dowrick & Bentall, 2007:1267).

These religious influences of WBKS on AIKS can be traced back to the 1820's during the British settlers' occupation of the Cape and the subsequent spread throughout South Africa, in its wake establishing numerous missionary stations. The Anglicisation of Southern Africa soon spread throughout the rest of the African continent, with the Christian religion being preached in order to "convert and save Africans" (Joyce, 2009:21).

This spread of religion through Africa is one of the examples where two opposing forces, namely religion and AIKS, met and "something new" was created.

Through the meeting of these two forces, that is the exposure of religion to AIKS, a new form of healing emanated, manifesting through the birth of a new type of healer known as the prophet. This prophet, according to Pienaar and Manaka-Mkwanazi in Uys and Middleton (2013:136), prays through known ancestors to the "unknown god" who would then give guidance towards the healing process. Notably, the difference between the prophet and the diviner is that the prophet does not make use of the throwing of bones or the use of medication but rather relies on the use of "holy water" and readings from the Bible (Uys & Middleton, 2013:136). In the context of this research, the prophet is therefore a practitioner who bases healing on the Holy Scriptures and the diviner in contrast is a person who not only seeks answers from the Ancestors but also uses medication of an indigenous nature in the treatment of a health seeker. This opinion of Uys and Middleton (2013:136) is also noted by Mzimkulu and Simbayi (2006:420), who refer to the establishment of an independent African church that broke away from the western oriented missionary churches. It was within this African church that the prophet started practicing.

Subsequently, in contrasting WBKS and AIKS, the researcher notes that in terms of AIKS, the African world view looks at the essence and existence of man not from knowledge based on scientific reasoning but from direct experience and the transfer of this experience to the community and family.

Thus, in conclusion, the sum total of AIKS is more than a mere magico-religious belief system. Instead, it is a holistic view of life, with knowledge generated through the lived experience of the cultural group and the transfer of this knowledge from generation to generation through verbal communication. Maila and Loubser (2003:277) refer to this AIKS as to be "user-derived and not scientifically derived." It however complements modern day innovations as seen in WBKS. The WBKS will be described in the next section in order to introduce the reader to the opposite system.

2.2.3 Broad overview of WBKS

The WBKS prides itself on being rational (Tjale & De Villiers, 2004:3). Rationality implies exactness, relying only on true observations (Rosnow & Rosenthal, 1999:3). Within the WBKS, there is no place for mysticism, and there are definite causes and effects. Knowledge is gained according to scientific measurement and proof under strict control (Henning, 2004:3). This knowledge system is also described as "exact thinking and correct thinking" (De Vos *et al.*, 2009:3).

WBKS are generally endorsed by most governments and organisations such as the World Health Organisation (Teuton *et al.*, 2007:1261). WBKS see disease as a biological reaction and the intervention should be medicine aimed at killing the bacteria and virus, as well as to suppress the symptoms associated with the illness (Tjale & De Villiers 2004:84; Andrews *and Boyle,* 2003:85). In the context of this research, WBKS is deemed to be knowledge generated through scientifically researched evidence. However the two opposing world views inevitably had to meet.

2.2.4 When two opposing world views meet

> *"When two powers meet one will rub off on the other and after the experience neither of the two parties will be the same."*
> (Mumford & Anjum, 2011).

Reflecting on the statement in the text box above, the researcher will endeavor to explain how the words of Mumford and Anjum (2011) above, echoe the findings of Higgs (2008:446) and Joyce (2009:13), where they indicate that through the colonial influence, the African people's world view was ignored and Africa was forced into an "inverted image of the Western Eurocentric identity". The researcher will continue to argue, through quoting research, how the African world view due to the tenacity of culture managed to survive the influence from WBKS and added in the creation of "something new".

African countries, through their many diverse cultures, share a commonality; namely the influence of the Western-based knowledge on the African continent. Despite the influences of the WBKS, Africa has proven to be a continent where the diverse cultures possess tenacity and resilience, hence westernisation has not changed deep-seated cultural beliefs (Izugbara & Undieb, 2008:165). The AIKS have survived the influence of the WBKS. The contact between AIKS and WBKS has not occurred without conflict.

Conflict between WBKS and AIKS is observed through the example of the management of witchcraft-related killings, a practice that is acceptable in some African cultures and taboo in Western cultures.

The attitude of WBKS is further portrayed in the way in which witchcraft in AIKS and the dealings with alleged witches within traditional tribal councils is frowned upon. For scientifically-

based knowledge systems, there is no belief in supernatural or magico religious beliefs as supposedly found in AIKS.

Hund (2003:10) reported that within AIKS, if a person was deemed to be a witch, a tribal court was held and witches found guilty were executed. South African courts were not equipped to deal with allegations of witchcraft and this led to the promulgation of the South African Suppression of Witchcraft Act, No. 3 of 1957, subsequently amended by Act 50 of 1970. This act now allows for persons accused of witchcraft to pursue an action of defamation of character against the accuser (Hund, 2003:10).

Similarly, even within the "rational" WBKS there are certain groups who share some belief in unscientific supernatural and magico-religious beliefs. This gives rise to conflicting opinions amongst groups who share the same WBKS. One such example can be found in the practice of Satanism and demonic possession and Christianity and the exorcism of demons.

Because Satanism is practiced in a covert form and therefore surrounded with mysticism, Langone (1990:101) found that media publication spurts on the exploration and experimentation with this form of belief system and it tickles the interest of especially adolescents. The researcher is of the opinion that Satanism is a form of magico-religious belief system as it is reported by Langone (1990:102) that participation in satanic rituals, where members allegedly drink human blood, forms pacts with Satan and will subsequently possess more power. Miller *et al.* (1999:211) made a similar observation with regards to cult members who believed participation in such rituals will provide them with a longer life, increased health and power over others. This magico religious thinking is further evident through ideas of reference and odd beliefs as is manifested through the behaviour of the members of a cult (Miller *et al.*, 1999:212). Wheeler, Wood and Hatch (1988:547) echoe this finding of other authors and continues to point out that the satanic rituals not only intrigues adolescents but leaves them with the belief that there is power in the rituals and that there is personal, religious and sexual gratification in attending such rituals. This belief of sexual gratification is confirmed in the writings of LaVey (1969:87) (the father of Satanism) wherein it is stated "...The purest form of carnal existence reposes in the bodies of animals and human children who have not grown old enough to deny themselves their natural desires...".

Society is quite unaccepting of the practice of Satanism, not so much the worshipping of Satan but rather the rites involved, such as alleged human sacrifices which is considered to be crime against humanity and therefore punishable under penal law. Satanism, as practiced religion and the modern church of Satan, was established on *Walpurgisnacht,* (A witches' Sabbath) 30 April 1966 when Anton LaVey proclaimed himself to be the high priest of the church of Satan.

(Langone, 1990:123), LaVey continued and wrote the Satanic Bible in 1969, (Langone, 1990:124). Satanism is filled with mysticism such as the symbols, séances, meetings and black weddings, even human and animal sacrifices, use of drugs and attendance of sexual orgies (Wheeler *et al.,* 1988:545).

Therefore, the researcher is of the opinion that WBKS are used as a departure point to define concepts not indigenous to what is deemed the norm from the Western perspective, and subsequently places value judgment on practices from a WBKS perspective, yet within WBKS there are also sub cultures such as the practitioners of Satanism which is also not understood within the WBKS. This leads to condemnation of practices which do not form part of what WBKS deems to be the norm with the researcher observing this as a form of ethnocentrism whereby "different practices" are condemned, and "own" practices are accepted to be the only truth.

To conclude, Ralushai in his summary report on witchcraft violence in South Africa (cited by Hund, 2003:125), confirmed that despite early missionaries' "condemnation of indigenous healers" the practice have continued to survive; this confirms the tenacity of cultural practices and includes the tenacity of sub-cultures such as Satanism. The researcher concludes that the two opposing forces are still in existence and are continually shaping one another.

2.2.5 WBKS versus IKS

The researcher is of the belief that Africa as a developing continent does not differ much from the rest of the world. As seen in the literature, countries such as Australia, Nieu Zealand and the United States of America to name but a few, are all in the position where there is more than one health care perspective and knowledge system running alongside one another. Tjale and De Villiers (2004:2) and Berg (2003:195), echoes this observation when pointing out that in South Africa we have the WBKS and AIKS running parallel with one-another, which will influence the health care system.

In order to understand the role of the different knowledge systems, it is essential to explore both and their role within the South African context. The "rationally focused" WBKS is often a barrier to understanding the AIKS (Hund, 2003:33).

The WBKS is based on scientific measurement and scientific reasoning, whereas the coinciding different views of health care systems are defined to be pluralistic (Teuton *et al.,* 2007:126).

Even though the AIKS and the health care rendered within this system is seen as lay care and therefore not viewed as professional, all cultures in one way or another depend on this form of care due to the often inaccessibility of Western-based care to people in rural areas, hence they primarily seek the help of the indigenous healer (Atindanbila & Thompson 2011:459). Leininger, as quoted by Tjale and De Villiers (2004:152), identified four types of lay care used by all cultures and further elaborates that this type of care arises from experience and common sense. The types of lay care identified are care given by family members, social networks, self-help groups and self-medication.

The researcher, like most South Africans, has directly experienced health care rendered by her mother, care which is based on the family's knowledge system which also forms part of the IKS. One such example is the consumption of heated red wine during a bout of measles. Within this knowledge system of the family, there is a belief that the consumption of the red wine would expedite a breakout of the rash associated with measles and therefore prevent complications associated with measles. This is one example of a practice that has not been medically tested at the time, but is an example of knowledge passed down within the different generations of the researcher's family.

In Africa, there are distinctly different healing systems and views around mental health. These can be divided into indigenous, religious and allopathic views of healing systems (Ensink & Robertson, 1999:24; Okpako, 1999:482). Sorsdahl *et al.* (2010:284) note that the option of more than one healing system allows for the preferences of the population as to which system they want to utilise. The option of more than one healing system acknowledges the existence of more than one view of illness and the seeking of health care based on the view of individual people (Beckerleg, 1994:299). Ovuga, Boardman and Oluka (1999:276) submit that it is beneficial to have different healing systems running alongside one another as it allows the health care user the freedom to seek alternatives should they be dissatisfied with one or the other system. These aforementioned views differentiated from one another through their individual definitions will inevitably lead to different treatment and management strategies. According to Yen and Wilbraham (2003b:564), the AIKS differs from the WBKS in that it attempts to focus on why a phenomenon happens as opposed to how it happens. The "how it happens" is based on scientific reasoning as found in the WBKS.

Noteworthy is how WBKS refers to the use of indigenous practices and AIKS as "alternative medicine" when this practice is sought over the Western-based medicine. Where Western-based medicine is used in conjunction with alternative treatment, this is referred to as "complimentary medicine" (Andrews & Boyle, 2003:85; Janse van Rensburg, 2009:158). This reference leads the researcher to deduce that through the terms used above, namely the use of

complementary medicine, there is evidence of a readiness to include these types of practices. Therefore the stage is set for collaboration between the two opposing knowledge systems. Regardless of the set stage, the two opposing world views have their different opinions of one-another.

2.2.6 Attitudes of Western-based health care practitioners towards AIKS

Culture is important to every person as it defines a person and allows one to make sense of the world. Therefore culture is shared by a group of persons and allows for standardisation of what the specific group believes. It further sets boundaries for those who are included in the same group (Tjale & De Villiers, 2004:66).

Due to the fact that people with different cultures have different values, it often so happens that people with one culture cannot associate with practices and beliefs of another culture outside their own. They then would deem their own sets of beliefs superior to that of another culture. This is referred to as ethnocentrism (Tjale & De Villiers, 2004:45; Andrews & Boyle, 2003:7). Ethnocentrism hinders consideration and acceptance of other cultures. In a situation such as the nurse-patient relationship, where the nurse has a lack of understanding of the culture of the patient, this situation can lead to conflict and feelings of inferiority in the patient. Yen and Wilbraham (2003b:564) point out that historically the psychological and psychiatric institutions made assumptions on what is referred to as the "primitive African personality" and attempted to manage mental illness from a Western knowledge based perspective, therefore adding to the ethnocentrism as stated by the authors above.

WBKS has attempted to understand AIKS. However, in the attempt to explain AIKS, the WBKS has unfortunately added to the creation of confusion through loose referrals and the synonymous use of terms such as reported in a study by Hund (2003). Hund (2003:12-15), reported the findings of academic writers where they refer to "*sangomas*" as witchdoctors, adding to the impression amongst the layperson that a "*sangoma*" does witchcraft.

Similarly, authors such as Berg (2003:196) have noted that within WBKS indigenous healers are often referred to as witchdoctors and that this term is loosely generalised to different cultures. This generalisation often leads to confusion, as for example in the Xhosa culture the "*isangoma*" acts as a spiritual medium between the client and the ancestors and the "*inyanga*" is a diviner and herbalist focused on prescribing medicines and cures. However, in the Venda and Tsonga cultures, both the *sangoma* and herbalist are referred to as "*inyanga*". Noteworthy is that all "*sangomas*" are herbalists and diviners, yet not all diviners are "*sangomas*". The differentiation lies in the length of training and if a person received a calling "twaza" to become a

sangoma (Mzimkulu & Simbayi, 2006:420). Yet Berg (2003:196) informs that within WBKS all of these healers are loosely referred to as "witchdoctors", even though there are clear distinctions between the different functions of the different types of healers in AIKS.

In the current curriculum of health care, the western and allopathic worldviews are inculcated into practitioners during training. This adds to the difficulty that health care providers experience in accepting that indigenous healers should be included as part of the health care system (Tjale & De Villiers, 2004:4). Thus it might be difficult for nurses to understand and value AIKS in the WBKS because they might feel superior with regards to knowledge in their area of expertise.

Teuton *et al.,* (2007:1268) and Yen and Wilbraham, (2003a:550) observe that staff generally feel that psychotic disorders fall within an area of specialisation and are ideally the domain of qualified psychiatric staff. As such, the staff reportedly felt more at comfort with indigenous and religious healers dealing with non-psychotic disorders. This bias is demonstrated in staff reporting that the indigenous and religious healers are not skilled enough to deal with psychosis and might misdiagnose psychopathology that should be assisted by WBKS (Teuton *et al.,* 2007:1268-1270; Yen & Wilbraham, 2003a:552, 557).

Contrary to this statement, Berg (2003:196) celebrates indigenous healers to be skilled psychotherapists who underwent years of rigorous training and subsequently have the necessary approval of the Ancestors. Additionally (Yen & Wilbraham, 2003a:550) confirm the hesitance of staff to refer to indigenous healers through reporting a finding in their study where the decision for the multi-disciplinary team to allow consultation with an indigenous healer is not made by professionals but rather it is "patient- or family driven".

Teuton *et al.* (2007:1268-1270) further explain that the bias does not end with statements such as reported above but continues to include judgments where nursing staff assumed that indigenous healers were secretly administering neuroleptics to patients to boost their statistics of "curing" patients. The nurses continued to report that they think indigenous healers use "*muti*" consisting of human flesh. *Muti* is a Zulu word meaning medicine (Labuschagne, 2004:192). This "*muti*" is then given to unsuspecting patients. The nurses elaborated further in alluding to the fact that the indigenous healers instill fear in patients through informing them that they have provoked the anger of the Ancestors, hence ensuring that patients come for follow up visits where rituals are performed to appease the Ancestors. All of the above would ensure that the indigenous healers generate financial income from the unsuspecting patients.

In elaboration on *muti* consisting of human flesh, it is noted that:

Traditionally the chief of a cultural group was allowed to sanction a "medicine murder" if it was for the benefit of the community or when a new chief was installed. In the case of Gadiwe v The State (2007), the report was that the life and energy of the victim will be transferred into the person using the *muti* containing human flesh. The allegation made above is supported by Roelofse (2012:1) who sites (Prinsloo & Du Plessis, 1989:621; Ralushai, Masingi, Madiba & Van den Heever, 1995). These medicine murders are reportedly not committed by strangers but rather a family member or acquaintance of the victim (Labuschagne, 2004:193). *Muti* is reported to be harvested from live victims and the area harvested can be directly linked to the needs of the *sangoma's* customer. In example, Labuschagne (2004:193) reports that the harvesting of hands supposedly brings wealth to the person who will make use of the muti. The *Inyanga* and *sangoma* never took part in this ritual killing. This practice is in direct contrast with Western Based knowledge and therefore the supplier of this type of *muti* is punishable by law in South Africa (Hund, 2003:90). The perception of the nursing staff that the treatment of psychosis should occur within health care in the WBKS only, as reported by Teuton *et al.* (2007:1268); and Yen and Wilbraham (2003a:550), leaves the researcher with the impression that an underlying motive for statements such as these might stem from ignorance or possibly feelings of being threatened by the utilisation of AIKS as opposed to the WBKS which the nurses are more acquainted with. This type of judgment leads to a disregard of the role of indigenous practices and an attitude of rejection.

WBKS through claims by scientists adds to the discouragement of the use of indigenous medicine by claiming that the dosages used are imprecise and the safety of all plant remedies have not been tested (Okpaka, 1999:483). This perception of WBKS is echoed in a study where Abbo (2011) reports that indigenous medicine and treatment is dismissed as unsafe practices. In contradiction with the statement by Okpaka (1999), Breidlid (2009:142) opposes what he refers to as a "lack of respect" for AIKS by western scientists through portrayal of the assumed superiority of the western epistemology. Attitudes such as these will prevent the necessary sustainability of AIKS, frustrating their endeavour to meet human development needs.

The researcher concurs with the statement of Breidlid (2009:142) and notices that regardless of tests being done on treatment within the AIKS in order to dispute the use thereof, there are benefits to the use of AIKS. AIKS must have its deserved place in the health care system, as will be explained in the following section.

In addition to treatment of ailments through rituals and administration of indigenous medicine, a study by Okpako (1999:483) addressed the impact of the placebo effect of traditional African

medicine. In the course of this study, it was proven that the therapeutic intervention such as the rituals accompanying the use of indigenous medicines contributes significantly to the relief of illness, hence the reference to the placebo effect of the traditional African medicine. The placebo effect of AIKS is further demonstrated by Holland (2001:13) who submits that about 40% of illness may possibly have a psychological cause and that the success rate of the traditional healer lies in the AIKS form of healing that focuses more on the spiritual wellbeing of the patient.

This reference to the placebo effect is not always made as a positive remark, as observed in the experience of the researcher. As the researcher has noted, there are incidents where patients are injected with normal saline for pain control and when the normal saline solution alleviates the pain, health care providers will record this as malingering behaviour on the side of the patient, without a clear understanding of the placebo effect. Conversely, the attention of the health care provider is of far greater benefit to the health care user than the mere administration of medication.

Okpako (1999:483) and Holland (2001:20) echoed this notion, elaboring that due to the close nature of the relationship between the indigenous healer and his client, as well as the close ties between them, the placebo effect is much more pronounced than is the case in the relationship between the western practitioner and his client.

The placebo effect stems from a deep seated belief in the power of the treatment (Becker, 1974:108). South African born actress Antoinette Pienaar, a white South African woman who is undergoing an apprenticeship under a renowned Khoisan herbalist "Oom Johannes," also emphasises the importance of a person's belief in the efficacy of any herbal medicine. A person who does not believe in the efficacy cannot expect healing to take place (Pienaar, 2008:36). "Oom" (uncle) Johannes reportedly tells a patient, "Go, take the herbs and believe" (Pienaar, 2008:37).

Over and above the reported placebo effect, an interview with Mutwa, a sangoma as referred to in Hund (2003:154), revealed that the sangoma reports that communication will be on the level of a patient, and the sangoma will also never divulge his personal opinion to a patient even if the patient feels he was bewitched and the sangoma reportedly knows this is not the case. Therefore, the perception created is that AIKS might be more flexible than WBKS due to the acceptance of more than just biological causes for illness.

As early as 1961, the opposing views of AIKS and WBKS were evident. Tjale and De Villiers (2004:5) cite Szasz who postulated that traditional medicine might possibly be superior to

western medicine as indigenous healers know their clients on a more personal level as opposed to the medical doctor in the westernised medical model.

2.2.7 Attitudes of indigenous healers towards the WBKS

To understand the attitudes of indigenous healers toward the WBKS a perceptive consideration of the two opposing worldviews is essential.

Teuton *et al.* (2007:1267) reported that the indigenous healers in the study indicated that a client could be treated by both the indigenous healers and western medical personnel. Beckerleg (1994:303) echoes this and refers to this practice as medical pluralism. It was noted that Swahili people studied by Beckerleg sought the medical advice and intervention of both Western medicine and a "*sharif*" (a type of indigenous healer in Kenya who consulted the Quran to try and find a diagnosis). In support of the authors cited above, Ensink *et al.* (1999:29) also reported the practice of multi-pluralism in isiXhosa speaking patients in Cape Town, who consulted diviners, faith healers and herbalists simultaneously, in attempts to find a cure for mental illness. Within AIKS, some forms of illness can occur naturally. Uys and Middleton (2013:132) report that this illness is referred to as "*umkuhlane*" and further inform that indigenous people readily seek the help of practitioners within the WBKS for the treatment of this type of illness. This leads the researcher to deduce that the indigenous healers and indigenous people are more tolerant to opposing views when compared to practitioners within the WBKS/ bio-medical perspective. Indigenous healers who took part in a study by Sorsdahl *et al.* (2010:287) reported that they are aware that often western medical practitioners do not agree with their methods of treatment, and this may be due to some of the "*muti*" recipes used and the ingredients in it. One such recipe shared, allegedly cures a condition known as "*amafufunyana*" which is a form of bewitchment. The recipe contains the following ingredients: "1 teaspoon of Methylated spirit, ½ teaspoon of Benzine ®, a few pieces of the "*Indonya*" (a traditional herb), 1 teaspoon of vinegar and ½ teaspoon of a herb called "*umdlebe*". This mixture is then administered in the form of an elixir. According to Sorsdahl *et al.* (2010:287) the indigenous healers reported that western medicine is not in agreement with this treatment because it contains Benzine.

Hund (2003:154) reported on an interview with a "*sangoma*" named Mutwa, that African people are very wary of "white people" because white people do not believe in the culture of the African people. The sangoma reported that this disbelief of white people with regards to the culture of African people can negatively influence the soul of the African person. African people are more sensitive to the soul than white people (Hund, 2003:154). These differences between the two systems have led to mistrust between the two opposing world views.

2.2.8 Resistance to share AIKS

Although both the WBKS and IKS can learn from each other, divergent opinions and experiences are noted.

Sorsdahl *et al.* (2010:287) reported that the indigenous healers are very resistant to share secrets of the trade and recipes for "*muti*" with any person other than an initiate undergoing training, considering that the practices are deemed to be the intellectual property of the traditional healer and the initiates only. The researcher observed the same during data collection as will be noted in Chapter (4) four.

This hesitation by indigenous healers to share their knowledge is echoed in a statement by Doubell (2010) during a power point presentation, where he advocates that the rights of indigenous healers should be protected against exploitation by commercial players. This quest for protection is also reflected in the Intellectual Property Rights from Public Financed Research Act (51 of 2008), wherein the act regulates benefit sharing in the commercialisation of indigenous knowledge and practices (South Africa, 2008).

The Khoisan chief, Adam Kok the 5th, during a conversation in a Khoisan village in 2012, referred to the previous utilisation of the knowledge of the *hoodia* plant by Western-based scientists. The scientists reportedly made financial gain out of the marketing of *hoodia* for medicinal purposes. The commercialisation of *hoodia* was done without recognising that this is indigenous knowledge. None of the financial yield was ploughed back into the already impoverished Khoisan community whose intellectual property was used. This exploitation of intellectual property strengthens the perception that indigenous knowledge is only acknowledged if money is to be made out of it (Quiroz, 1994, Kok, 2012, Raphesu, 2010).

2.2.9 Legalisation of indigenous health practices

Acknowledgement of AIKS and its role in South Africa has been researched and attempts have been made to form collaborations between AIKS and WBKS. This collaboration included legitimisation of AIKS practices (Yen & Wilbraham, 2003a:543). Sillitoe (2000:4) and Chivaura, as cited by Ncube (2006:219), warn that the WBKS cannot be used to "interpret and categorise" the AIKS as this will encourage a person to view AIKS as filled with myths and superstitions.

The recognition of the indigenous healing practices used by indigenous healers has led to a quest to professionalise the AIKS practices to ensure safety to the user. Therefore the

Traditional Health Practitioners Act (35 of 2004) was promulgated to regulate the profession. Through this act the practices, training and registration of these health care providers are regulated (Janse van Rensburg, 2009:157; South Africa, 2004). Any person in terms of this act who practices as a "Traditional Medical Practitioner" but who is not registered in terms of this act is guilty of a criminal offence and can be fined up to R2 000,00 or 2 years imprisonment (Hund, 2003:109).

The establishment of a professional regulating body for professionals gives recognition to their practices. It can therefore be accepted that this recognises Indigenous healing practices as part of the health delivery system in South Africa. Through the promulgation of the Traditional Health Practitioners Act (35 of 2004), more health care options are available to South Africans and each person can make use of health care services according to their own preferences (Sorsdahl *et al.*, 2010:285; South Africa, 2004).

Unfortunately, ignorance often leads to a breakdown of collaborative efforts. Ignorance is demonstrated in a study by Yen and Wilbraham (2003a:547), when the multidisciplinary team entered into discussion with indigenous healers by providing them with vignettes of a patient with a mental illness that was difficult to diagnose. Ignorance, though not intentional, became evident through a lack of understanding of the complexity of diagnostics through rituals. The indigenous healers cannot perform divination rituals on a "paper person". This knowledge pertaining to diagnostics within AIKS lacked in the multi-disciplinary team who invited the indigenous healer to take part in the diagnostic formulation and discussion of the patient.

Further examples of ignorance are evident in a study where Hund (2003:35) reports that ignorance of AIKS and imperialism by WBKS led to the enactment of the Witchcraft Suppression Act No 3 of 1957 amended by Act 50 of 1970) and that this caused an increase in witchcraft violence. Therefore the Ralushai Commission Report recommended the repeal of the act and in addition recommends rehabilitation of the legitimate role of the sangoma. The sangomas in terms of this report should be brought under state control. This alludes to the recognition of the role of the sangoma and their healing practices.

Robertson (2006:87), Abbo (2011) and Pienaar (2013:151) report that about 70% of South Africans use indigenous healers as primary health care providers, therefore the legitimate role of the Indigenous Healer must be recognised in order for the gap between the two opposing treatment models to be bridged as this will encourage the rendering of culturally safe care to all. (Berg 2003:196).

For this to happen, closer collaboration between Western-oriented care and primal care based on IKS is necessary.

2.2.10 Movement towards co-existence of AIKS and WBKS

Higgs and Higgs (2001:9) propose that one can change your perception of others and how you relate to the world, leading to the creation of something "more beautiful and better than we had before". Therefore, the caution is for one not to attempt to understand AIKS from a WBKS perspective (Sillitoe, 2000:4). Instead, one would rather attempt to understand the perception of others and other cultures from within their unique frame of reference, as opposed to trying to fit different cultures into one's own world view. The Western worldview and influence in Africa is being challenged, and recognition is given to the African world view by means of an African philosophy. This gives a deserved recognition to the AIKS through what Higgs (2008:499) refers to as the "African Renaissance". This renewal is focused on the expansion and inclusion of the African World view in education (Higgs, 2008:499, 450-455; Ndofirepi, 2011:248).

Higgs (2008:447) points out that some of the Western cultures have since started realising that AIKS, though not seen as scientific reasoning, has much to offer and might possibly assist the scientific community to understand natural phenomena. In addition, it might also prove to be essential for sustainability, hence the support of the quest of O'Donoghue, Masuku, Janse van Rensburg and Ward (1999) as quoted by Maila and Loubser (2003:276) to have AIKS included in education and health curricula. Abbo (2011) strongly recommends that curricula in medical schools must include AIKS as a deeper knowledge will allow more open discussions between western and indigenous health practitioners, thereby increasing cultural competence. The quest to include AIKS in educational curricula is echoed in recommendations in a chapter titled "Notes on African Witchcraft" by Chavunduka in a book edited by Hund, wherein he proposes that teaching of African traditional medicine should be introduced into educational institutions (Hund, 2003:142). Additionally, Berg (2003:195) reminds one of the urgency to become acquainted with other world views as ignorance can have disastrous consequences for effective health care provision. Noteworthy is that Indigenous Knowledge Systems still exist despite the introduction of the "superior" WBKS. There have been attempts made to ensure that both practices run concurrently and become more interfaced with one-another (Janse van Rensburg, 2009:157). Perceptions of health and illness are thus influenced by the specific knowledge system of the person or cultural group we are dealing with, and this especially influences perceptions about mental illness.

2.3 PERCEPTIONS OF MENTAL ILLNESS

Mental illness in most cultures is associated with disability (Shankar, Saravanan & Jacob, 2006:221). Additionally, mental illness was historically viewed as people being "mad, fools or possessed" (Andrews & Boyle, 2003:272). In order to understand the concept of mental illness, it is necessary to explore the phenomenon and management within the perspective of the culture a person is dealing with.

2.3.1 Mental illness explained within the AIKS

The topic of mental illness within the AIKS has not been broadly investigated. However, Shankar *et al.* (2006:221), Teuton *et al.* (2007:1260) and Ovuga (1999:276) assert that the concept mental illness is defined within the frame of reference of the person requested to define it. In conjunction with a personal frame of reference, conceptualisation of the concepts with regards to what constitutes mental illness is also based on the cultural system of beliefs of a specific group of people (Kabir *et al.*, 2004:2; Hund, 2003:33).

All studies consulted pointed out that the recognition of a condition such as mental illness was based on the observation of the behaviour of the person who is deemed "mentally ill" (Kabir *et al.*, 2004:4; Shankar *et al.*, 2006:225; Sorsdahl *et al.*, 2010:286). Within the AIKS, symptoms of mental illness furthermore include eccentric behaviour, wandering aimlessly and talkative behaviour (Kabir *et al.*, 2004:3).

Possible causes of mental illness include supernatural causes, witchcraft, breaking of taboos, especially in cases where a disease is of a chronic nature as pointed out by Tjale and De Villiers (2004:147-149). Joyce (2003:48) also informs that any illness that cannot be diagnosed and healed within the western knowledge based system is deemed to be a "calling from the ancestors". The cause of mental illness due to intervention by a traditional healer is mentioned by Holland (2001:13), wherein the author indicates that he traditional healer reportedly possesses the power to inflict mental illness on an individual. This sheds light on an understanding of mental illness and illness per se as attributable to factors external to the person as cited by Baumann (2007:44). A study in a village in Nigeria, however, had respondents identifying alcohol and street drugs included as potential causes of mental illness (Kabir *et al.*, 2004:3). This finding was corroborated in a study by Abbo (2011), where alcohol was specifically linked to the presence of mania. Hence the statement can be made that mental illness within AIKS is not a natural occurrence, but is rather caused by some sort of interference (Janse van Rensburg, 2009:159).

Directly in contrast with the African world view is the perception of the WBKS, where reportedly Africans are labelled as having an external locus of control because they are deemed to be unwilling to accept responsibility for their own misfortune (Abbo, 2011).

The supernatural origin of mental illness is also cited by Sankar *et al.* (2006:225), who identified the Indian term "*saivinai*" which translates to black magic, as a cause of mental illness in Indian people. The term "*saivinai*" also relates to possession by dead people in the Indian folklore (Sankar *et al.,* 2006:255), or a "*Jihn*" in Swahili folklore (Beckerleg, 1993:310). Ensink and Robertson (1999:24) quote Farrand (1984) who notes that indigenous people will rely on the treatment of indigenous healers if they experience the cause of an illness to be due to bewitchment or other supernatural causes.

In elaboration of the supernatural causes of mental illness, the isiZulu culture believes that witches or "*Abathakathi*" are responsible and that bewitchment is done my means of "throwing" illness. Such symptoms of the "throwing of illness" are mental disturbances (Crawford & Lipsedge, 2004:133-134). Witches in the Zulu culture are considered to be men because men are physically stronger than women. However, not all mental disturbances are referred to as bewitchment. Crawford and Lipsedge (2004:136) explain that if a person is called to become a diviner, he or she will be psychologically affected through a condition known as "*Ukuhlanya*". This condition is reportedly brought on by the Ancestors calling a person to become a diviner. Similarly, in the isiXhosa culture a person who receives the calling to become a diviner "*ukutwasa*" may show symptoms of psychiatric illness (Ensink & Robertson, 1999; Ensink & Robertson, 1999:26).

Additionally, Mzimkulu and Simbayi (2006:418) identify spirits called "*ngozi*" as the causative factor in psychotic illness; these spirits are the spirits of a person(s) who was killed by the patient or his Ancestors.

Even though the role of the ancestors in the Zulu culture is to watch over the people and their well-being, the ancestors will withdraw themselves if a person has displeased them. The Zulu culture believes that unseen spirits reside in all people and when the ancestors are displeased with a person, other people may use these spirits against the person in whom they reside. Witches have secret knowledge to use these spirits (Hund, 2003:64). Innocent acts such as stepping over dangerous tracks as laid down by witches or potentially being poisoned with soil and ants from graves can cause mental illness in a person. Furthermore, a witch can send evil in the form of the "Lightning bird", "*tokoloshe*" or a "river snake" to an unsuspecting person, who will then fall ill with a mental illness (Ensink & Robertson, 1999:34).

Within the AIKS the indigenous healer can differentiate between mental illness and what is deemed to be a calling to become a diviner. This is done by examining the symptoms which the client presents to the diviner. Mental illness is seemingly more severe and the symptoms would interfere with the normal functioning of the client. The symptoms will include erratic and bizarre behaviour, which would include a deficit in self-care which is absent in the event of "*twaza*" or a calling to become a Diviner (Mzimkulu *et al.*, 2006:424).

The ancestors, as reported by Holland (2001:186), can bring about illness and even death. However, this is done to induce good behaviour and therefore it is seen as some social regulator, and the ancestors evidently have a parental role in society.

Regardless of the cause and perception of mental illness, the phenomenon is well described in both perspectives (the WBKS perspective will be discussed in section 2.3.3). There are, however, different opinions as to whether the WBKS's management of mental illness is culturally appropriate, hence the appeal to negotiate with indigenous healers to form a more culturally grounded understanding of the patient's problem. This is because a problem might not be understood by the Westernised knowledge system in the same way as done by traditional practitioners (Yen & Wilbraham, 2003a:544-545).

2.3.2 Treatment of mental illness within AIKS

Several authors touched on the topic of how mental illness is treated in the different AIKS. A commonality is that the treatment is directly related to what is considered to be the etiology of the disease (Mzimkulu *et al.,* 2004:425; Sankar *et al.,* 2006:230).

The indigenous healers rely on guidance by Ancestors to treat mental illness. Such treatments attempt to correct imbalances or appease the Ancestors where taboos have been broken. The treatment consists of holistic care to both the client and the family, whereby a person is cleansed through the administration of herbs that will induce vomiting. Combined with this, the indigenous healers will perform rituals such as singing and dancing at the client's home to exorcise evil spirits. Mzimkulu *et al.,* (2006:246) note that the rituals are often accompanied by the consumption of alcohol and slaughtering of a goat. Additionally, the healer or his wife would bath the afflicted person in "muti" as the final step in the cleansing ritual. One of the drugs used in the treatment of psychosis was identified by Prince 1960 to be *Rauwolfia vomitoria* as cited in Abbo (2011.). The Collins Paperback English Dictionary (2004:1075) defines "*muti*" to be "a form of informal South African medicine, usually herbal." The word is derived from the isiZulu word "*umuthi,*" which means tree. Herbs are used by means of ingestion, sniffing, smoking, steam inhalations or enemas (Mzimkulu & Simbayib, 2006:425).

Within the AIKS, it is not uncommon to find practitioners who specialise in certain illnesses. Some healers tend to specialise in the management of mental confusion which includes specific symptoms such as unprovoked aggression, repeated running away from home and inexplicable behaviour. This specialisation stems from previous success in the same types of behaviour (Crawford & Lipsedge, 2004:138). In the Southern Sotho culture, the "*Lethuela*" who is usually a female, specialises in the treatment of mental illness (Hund, 2003:79).

At a conference of the World Council for Psychotherapy, Berg (2003:195) refers to a statement by Madu, Baguma and Pritz (1999) wherein the authors refer to the positive effect that rituals have on the mental health of individuals. Rituals reportedly allow the individual to re-establish links with the Ancestors because disconnectedness adds to suffering in the individual (Berg, 2003:202). Berg (2003:202) continues to inform that because of family participation in rituals, the link between the patient and family will necessarily also be re-established. This emphasises the importance of spirituality to the African person.

AIKS practices that revolve around religious themes also consider mental illness to be a form of spirit or demonic possession and suggest that such illness could be treated by spiritual methods (Edwards *et al.,* 1983:215; Crawford & Lipsedge, 2004:139; Sankar 2006:230) as is evident in the following examples.

The Southern Sotho "*Lethuela*" uses hypnosis and exorcism to treat mental illness. Similarly, the Tsonga people believe in magic. In the event of mental illness against the background of a long term illness, they feel it is due to "*baloyi,*" a form of bewitchment. The Northern Sotho culture uses the services of a "*Seloadi*" who is a gender blind person - neither male nor female. This "*Seloadi*" takes on the role of "*Ngaka,*" who acts as a spiritual medium and healer. The Swazi culture makes use of a "*Sangoma*" who could be either male or female to diagnose illness and use the "*Nyanga*" who makes homemade medicine to treat mental illness (Joyce, 2009:79, 89, 99, 108). Most of the *Ngu* tribes, as found in South Africa, believe in the involvement of bewitchment in the phenomenon of mental illness (Joyce, 2009:13). The existence of possession by demons is also supported in the Holy Bible where it is reported that Jesus cast out many evil spirits (Bible, 1984). Various subcultures within Westernised cultures include groups of people who believe in the existence of demonic possession as cause of mental illness, as Pfeifer (1994:247) notes. Demonic possession is usually treated by means of exorcism; this treatment is a common practice in the Roman Catholic- and Charismatic churches (Pfeifer, 1994:247). Notably, researchers warn against the potential damage caused by performing exorcisms where a patient has formally been diagnosed with a psychiatric illness.

Allen (s.a.), Crawford and Lipsedge (2004:139) and Khatab and Mousel (1998:99) reported incidents where people died during the performance of exorcisms.

The rites that are performed during an exorcism involve prayers, commands, fumigation, burning of herbs and sprinkling of holy water (Bancroft, 1998; Sankar *et al.*, 2006:230). Exorcisms and their effect are medicalised by authors, who compare them to certain psychological interventions such as "abreaction" therapy. During this therapy, the allegedly possessed person is excited into an emotional frenzy during which he displays an exaggerated state of the emotions he is suffering from, such as exaggerated anger and fear. During this intense display and emotional effort, the possessed person becomes so tired that he collapses from mere exertion. After the collapse, the person feels relief and calm and is often left with a feeling that he is relieved from the demon that possessed him (Bancroft, 1988).

Belief in possession does not only exist in the AIKS associated with African cultures. It also stems from faiths such as Christianity, Judaism, Hinduism and Voodoo-ism (Bancroft, 1998). As much as some people believe in the existence of demonic possession, the researcher (during her career as a psychiatric nurse practitioner) has experienced that staff in general share the sentiments of authors such as Henderson (1982:129) who strongly indicates that there is no such thing as spirit or demonic possession, but that the sufferer is merely "possessed" by intra-psychic conflicts from earlier life.

Contrary with beliefs such as disregarding the existence of demonic possession, therapists within WBKS do acknowledge the existence of Satan worshipping and the negative effect these practices will have on the mental health care user and mental health care provider (Wheeler *et al.,* 1988: 549). In elaboration, Wheeler *et al.* (1988:549) advise that Satanism thrives on fear and therefore when dealing with a mental health care user involved in Satanism, the mental health care provider should not display any signs of fear. Wheeler *et al.* (1988:549) further explain that it is usually rebellious adolescents who get involved in Satanism and display magico-religious thinking. They resist any form of authority and will therefore necessarily display difficulty in establishing rapport with the mental health care provider.

Faith healers who "cure" through prayer and the laying on of hands have received such special powers through a higher "power" by means of divine intervention (Barret, s.a.). Faith healers are included in the category of indigenous healers. They occasionally practice exorcism if they deem illness to be due to a form of possession (Naidoo, 1985:3).

In AIKS, if mental illness is not due to bewitchment, the *sangoma* will use the hallucination and delusion of the patient to move him towards sanity. The *sangoma* will play along with the

hallucination and will interact with the hallucination and chase it away or command it to leave until such time as the patient reports that the hallucination is gone (Hund,2003:156). In the event of phobias, the person will be invited to a sacrificial rite and the skin of the animal that is sacrificed will be shaped into a pillow. The patient will be requested to lie face down on the pillow and he will be held down in this position by strong men. The *sangoma* will then place the object of the phobia on the patient's back. The patient in this position will have difficulty in breathing and will, in order to prevent suffocation, give in to the presence of the object of his phobia in order to be able to breathe normally. This succumbing and acceptance of the object of the phobia is deemed to be a cure of the phobia, according to Hund (2003:157).

Further to the treatment of mental illness through different indigenous healers, families within AIKS reported that they would willingly look after their family members who suffer from mental illness (Ohaeri & Fido, 2001:494). This is confirmed by Paul and Pienaar (2013:38) . The researcher assumes that this is an attempt to keep mentally ill persons as part of the family unit and the community.

2.3.3 Mental Illness explained within the WBKS.

> *"Pains of the mind can only be cured by the mind." Victor Hugo Francisco Makumbuy,* as quoted by Dr Peter Becker (Becker, 1974:114)

Mental illness has been surrounded with mysticism in all cultures.

During the middle ages, there was a general belief that mental illness was due to demonic possession (Robertson *et al.*, 2001:1). The era of the Modern Scientific psychiatry started during the French Revolution under the guidance of Phillipe Pinel who started with empirical observation and recording of cases (Robertson *et al.*, 2001:3). This revolution caused a shift in the perception of Westerners, who began to appreciate that there is more to Mental Illness than demonic possession. Mental illness is now defined as maladaptive behavioral patterns that interfere with a person's ability to function normally in relationships, in his/her occupation and it causes the person discomfort (Baumann, 2007:561). The Mental Health Care Act (17 of 2002) further defines mental illness to be "a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such a diagnosis." (South Africa, 2002).

Mental illness is further explained through a plethora of signs and symptoms as depicted in the Diagnostic and Statistical Manual IV (DSM IV) established through research (Robertson *et al.*,

2001:9). The DSM IV, recently upgraded and adapted to the 5th edition (DSM-5), allows for reliable diagnosis and is very objective in establishing differential diagnoses. There are definite medical, genetic, social and psychological causes for mental illness, and the phenomenon is explained from a bio-psycho-social model, with the emphasis based on an allopathic point of departure (Robertson *et al.*, 2001:16).

Allopathic medicine is defined to be the "system of medical practice which treats disease by the use of remedies which produce effects different from those produced by the disease under treatment. Medical doctors practice allopathic medicine." (Medical Glossary, 2005). The term allopathy was coined by C.F.S. Hahnemann in 1842, where he determined that allopathic medicine treats disease with drugs that will result in producing the same symptoms as one would expect in a healthy individual.

The researcher noted through literature that regardless of the scientific knowledge whereby a diagnosis and etiology of psychiatric illness is made within the WBKS, and the evidence that there are definite physiological causes for such mental illness which creates an empathetic understanding of mental illness, severe prejudice still exists even in the health care fraternity.

This prejudice towards mentally ill persons from members of the health care fraternity is demonstrated in studies such as those undertaken by Ogunsemi, Odusan and Olatawura (2008:150), wherein it is reported that the medical students who took part in the survey would not want psychiatrically ill persons to stay next to them, nor would they want a family member to marry them. The view of Ogunsemi *et al.* (2008:150) is shared by Ewhirudjakpor (2009:22) who identified that medical practitioners, regardless of their medical background, still had deep-seated beliefs about mental illness that are contrary to scientific knowledge. Contrary to scientifically-based knowledge, it was identified in a study that some health care providers identified curses and witchcraft to be a cause of mental illness (Ewhirudjakpor, 2009:22).

The researcher has observed that some practitioners within the WBKS notoriously frown upon perceptions of religious healers, believing that hallucinations and the "hearing of voices" might be caused by demonic possession and factors other than the allopathic theories on the cause of conditions such as schizophrenia. Statements such as these mentioned above are often ridiculed and made out to be "old wives tales". This experience of the researcher is echoed through the quotation of Rose (1997) in Barret (s.a.): "After nearly twenty years of work, I have yet to find one 'miracle cure'; and without that (or, alternatively, massive statistics which others must provide) I cannot be convinced of the efficacy of what is commonly termed faith healing".

This type of prejudice within the medical fraternity might prevent referral to indigenous healers as part of the multi-disciplinary team, regardless of the belief system of the client.

Notably, the majority of health care providers are quite intolerant to the belief in spiritual healing and as reported by Barret (s.a.), a medical doctor claims that numerous scientists have "de-bunked" allegations of spiritual healing. Allegations such as this are made out to be an illusion of Christian Science, whereby illness stems from faulty beliefs and that prayer works through replacing faulty beliefs or "bad thoughts with good ones" Barret (s.a.). These beliefs still influence the way in which mental illness is treated.

2.3.4 Treatment of mental illness within the WBKS/Allopathic view

Regardless of the statistics claiming that four fifths of the world population reside in non-Western countries, the reality is that psychiatric resources are mainly localised in industrial societies, making psychiatric services mainly part of WBKS (Andrews & Boyle, 2003:277).

Allopathic treatment of mental illness commences with a diagnosis of the illness by means of Mental Status Examination, where all the signs and symptoms of the illness are confirmed. This Mental Status Examination includes a detailed history taking and corroboration or verification of information given by the patient with a family member (Robertson *et al.,* 2001:39-50).

Psychotropics or allopathic medicine were first discovered during the early 1950's (Robertson *et al.,* 2001:417). Prior to the administration of these psychotropics, patients often had to undergo cruel treatments such as lobotomies, leucotomies, and electro convulsive therapy, without the comfort of anaesthesia and occasionally, insulin comas were also induced (Robertson *et al.,* 2001:445-446).

Hospitalisation has since moved away from custodial care to the implementation of community mental health centres where community health groups have also been established. The aim of mental health has moved from hospitalisation in specialist hospitals to a more community-based service (Robertson *et al.,* 2001:418). However, the mentally ill person is still contained in a hospital setting, depending on the degree of distress the person suffers. Yen and Wilbraham (2003a:554) report that this containment is not to remove a person from society but to provide a safe area for the patient, where they will feel secure. The researcher doubts whether this will be the case in the event of incarceration, especially if the care givers do not understand the patient's world view and belief system, and do not share the sentiment of the patient with regards to his/her perceived cause of the illness. Yen and Wilbraham (2003a:555) confirm this suspicion of the researcher in stating that the patient being nursed by predominantly "white"

English speaking practitioners will add to a difficulty in the different parties' understanding of one-another, resulting in an escalation of the level of distress the patient experiences.

Such an example of increased levels of distress is observed in mental health institutions where health care users are not allowed to keep any personal possessions with them. The Zulu people customarily wear bangles made from goat skin after sacrificial rituals. Uys and Middleton (2013:135) assert that these bangles remind the person wearing them of the bond between them and the ancestors, providing an assurance of recovery from illness.

When the mental health care provider lacks an understanding of such connotations and forcibly remove such bangles, this raises the anxiety level in the mental health care user because the mental health care user perceives this as a taboo. This is how ignorance becomes counterproductive in a therapeutic relationship between the mental health care user and the mental health care provider.

Robertson *et al.* (2001:425,426) advocate for the development of a culturally competent system of care that will provide care to all cultures. Unfortunately, this support does not obscure the fact that allopathic health care providers are not always in support of the inclusion of indigenous healers as part of the team. An area that needs special attention is how the aggression associated with mental illness is dealt with.

2.4 AGGRESSION ASSOCIATED WITH MENTAL ILLNESS

The phenomenon of aggression in psychiatry has been well researched and documented by several researchers (Needham, 2004:2; Lewis-Lanza *et al.*, 2006:71; Chen, Hwu & Williams 2005:71). The researcher noted that several authors use the word violence and aggression interchangeably, an opinion also reflected in the work of Irwin (2006:309) and Lucas and Stevenson (2006:195).

The Collins English Paperback Dictionary (2004:31) defines aggression as "an attack or harmful action, or any offensive activity that stems from a hostile or obstructive mental attitude". More clarification, however, lies in the following definition declaring aggression to be "a desire to produce fear or flight in others" Penguin Dictionary of Psychology (1995:18). Most authors agree that aggression is used as a term to depict acts such as threats, the use of profanities or raising the tone and volume of voice to others, without resorting to a behavioral action where there is an intention to do physical harm to a person or the property of another person (Uys & Middleton, 2013:255; Mason & Chandley, 1999:6).

Noteworthy is Owen *et al.* (1998:1458) who pointed out that a person using aggression might do this in order to act as a warning that violence might follow on aggression if not managed correctly. Aggression comes in different forms which range between different extremes from verbal aggression through physical aggression. Mason and Chandley (1999:60) indicate that the louder the person's voice becomes, the higher the potential for violence. Verbal aggression can therefore be seen as a warning of imminent violence. Verbal aggression should not be seen as harmless as Ilkiw-Lavelle and Grenyer (2003:90) pointed out, considering that constant exposure to verbal aggression and the emotional effect suffered can equate to one episode of physical violence.

Aggression is not only observed in institutions where mentally ill persons are cared for. It is a social phenomenon that affects all aspects of society and it is transferred to institutions through MHCU who reflect the values of society (Levin, Hewitt & Misner, 1998:249).

2.4.1 The view of aggression associated with mental illness from a WBKS perspective

Aggression and violence in hospitals and the psychiatric milieu is deemed to be the norm, as opposed to a rare occurrence. This statement has been proven by numerous authors (James, Isa & Oud, 2011:130; Oostrom & Van Mierlo, 2008:320; Needham, 2004:2; Chen *et. al.*, 2005:141). Nurses are the backbone of any health institution, due to the much higher ratio of nurses per patient compared to the ratio of other health care practitioners. Due to the number of nurses per patient and the nature of the job description, namely direct health care to the health care user, nurses will definitely be more exposed to mental health care user-related violence when compared to the other categories of health care providers (Aquilina, 1991:200; Binder & McNiel, 1994:545; Carmel & McNiel, 1989:46; Bjørkly, 1999:62; Hahn, Needham, Abderhalden, Duxbury & Halfens, 2006:197). During a previous study where the researcher determined the attitudes of mental health care practitioners towards the management of aggression and violence, the findings corresponded with the report by James *et al.* (2011:133), namely that the nurses view aggression as negative (Bock, 2010:99) this necessitates empowering the nurse to deal with management of aggression and violence.

The incidences of mental health care user-related violence have necessitated numerous research projects, hence the phenomenon of aggression in persons with recognised mental illness has been well researched and documented by different researchers.

This has allowed mental health care providers, of whom the nurse forms an integral part, to make certain predictions with regards to the clientele more likely prone to aggression and

violence. Koen (2003:254) proved a link between substance abuse and violence in male mental healthcare users with schizophrenia, as supported by similar findings by Milton *et al.* (2001:439). Similarly it is common course that aggression is related to other mental illnesses such as psychosis and manic episodes.

The nurse has a vital role to play in the management of aggression and violence and Irwin (2006:311) advises that the nurses are the "most significant variable in all prevention strategies". Risk assessments used to predict the potential for violence in the patient might hamper the nurse-patient relationship, where the nurses who perceive the patient as a potential threat might be influenced against the patient and this in turn may complicate treatment, management strategies, and the quality of care. This creates a juxtaposition where behaviour that must be countered is actually caused.

Through numerous studies, it is evident that the factors that precipitate and contribute to aggression include confined areas, overcrowding, high temperatures, low staffing levels, seclusion and the use of restraints (Soliman & Reza, 2001:77-79; Duxbury, 2002:331-333; Duxbury & Whittington, 2005:470; Ignelzi, Stinson, Raia, Osinowo, Ostrowski & Schwirian, 2007:453; Geen & Donnerstein 1998:Loc1987). Sublette and Trappler (2000:132) reported in a study with Jewish patients that not allowing practices within the Judaism, such as reading the *Tanakh* and *Talmud* and performing ritual prayers, increased the anxiety of the patient, and as known; raised anxiety levels may contribute to the incidence of aggression. Through a blanket application of ward rules such as withholding religious material from a person who is deemed "religiose" (Penguin Dictionary of Psychology, 1995:659), the AIKS of the specific patient is ignored and, therefore, the relationship between the practitioner and the patient becomes non-therapeutic. In addition to this reality, the existence of counter transference is also reported, where therapists and health care providers attempt to "enlighten" patients to different religious views (Sublette & Trappler, 2000:130). The above mentioned attitudes from staff and authoritarian interaction styles, refusing requests and unreasonable demands, are examples that not only allude to ignoring the knowledge system of a mental health care user but also typical examples of causes of aggression in mental health care facilities (Lucas & Stevenson, 2006:199).

Shockingly, the opposite has been reported where the nursing staff is implicated to be the aggressor as opposed to being the care giver to the person suffering from a mental illness. (Lucas & Stevenson, 2005:197). The extent of aggression patients suffered, as proven in a study by Lucas and Stevenson (2005), varied from verbal abuse, physical assault to reported sexual abuse.

Knowledge of the nature of aggression and strategies implemented thus far have not succeeded in preventing aggression. The researcher will elaborate in the next section on the management of aggression in the WBKS and how it exacerbates an already complicated problem.

2.4.1.1 Management of mental illness related aggression and violence within the Western-based scientific knowledge/bio-medical system

In South Africa, the Mental Health Care Act (17 of 2002) makes allowance for a person who is mentally ill and a danger to himself, other persons or their property, to be admitted to a hospital for observation. Furthermore, if the person resists treatment and is not prepared to undergo any form of treatment, the same act informs practitioners that such a person can be forced to undergo treatment as an involuntary person. This implies that the person deemed a danger to himself or others can be admitted to an institution against his wishes (South Africa, 2002).

Therefore aggression in a person suffering from a mental illness is considered seriously, where intervention must be implemented. In addition, sanctions such as the use of seclusion, involuntary hospitalisation and closed-ward systems are imposed on the patients in any event of aggression, as experienced by the researcher. It is clearly noted that numerous studies were conducted with regards to the management of aggression and violence and a commonality amongst the findings was that if a person was deemed a threat to him/herself or the safety of others, such behaviour is managed through single seclusion, prescribing medicine or increasing the dosage and even the use of restraints (Canatsey, Bermudez & Roper, 1994:13; Fisher 1994:1589; Duxbury, 2002:325).

Methods such as seclusion and the use of restraints are seen as the "traditional methods" whereby aggression is managed. These "traditional methods" are deemed to do more harm than good, and they have been implicated to exacerbate the problem of aggression, as opposed to effectively managing it (Duxbury, 2002:325; Canatsey, Bermudez & Roper, 1994:13; Ilkiw-Lavelle & Grenyer, 2003:392; Fisher, 1994:1589). Hahn *et al.* (2006:198) partially agrees with this statement but continues to refer to a study by Duxbury (1999), wherein it is evident that nurses treat aggression by means of the biomedical model which indicates an exclusion of AIKS.

Opposed to the European countries that use restraints as part of managing violent and aggressive MHCU's, the South African hospitals do not use restraints to manage aggression in the majority of mental health care institutions. In mental health care, as reported in section 2.4.1 of this study, the management of aggression and violence is primarily the function of the nurse,

due to the nature of her job description and scope of practice. In view of this statement, it is therefore within the scope of the nurse to perform risk assessments for the propensity of aggression, as well as to receive the patient on admission, perform assessments and ensure that the environment in the ward is safe. The nurse must also observe for signs of aggression and implement the necessary interventions to curb such problems (Mc Hugh & Wain, 1995:23).

Adding to complications in the management of aggression, Bock (2010:101) identified a difference amongst staff as to what constitutes aggression. It was identified that the methods and application of techniques to deal with aggression is not applied consistently, thus causing confusion in patients with a resultant increase in dissatisfaction with regards to treatment regimes. This situation perpetuates a perception that some staff members are more lenient with regards to the application of ward rules and implementation of methods to deal with aggression and violence such as the use of seclusion, than others. This will necessarily add to an already complicated treatment regime.

2.4.2 AIKS view of aggression associated with mental illness

Aggression was cited to be the most common feature associated with mental illness in a study performed by Kabir et al. (2004:3). Several authors are in agreement that extreme forms of behaviour such as violence might be indicative of an underlying mental illness (Shankar *et al.,* 2006:231, Ewhirudjakpor 2009: 24; Sorsdahl *et al.,* 2010:286).

Additionally, aggression has been cited as a symptom of a mental illness and might be due to disconnectedness with ancestral spirits (Degonada & Scheidegger, 2009). This aggression in mental illness has also been identified as associated with "*twaza*" or a calling to become a traditional healer, until such time as the person accepts the calling, the aggression, social isolation and bizarre behaviour will persist, according to Atindanbila and Thompson (2011:458).

2.4.2.1 Management of mental illness related aggression and violence within the AIKS

A survey amongst indigenous healers in Mpumalanga revealed that some of the indigenous healers managed aggression associated with mental illness by physical means, such as tying the person up with ropes and occasionally chains, to prevent harm or injury to others (Sorsdahl *et al.*, 2010:286).

The pharmacological management of aggression revolved around the use of "*muti*". This "*muti,*" that is the combination of different herbs and some unknown substances (sometimes even

human flesh as noted in section 2.2.6), can be administered to the patient via different routes and applications such as sniffing, drinking, inhalation of vapours when burned, topical application in incisions made by the indigenous healer and baths with "*muti*" in it. The administration of "*muti*" is only one part of the treatment regimen and it is further followed up with rituals to complete the healing process (Degonada & Scheidegger, 2009; Okpako 1999:482).

In addition to the treatment, the afflicted person is also encouraged to stay in the home of the traditional healer where the traditional healer would ensure compliance with the prescribed treatment. This practice is done because due to the nature of the relationship between the healer and the client and due to the smaller communities within the AIKS in the rural areas, the mentally ill person and the healer are often known to one-another (Sankar *et al.*, 2006:226). Noteworthy at this stage, is that during the sixth century within WBKS, when the belief in demonic possession of the mentally ill was rife, the mentally ill were cared for in monasteries operated by the church. Later, during the twelfth century, mentally ill persons were cared for in the houses of very religious people, all in an attempt to include them in family life (Koenig & Larson 2001:68). This observation leads the researcher to note some similarities between AIKS and WBKS, which will be elaborated on in the conclusion of this chapter.

In continuation, the theoretical assumptions that Traditional African Medicine (TAM) practitioners make about the origins of an illness are consistent with their methods of treatment of the illness (Okpako 1999:482), therefore:

The treatment of severe mental illness with associated aggression within the AIKS is very difficult and complicated and the treatment is almost coercive and occasionally so severe that it has led to injury of the patients (Ensink *et al.*, 1999:25).

Clients who are very aggressive are often tied down, beaten into submission and some have even been the victims of sexual assaults in order to contain them. The severe treatment stems from reports that these violent clients are a severe challenge to both the family and the indigenous healer (Mdluli & Msomi 1989:15).

Contrary to the ensuing thought, not all aggressive clients are abused by indigenous healers, as some healers reportedly calm the client down by talking to them and burning herbs that relax and calm the client (Mzimkulu *et al.*, 2006:425). During a *lekgotla* negotiated and held in Lesotho during November 2012, and attended by the researcher, the indigenous healers from the district reported the existence of aggression as associated with mental illness. However, the

most effective way in dealing with this aggression, as reported by the indigenous healers was to:

- Immediately untie a person, if the person is brought to them tied up by the family.
- Talk to the person in a neutral and calm way.
- Attempt to understand the cause of the aggression.

2.5 CULTURAL SAFETY AND CULTURAL SENSITIVITY

As a psychiatric nurse, the researcher witnessed the forced removal of "medicine against evil" from an Indian lady admitted at an acute psychiatric unit. The health care user carried a small pouch attached to a string around her neck, and because the staff and ward rules do not allow any mental health care user to wear any ornate decorations in the ward, she was asked to surrender the item for safe keeping. The client resisted and attempted to explain that she is wearing it for protection. The staff did not acknowledge this explanation and continued to remove the pouch forcefully. The client reacted aggressively in an attempt to keep this pouch with her. The mental health care user was eventually sedated and placed in seclusion because of "aggressive behaviour". Retrospectively, after a study of the literature, the researcher is horrified by her own ignorance at the time of the above incident. A question that the researcher poses to herself is, "What harm could have come from allowing this particular patient to keep this small pouch in her possession?

Furthermore, would it have been possible to keep this pouch on a shorter string around the arm as opposed to a longer one around the neck which poses a danger to commit suicide through hanging? This potential action would have fitted in with Leininger's theory of cultural care as it would have been the concept of culture care accommodation, catering for negotiation in action (Leininger, 1991:42; and Tjale and De Villiers, 2004:23). .

Did the forceful removal cause the patient more emotional damage?

The pioneer of cultural safety in New Zealand, Irihapeti Ramsden, is quoted by Fulcher (2002:690) and she answers this question by stating that if the cultural needs of a person are not met, it causes emotional damage, which is seen as culturally unsafe practice.

Fulcher (2002:702) echoes Ramsden's call for cultural safety and concurs that it is important to know how connected a person is to his/her cultural traditions in order for care givers to provide culturally safe care, as "...cultural safety gives meaning to the aspects of caring" (Fulcher, 2002:701). This cultural safety theory of Ramsden fits in very well with the cultural care theory

of Leininger, and allows for the care provider to "come into the health care/client relationship "recognising themselves as bearers of their own culture and to understand how that culture impacts on other people (Ramsden & Spoonley, 1994:164) and (Richardson, 2010:1).

Andrews and Boyle (2003:6) explain Leininger's Sunrise model and shed light on what the Westernised worldview should strive towards, namely to preserve, accommodate and repattern the care given so that it will become culturally congruent. Keep all the good practices and reshape the potentially dangerous practices. Would the staff involved in the incident in the example above have had enough information on different cultures and what are safe practices, then the whole situation would most probably have been dealt with differently?

The example above also serves to prove that the staff involved reasoned from a WBKS perspective and ignored the IKS of the client involved.

In further elaboration, Leininger (1967:33) warns that ignoring cultural differences seriously interferes with the nurse's ability to help the patient. What the nurse might see as resistance from the patient can be traced to the difference in the cultural backgrounds of the nurse and the patient (Leininger, 1967:33).

The researcher is also in agreement with the findings of Koenig and Larson (2002:74), where they recommend that supporting spiritual beliefs of a mental health care user ensures comfort for the patient and will reduce the stress they experience significantly. The authors continue to explain that in the event of beliefs being bizarre, it is necessary to determine if these beliefs are due to psychosis or part of the religious culture of the patient (Koenig & Larson 2001:74). Even though the authors Koenig and Larson (2001:74) point out that it is difficult to ascertain if the beliefs are valid, the researcher is of the opinion that the necessary information is obtainable through collecting co-lateral information from the family of the mental health care user. The researcher strongly feels that through researching the beliefs and customs of MHCU, one can truly create an accurate understanding of the MHCU and his frame of reference in order to provide holistic care.

The researcher is therefore of the opinion that all nurses should become culturally sensitive and aware of the different backgrounds of their patients in order to render safe and congruent care to all health care users.

2.6 TRAINING IN THE MANAGEMENT OF VIOLENCE AND AGGRESSION

Breidlid (2009:142) warns that the exclusion of AIKS will hinder the development of a scientific understanding of a natural phenomenon, hence championing the inclusion of AIKS in education. The researcher is in agreement with the previous author and is of the opinion that AIKS must be included in training programmes that prepare health care providers in the management of aggression and violence. Hahn *et al.* (2006:197) quoted Needham (2002), who has pointed out that there is a lack of systematic staff training in risk assessment and the management of aggression. The researcher concurs with the literature, where it is proposed that staff should receive training that allows for the implementation of more preventative methods such as communication, and de-escalation techniques (Hahn *et al.*, 2006:198; James *et al.*, 2011;133).

Numerous strategies and policies have been implemented to assist health care providers to deal with patient-related aggression, such as policy CG029 in the National Health Service Litigation Authority (NHSLA), which formulated risk management standards as an approach to educate health care providers in the therapeutic management of aggression (McHugh & Wain, s.a.). It was initiated in East London in the United Kingdom. This policy focuses on predictors of violence, talk down techniques, safe restraining, de-briefing and the writing of post incident reports. The policy includes guidelines on talk down techniques. However, as with most policies, it provides general guidelines that do not include additional management strategies that associate with Indigenous Knowledge Systems. Instead, the guidelines focus on management from within a WBKS.

The literature indicates that training programmes may bring about attitudinal changes in health care workers with regards to an improvement in the ability to deal with aggression and a decrease in anxiety levels (Patterson, Turnbull & Aitken, 1992, Collins, 1994:31, Grube, 2001:307, Beech and Leather, 2006:28 and Hahn *et al.*, 2006:198). The opposite has been detected in a few studies with no tacit proof of attitudinal change (Collins, 1994, Needham, Abderhalden, Halfens, Dassen, Haugh & Fischer, 2005; Hahn *et al.*, 2006:200).

Notably, a study conducted in Scotland showed that staff felt they benefited by a training session that reduced anxiety and increased their confidence and physical skills to deal with aggression (Bell & Waclawski, 2002). A concern that manifested after the training was that staff reported a significantly higher incidence of aggression and physical injuries (Bell & Waclawski, 2002). The researchers continue to explain this phenomenon as a possibility that staff might engage in more physical incidents due to their newly acquired skills. However, this is not based on researched evidence.

Regardless of training programmes, the researcher is of the opinion that due to the fallible nature of humans, mistakes are bound to happen in terms of the talk down and de-escalation techniques employed. The researcher therefore implemented a training programme in the Western Cape, a province in South Africa, which included amongst de-escalation and talk down techniques also dignified break away and safe restraining techniques. The initiative behind dignified break away techniques is based on the finding that it is not always possible to prevent situations where staff will be assaulted by violent patients. Furthermore, the researcher noted that staff sometimes fall back on previous methods of managing aggression, forfeiting newly acquired skills. This leads to staff failing to de-escalate aggression, which imminently leads to violent behaviour on the side of the mental health care user. With the implementation of dignified break away techniques, the staff can break free from a violent mental health care user without injury to themselves or the patient. The researcher could not find any training packages which included cultural awareness, sensitivity and cultural safety as part of the management of aggression and violence during the literature search.

2.6.1 Content of the curriculum for training packages in the management of aggression and violence

The literature consulted indicates that the majority of current training packages include:

- Definitions of aggression and violence
- Nature and prevalence of aggression
- Theories on aggression

Nursing interventions such as prediction of violence, communication, breakaway techniques, boundary setting, post incident care, ward security and ethics of aggression management.(Duxbury 2002:335; Duxbury & Whittington, 2005:476; Hahn *et al.*, 2006:203; James *et al.*, 2011:454; Bock, 2010:104).

However, In order to provide training packages to equip health care providers with the skills to deal with the management of aggression and violence, the researcher is of the firm belief that it is imperative that the training course acknowledge cultural differences in order to render care that is culturally safe. The rapport between the mental health care user and mental health care provider will only really become fully effective if the mental health care provider has an in-depth understanding of the multitude of different cultural identities he or she has to deal with on a daily basis. Andrews *et al.* (2003:5) warns that cultural conflicts may emanate due to the use of techniques which are not always culturally acceptable. The knowledge of different cultural practices will therefore influence the efficacy of care rendered. Dr Madeleine Leininger identified

similarities and differences between cultures as early as 1950 and advocated for the acknowledgement of the preservation of good cultural practices, acknowledgement and accommodation of safe practices and the re-patterning of unsafe practices. (Andrews & Boyle, 2003:6; Tjale, 2004:21-23).

A proposed training package should therefore contain the following components as portrayed in figure 2.1. The following schematic representation is proposed for use by a person when they manage aggression and violence.

Figure 2.1: SIP-DD Concept map of proposed training programme for the culturally safe management of aggression and violence (designed by TM Bock)

The full curriculum for the training programme can be found as annexure three of this thesis.

The aim of the training programme (primarily designed based on the findings of the study (Bock, 2010) wherein the researcher identified that mental health nurses could not identify the cause, predict aggression or perform talk down techniques) is to:

- Sensitise the learner to cultural awareness, sensitivity and culturally safe care.
- Make the learner aware of their own levels of cultural awareness, sensitivity and culturally safe care.
- Encourage the implementation and maintenance of safe cultural practices to allow for a better mental health care user experience in the mental health care institution.
- Acquaint the learner with the concepts and definition of violence and aggression.
- Educate the learner regarding the different causes of aggression and violence.
- Equip the learner with the knowledge on how their individual management styles will influence aggression and violence.
- Increase the ability of the learner to predict aggression and violence in MHCU.
- Enhance the ability of the learner to perform appropriate talk down techniques.
- Equip the learner with the basic skills in dignified break away techniques.
- Encourage the use of safe restraining techniques when talk down techniques prove inefficient.
- Equip the learner with the necessary skills to deal with specialised groups such as adolescent, geriatric patients and the client with a neuro-developmental disorder.

2.7 CONCLUSION

There are two apparently opposing views with regards to the management of aggression and violence. Despite some medical practitioners' intolerance of the Indigenous Knowledge Systems, there are many similarities with regards to the management of aggression and violence.

In both AIKS and WBKS, mentally ill people in general have an unfavorable public image (Kabir *et al.*, 2004:5), and it should be noted that the cultural conception of mental illness will necessarily influence the way the health care user and the community perceive Western-based treatment (Farrand,1984 cited by Ensink *et al.*1999:24)

The mentally-ill aggressive person is removed from the environment that influences him to be more aggressive. The aggressor is physically or mechanically restrained to prevent further injury to self or others or the property of others. This treatment happens in both the AIKS and WBKS.

People are engaged on a therapeutic level, be it through psychotherapy or the use of rituals. They receive "pharmacological" intervention, albeit psychotropics or "muti". Both the WBKS and the AIKS prescribe treatment and require compliance with treatment. Even though the prescriptions might differ in the two mentioned systems, there are set regimens and both systems lay claims to being able to either cure or induce some type of remission where the health care user remains symptom free. Both systems are used to prevent further harm to self or others.

At face value, it seems as though both systems appear to benefit both the patient and society. However, the two systems are not yet fully integrated and therefore the patient might be forced to use the WBKS where his cultural beliefs are not always considered.

In addition to the above literature, it is implied that a pluralistic approach might not always be the best option, as Degonada and Scheidegger (2009) reported in their findings. The latter indicated that the outcome of treatment in some patients was worse when they had to be sent to a medical doctor in addition to seeing the indigenous healer. It seems as though treatment with an indigenous healer only provided the best results for certain patients.

From the literature consulted, it is clear that there is a gap in courses aimed at managing aggression and violence. There is apparently a skills gap in terms of equipping health care providers with the necessary information around AIKS and the management of aggression. The current training courses all focus on a Westernised approach. This approach might not be effective in the Southern African context which is characterised by many diverse cultures.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the methodology followed during this study. It also elaborates on the aims of this study and how the researcher decided on the instruments to be employed. The procedures that were used during data collection, as well as sample selection and the ethical considerations during the research process are described. A discussion of the data analysis methods that were utilised concludes this chapter.

3.2 METHODOLOGY

3.2.1 Research approach and design

The researcher used a mixed methodology design. This design encompasses more than a mere combination of qualitative and quantitative data in a single design (Davies, 2007:25; Polit & Beck, 2012:603). It requires integration of data at some point in the design (Andrew & Halcomb, 2009:3, Creswell & Plano Clark, 2011:Loc 264; Polit & Beck, 2012:603; Creswell, 2014:14). Davies (2007:11) cautions that a mixed method research should only be undertaken when a person has enough time to do this type of research. With this exploratory mixed method design, the researcher had two distinct phases of data collection (Creswell, 2012:226). This approach enabled the researcher to explore the knowledge of indigenous healers and the IKS used in the management of mental health care user related violence?

The information obtained during the qualitative phase augmented the existing literature and guided the researcher to adapt the training programme designed during 2010 as a recommendation from her previous research, for the management of aggression and violence to include components of cultural awareness and safety, while also adapting the existing Management of aggression and violence attitude scale (MAVAS) to suit the situation in South Africa. Therefore the proposed integration of data, which is characteristic of mixed method research, took place during the refinement of a training programme and adaptation of the MAVAS questionnaire. The training programme was used during the subsequent quantitative phase of this research.

This assumption of the researcher is confirmed by Polit and Beck (2012:605) who propose the utilisation of mixed method research especially for the purpose of instrumentation in preparation of a quantitative research project.

The researcher will continue with an in-depth explanation of the processes followed during the subsequent qualitative and quantitative phases of this sequential exploratory research in sections 3.3, 3.4 and 3.5 of this research thesis.

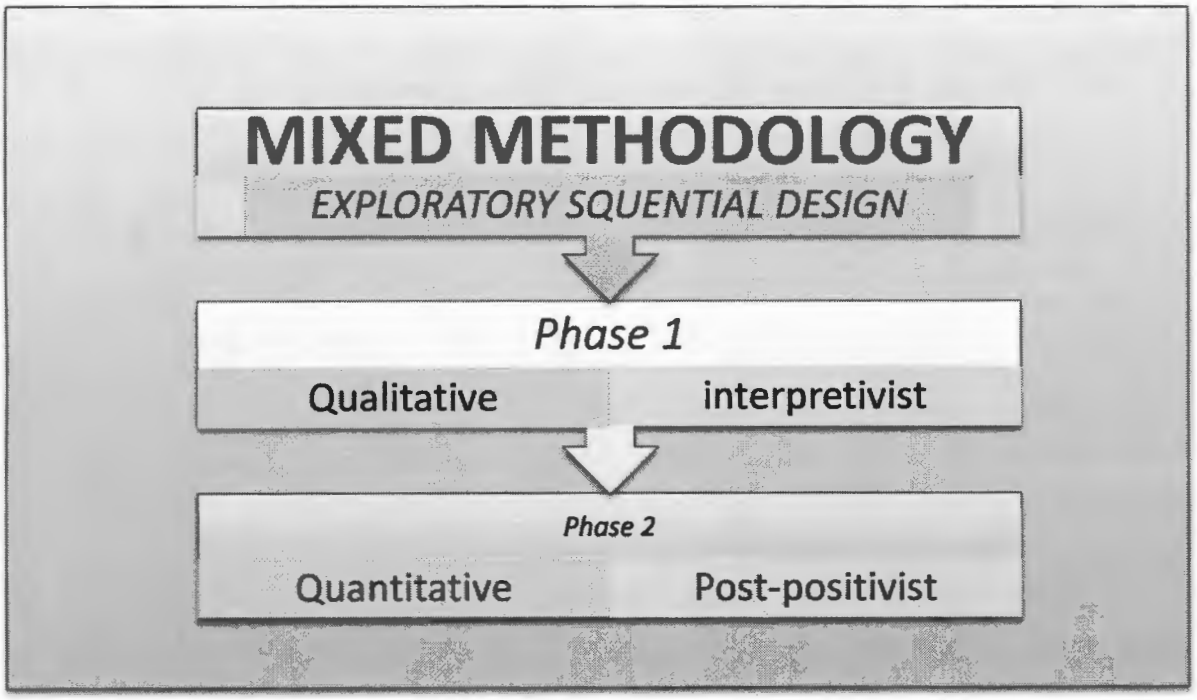


Figure 3.1: Schematic representation of the methodology (designed by TM Bock)

3.2.2 Overview of the research design and methodology

3.2.2.1 Qualitative phase

The qualitative phase of the research consisted of *makgotla* (plural for lekgotla) with indigenous healers. Information obtained during this phase was used to adapt the structured MAVAS questionnaire and refine the training programme as referred to in section 3.2.1 to include components of IKS.

Lekgotla (singular) is not a very common method of collecting data; it has proven to be an extremely valuable method of collecting qualitative data, especially when dealing with knowledge within the AIKS. The *makgotla* has been compared with focus groups, yet this is an erroneous perception as the *makgotla* have a very distinctive method and process to be followed, which is very well described by Pienaar (2004:25). During *makgotla* the researcher

does not take actively part in questioning Pienaar (2013:73 describes it well that during makgotla the researcher sits and "listen respectfully". Similarly there is a set protocol for the attendees of the *lekgotla* to follow, the researcher observed that the elders speak first followed by the younger male and the females addressed the *lekgotla* last. All attendees could offer their opinion and the validation of inputs occurred after the *lekgotla* when the members approached the researcher.

Makgotla are arranged through the chief in the community. In this instance, the chief of a *Khoisan* community and the chief of the Basotho indigenous healers were the appropriate persons to approach in terms of the negotiations.

The process, as described by Pienaar (2004:25), was followed when the researcher approached the chief of the *Khoisan* community in a village in the Northern Cape, as well as the Chief Basotho Indigenous Healer.

The researcher explained the purpose of the research to both chiefs during the respective *makgotla.*

Once the *makgotla* was negotiated, the Chief of the particular community and the Chief of the indigenous healers called together the local indigenous healers. At this platform, the Head of the indigenous healers posed the researcher's questions to the attendees: "How do you manage aggression and violence in people who are mentally ill in your community?", and "How effective is this management of aggression and violence?"

In the Northern Cape, the chief of the *Khoisan* community called the community and the *gheiga's* together and similarly introduced the question.

As seen in the subsequent paragraph, the nature of these questions lends itself to qualitative research.

Henning, Van Rensburg and Smith (2011:3) as well as Polit and Beck (2012:607) recommend a qualitative approach to investigate "how and why" a phenomenon takes place. Social reality is explained by Henning *et al.* (2011:13) to be an attempt at understanding from the perspective of the role players, hence the decision to conduct *makgotla* with indigenous healers in order to understand how they manage aggression as associated with mental illness.

3.2.2.1.1 Adaptation of the MAVAS questionnaire

The researcher only had to make a slight semantical adaptation to the questionnaire, namely question 11, the word 'physical' was added to 'restraint' as it is not general practice in South Africa to restrain a person mechanically by means of cuffs and braces. The rest of the MAVAS questionnaire was kept as is, since it had previously proven to be well accepted by participants in the previous study conducted by Bock (2010) in four psychiatric hospitals in a province in South Africa.

The body of knowledge gained through *makgotla* was used in the development of the conceptual model and content for the training programme, as will be elaborated on in Chapter (3) three.

3.2.2.2 Quantitative phase of the research

The quantitative phase of this research project consisted of the utilisation and application of the adapted MAVAS questionnaire (annexure five in this study) and the Intercultural Sensitivity Scale (as found in annexure six). This was all in the form of a pre- and post-test to determine attitudes towards the management of aggression and violence as well as culture sensitivity.

The researcher used a pre- and post-test to determine if there were any attitudinal changes in the participants in this study.

The post-test was conducted after the administration of different components of the treatment to different groups of participants in this research. During this quasi experimental phase, the researcher attempted to control variables through the administration of the questionnaires during different stages in the training course to the different groups. The researcher will elaborate on this in the following section.

3.3 THE QUALITATIVE PHASE OF THIS RESEARCH PROJECT

As referred to in section 2.2.2.1 the aim of the qualitative component was to augment existing literature, to obtain information indigenous to the community under focus in the study. Thereafter, this information was included in a training programme geared towards culturally safe management of aggression and violence as designed by the researcher.

3.3.1 Population and sampling

The researcher approached and interviewed *Basotho* Indigenous healers and a *Khoisan* village, bearing in mind that there is very little information available in terms of how the *Khoisan* and *Basotho* manage violence and aggression in relation to mental illness.

In comparison, existing literature elaborates on cultures such as the *Xhosa, Zulu* and other cultures from Southern Africa through studies by Mufamadi (2001), Sorsdahl *et al.* (2011), Ukpong *et al.* (2011), Teferra and Shibre, (2012), to mention but a few. There is limited information available on how it is dealt with by the Basotho and the Khoisan.

The researcher made use of purposive sampling, where the researcher sampled the population which would most benefit this study. The latter is described by Polit and Beck (2012:517) as well as Burns and Grove (2011:313), who refer to this form of sampling as judgmental sampling. This selective sampling method opted for by the researcher stemmed from an in-depth literature review, revealing that limited knowledge is available on the IKS management of aggression and violence as associated with mental illness within the Basotho and Khoisan cultures.

This insight gained justifies why the researcher made use of purposive sampling for identifying the participants in the qualitative phase of this research. De Vos *et al.* (2009:202), as well as Babbie and Mouton (2003:166) explain the legitimacy of this sampling method if the researcher has a specific aim in mind and has knowledge of the population required for the study.

3.3.2 Consent

The researcher negotiated the *makgotla* with the Chief and informed the Chief about the value of the input of the Indigenous healers, considering that their input would help in adapting a questionnaire to suit the Southern African context. Focus was on the ultimate goal of generating a training programme aimed at enhancing cultural sensitivity and awareness, whilst promoting culturally congruent care to mentally ill persons within a specific cultural context. Without such negotiation, the first level of consent to collect data would have been unsuccessful.

Consent was catered for in the following ways: Amongst the Basotho healers, after the village Chief was satisfied with the explanation, he called the head of the indigenous healers and explained the nature of the research to him. Thereafter, the head of the indigenous healers called upon indigenous healers in the community to a *lekgotla,* where the research questions were posed by the head of the indigenous healers to the participants in the *lekgotla.* In addition

to this explanation, the researcher also provided the chief with the written ethical approval granted by the HREC of the North West University (NWU) – (see annexure seven).

In the Khoisan village, the Chief called the community together in the community hall where the key question of the researcher was posed to the community members who took part in the *lekgotla*. The researcher also provided the chief with a copy of the ethical clearance from NWU.

During the *makgotla* with the Basotho healers and the Khoisan village, the researcher explicitly sought verbal permission to record the proceedings by means of a digital audio recording and, where appropriate, video recording. The researcher guaranteed the attendees that they need not offer their names and that their names will not be made known. The researcher also explained that the recordings will be in safe keeping and not be made public. The researcher explained that the recordings will be transcribed on paper. The chief asked for a copy of the audio recording. This was provided to the chief during the validation of the data collected. With the necessary consent given, the chief of the Khoisan village granted permission for video recording of the *lekgotla.*

3.3.3 Rigour during the qualitative phase of this research

During the qualitative phase, the researcher strived to obtain rigour by means of validating the data collected (Rolfe, 2006:307).This will be further elaborated on in the following section

3.3.3.1 Trustworthiness/credibility, validity and confirmability

Trustworthy/credibility

Polit and Beck (2012:584) describe Lincoln and Guba's framework for the development of trustworthiness of a qualitative study, which framework includes the concepts of credibility, dependability, confirmability and transferability. This model suited the study undertaken by the researcher and the concepts were addressed in this study as follows:

Credibility, as used in the Lincoln and Guba framework, refers to the confidence in the truth of the data. This alludes to carrying out a study so that the believability of the research will be enhanced (Polit & Beck, 2012:585).

Trustworthiness was further established through *makgotla* with indigenous healers, which the researcher recorded and transcribed verbatim to a word document. This data also included

narrative descriptions of the settings of the *makgotla* and the behaviours and body language of the participants as suggested by Burns and Grove (2012:94).

The *lekgotla* in the Khoisan village was done in Afrikaans, a language indigenous to the area, and the mother tongue of the researcher. The use of this process of asking participants about the findings as final validation fits in with the phenomenological analysis of data described by Colaizzi (1978) as cited by Polit and Beck (2012:566), a model adopted by the researcher too. This process used will be described more comprehensively in Chapter (4) four of this thesis.

It is worth noting, however, that the *lekgotla* with the Basotho healers was conducted in *Sesotho,* the language of the Basotho indigenous healers. The researcher audio-recorded the *lekgotla* with the Basotho healers. The audio recording was presented to a Mosotho colleague of the researcher, who holds a master's degree in nursing. He translated the recordings verbally, whilst the researcher typed the translation to a word document. This colleague also attended the *lekgotla* and assisted the researcher with interpretation during validation of the findings of the *makgotla,* especially with the few indigenous healers in attendance who could not converse in English. The transcribed documents and audio recording were subsequently presented to a postgrad master's degree student who is multilingual and fluent in Afrikaans, English and *seSotho.* The postgrad student in return translated the English back to *seSotho*, then the researcher and a colleague compared the documents to see if it was still an accurate reflection of the original content. Ultimately, the documents proved to be accurate and credible.

The researcher additionally sat down with individual members of the *lekgotla* to confirm what they said during the *lekgotla.* This helped to confirm the data which was collected, and allowed for further clarification to ensure the validity of the collected data (Creswell, 2012:201). In research circles, it is also known as member checking. This member checking and back translation of the transcripts helped ensure the dependability of the data collected in terms of the Lincoln and Guba framework (Polit & Beck, 2012:585).

The member check as described above also served the purpose of triangulation of data as described by Polit and Beck (2012:431) wherein they explain that returning to the population to validate the data serves as time triangulation, a process which they deem similar to a test and re-test situation in quantitative research.

In order to add further validity to the research, the researcher provided substantial description of the research setting, observations made in terms of non-verbal communication and group dynamics during the *makgotla,* as can be seen in annexure one of this work.

After the completion of the both the *makgotla* with the Basotho healers and the Khoisan village, the researcher was approached by individual indigenous healers and community members who, during a one-to-one informal conversation, added to what was discussed during the different *makgotla*. This approach from the indigenous healers was additional evidence of the trust relationship that was established during the negotiations for the *lekgotla*.

Confirmability

According to Klopper and Knobloch (2010:323), confirmability focuses on the characteristics of the data. The confirmability and objectivity or, as referred to by Polit and Beck (2012:722), the neutrality of this data was enhanced through the researcher presenting all available raw data to a colleague, Dr E Van Wijk, who has a PhD in nursing. The latter is well-experienced in qualitative research. Dr Van Wijk participated as an independent coder. This process determined that the independent coder and the researcher identified the same codes and categories. The confirmability was further enhanced through validating the findings with the community where it was collected.

Transferability

The aim of this research was to give an informed description of how the indigenous healers manage aggression and violence. The researcher made sure not to transfer this information to another setting, but rather to include positive practices in a new training programme focused on managing aggression and violence in a culturally safe manner.

3.4 QUANTITATIVE PHASE OF THIS RESEARCH

The researcher deployed a mixed method research design with a sequential exploratory approach. When the research begins with a qualitative phase followed by a quantitative phase, it is an exploratory sequential approach (Creswell, 2014:225). During the quantitative phase, the researcher followed a quasi-experimental design with three experimental groups and one control group.

3.4.1 Population and sampling

The researcher made use of different levels of sampling for the different stages in the quantitative component of this research.

The researcher primarily made use of purposive sampling, based on findings in the literature study and, thereafter, proceeded to perform randomised cluster sampling. In the latter, the researcher randomly selected which hospitals will fall into which experimental group.

The population for this quantitative component of the research constituted of all categories of staff working in the acute admission units of mental health care institutions in South Africa.

The researcher initially opted to exclude the Western Cape psychiatric hospitals from this study as the researcher previously conducted research in these four psychiatric hospitals to investigate the attitudes of staff towards the management of aggression and violence. After further investigations and numerous requests from the Provincial Government of the Western Cape inviting the researcher to come and present training in the rural areas in the Western Cape and facilities with 72-hour admission units as described by the Mental Health Care Act (17 of 2002), the researcher and her supervisor decided to include the aforementioned facilities in the Western Cape. The researcher took this action of not including the four psychiatric hospitals in the Western Cape in an attempt to prevent a type I and type II error in the research project, as she had previously conducted research there and had a roll out of a training programme based on findings of her previous study. In the latter, indications were that less than 20% of the staff in the acute admission units of the four psychiatric hospitals in the Western Cape had received training in the management of aggression and violence.

Further to this, there was also a poor response from several provinces when approached for the necessary permission to conduct the research there.

3.4.1.1 Selection of the hospitals and experimental groups to take part in the study

After the researcher obtained the necessary ethical clearance from NWU to conduct the study, the researcher approached the Departments of Health in Gauteng, Freestate, North West Province, Northern Cape, and the Western Cape. Thereafter, the researcher selected all Psychiatric Hospitals with acute admission units in the respective provinces. Finally, the researcher included all the hospitals that provided the necessary permission to conduct this research project there.

As previously stated, it was quite a task to obtain permission and some hospitals did not provide the necessary permission regardless of permission granted by the National Health Research Councils of the different provinces. Ultimately, the researcher secured permission in four different hospitals, one in each of the provinces who positively responded to the request,

namely Gauteng, Northern Cape, North West Province and Western Cape. These provinces are the primary provinces where the participants who took part in the qualitative phase of this research come from geographically, and where the members would be referred to in the event of a mental Illness. The researcher thereafter continued to randomly select the different hospitals for allocation to the different experimental groups. This process will be described in the following paragraphs.

Purposive sampling, as an example of the non-probability sampling method, is acceptable if the researcher is well acquainted with the particular population to be used in the research according to Babbie and Mouton (2003:166), or in the event where the persons fit the criteria of what is to be researched, according to Henning (2004:71).

The researcher, as part of the quasi-experimental design of this research, attempted randomisation within the non-probability sample as a second level of sampling. The researcher randomly selected hospitals for each of the experimental groups. The aim for this randomisation was to allow any of the four hospitals an equal opportunity to be selected to receive the treatment as described in the table.

The researcher wrote down the names of the three mental health care institutions with acute admission units who granted the researcher the necessary permission to conduct her research there. The numbers two, three and four were also written down on papers, as were three different treatments decided upon to be given to the three different experimental groups. The Information mentioned above was written on equal size 5 cm by 5 cm papers, folded in four, placed in equal sized cups marked group, hospital and treatment, as can be seen in the photo below.

Photo 3.1: Marked cups used to place the folded papers marked with the names of the hospitals, the treatment and the numbers of the experimental groups (photo by TM Bock)

The researcher then proceeded to place all the marked papers in the appropriate cups as is evident in the photo below.

Photo 3.2: Folded papers in the appropriately marked cups (photo by TM Bock)

After the abovementioned procedure, the researcher asked a friend to select one folded piece of paper from each of the cups marked hospital, group and treatment and to paste the three selected underneath one-another on a wall. The researcher's friend proceeded until there were no more folded papers left in any of the cups.

On the wall, there was now a randomly selected group with a number, hospital and treatment partitioning reflected through this randomised process followed. This selection can be seen in the picture below.

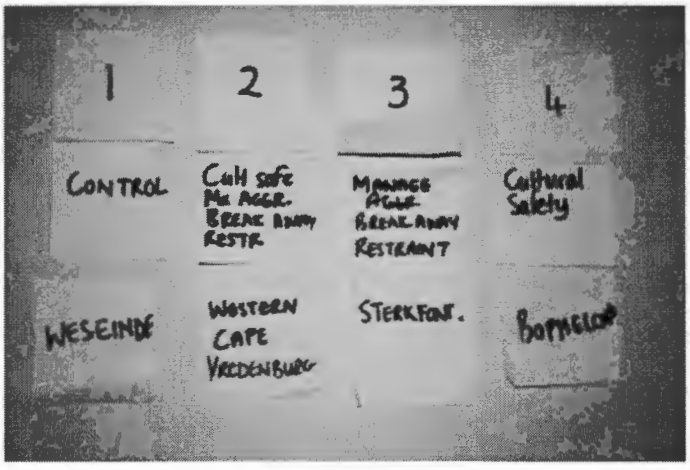


Photo 3.3: Randomised selection of treatment and groups (photo by TM Bock)

Below is a representation of the randomised selection of the different experimental groups, in table format.

Table 3.1: Table representing randomised selection

Group Number	1	2	3	4
Treatment	Control group/no treatment .Will be given the literature to read	Management of aggression understanding aggression and theories on aggression Break away techniques Safe restraining Cultural safety De-escalation techniques	Management of aggression understanding aggression and theories on aggression Break away techniques Safe restraining Cultural safety De-escalation techniques	Management of aggression understanding aggression and theories on aggression Break away techniques Safe restraining Cultural safety De-escalation techniques
Mental health care institution	A psychiatric hospital in the Northern Cape	A hospital with a 72 hour facility in the rural areas of the Western cape	A Psychiatric hospital in the Gauteng Province	A Psychiatric hospital in the North West Province
Instrument used	MAVAS and Intercultural Sensitivity Scale	MAVAS and Intercultural Sensitivity Scale	MAVAS and Intercultural Sensitivity Scale	MAVAS and Intercultural Sensitivity Scale
Pre- and post-test	Yes, the posttest requested via e-mailed copies back to the researcher	Yes the post test conducted upon completion of the whole training course	Yes the course interrupted after presentation of cultural sensitivity, and Management of aggression understanding aggression and theories on aggression the post test conducted, thereafter the rest of the course presented in full	Yes the course interrupted after presentation of cultural sensitivity and the post test conducted, thereafter the rest of the course was presented in full

The admission units of the hospitals chosen for the study and all the staff involved in the multi-disciplinary team were all invited to voluntarily participate in the research project. The researcher opted to include all of the mental health care practitioners working in acute admission units of a particular hospital. The researcher approached the CEO's and the nurse

managers of the different hospitals and made appointments where she would come and present the training course. The managers arranged for staff to come and attend the course.

3.4.2 Inclusion and exclusion criteria

In the event where a province did not have a mental health care institution, this province was excluded from the research, such as the Southern Cape.

The four psychiatric hospitals in the Western Cape were excluded from the study as the researcher previously explained.

Additionally, any mental health care institutions without acute admission units were also excluded from the study. The rationale for this decision can be found in the literature which informs us that aggression incidents by MHCU are more rife in acute admission units as opposed to long term psychiatric units where MHCU are no longer in the acute phase of a mental illness.

All the hospitals included in the study based on the criteria mentioned in the previous paragraph were included in the study for the purpose of random selection.

From these hospitals, the appropriate sample of all the staff in the acute admission units was used. This included all the members of the multi-disciplinary team, who through the nature of their work had direct contact with MHCU. The personnel, in terms of the Mental Health Care Act (17 of 2002), included all categories of nurses, psychiatrists, medical officers, clinical assistants undergoing training in psychiatry, psychologists, occupational therapists and social workers. The researcher included the security personnel in the ward, following reports in the literature and by the staff in the admission units, that the security personnel assist the staff in the physical restraint and physical containment of the aggressive mental health care user.

3.4.3 Rigor during the quantitative component of this research

3.4.3.1 Validity/legitimacy

The MAVAS questionnaire has well been assessed as a valid instrument.

The researcher in a study (2011) piloted the MAVAS questionnaire after having adapted Question 11 to suit the situation in Southern Africa. The question was rephrased to read "Patients who are violent are often physically restrained when administering medication." It

previously read, "Patients who are violent are often restrained for their own safety." During the Pilot test in 2011, it was concluded that this semantic change made no difference to the content and the understanding of the questionnaire. As South Africa still does not make use of restraint for any purpose other than administering medication, the researcher opted to use the adapted MAVAS questionnaire for this study also.

The MAVAS questionnaire, having been tested by Duxbury during 2003, has proven to be both reliable and valid. Bock (2010:39) reported the findings of Duxbury (2003), wherein it was established the after factor analysis and determination of four themes set a tan eigenvalue of 1.8, whilst the overall factor analysis was favourable as each theme loaded at a reported 0.8 and above.

These values make this instrument credible. After a test–re-test situation on the same group, the scores were compared by means of a Pearson's r correlation coefficient, and the results were a reliable coefficient of 0.89. Based on the above, the researcher feels confident that the MAVAS instrument would be the ideal instrument to use in the test-re-test situation after the administration of different treatments.

Similarly the Intercultural sensitivity scale designed by Chen and Starost (2000), has been proven to be valid and reliable by Fritz *et al.* (2002:168) through testing it by means of factor analysis and testing the tool against seven (7) other scales for concurrent validity which proven satisfactory.

3.4.3.2 Reliability

The researcher established the reliability and internal consistency of the adapted questionnaire, as outlined in section 3.4.3.1. Therefore, the researcher decided not to repeat this pilot again.

3.4.4 Control during the research project

3.4.4.1 Prevention of cross-contamination

As the researcher had quasi experimental design with a control group and three experimental groups with three different treatments, it was necessary to prevent cross contamination between groups. Therefore, the researcher randomly selected different groups from different provinces to prevent this type of cross contamination where one group could influence another group's responses during either the pre or post-test (Babbie & Mouton, 2003:230). The post-test

administered to the control group was used to determine whether exposure to the measure instruments possibly had an influence on the attitudes and cultural sensitivity and awareness of the respondents.

3.4.4.2 Control over extraneous variables

Any research project, according to Burns and Grove (2012:177), will have unexpected variables interfering with the research and relationships between the variables which may cause an interference in terms of the causal relationships between the variables. In essence, control therefore implies that the researcher will attempt to ensure that all influences on the dependent variables will be held constant in an attempt to prevent any form of contamination of the findings (Polit & Beck, 2012:177).

Some variables cannot be controlled and are referred to as confounding variables (Burns & Grove, 2012:177). Possible confounding variables in this study would be the level of education of the participants, as well as their years of service. However, due to a test–re-test situation, these variables are not controlled as the aim of the research is to see if there are changes in attitudes towards the management of aggression and violence and cultural sensitivity. These variables should not play a role because, regardless of age, years of service or level of education, the aim is not to test the participants but to determine the effect of the treatment.

In an attempt to control some of these variables, the researcher conducted the research at the participants' places of employment to stay in their natural environment and prevent influences from being in a different milieu or what Burns and Grove (2012:177) refer to as environmental variables.

The researcher had questionnaires delivered to respondents' places of employment and had the questionnaires collected a week later, in an attempt to prevent the Pygmalion and Hawthorne effects, whereby respondents are influenced by the presence of the researcher (Babbie & Mouton 2003: 221; Rosnow & Rosenthal, 1999:3, 19). Unfortunately, due to the 10% response rate in the control group, the researcher sacrificed the Hawthorne effect and administered the pre and the post test on the same day to ensure a better response rate. This will be elaborated on in Chapter five.

The researcher, after experiencing the poor response rate in the control group, ensured that the time span between the pre- and post-test was exactly the same for all groups. As Rosnow and Rosenthal (1999:186) report, it is important to allow all groups in the research design equal time for the treatment to take effect.

3.5 ETHICAL AND MORAL CONSIDERATIONS

3.5.1 Risks, benefits, and ethical considerations

In terms of the Helsinki declaration which was adopted in 1964 and subsequently revised up to the latest revision of 2004 (Burns & Grove, 2012:105), this research was conducted to generate knowledge and influence training programs for mental health care providers to enhance their ability to manage aggression and violence therapeutically, and to incorporate Indigenous Knowledge Systems in the individualised health care user package of care.

3.5.2 Risks

The researcher foresaw no risk to any of the participants in the study, but made her contact details available to all participants in the event that a need arose to discuss any concerns. There was the possibility that on completion of the questionnaires, the participant might have experienced flashbacks of previous mental health care user related violence, where the participant might have been either present or a victim. In such an event, the participant may contact the researcher, whereby the researcher will formally refer the participant to the Government Employees Assistance Service for necessary counseling.

3.5.3 Benefits

The outcomes of this research project provided information beneficial to the participants, with secondary benefits such as an improvement in the ability to manage aggression and violence. This is advantageous to both mental health care providers and MHCU.

3.5.4 Ethical considerations

The researcher submitted this proposal to the Health research and Ethics Committee of North West University for the necessary ethical clearance. On receipt of ethical clearance, the researcher submitted a copy of the proposal and proof of ethical clearance to the Western Cape Government Department of Health, Gauteng Government Department of Health, KwaZulu-Natal Government Department of Health, Northern Cape Government Department of Health, Eastern Cape Government Department of Health, as well as the Orange Freestate Government department of Health. The researcher registered the research on the National Health Research Database of South Africa. Upon approval by the different provinces, the researcher secured permission from the respective hospitals where the research was conducted.

Over and above the ethical considerations, the researcher also applied moral principles such as referencing the works of others, giving a true reflection of the data collected and reporting objectively, as is pointed out by authors such as Burns and Grove (2012:103).

The researcher adhered to the following ethical considerations for her nontherapeutic research project and for the protection of all participants' rights:

3.5.4.1 Anonymity

The researcher maintained anonymity of participants through the administration of structured questionnaires, where no participant was required to affix their name. As much as possible, the researcher asked participants to sign informed consent to take part in this research project. Anonymity was ensured as the questionnaires and the consent forms were returned in different boxes in order to prevent the researcher from making any possible links between questionnaires and consent forms.

The researcher ensured anonymity of the institutions where the research was conducted. However for the purpose of distinguishing between the control and experimental groups, the researcher used different coloured questionnaires for the purpose of data capturing. All the same, anonymity was maintained as described in the previous paragraph.

3.5.4.2 Confidentiality

The researcher maintained confidentiality by not making public the names of the institutions involved in the research project. Furthermore, the researcher handled all documents received confidentially and it is still kept locked away at the researcher's residence. Additionally, the researcher kept confidential any information shared privately by respondents.

3.5.5 Informed consent

All participants in this research were informed about the aims of this research project, namely to establish baseline data in terms of their attitudes towards the management of aggression and violence, their perception of cultural sensitivity and awareness and the effects of a training programme on their ability to manage aggression and violence within a culturally sensitive context.

The rights of the research participants were spelled out in the consent form prior to participation in the research project. All participants were informed that their participation was entirely voluntary and that they could withdraw from the study at any time without being disadvantaged in any manner. The value of the contribution is also spelt out in the information leaflet attached to the consent form.

Notably, the researcher asked participants to submit their consent forms in a separate box provided. However, where the researcher noted more questionnaires than consent forms, the completed questionnaires were deemed as consent given.

3.5.6 Ethical considerations pertaining to conduct of the researcher

The researcher will publish the findings of the research project. The researcher accurately and objectively presents the findings of the research, and references all sources used.

The proposed training programme was presented to the College of medicine in Rondebosh Cape Town and they awarded CPD points for the Health Professional Council Members to attend this course.

Additionally, as the participants during the qualitative phase of this research are from marginalised communities and have indigenous knowledge, the researcher committed to not make known privileged information which came to her knowledge during the *lekgotla*, especially in terms of the use of indigenous medicines which are not common knowledge. For the intellectual property of these marginalised communities, the principle of cognitive justice will be elaborated on as part of this consideration by the researcher.

3.5.7 Cognitive justice as ethical principle

Due to the experience of the *Khoisan* community in terms of the exploitation of their indigenous knowledge, the researcher will at all times refer and acknowledge the knowledge and practices which belong to the Khoisan and the *Basotho*. Shiv Visvanathan (1999) coined the term and advocated the equality of "knowers," in this case the Basotho and Khoisan. Therefore the researcher, with the permission of these groups, will formally acknowledge all of their knowledge referred to in the management of aggression and violence.

3.6 CONCLUSION

This research project was a very labour-intensive process as is expected with a mixed method research project. It came with an unexpected amount of obstacles in terms of obtaining the necessary permission to collect data and getting access to the different hospitals. The researcher will discuss the collection of the data and the analysis thereof in depth in chapter four and five. The information will be dealt with in separate chapters, even though they are linked and part of a continuum.

CHAPTER 4

QUALITATIVE PHASE: RESULTS, DATA ANALYSIS, INTERPRETATION AND DISCUSSION

4.1 INTRODUCTION

Chapter (4) four focuses on the qualitative phase of this sequential exploratory design. This chapter will describe the methodology and the findings upon analysis of the data. This provides the perceptive context for the development of the curriculum to facilitate cultural safe management of aggression and violence. After discussing the findings from the two *makgotla*, the researcher will proceed with a convergence.

During this study, the researcher used *makgotla* to collect qualitative data in order to augment existing literature in terms of the way in which Indigenous healers and the community manages aggression and violence as associated with mental illness.

4.2 PURPOSE

The information collected during the qualitative phase was incorporated into a curriculum for a training package aimed at changing the attitudes of MHCU towards the management of aggression and violence.

This chapter will further elaborate on the data collection method followed, the analysis of the data and the themes, categories and concepts identified during data analysis, as well as the context during which the data collection took place.

4.3 DESCRIPTION OF THE POPULATIONS

The researcher conducted *makgotla* in a rural village with the *Basotho* Indigenous Healers and a *Khoisan village* (Northern Cape, South Africa). The *makgotla* constituted of indigenous healers and community members in both the *Basotho* village and the *Khoisan* village. The *lekgotla* with the *Basotho* comprised of 12 Research team members and 54 Indigenous healers and community

members. In the *Khoisan* village, there were 5 (five) research team members (all involved in IKS research), amongst which was the researcher and 35 community members.

The sample was selected through purposive sampling. The researcher opted for purposive sampling as the information needed for the research question to be answered clearly lies within the exclusive knowledge of the Indigenous Healers and the indigenous community members.

Notably, the indigenous healers had no western medical or psychological training in the management of aggression and violence, yet they have to manage these conditions. Their current knowledge in terms of the management of aggression and violence relies deeply on common sense and knowledge that was transferred to them during their initiation as Indigenous healers, as is evident in the following extract from the transcript of the *lekgotla* with the *Basotho* healers. Additionally, the healers also rely heavily on intuition.

> "Somebody that knows what it is to be an indigenous healer and those tremendous initiations of the traditional healer (ngaka ya sitso- doctor of culture); they will know how to deal with mad people."

4.4 DATA COLLECTION

During this study, the researcher made use of *lekgotla* to collect data. *Lekgotla* is comprehensively described in Chapter (3) three.

4.4.1 Negotiations for the Lekgotla in a rural village in Lesotho

The *Lekgotla* was negotiated in terms of the standard protocol, whereby the researchers negotiated with the different Chiefs and informed said chiefs of the intent and nature of the *lekgotla*. The Chiefs called upon the Head of the *Basotho* indigenous healers, who in turn called all the indigenous healers in the community together for the intended *lekgotla*. The researchers attended as quiet observers and the Chief of the Indigenous healers was coached regarding the aim of the questions and he was subsequently requested to chair the *lekgotla*. The chief and members of the *lekgotla* were assured that anonymity would be ensured and that there is no need to share information deemed to be sacred.

During the negotiations, the three researchers discussed the aims of the *lekgotla* with the Chief Indigenous Healer, namely to answer their respective questions.

For the purpose of this research the researcher posed the following question:

"How do you manage violence and aggression in a mentally ill person?"

4.4.2 Context of the *Lekgotla* in the rural *Basotho* village.

A rural *Basotho* village was used as gathering place for the *lekgotla*. It is a quaint, neat little village with several huts and the community centre where the *lekgotla* took place.

The Chief Indigenous Healer welcomed everybody present and posed the questions to the *lekgotla*. Apart from the 12 members of the Research team, there were 30 Indigenous healers who attended the *lekgotla*. A *lekgotla* is open for any member of the community to attend and all members have equal input into the question posed. The researcher observed that there were male and female Indigenous Healers present. The male indigenous healers were the first persons to respond to the questions, and the elders replied first. After the youngest male responded, the female indigenous healers would take their turn, also in ranking of the elders first. The observation of the researcher is that everything is dealt with in a respectful manner and that all inputs were welcomed. The Indigenous Healers were all dressed in Traditional clothing with different goatskin headbands and head coverings made out of beads. During a one-on-one conversation, the indigenous healers said that those wearing the goatskin head gear received their calling to become an indigenous healer during a dream and those who were wearing the beads received their calling via a vision while they were awake.

The Chief of the *Basotho* Indigenous Healers opened the proceedings by welcoming all present, and explaining the nature of the questions to be addressed.

The negotiations and context of the data collected in the *Khoisan* village is discussed in section 4.8 and will be concluded in section 4.10 with the convergence of the data collected in the *makgotla*.

4.5 DATA ANALYSIS

The data which was collected by means of audio recording and video recordings were transcribed verbatim by the researcher herself. The data in *seSotho* was translated from *seSotho* into English by the researcher's colleague who is a bilingual *Mosotho* man with a Master's degree in nursing. The English transcript was then given to another colleague, a qualified teacher who translated it

back to *seSotho* to validate the translation. The transcripts in Annexure Three are verbatim reports and translations of the *makgotla*. The researcher did a manual coding of the data as opposed to the use of a computer programme, the reason being that the researcher wanted to immerse herself in the data.

The phenomenological analysis technique used for the data analysis was described by Coliazzi (1978) as cited by Polit and Beck (2012:566) and the researcher observed that this method fits the procedure of lekgotla extremely well, as validation of the data is a crucial part of the conclusion of any lekgotla. This method consists of seven steps, but the distinguishing characteristic of the use of this method lies in the seventh phase, during which the researcher validates the findings with the participants in the research project.

During the steps of the Colaizzi method, the researcher proceeded as follows:

- **Phase 1**

The researcher read through all the transcripts and field notes made whilst listening to the recording of the *lekgotla* to get an overall perception of the material.

- **Phase 2**

The researcher highlighted all significant statements in the text as can be seen in annexure 2.

- **Phase 3**

The meaning of each statement was formulated in a code in a column next to the statement.

- **Phase 4**

Discrepancies were coded as differences and all codes were validated as a reflection of what was said.

- **Phase 5**

Results were integrated into a description of categories and sub categories.

- **Phase 6**

Themes were discussed and examples provided to validate the information through the verbatim text.

- **Phase 7**

The preliminary findings were presented to participants during a validation session.

A discussion of the themes, categories and concepts will follow.

4.6 THEMES, CATEGORIES AND CONCEPTS

All the transcribed data was then read and re-read along with the video and audio recordings. This data was then coded and emerging categories, concepts and themes were identified. After this process, the researcher gave a copy of the transcripts to Dr. E Van Wijk who acted as an independent coder. When compared, it was clear that the researcher and Dr. Van Wijk both identified similar concepts and themes. Our method was thematic content analysis to develop themes and categories. These themes and categories were then eventually used to develop a conceptual framework for the course developed as treatment during the quantitative part of this research.

4.7 PRESENTATION OF FINDINGS OF THE LEKGOTLA WITH THE BASOTHO

The data analysis resulted in the identification of six core themes, namely mental illness, aggression and the management of aggression according to indigenous knowledge and health practices. Several categories were identified with themes.

4.7.1 Theme 1: Comprehension and conceptualisation of mental illness according to indigenous knowledge

Amongst the Basotho healers, mental illness is explained by Female Healer no. 3 to be:

> "Mahlanya, (Confused/mad ones), they are not thinking straight."

An elder amongst the *Basotho* healers explained that madness must have something to do with nerves because the medicine helps.

> "There is medicine burnt when he comes into the house, it will make him drowsy and then when he is mad it is not madness; it is the nerves, and when the medicine makes him drowsy, this calms down the nerve break, and he will be soft, calm and sleep."

4.7.1.1 Categories

- *Causes of mental illness*

The *Basotho* healers deem mental illness to be caused by numerous factors inclusive of unknown causes, intra psychic pain, problems, lack of support systems and even environmental causes.

> Female Healer 3 referred to unknown causes as: "People coming from the caves."

> Male Healer 1 posed the following cause: "Some of the mad people must be removed from the place where they are because they are mad because of the surroundings they find themselves in."

> Female healer 2: "... no family at all. Maybe this is the problem that caused him to this state (sic)."

Furthermore, they emphasised that often mental illness is misdiagnosed in a person, as captured in the following words of Male Healer Number 1:

> "Some of the mad people are just mad and just want someone to sit and talk with them then the madness is gone."

- *Management of mental illness*

The treatment of mental illness is linked to the identified cause of the Mental illness as highlighted by Male Healer number 2:

> "As for me, this type of sick person, (sic) the way I treat them depends on what caused the madness."

There are no set protocols for the management of mental illness. This statement is corroborated by a claim by Male Healer 3, as is evident in the following:

> "Let me say to you, it differs according to the indigenous healers."

The *Basotho* Healers felt that a real Healer will be able to manage the mentally ill person. This is evident in the statement of Female Healer 3:

> "Somebody that knows what it is to be an indigenous healer and those tremendous initiations of the traditional healer; they will know how to deal with mad people."

The one attendee to the *lekgotla* laid claims to the ability to cure mental illness, as seen in the words of Female Healer no. 3:

> "I don't just work with people (Sic) sick; I even cure mad people (Mahlanya), really mad ones; even if they are from a Mental hospital."

An important aspect in the management of Mental Illness is considered to be family involvement, as mental illness is often caused by a lack of a support system. The Chief healer explains the importance of family involvement, especially in the event of mental illness being of a chronic nature.

> "If he continues to be mad... this person starts from here being helped but again we must make sure he understands and family understands the situation he is in."

The family involvement in the management of mental illness is echoed by all the healers through either clapping of the hands, nods of agreement and even echoing statements such as the following:

> Male healer 2: "I will talk to the family to explain what has happened. "He will not talk; I will talk to the family."

> Female healer 2: "This man with no family, I will ask who he works with. Maybe this is why he became so ill."

The use of indigenous medicines is an important component in the treatment of Mental Illness.

> "When this man comes here, he will find medicine burned as he is coming through. Others will find they must sniff here is medicine burning." Male Healer 2 confirmed. "I will touch him with medicine in my hand." "He will step over the medicine." Male Healer 1, "Some will need medicine to drink; some will need medicine to bath for cleansing."

Although Psychiatric Hospitals play an important role in the management of Mental illness, the Chief *Mosotho* Healer judges these hospitals to be non-therapeutic in appearance, as is evident through his following statement.

> "I have seen that there are huge walls around the hospital for mad people. When you are a visitor there, it looks as though you are in prison."

4.7.2 Theme 2: Identifying aggression

The *Basotho* Healers recognise aggression, and that it could potentially be lethal, but they place great value on separating the aggression or behaviour from the person. The healers went as far as stating that not all mentally ill people are necessarily violent.

Female healer 2 pointed this out beautifully in saying:

> "Do not look at what they are doing. Bring back their mind so that it can come back from what he is doing."

Furthermore, this approach where the indigenous healer fits the treatment to a specific client confirms the researcher's belief of no valid "one cure, suits all" regime to manage mental health care user related violence, because people differ in terms of their culture and knowledge system. This is evident through the following quotation by a *Mosotho* Indigenous healer:

> There are mad people who are very mad and they take some stuff orally. Others need to smoke something. Some of the mad just need medicine for cleansing. They use this when bathing and that will help them out of the state they are in. It all depends on how madness got onto this person."

The healers also emphasised that one must not just accept that all people with a mental illness are prone to aggression.

4.7.2.1 Categories

- *Mental status*

The *Basotho* Indigenous Healers distinguished between the emotions and physical behaviour in a person diagnosed with aggression.

> "The mind of the person is aggressive, not he himself"

- *Emotions*

It is imperative that the indigenous healer be in control of their own emotions as it may rub off onto the patient and aggravate the patient.

> Female healer 2: "At this point if he wants to hit you do not take a stick to hit them back. The only thing I do is to be calm and show no sign of violence."

- *Behaviour*

As the behaviour of the mentally ill person might be inappropriate or disinhibited, it is crucial for the healer to remain in control of the situation.

> Female healer 2:"Most of the time when they come they ask can I kiss this women? As a female healer you do not allow this to happen to you."

- *Common misinterpretation of behaviour*

The indigenous healers who took part in the *lekgotla* pointed out that not all mad people are aggressive. Furthermore, human reaction such as distress has been reportedly misconstrued to be aggression, when in actual fact it was a normal human reaction. This was elaborated on by the Chief Healer in the *lekgotla:*

> "...this man who was jumping was coming from another house where he was dumped by his girlfriend. People thought he was mad and started calling ambulances. They captured him and said he must be taken to the hospital."

4.7.3 Theme 3: Recognising the causes of aggression

4.7.3.1 Categories

- *Manage the cause of the aggression*

The participants in the *lekgotla* were all in agreement that the way in which the aggressive person is approached will have an effect on their aggressive state. The approach must be neutral and the person managing the aggressive patient needs to stay calm and show and in understanding of the patient's situation. Through showing an understanding and not trying to communicate immediately, the patient will often calm down. The calmness of the intervener will rub off onto the aggressive person.

- *Hospitals may not be the most appropriate way to manage aggression associated with the mentally ill*

The indigenous healers described psychiatric hospitals as non-therapeutic because even whilst visiting them, the hospitals looked more like prisons than what their perception of a hospital would be. They are part of the environmental causes of aggression, hence the advice that if this is the situation then these causes could be remedied through removing a person from those conditions.

> Chief Healer: "In Gauteng, I have seen that there are huge walls around the hospital for mad people. When you are a visitor there it looks as though you are in prison."
>
> Male healer No 1: "Some must be removed from the place where they are because they are mad because of surroundings they find themselves in".

These beliefs of the indigenous healers is echoed by researchers within the WBKS as seen through the work of (Soliman & Reza, 2001:77-79, Duxbury, 2002:331-333; Duxbury & Whittington, 2005:470; Ignelzi *et al.,* 2007:453), where they confirm that confined areas, overcrowding, high temperatures, low staffing levels, seclusion and the use of restraints precipitate aggressive behaviour.

The behaviour of people can lead a person to become aggressive, and this is well noticed by the *Basotho* Indigenous healers.

4.7.4 Theme 4: Predictors of aggression

The indigenous healers were very clear about identifying the symptoms of aggression and what the possible causes were. Causes were linked with mental illness, and absence of a support system. There was no offer at all to possible predictors of aggression, or to preempt aggression. This may stem from the African perspective about time, as explained by Beyaraza who is cited by Smith (2001); the African is living in the here and now because the future must still come and he will deal with the future once it has arrived. For the African, the concept of time is two-dimensional, namely the past and the here and now.

4.7.5 Theme 5: Indigenous techniques in the management of aggression

The healers described the dangers associated with aggression and the Chief Indigenous Healer emphasised that the aggressive person is capable of killing a healer, hence it is important that they must be approached in a calm manner.

4.7.5.1 Categories

- *Verbal component*

Verbal skills are used in a calm manner, as explained by female healer no. 1

> "To get them there you need to "gekisa" (beg) them, to be calm. It is very important that with these people you be calm when you approach them because in their mind they are already aggressive. If you come with aggression, you will aggravate them."

> Female healer 3: "I will ask him what he sees and what he hears."

A theme which grew out of initiating the verbal management of aggression is the building of rapport and making the person feel welcome. This is accomplished through inviting a person into the yard or house of the indigenous healer to come and sit down to talk and even the offering of a beverage, as derived from the following statements.

> Female healer 3: "I give this man a sacred hand and he sits down. I would take a mug and give him water and say. 'Sit here my love', and immediately the person become calm and sit down. I befriend them."

Female healer 4: "When they are calm I tell them to sit down; then give them my hand."

- *Physical component*

The *Basotho* healers disclosed to the researcher that if the aggressive person becomes aggressive, it is better not to react physically. The *Mosotho* healer informed as follows:

"At his point if he wants to hit you do not take a stick to hit them back (sic): I do not agree with this treatment you will make him mad worse (sic)."

Female Healer 3: "Even after violent, when I give them a hand of mercy protection they become calm because I am calm."

One of the physical strategies proposed by the indigenous healers, in an attempt to gain control over the aggressive person, is to get that person to sit down. This is accomplished through extending an invite to make the person feel welcome.

Female Healer 2 expressed the importance of getting the aggressive person to calm down through the following: "Make sure you get them to sit down so that you can talk to this person, this is corroborated by Female Healer no 3 who similarly invites the person to sit down in a sacred place and then to talk to this person in a calm manner."

All of the Healers are in agreement that if a mental health care user is brought to them and this patient is tied up, it is important to build rapport, gain their trust and have them untied. Untying them will make them feel welcome, and thus become more co-operative.

Female Healer 3: "When they come in my yard tied up I say 'Untie him'. I go to them and give them a hand of mercy protection and a hand that calms them down."

Female healer 2: "When he comes to my house I untie him."

- *Do not intervene when no intervention is necessary*

The *Basotho* healers are convinced that it is not always necessary to intervene. In some instances, you just need to remove the cause of the disturbing behaviour and merely engage in a conversation with a person.

Male Healer no.1 "Some of the mad people are just mad and just want someone to sit and talk with then the madness is gone."

- *Medicinal component*

The Healers admitted to treating aggression and violence as associated with mental illness through administering different medicines. The decision around the type of medicines used is based on Knowledge acquired during training and initiation into becoming an indigenous healer. It also relies heavily on spirituality, as can be seen in the responses of Female healer 2 and 3.

"These medicinal plants (sic) are there and there are medicines we use even though they are different. I will give only these I believe would help." "Somebody that knows what it is to be an indigenous healer and those tremendous initiations of the traditional healer; they will know how to deal with the mad people.

"Not on all mad people you will give something to smoke or drink"

The healers pointed out different routes of administering medicines, such as:

Female healer 1: "....go through the smoke..."

Chief healer: ...Medicines are burnt..."

Male healer 1:"some takes stuff orally others smoke stuff..."

Male healer 1: "Some of the mad just need medicine for cleansing. They use this when bathing, that will help them out of the state they are in."

Male healer 2: "... I will go to the gate and have medicine in my hand; I do not touch them with the medicine in my hand, but will throw the medicine on the ground and get him to step over the medicine." "When he is inside my house I will touch him with the medicine in my hand."

All of the healers who joined in the *lekgotla* agreed that medicine is not administered while a person is acutely aggressive, nor are all forms of aggression treated with medication, as is evident in the following statements:

> Female healer 4: "No I do not give medicine when he is violent; I only give medicine when everything has calmed down."

It is evident through the transcript that there are differences in the treatment of aggression and the treatment of mental illness. Acute aggression is managed through giving medicine to calm a person down and mental illness is only managed once the person is calm. No consent is required to administer sedation, but consent and understanding are required to treat mental illness. The literature informs us that *Imphepho* is used as a sacred medicine which helps calm a person down (Africa Mystics, 2015). The literature confirms that this medicine is smoked or vapourised as alluded to by the Basotho healers.

> Older male healer: "When a man comes here he will find medicine burnt as he is coming through. Others will find medicine they must sniff...it will make him drowsy when he is mad." "This person starts here from being helped but again we must make sure he and his family understands the situation he is in."

4.7.6 Theme 6: Diminishing destructive methods of dealing with aggression and violence

The Indigenous healers referred to practices which they find unacceptable, namely restraint, bondage and physical beatings, to the extent where a mentally ill person would become so tired that they pass out.

4.7.6.1 Categories

- *Verbal component*

Communication and understanding are very important aspects in the management of mental illness and aggression in the *Basotho* community. The use of communication skills is reported to be the entry point into the management of aggression. Female Healer no1 indicated that it is crucial that the healers stay calm when dealing with the aggressive person. Remaining calm makes it easier to calm the aggressive person down as evident in the following statement.

Female healer no 1: "Yes yes you as a person must be above this person... do not be violent be calm when working with them, they are sick. To get them there, (calm) you have to gekisa (beg) them, to be calm. You need to approach them calm because in their mind they are already aggressive. If you come in with aggression you aggravate what is in their mind."

- *Physical component*

The indigenous healers reported an old seSotho proverb which states,

"The back of a mad person is corrected by smacking them."

are too tired to fight anymore. They will then be given medicine to make them sleep and after they wake up the treatment of the mental illness will commence.

4.8 NEGOTIATIONS FOR THE *LEKGOTLA* IN A *KHOISAN* VILLAGE

Negotiations for the *Lekgotla* took place in the humble residence of the chief and his wife. Upon arrival at the Chief's house, the researcher enjoyed the view of the hills and the soccer field on which a few goats were grazing. The researcher were awaiting the arrival of the Chief, as he was down at the community centre making sure everything is ready for the research team. While waiting for Chief, the researcher sat on the stoop and had a conversation with the Chief's wife.

When the Chief arrived, the researcher were invited into the Chief's house, a welcome cool relieve from the humid heat outside. After introductions and being offered some cool drink, the researchers and Chief discussed the aims of the *lekgotla*, and what the researcher endeavoured to discuss with the community. The researcher gave out the topic, the management of aggression and violence in the community and the methods the community uses when a person with a mental illness becomes aggressive and violent.

The Chief agreed to lead all proceedings which took place in the *Khoisan* village Community centre, and gave the necessary permission for the *lekgotla* to be captured via video recording as well as still photos. The Chief requested that the material be made available to him and that the material captured be used for the purpose of the research only and not for commercial purposes. The researchers agreed to this request.

4.8.1 Context of the *lekgotla* in a *Khoisan* village

The specific *Khoisan* village where the *lekgotla* was conducted is quiet and humble. When the researcher arrived, goats were running across the veld, whilst the ants were scurrying on the ground. One could hear a cock crowing and announcing the imminent rain rolling along with the thunder clouds in the distance. At the house of one of the elders, a big pot of food was bubbling over an open fire, spilling the appetising aroma of chicken stew. Ladies were busy kneading dough for "rooster brood" (a type of bread in the form of a bun, which will be baked over the warm coals), and the whole of the community was in preparation for the feast to be held after the *lekgotla*.

The *lekgotla* only commenced after the researchers negotiated the proceedings with the Chief of the *Khoisan*.

4.9 PRESENTATION OF FINDINGS OF THE *LEKGOTLA* IN THE *KHOISAN* VILLAGE

4.9.1 Theme 1: Comprehension and conceptualisation of mental illness according to indigenous knowledge

As conceptualised in the indigenous *Khoisan* community, mental illness is a condition that affects the brain of a person.

> "Their heads are not working to well"/

Mental illness is diagnosed through observation of the behaviour of a person, as their behaviour will often be contrary to the norm for the community. An example may be through a display of inappropriate and often sexually disinhibited behaviour as described by some of the ladies during the *lekgotla*.

> "This child cannot speak but he comes with a five rand coin to the women and shows that he wants to have sex with them."

> "She will all of a sudden dress flamboyantly in very high heels and go visit the "English" church, and then during the sermon she would develop the "loop siekte" (wandering illness) get up from the pew and walk out of church mid-sermon."

Mental illness is observed through the eyes of the community to fluctuate between bouts of *compos mentis* and illness. This point towards the identification of mental illness going into periods of remission.

4.9.1.1 Categories

- *Causes of mental illness*

The *Khoisan* community identified that there might be an evil cause for aggression and this will be dealt with on a spiritual level. The elder referred to this as quoted.

> Male Elder: "A restless spirit inside the person."

Mental illness is further identified as an illness of the brain.

> Chief: "Their heads are not working so well."

The community has experienced cases where some of the mentally ill persons to use their mental illness to their own benefit as alluded to by a member.

> Member1: "The community has experienced some of the psychiatric patients to be "aspris" because their behaviour is often a means to an end. One day they cannot do anything for themselves, the next minute they know how to work with money."
> "Today he is o.k. and tomorrow he is mad."

- *Management of mental illness*

The community in general is very tolerant of the mentally ill and tries to accommodate them in the community. However, if the mental illness causes a severe disturbance, they prefer to have the person hospitalised.

> Member 7: "if you do not pull yourself together they will take you with the ambulance to Bloemfontein of Weseinde." (Bloemfontein refers to the Freestate Psychiatric Complex in Bloemfontein, the capital of the Freestate province and Weseinde being a psychiatric hospital in the Northern Cape.)

> Member 7: "You see that child there...we do not really know how to deal with him, except to talk to him calmly and calm him down when he gets so upset."

It is also interesting to note that the *Khoisan* community members felt that mental illness might be under the control of the patient; an understanding reflected in the following statement.

> Member 7: "...pull yourself together..."

In situations where the cause of mental illness is deemed to be due to a restless or evil spirit, the management revolved around a spiritual nature as responded by the Elder male:

> Male Elder: "Spiritually you need to invite God into you to counteract the upset spirit in the other person. You must ask God for guidance."

Mental illness and the mentally ill are accepted as part of the community, therefore the community members reach out to the mentally ill to provide assistance where needed.

Members of the *lekgotla* in the *Khoisan* village reported that they often reach out to help the mentally ill. The Indigenous Healers confirmed this and emphasised the importance of reaching out to the mentally ill as one of the causes of Mental Illness is identified as lack of a support system.

The *Khoisan* community identified the use of indigenous medicines as an important aspect of the treatment of Mental Illness. They also consider Psychiatric Hospitals to play an important role in the management of Mental illness.

4.9.2 Theme 2: Identifying aggression

Aggression is diagnosed through observation of the behaviour of the aggressive person, and it became apparent during the *Lekgotla* that aggression is definitely associated more with mental illness.

> Chief: "... those people who do not have all their faculties, we know that in general they are more or less always aggressive and that they want to make and break things."

Where there is no evidence of mental illness, the community referred to this person as getting on his high horse for nothing.

Chief: "...this person gets on his high horse for nothing and get upset for no reason. They get into the boxing rink quickly."

The Chief advised that during this *Lekgotla* we should not discuss the increase of aggression due to drug abuse in the community

Member 2: "From my side...I know with me I have a man who is not always well and can get upset."

The nature of aggression has been described as to be unpredictable by different attendees to the lekgotla, as is evident in the following:

Chief: "The person who would sit and then all of a sudden feel he must punish someone for no apparent reason."

Member 5: "...You will think he goes this way but then he goes that way."

4.9.2.1 Categories

- *Mental status*

The *Khoisan* community did not elaborate much on the mental status of the aggressive person. However, the Chief alluded to the increase of hard core drug abuse in the community and that this has increased in incidences of aggression and a sub judice court case where murder was as a result of aggression and drug abuse.

- *Emotions*

The *Khoisan* Community agreed that it is extremely important to maintain control over your own emotions when dealing with the aggressive person.

Member 3: "When the mad person is so angry, you stay calm. It does not help to become angry."

Member 7: "When he is very very (sic) you need to be very very humble and calm, and talk to him with respect."

Member 6: "...the way in which you speak to a person who is a bit high. If you speak with calmness and in good spirit and tone of voice this will bring the person down."

Member 5:"If a person goes up the stream...stay calm and do not speak because you will give him power."

Member 2: 'This person with aggression you must speak in a calm voice this is the key. Do not backchat and do this with calmness."

- *Behaviour*

The mentally ill person is deemed to be more prone to violence.

Chief: "We have people like that in the community who "lost" it. Do you work the same way to calm him down as the others?"

Member 1: "You work with him in a different manner because there is a restless spirit in him."

Member 1: "The ladies seem to manage the men. They do something because they can get injured (sic). What is it they do? They seem to be able to manage the men."

- *Common misinterpretation of behaviour*

There was an open declaration that aggression often stems from misinterpretation of behaviour. This was explicitly stated by one of the attendees:

Member 7: "The child knows what he wants but he cannot speak, I take him to the shop to pick out what he needs. The shop owner does not want him there because he is says the child steals because he is mad. This makes the child aggressive."

4.9.3 Theme 3: Recognising the causes of aggression

Causes of aggression in the *Khoisan* community have been linked wth mental illness and substance abuse.

Member 8: "They sometimes get so angry because they hear voices talking to them or they get angry because of some inner pain which can only be healed by God."

The behaviour of other people can lead a person to become aggressive. This is one of the observations made by the Khoisan community and was thus captured:

Member 9: "See that child there is one of the mad people, he is without a mother and a father and his younger brother takes his pension money, this makes him aggressive. I have witnessed people pouring water over him or throwing stones at him and this makes him more aggressive."

4.9.3.1 Categories:

- *Manage the cause of the aggression.*

The *Khoisan* community differentiated between mental illness, restless spirit possession and substance abuse as potential causes of aggression. They only referred to spiritual management of aggression, where there is a restless spirit involved.

Member 1: "You ask God how you must react. Spiritually you must invite God into yourself to counteract the upset spirit in the other man. You ask God for guidance and which words you must use. Nothing is impossible with God the evil spirit is compelled to listen to the voice of God."

- *Hospitals may not be the most appropriate way to manage aggression associated with the mentally ill*

The Khoisan recognised the importance of mental hospitals, and even threatened some of the community members with hospitalisation when they become unruly.

4.9.4 Theme 4: Predictors of aggression

The *Khoisan* community deems aggression to be somewhat unpredictable in nature, as pointed out by the Chief.

"Now aggression is when a person gets on his high horse for nothing and get upset for no reason..."

4.9.5 Theme 5: Indigenous techniques in the management of aggression

The *Khoisan* community elaborated on the management of aggression and referred to a practice called "*Xarrare*" (this process is normally used to praise or calm down-e.g. you '*xarrare*' a baby-singing lullabies and rocking or praise a person to make them feel important in an adult manner). This practice is very specific to the *Khoisan.* They continued and alluded that the *Khoisan* women who are more vulnerable compared to the aggressive men are on the contrary quite efficient in the use of *xarrare* to calm down the aggressive male through the use of this very indigenous technique which will be elaborated on in the following section.

4.9.5.1 Categories

- *Verbal component*

The whole of the *Khoisan* community was in agreement that in order to manage aggression, it is very important to stay calm. This was echoed in many different ways as captured in the following extracts:

> Member 3: "I have witnessed when the mad person is so angry and you stay calm it does not help to argue, just sit down and whistle softly until he is calm."
>
> Member 2: "This person with aggression. You must speak in a calm voice. This is the key."
>
> Member 5: "If a person goes up the stream, stay calm and do not speak because if you do you give him power."
>
> Member 6: "When I get upset he has such a beautiful personality he would just say, 'Oh my sweetheart.' And then I calm down." (Example of xararre)

- *Physical component*

The Khoisan community informed the researcher that if a person becomes aggressive, it is better not to react physically.

Member 7: "Gently hold him tell him to calm down (Showing how she holds a person, and rock them gently in a swaying motion; to calm them down.) You will then feel his body become calm." (Example of xararre)

- *Do not intervene when no intervention is necessary*

The Khoisan pointed out that often it is useful to use diversionary techniques and to have no other form of intervention, as this would assist a person to calm down.

Member 2: "Rather send a person like that to go fetch water."

- *Medicinal component*

The members of the community reported during the validation afterwards that they administer medication when a person has calmed down. This medicine is part of the calming down technique.

Member 8: "If you haven't got medicine to calm them down you can give them sugar water, duwweltjiestamphout or grashout to drink. This will help them calm down."

4.9.6 Theme 6: Diminishing destructive methods of dealing with aggression and violence

The *Khoisan* mentioned some ineffective techniques sometimes used, such as threatening the aggressive person, beating him or throwing water over them when they are aggressive. They say they do this because they do not always know how to deal with the aggressive person. They have, however, noted that these techniques make the aggressive person more aggressive.

4.9.6.1 Categories

- *Verbal component*

It is evident that some members of the *Khoisan* community use coercion to manage aggression as is explicitly stated by one of the members:

> Member 7: "If you do not pull yourself together they will take you with the ambulance to Bloemfontein. You must calm down or you will be taken to Mental hospital in Northern Cape. You act as though you are mad but you are not really mad."

Because some people view mental health to be under the control of the person they, often tell them to pull themselves together, or they would use verbal threats to coerce them into controlling themselves. The *Khoisan* communities identified this as being ineffective and often resulting in power struggles between the aggressor and the rest of the community.

Threats to have a person admitted to a psychiatric hospital are equally ineffective and often evoke more aggression in the aggressor.

The *geigas* in the *Khoisan* community and *Basotho* healers pointed out that when verbally managing aggression, timing is also a factor to be taken into consideration. Verbal techniques are ineffective when a person is still very belligerent.

- *Physical component*

The indigenous healers reported an old seSotho proverb which states,

> "The back of a mad person is corrected by smacking them."

One of the elders in the *Khoisan* community reported that sometimes aggression is managed through beating up a mad person.

> "Jy fok hom op!"(Loosely translated "You give him a beating.")

During the validation after the *lekgotla,* one of the members described some additional destructive techniques which seem to aggravate the aggression.

> Member 9: "I have witnessed people pouring water over the mad person who is so angry, but does not always work; sometimes it makes them more aggressive."

Noteworthy is that both communities reported these physical beatings to be not effective at all as they increase aggression.

Both communities reported that the aggressive person must be ready to accept physical contact by the person managing their aggression. The *Khoisan* community referred to this as *"Xarrare"*, a form of embrace and pacifying a person like you would rock a baby. The *Basotho* healers referred to the use of a "hand of mercy". When touching the aggressive person, you yourself need to be calm.

Both communities rejected the use of restraints. The *Basotho* Healers advise on the need to "Untie a person." "The person will become calm if I am calm."

4.10 CONVERGENCE BETWEEN THE BASOTHO AND KHOISAN DATA

4.10.1 Comprehension and conceptualisation of mental illness according to indigenous knowledge

Mental illness is diagnosed through regarding the behaviour of a person, as their behaviour will often be contrary to the norm for the community, such as through a display of inappropriate and often sexually disinhibited behaviour. This observation by the community and indigenous healers is in line with the DSM-5 definition which points out that "Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." (DSM-5, 20:2013).

Mental illness is observed through the eyes of the community to fluctuate between bouts of compos mentis and illness. This points towards the identification of mental illness going into periods of remission. These references by the Indigenous Healers, as found in the transcript Annexure 2, confirm the findings of Kabir *et al.* (2004:4); Shankar *et al.* (2006:225) and Sorsdahl *et al.* (2010:286) wherein the authors pointed out that the recognition of a condition such as mental illness was based on the observation of the behaviour of the person who is deemed "mentally ill". Kabir *et al.* (2004:3) further confirms what IKS identified as symptoms of mental illness such traits as eccentric behaviour, wandering aimlessly and talkative behaviour (Kabir *et al.*, 2004:3).

Both the *Basotho* and *Khoisan* identified that: "a mad person does not think straight".

Some causes of mental illness are not known for the indigenous healers. This is especially true if the patient brought to them is not familiar or a member of the community or village where the healer practices.

4.10.2 Causes and management of mental illness according to indigenous knowledge

Both cultural groups made a link between the cause and the management of mental illness. Depending on the cause, the management will be adapted accordingly, as explored in a study by Mufamadi (2001:92). In the latter's study, the indigenous healers also reflected on the distinction of the different causes as determined by the symptoms the person presents. Where the cause is deemed to be of a spiritual nature or internal pain, it is dealt with in a spiritual manner. Sometimes the cause might be unknown and you deal with this mental illness in a very individualistic manner.

Mufamadi (2001:88) explains this well through her observation that the traditional healer's view of the disease is so much more in line with the patient's view; hence the success rate in curing the disease is ultimately so much higher. In further elaboration, the traditional healer will treat both the invading ghost and the symptoms of the illness, catering also for the associate psychosocial problems of the illness.

4.10.3 Identification of aggression

Neither cultural group attempted to predict aggression. Both groups, however, had specific criteria by which they defined and identified aggression.

4.10.3.1 Causes of aggression

Within the Indigenous Knowledge System, the causes of aggression have been linked to mental illness, the use of substances, environments and often some degrees of unpredictability.

Even though both the *Khoisan* and the *Basotho* made a link between mental illness and aggression, the *Basotho* indicated that not all mentally ill persons are prone to aggression. However, there are definite situations which would invariably add to incidences of aggression, such as the behaviour of other persons and even the mere appearance of hospitals which look like prisons. Jansen *et al.* (2003:84) reported similar findings and also linked the use of restraints with an increase in aggression. The *Basotho* feel it is important to remove a person from the situation which makes him feel aggressive. These different observed causes as identified by the indigenous healers correlate well with findings of Jansen *et al.* (2006:82), where the authors elaborate on how the attitudes of staff or persons towards a mentally-ill person will influence the behaviour of the

client. Similarly, Roos (2005:53) reported that taking care of difficult patients will influence the behaviour of the nurse negatively.

This observation by the Indigenous healers is reiterated by researchers within the WBKS as seen through the work of (Soliman & Reza, 2001:77-79; Duxbury, 2002:331-333; Duxbury & Whittington, 2005:470; Ignelzi *et al.*, 2007:453), where they confirm that confined areas, overcrowding, high temperatures, low staffing levels, seclusion and the use of restraints precipitate aggressive behaviour.

4.10.4 Management of aggression according to indigenous knowledge

Divination of the individual causes of aggression and mental illness is done by either the throwing of bones or observation of the patient, which is similarly described by Mufamadi (2001:93)

The subsequent treatment and medicine is also divined. It is very individually and culturally based and no set protocols are followed as is evident in WBKSs through a reference by Duxbury (2002:325), where the author points out that violent and aggressive persons are sedated and restrained.

As observed by the researcher, there seems to be one difference between Western Based Medicine and Indigenous Knowledge Systems, and that is the individuation of treatment within the Indigenous Knowledge Systems as opposed to the prescription of protocols as often seen in Western Medicine.

The *Basotho* healers, contrary to the *Khoisan* community, reported that they are well equipped to deal with aggression due to the nature of the training they underwent when they became "*Ngaka*" (Indigenous Healers). Berg (2003:196) echoes this self-awareness of the indigenous healers through reporting that the rigorous training of the indigenous healers made them skilled psychotherapists.

Unfortunately, the flip side of the coin also holds as both the *Basotho* and the *Khoisan* reported that there are incidences where destructive methods are used to manage aggression. They are convinced that these methods add to the aggression, and are destructive in nature.

4.10.4.1 Verbal management of aggression

The calmness in the voice, when communicating with a person who is aggressive, was noted by both the *Basotho* and the *Khoisan*. A theme that emerged from both groups is to make the aggressor feel comfortable, through inviting them to sit down and not necessarily communicating but just having a calm presence.

Verbal management for both cultures included a form of debriefing which relied on the correct timing, which is when the aggressor is calm. There would be negotiations and consultation about the causes and the effect of the aggressive behaviour.

The role of a mediator, in this case the Indigenous healer, is very important as they would also talk to the family and involve them, explaining to the family what is happening with the patient. This family involvement is also noted in the study by Mufamadi (2001:95), which confirms the importance of the African principle of family involvement and Ubuntu. Not only will this involve the family. It will help strengthen the family bond and foster re-integration of the affected member with his family.

4.10.4.2 Physical management of aggression

Both the *Khoisan* and the *Basotho* prefer not to react physically towards aggression and to not make use of restraints. However, if the person is a bit calmer, physical contact will become more bearable to the aggressor. The decrease of the use of restraints is also recommended by Hopton (1995:115) who recommends the use of therapeutic intervention strategies. The physical contact would revolve around making a person feel welcome and invited. However, on the odd occasion where the person is physically aggressive, it might be necessary to bring the person physically under control in order to administer medication.

4.10.4.3 Do not intervene if no intervention is necessary.

Both the *Khoisan* and *Basotho* informed that often no interaction is necessary other than removal of the cause of the aggression (albeit a person or situation).

4.10.4.4 Medicinal component

The use of medication plays a role in the *Khoisan* and the *Basotho* community. Both groups prefer to offer the medication to a person when they are a bit calmer. The *Basotho* have reported on the administration of medication as emergency management even against the wishes of the person.

Reportedly, they sometimes have to fight a client in order to get him to step over medication to calm him down.

This practice is familiar as the researcher has experienced within Western Based Knowledge and practice that MHCU who are out of control often are restrained and medication would be administered against their wishes in order for them to be sedated to assist them to gain control over themselves and their emotions.

The difference, however, remains that in WBKS there are set protocols for the administration of sedation and the only time these set protocols are deviated from is in instances where there is a known allergy or previous adverse reactions to any of the set medications.

As opposed to the *Khoisan,* the *Basotho* felt that the sharing of the medication used during these practices is privileged information.

4.11 CONCLUSION

The analysis of the data collected during the *makgotla* provided insightful considerations. The researcher noted that the practices have more in common with WBKS than expected. Leininger has identified seven cultural and social structural dimensions that influence a person's perception of health, illness and care. These Leininger referred to as universals as they occur in all cultures (George, 2002:491; Tjale & De Villiers, 2004:22). Similar to the theory of Leininger, the researcher identified more commonalities than differences between the management of aggression within the IKS and WBKS.

Both IKS and WBKS have identified causes for aggression, and these include mental illness and neurological problems. Within both IKS and WBKS, there is administration of some form of psychotherapy, ritual and family involvement. Medication plays a significant role in the management

of aggression associated with mental illness. The causes of aggression will determine the management in both the IKS and WBKS.

Although there are good strategies in the management of aggression and violence, there are reported destructive techniques such as shouting or the beating of clients and patients, in the management of aggression and violence in both IKS and WBKS. This potentially exists due to a lack of training and information about aggression and mental illness and a lack of understanding the perspective of the MHCU. Unfortunately, there remains friction between Western Based Treatment and Indigenous Knowledge System practices, as Western Based Medicine focuses on the physical and materialistic causes of illness, whereas Indigenous Medicine focuses on the spiritual origin of the illness, as observed by Richter (2003:12).

The proposed conceptual model, as represented below, includes the components which should form part of a training course in the culturally safe management of aggression and violence. As is evident in the transcripts and analysis of the data, the *Basotho* and *Khoisan* go through a similar process when dealing with aggression and violence as seen in mental illness. This includes an understanding of self, being sensitive to another person's culture, identifying the manifestation of aggression, determining the possible causes of aggression and dealing with aggression according to the cause. Both the *Basotho* and the *Khoisan* are clear that the cause of aggression must be removed if the behaviour is to be resolved. Chapter six (6) will focus on the recommendations and an in-depth explanation as to how the conceptual map was implemented.

Figure 4.1: SIP-DD Concept map of proposed training programme for the management of aggression and violence (designed by TM Bock)

The following chapter will focus on the analysis of the quantitative data collected pre and post the administration of treatment compartments, based on a training package inclusive of knowledge shared by the Basotho and Khoisan healers and the literature availed to the participants in the respective hospitals described in Chapter (3) three.

CHAPTER 5

QUANTITATIVE PHASE: RESULTS, DATA ANALYSIS, INTERPRETATION AND DISCUSSION

5.1 INTRODUCTION

This study is an exploratory sequential research with a qualitative phase consisting of *makgotla*. The data generated was used to refine a training programme, which was presented as part of a pre- and post-test. The study endeavoured to determine whether a training programme focused on culturally safe management of aggression and violence which includes training in cultural safety and awareness will influence the attitudes of mental health care providers in the management of aggression in MHCU.

The previous chapter (chapter four) focused on the results, data analysis, interpretation and discussion of the findings of the qualitative phase. The present chapter focuses on the results, data analysis, interpretation and discussion of the quantitative phase.

This quantitative phase of the exploratory sequential mixed method project entailed a pre- and a post-test used to determine if the training programme (treatment) influenced the attitudes of respondents towards the management of aggression and violence. This pre- and post-test was administered to all groups, even the control group, as it is possible that the questionnaires used might influence the attitudes of respondents towards the management of aggression and violence. For this research, the researcher used a non-directional hypothesis, namely: "The administration of a training programme will effect attitudinal changes towards the management of aggression and violence in respondents".

5.2 TRAINING PROGRAMME (TREATMENT) PHASE OF THE RESEARCH PROJECT

The training programme (treatment) in this quasi-experimental design required the presentation of a course to manage aggression and violence. This training programme was developed after a consultation of relevant literature and the inclusion of the indigenous knowledge obtained during the qualitative phase of this research project, as will be elaborated on in section 5.2.3.

The researcher used the Management of Aggression and Violence Attitude Scale (MAVAS), and the Cultural Sensitivity and Awareness Scale in the pre- and post-test. The timing of when to administer the post-test was randomly selected and is described in the next section. A different sequence of the training programme (treatment) was presented in four different provinces in an attempt to prevent cross contamination of respondents which would have been likely if the researcher used different wards within one hospital or even possibly different hospitals within one province. The allocation of the groups and training programme (treatment) for this non-equivalent group design was selected as described in Chapter three, and is elaborated on in the following section.

5.2.1 Administration of the mavas and the cultural awareness and sensitivity questionnaires and training programme (treatment)

The administration of the training programme (treatment) was randomly selected, as described in chapter three, section 3.4.1.1.

The researcher administered the post-test at different intervals for the different experimental groups.

Group one (1) (Northern Cape): This group was given the pre-test which they completed; thereafter they received the literature to read at leisure and were requested to return the post-test to the researcher via e-mail. The CEO of the institution reassured the researcher that the three staff members who did not have access to e-mail could send their questionnaires back via his e-mail. Unfortunately only one (1) respondent answered the post-test; hence the data collected in the Northern Cape is disregarded.

The researcher felt morally compelled to expose all participants to the total training programme (treatment) as it focuses on cultural sensitivity, predictors of violence and safe break away techniques; hence the researcher assumes this to be beneficial to all participants. Therefore, with this in mind, the researcher interrupted the training programme at different intervals for the respective hospitals in order to do the post-test and provide the total training programme.

This moral obligation further compelled the researcher to also provide the control group with all of the course material to read at leisure after she received the post-test from them via e-mail a week later as agreed upon.

Group two (2) (Western Cape): The group was also given the consent form as well as both the pre- and post-test when they arrived for the training programme. The Post-test for all experimental groups was marked with a red sticker and a number which corresponded with the pre-test questionnaire to allow the researcher to differentiate between the pre- and post-test when capturing the data. The training programme (treatment) for group two entailed:

- Management of aggression, understanding aggression and theories on aggression
- Break away techniques
- Safe restraining
- De-escalation techniques
- Cultural safety

After the completion of the total training programme, the participants were given an opportunity to complete the post-test and place it in a sealed box provided by the researcher.

Group three (3) (Gauteng), received training in the following sequence:

- Management of aggression, understanding aggression and theories on aggression
- Cultural safety
- Break away techniques
- Safe restraining
- De-escalation techniques

The researcher administered the post-test for group three (3) directly after the presentation of management of aggression, understanding aggression, theories on aggression and cultural safety. The participants completed the questionnaires and placed it in the sealed mailbox provided. Thereafter, the rest of the training programme followed. Noteworthy in Gauteng a reported n14=82% of respondents have received training in the management of aggression and violence.

Group four (4) (North West Province): The training programme for this group commenced with Cultural safety and awareness and then the post-test was administered. Similarly, the respondents had to place the post-test in the sealed box as per the other provinces. After the completion of this post-test the respondents received the rest of the training programme.

- Cultural safety
- Management of aggression, understanding aggression and theories on aggression
- Break away techniques
- Safe restraining
- De-escalation techniques

5.2.2 Context of the training programme

Data was only collected in those provinces and hospitals that responded and consented to the researcher's application to conduct the research project there.

Evident from the correspondence in Annexure seven (7), the hospitals made it clear that it is difficult to release any staff to attend the proposed training as there are severe staff shortages. Furthermore, it was emphasised that the participation is voluntary. The researcher was dependent on the support of the Nurse Mangers and Chief Executive Officers at the respective hospitals to release staff for the proposed interventions.

The participants in this research were staff working in the acute-, sub-acute-, admission-, forensic admission and adolescent units of the respective hospitals. The population included all members of the multidisciplinary team namely all categories of nursing staff such as auxiliary nurses, enrolled nurses, registered nurses, registered psychiatric nurses, advanced psychiatric nurse practitioners, operational managers, occupational therapists, occupational therapist assistants, speech therapists, medical officers and registrars in some provinces. The homogeneity of these groups lies in them all being members of the multidisciplinary team working in acute psychiatric units.

Those hospitals who consented to the research and the training programme provided the researcher with a venue for presentation of the training. The researcher provided all training material, and the equipment such as the laptop and data projector. In addition to training materials, the researcher provided refreshments such as coffee, tea and biscuits during the allocated tea and lunch breaks.

5.2.3 Development of the curriculum for the training programme

As stated, the researcher already developed the foundational curriculum and followed the guidelines as set out by Arend Carl to identify gaps in the existing curriculum and then proceeded

to refine the curriculum (Carl, 1995:40). During 2010, the researcher obtained baseline data through a previous study and identified the gaps through comparing the responses of participants to the ideal responses on the MAVAS questionnaire. This baseline data was augmented through a literature review and it became the basis of the foundational programme. The data obtained during the qualitative component of this exploratory sequential research was then added to this foundational programme. The result is a combination of professional, western-based knowledge and indigenous knowledge from the community, to form a curriculum which includes "common knowledge" and cultural sensitivity and awareness in the management of mental health care user related violence. This approach to curriculum development is referred to as the academic approach by Carl (1995:39, 47).

The convergence of data took place during the development of the refined curriculum available in Annexure 2, and the adaptation made to the MAVAS questionnaire to suit the practices used in the provision of mental health care here in South Africa.

5.2.4 Nature of the training programme/curriculum

The researcher integrated Fink's taxonomy of significant learning when she designed the outcomes for the curriculum and training programme. The researcher deems this taxonomy by Fink to be the quintessential taxonomy to be utilised in the training programme for the management of aggression and violence.

The development of any training course that promotes significant learning consists of five steps as identified by Fink (2003:5). These steps, according to Fink (2003:5), are explained in the next section with further explanation as to how it was applied to the training programme (treatment) as designed by the researcher.

The researcher applied these steps to the training course as explained in section 5.2.3.1 to 5.2.3.5.

5.2.4.1 Step one (1): Consideration of situational factors such as instructional challenges of the course, and expectations from the learner and how the course will fit into the larger curricular context

As advised by Fink (2003:1) the researcher, after the *lekgotla*, combined the information from the *makgotla* and used the nature of the questions on the MAVAS questionnaire along with current

literature available and formulated outcomes for the curriculum. Thus the curriculum is based on the important learning goals identified during the above mentioned engagement results obtained from the study conducted by the researcher in 2010, (Bock, 2010).

5.2.4.2 Step two (2): Learning goals. What do you want the learner to learn that would stay with them for years?

- Understand the phenomenon of aggression as part of the Foundational knowledge identified through the application of Fink's taxonomy (Fink, 2003:9).
- Apply the newly acquired knowledge to effectively manage aggression and violence, through critical thinking.
- Integrate knowledge about aggression to identify and eliminate causative factors.
- Understand self and other human beings as alluded to in the Human Dimension aspect of Fink's taxonomy, (Fink, 2003:8).
- Show caring towards the client through being culturally aware and safe.

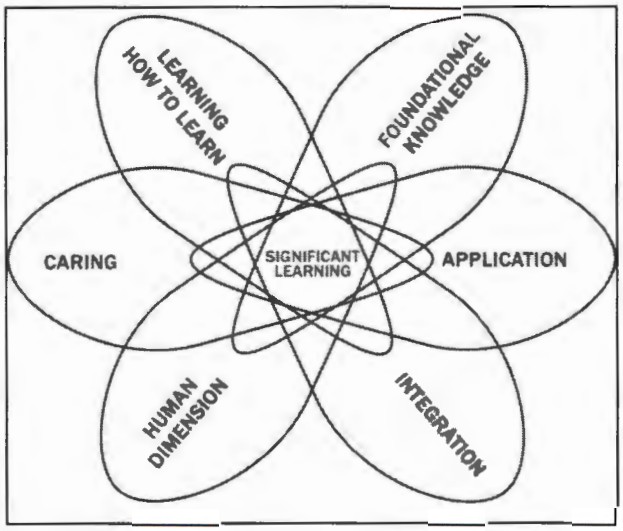


Figure 5.1: Fink's taxonomy of significant learning

5.2.4.3 Step three (3): Feedback and Assessment procedures. What will the students have to do to demonstrate that they have achieved the goals of the training course?

In terms of Fink's taxonomy of significant learning, the researcher set up the following outcomes for this course:

- On completion of this training package, the learner will be able to diagnose the early signs of mental health care user related aggression before it escalates into violence.
- The learner will be able to identify potential causes of aggression.
- The learner will be aware of their own perception of the management of aggression and violence.
- The learner will be able to deal with a mental health care user in a culturally aware and sensitive manner,
- The learner will be able to de-escalate aggression to a manageable level.
- The learner will be able to apply break away techniques which will allow them to break free from holds without injuring themselves or the mental health care user.
- The learner will be able to safely restrain MHCU where such methods are indicated.

The feedback from the learners was obtained through evaluating their responses on the MAVAS and Intra Cultural Sensitivity Scale, this provided further insights in terms of where the training programme should be tweaked. Furthermore, it conforms with Fink's assumption that change in a learner is an indicator of learning which took place (Fink, 2003:3). This form of assessment is forward looking assessment according to Fink (2003:14), a form of assessment where the teacher anticipates situations where the learner will require the knowledge and paints scenarios as close to real life as possible where she expects the learner to solve the problem. This is exactly the format the researcher used when she presented the training programme to the different experimental groups.

5.2.4.4 Step four (4) Teaching and learning activities. How would you involve the students?

Learners were involved through sharing experiences and they were requested to make recommendations pertaining to scenarios sketched by the course presenter, as explained in the

previous section. The use of the language skills during de-escalation of aggression was managed through role play.

During the presentation of the dignified break away techniques and safe restraint, it required the active physical participation of the learner and learners had to physically demonstrate the ability and competence to apply the skill taught.

5.2.4.5 Step five (5): Make sure the key components are all integrated

The researcher attempted to integrate all levels of the course as the participants were from vastly different levels of education and had different pre-knowledge. The researcher constantly evaluated the pre knowledge and encouraged discussion and self-reflection in all participants.

Further, integration focused on catering for cultural awareness and sensitivity into all components of the course.

5.3 PRESENTATION AND ANALYSIS OF THE DATA

Burns and Grove (2011:372) highlight the process followed for data analysis, elaborating on how data will be prepared for the analysis, description of the sample and the reliability of the measurements used. The hypothesis as well as questions that the research project wishes to answer guide the researcher and the statistician as to which statistical methods to use.

The two questionnaires in this project, namely the MAVAS questionnaire and the Intercultural sensitivity questionnaire, both collect ordinal quantitative data. This raw data was then captured on a Microsoft Excel spreadsheet and the researcher computed central tendency (the mean, mode, median). Brink (1987:56) advises that the mode and the median should be the calculation of choice when dealing with ordinal data.

Descriptive statistics was used to describe the demographic data and these are represented in tables, cone and bar diagrams. The captured raw data was submitted to a registered statistician, Ilja de Boer, who used the SAS Version 9 data analysis software.

The relationship between responses, within the experimental group and between experimental groups, was calculated by means of the *t*-test because there is an intervention involved in three

independent samples (Burns & Grove, 2011:404). Two tailed tests of significance were computed due to the non-directional hypothesis (N_1) set by the researcher. The non-directional hypothesis set by the researcher indicates that a significance level of 0.05 scores will be higher or lower than 95% of the population. Burns and Grove (2011:380) elaborate and state that in such a case, α= 2, 5% of the extreme statistical values will be in two tails of the extremes and would not be statistically significant. At this significance level of 0.05, $p<0.05$ will represent statistical significance. Therefore this level of significance means there is a 5% probability of error, or that the researcher is 95% confident of the findings.

5.4 RESULTS OF THE DATA

This section of the chapter presents the data generated during data collection for both the pre-tests and post-tests of all three experimental groups. It contains the descriptive statistics, the questionnaires and research objectives.

5.4.1 Demography of the respondents

5.4.1.1 Gender of the participants

Table 5.1: Gender of participants

	North West Province		Northern Cape		Western Cape		Gauteng	
Gender	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)
Male	53	32	4	33	11	46	5	29
Female	115	68	8	67	13	54	12	71
Total	**n=68**	**100**	**n=12**	**100**	**n=24**	**100**	**n=17**	**100**

68% female and 32% male for North West, 67% female and 33% male for Northern Cape, 54% female and 46% male for the Western Cape and 71% female and 29% male for the Gauteng experimental group is representative of the target population due to nursing being predominantly a female dominated profession in South Africa.

The only variable the researcher attempted to control was the type of ward where the respondents worked. The homogeneity of the respondents was mainly a result of being part of the

multidisciplinary team working with acutely ill MHCU in the acute admission units as per the Mental Health Care Act (17 of 2002).

5.4.1.2 Training received in the management of aggression and violence

Table 5.2: Table of training received.

	North West Province		Northern Cape		Western Cape		Gauteng	
Training received	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)	Frequency (*f*)	Percentage (%)
Yes	17	10	4	33	6	25	14	82
No	152	90	8	67	18	75	3	18
Total	**n=169**	**100**	**n=12**	**100**	**n=24**	**100**	**n=17**	**100**

The previous table (5.2) reflects the total population of N 222, with a reported 18.5% of the overall respondents reportedly having received training in the management of aggression and violence. The opposite holds, namely that the majority of 81.5% respondents had never received any form of training in the management of aggression and violence in MHCU. The different experimental groups reflect this overall percentage very closely with North West reporting 90% of respondents not having undergone training. The Western Cape is a close second at 75% followed by the Northern Cape with 67%. Gauteng is the exception to the rule and 82% of respondents indicated that they had received training in the management of aggression and violence. A similar observation with reference to gender in nursing was made by Bock (2010) during a previous baseline study conducted in the Western Cape.

5.4.1.3 Years of experience in the different groups

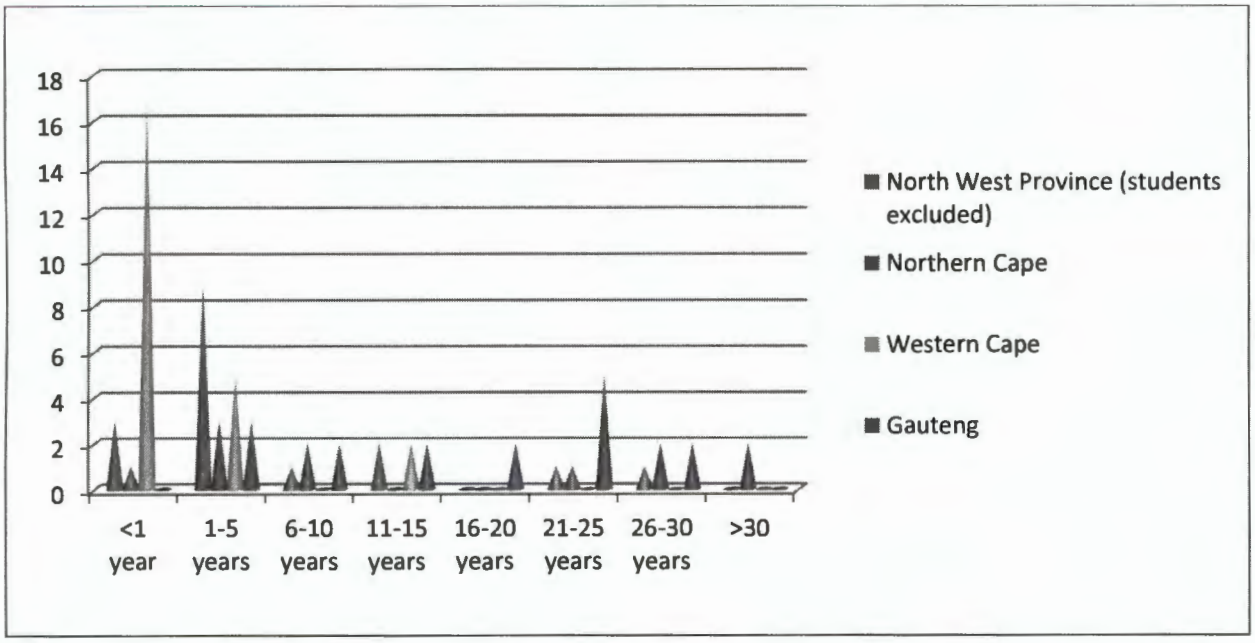
Table 5.3: Years of experience with student population included

	North West Province		Northern Cape		Western Cape		Gauteng	
Years of experience	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
<1 year	151	91	1	9	17	71	0	0
1-5 years	10	6	3	27	5	21	3	19
6-10 years	1	1	2	18	0	0	2	12.5
11-15 years	2	1	0	0	2	8	2	12.5
16-20 years	0	0	0	0	0	0	2	12.5
21-25 years	1	1	1	9	0	0	5	31
26-30 years	1	1	2	18	0	0	2	12.5
>30	0	0	2	18	0	0	0	
Total	166	100	11	100	24	100	16	100

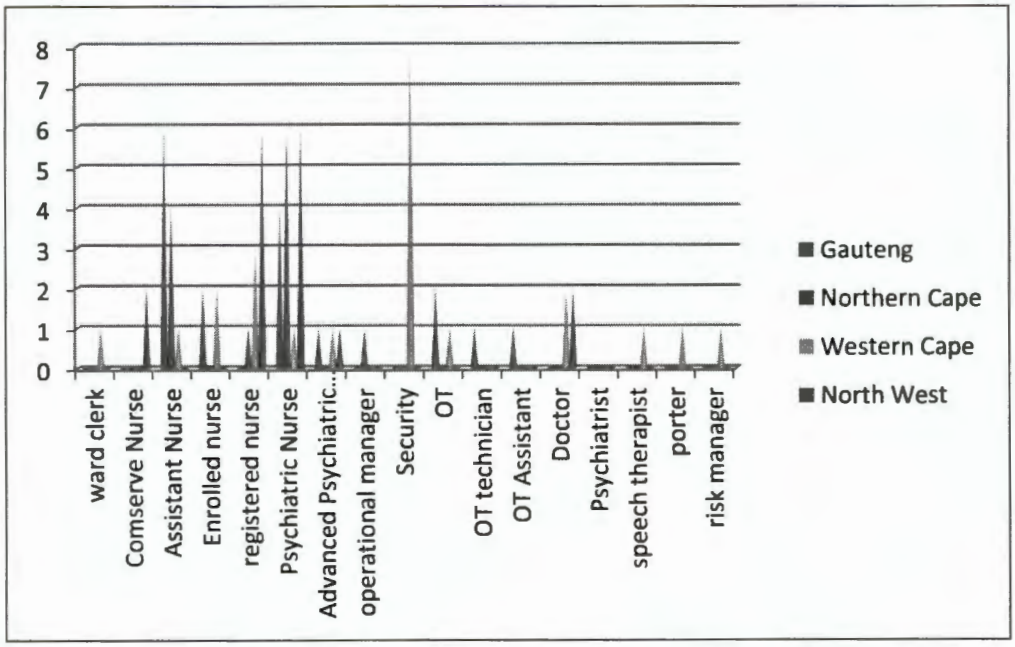
The participants in this research project, as reflected in the table above, are spread across the table which is divided in categories of 5 years. 97% of participants in North West had between one and five years of experience, whilst there was a similar observation of 92% of participants for the Western Cape. The Northern Cape reported the highest level of years of experience in the one (1) to 10 year group namely 45% of respondents.

Not all of the participants completed this questionnaire. Three (3) respondents in North West, 1 in the Northern Cape and 1 in Gauteng did not answer this question. The following cone shaped histogram shows the distribution of the years of experience of all the participants in the different experimental groups.

The cone shaped histogram below makes it visible that the majority of the respondents for the total population had between one (1) and five (5) years of experience as mental health care providers employed in acute admission units of mental health care facilities, as described and set out in the Mental Health Care Act (17 of 2002).



Graph 5.1: Graphic representations of the years of experience for the total group of respondents



Graph 5.2: Representation of the different occupational classes who took part in the research

5.5 RESPONSES ON THE MAVAS QUESIONNAIRE

These sections will present data with regards to what the attitudes of mental health care providers are towards the management of aggression and violence during a posttest and if the treatment intervention had any effect on the attitudes of mental health care providers.

The respondents were instructed to use the response keys as set out in the MAVAS questionnaire to determine their agreement or disagreement using a (√) with each of the 27 statements in the MAVAS questionnaire. The response keys were as follows:

- Strongly agree
- Agree
- Disagree
- Strongly disagree

5.5.1 Rationale for the pre-test and the post-test

The aim of the post-test was to address the null hypothesis (H_o) namely, to determine if the treatment administered had an effect on the participants. The null hypothesis (H_o) for this test stated, "The training programme will have no effect on the participants in this research." The non-directional hypothesis stated that the training programme will have an effect. The administration of three different training programmes (treatment) was compared:

5.5.2 Discussion of the results on the MAVAS questionnaire

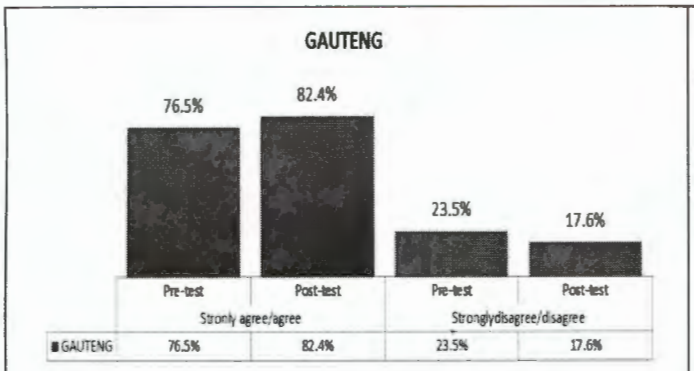
The MAVAS questionnaire consists of 27 questions as stated in section 5.5. All questions were answered by the respondents in the project, and the results will be discussed question by question.

The researcher discarded the questionnaires where respondents only completed the pre-test. In North West, 11 participants only completed the pre-test and submitted empty post-test. The researcher discarded this data as it would have skewed the results of the post-test.

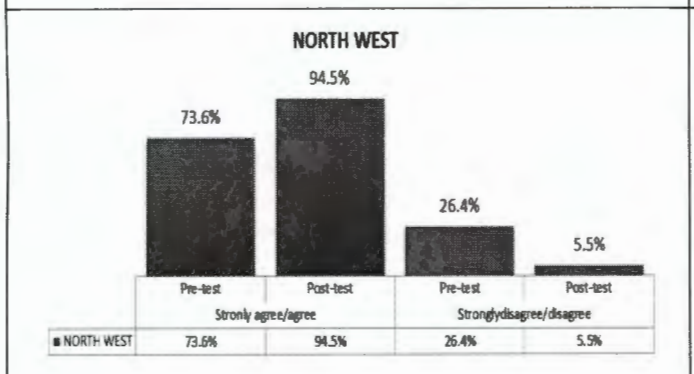
As stated, the results for the Northern Cape who were the randomly selected control group was also discarded as only one respondent completed the post-test. The computed results for each question will be represented by a bar diagram and table, then an interpretation of the results will follow. This chapter will conclude with a summary of the findings.

The analysis of the findings in the MAVAS questionnaire will be further discussed in section 5.6.

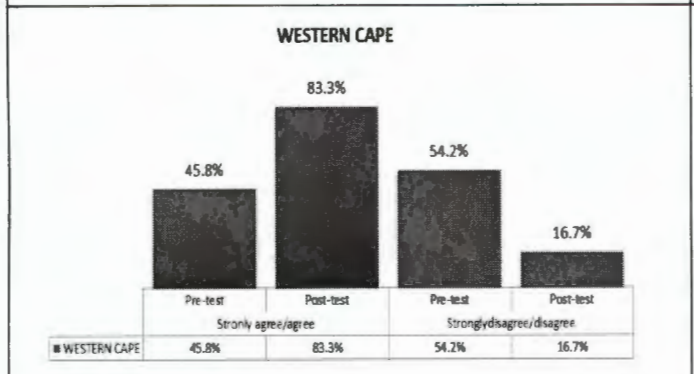
5.5.2.1 *Question one (1). Patients are aggressive because of the environment they are in*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	diff	95% Confidence Interval	
Mean	2.05882353	1.88235294	0.176	-0.277	0.630
Variance	0.43382353	0.48529412			
Observations	17	17			
Pearson Correlation	0.1522389				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.824				
P(T<=t) one-tail	0.211				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.422				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	diff	95% Confidence Interval	
Mean	2.07692308	1.40659341	0.670	0.476	0.864
Variance	0.58290598	0.48840049			
Observations	91	91			
Pearson Correlation	0.19062234				
Hypothesized Mean Difference	0				
df	90				
t Stat	6.864				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					



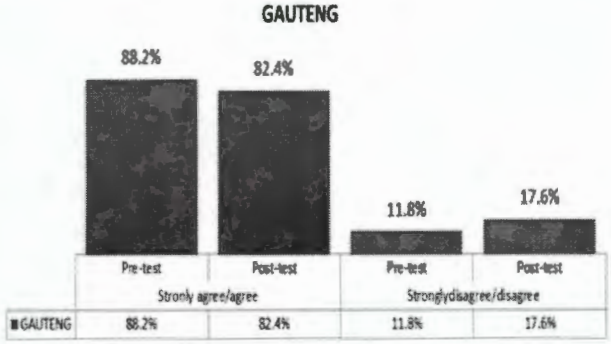
t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	diff	95% Confidence Interval	
Mean	2.41666667	1.58333333	0.833	0.090	1.577
Variance	1.73188406	0.94927536			
Observations	24	24			
Pearson Correlation	-0.16389413				
Hypothesized Mean Difference	0				
df	23				
t Stat	2.318				
P(T<=t) one-tail	0.015				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.030				
T Critical Two-tail	2.069				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

Graph 5.3: Patients are aggressive because of the environment they are in

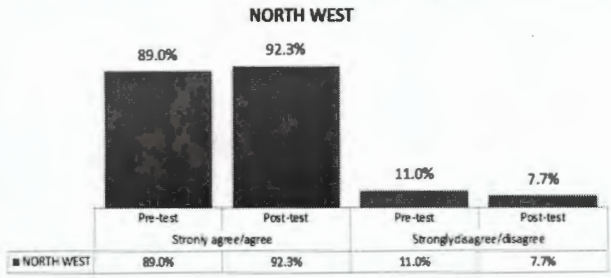
Questions for both the pre-test and the post-test were answered by all respondents, namely Gauteng n=17, North West n=91, and Western Cape n=24.

During both the pre-tests, the majority of the respondents show agreement with this statement.

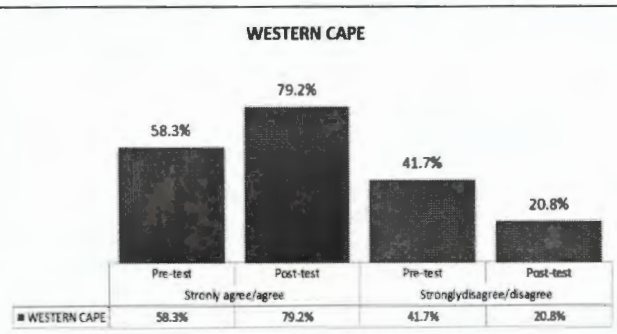
5.5.2.2 Question two (2). Other people make patients aggressive or violent



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ2	*POSTQ2*	diff	95% Confidence Interval	
Mean		1.88235294	2	-0.118	-0.595	0.359
Variance		0.61029412	0.375			
Observations		17	17			
Pearson Correlation		0.1306456				
Hypothesized Mean Difference		0				
df		16				
t Stat		-0.523				
P(T<=t) one-tail		0.304				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.608				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ2	*POSTQ2*	diff	95% Confidence Interval	
Mean		1.82417582	1.53846154	0.286	0.101	0.470
Variance		0.59096459	0.4957265			
Observations		91	91			
Pearson Correlation		0.27950244				
Hypothesized Mean Difference		0				
df		90				
t Stat		3.078				
P(T<=t) one-tail		0.001				
T Critical one-tail		1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.003				
T Critical Two-tail		1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)						

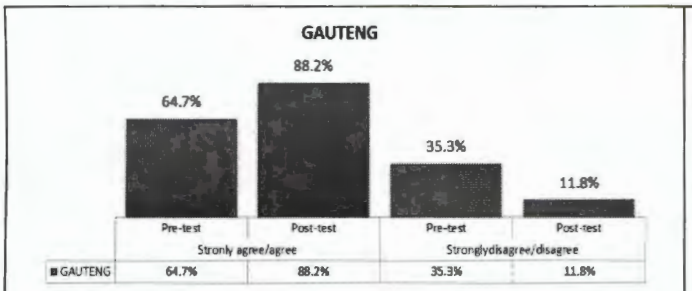


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ2	*POSTQ2*	diff	95% Confidence Interval	
Mean		2.20833333	1.70833333	0.500	0.051	0.949
Variance		1.30253623	1.17210145			
Observations		24	24			
Pearson Correlation		0.54394792				
Hypothesized Mean Difference		0				
df		23				
t Stat		2.304				
P(T<=t) one-tail		0.015				
T Critical one-tail		1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.031				
T Critical Two-tail		2.069				
Reject Null Hypothesis because p < 0.05 (Means are Different)						

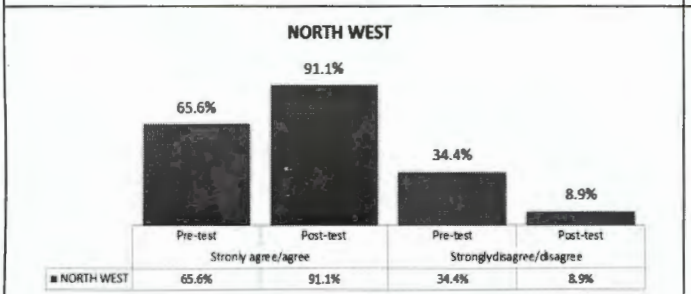
Graph 5.4: Other people make patients aggressive or violent

In both the pre-test and the post-test all experimental groups show agreement with this statement. It is worth noting that there is a significant statistical difference in the North West and the Western Cape experimental groups in terms of the pre-test and the post-test results. This effectively implies that the training programme had an effect on their attitudes towards the role others play in making a patient aggressive.

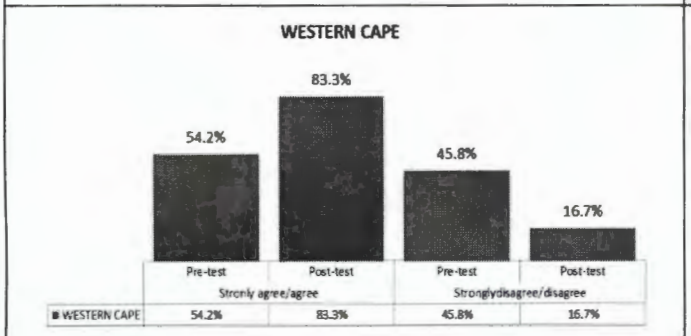
5.5.1.3 Question three (3). Patients commonly become aggressive because staff does not listen to them



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ3	*POSTQ3*	diff	95% Confidence Interval	
Mean	2.47058824	1.88235294	0.588	0.222	0.954
Variance	0.51470588	0.36029412			
Observations	17	17			
Pearson Correlation	0.42686736				
Hypothesized Mean Difference	0				
df	16				
t Stat	3.405				
P(T<=t) one-tail	0.002				
T Critical one-tail	1.746				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.004				
T Critical Two-tail	2.120				
Reject Null Hypothesis because p < 0.05 (Means are Different)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ3	*POSTQ3*	diff	95% Confidence Interval	
Mean	2.16483516	1.51648352	0.648	0.417	0.879
Variance	0.69474969	0.58583639			
Observations	91	91			
Pearson Correlation	0.03923445				
Hypothesized Mean Difference	0				
df	90				
t Stat	5.576				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					



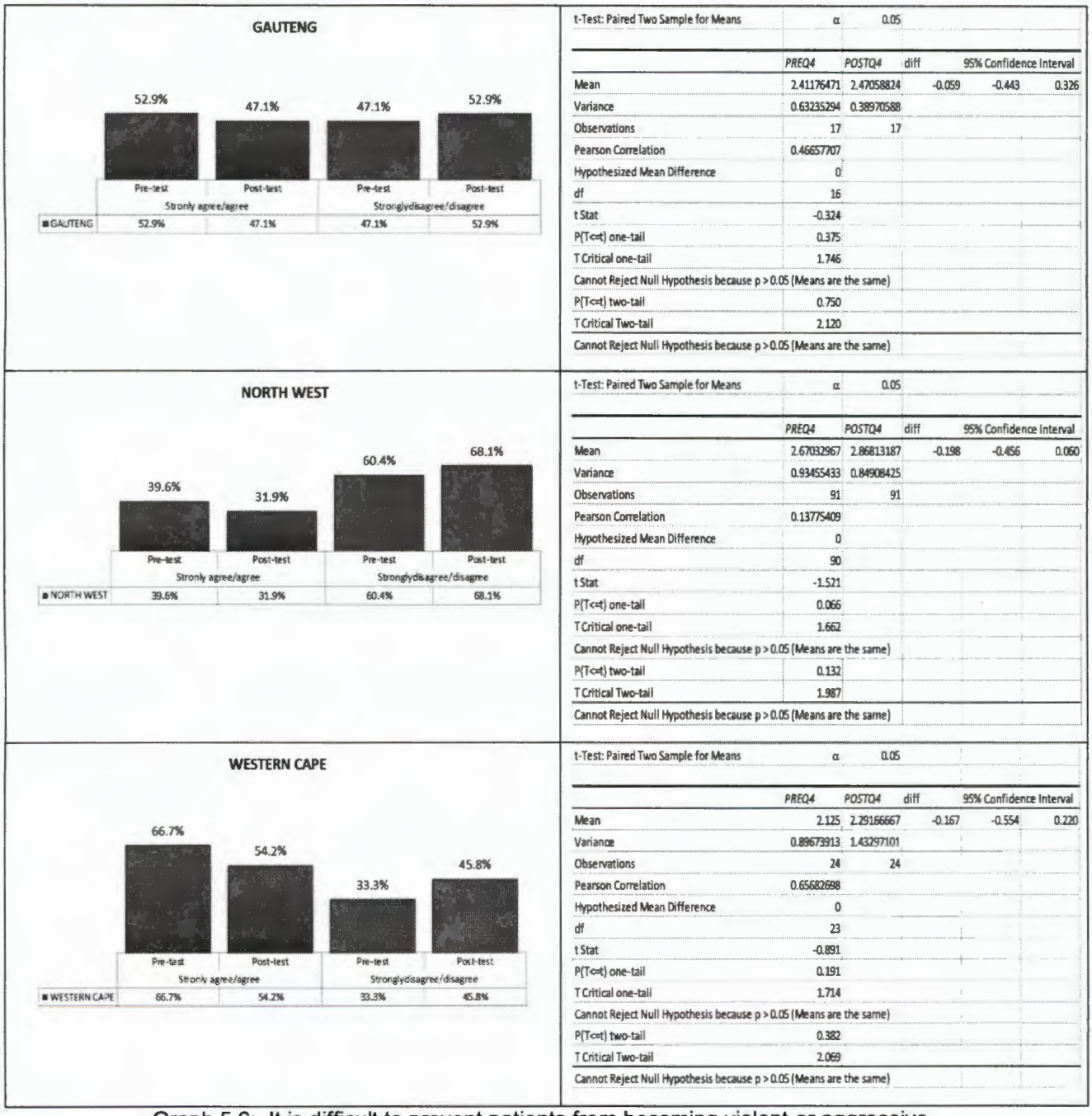
t-Test: Paired Two Sample for Means		α	0.05		
	PREQ3	*POSTQ3*	diff	95% Confidence Interval	
Mean	2.29166667	1.54166667	0.750	0.314	1.186
Variance	1.08514493	0.7807971			
Observations	24	24			
Pearson Correlation	0.43495089				
Hypothesized Mean Difference	0				
df	23				
t Stat	3.560				
P(T<=t) one-tail	0.001				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.002				
T Critical Two-tail	2.069				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

Graph 5.5: Patients commonly becomes aggressive because staff does not listen to them

All three experimental groups showed an overwhelming initial agreement with this statement, with percentages of agreement varying from 64.7% for Gauteng, 65.6% for the North West and 54.2% for the Western Cape. The Posttest results with reference to agreement with the statement were as follows: 88.2% for Gauteng, 91.1% for the North West and 83.3% for the Western Cape. It is observed that Gauteng, which only received training in cultural sensitivity and awareness and theories around aggression, showed a statistically significant change in attitude as did the Western Cape, who received the total training package. Inexplicably the North West group also showed a

statistically significant change in attitude even though they only received training in cultural safety and awareness. It is not clear if the completion of the MAVAS questionnaire might have played a role. The researcher will discuss this group's responses on the cultural safety and awareness questionnaire, in section 5.6.

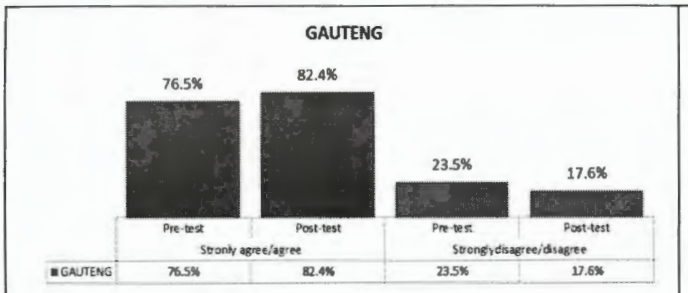
5.5.2.4 Question four (4). It is difficult to prevent patients from becoming violent or aggressive



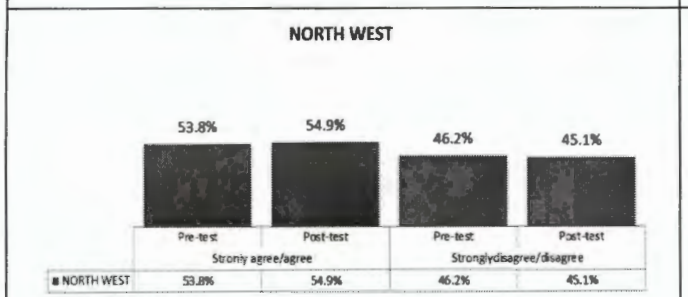
Graph 5.6: It is difficult to prevent patients from becoming violent or aggressive

All three experimental groups showed varied responses with the Gauteng and Western Cape group. Almost half the respondents found it difficult to prevent aggression. North West, however, did not agree with the statement that it is difficult to prevent aggression and violence.

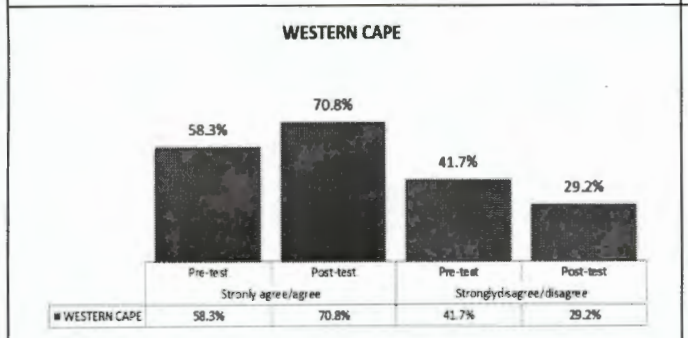
5.5.2.5 Question five (5). Patients are aggressive because of the environment they are in



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ5	*POSTQ5*	diff	95% Confidence Interval		
Mean	2.05882353	1.88235294	0.176	-0.277	0.630	
Variance	0.68382353	0.48529412				
Observations	17	17				
Pearson Correlation	0.33824581					
Hypothesized Mean Difference	0					
df	16					
t Stat	0.824					
P(T<=t) one-tail	0.211					
T Critical one-tail	1.746					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.422					
T Critical Two-tail	2.120					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ5	*POSTQ5*	diff	95% Confidence Interval		
Mean	2.53846154	2.42857143	0.110	-0.115	0.335	
Variance	0.94017094	0.89206349				
Observations	91	91				
Pearson Correlation	0.36397994					
Hypothesized Mean Difference	0					
df	90					
t Stat	0.971					
P(T<=t) one-tail	0.167					
T Critical one-tail	1.662					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.334					
T Critical Two-tail	1.987					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

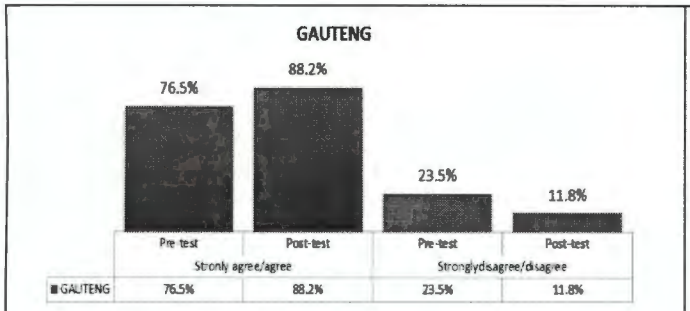


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ5	*POSTQ5*	diff	95% Confidence Interval		
Mean	2.29166667	2	0.292	-0.182	0.765	
Variance	1.17210145	0.7826087				
Observations	24	24				
Pearson Correlation	0.3631677					
Hypothesized Mean Difference	0					
df	23					
t Stat	1.273					
P(T<=t) one-tail	0.108					
T Critical one-tail	1.714					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.216					
T Critical Two-tail	2.069					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

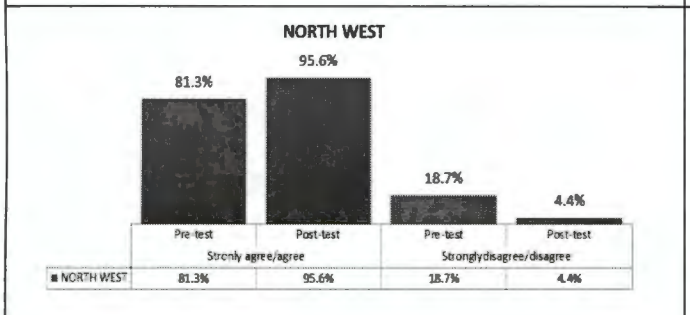
Graph 5.7: Patients are aggressive because of the environment they are in

All respondents answered this question. As can be seen, the post shows that Gauteng increased agreement after training from 76.5% to 82.4%, North West from 53.8% to 54.9% and the Western Cape from 58.3% to 70.8%.

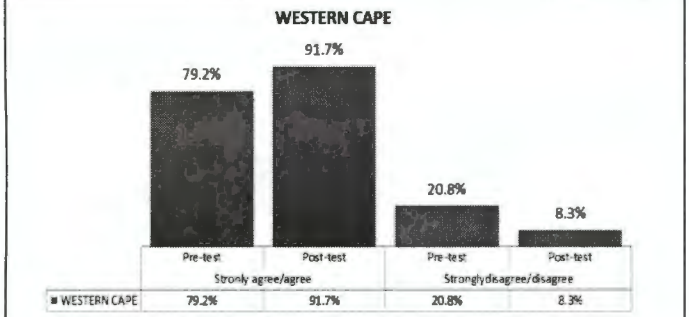
5.5.2.6 Question six (6). Poor communications between staff and patients lead to patient aggression



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ6	*POSTQ6*	diff	95% Confidence Interval	
Mean	2.05882353	1.76470588	0.294	-0.179	0.767
Variance	0.43382353	0.69117647			
Observations	17	17			
Pearson Correlation	0.25513126				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.319				
P(T<=t) one-tail	0.103				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.206				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ6	*POSTQ6*	diff	95% Confidence Interval	
Mean	1.82417582	1.40659341	0.418	0.216	0.619
Variance	0.83540904	0.46617827			
Observations	91	91			
Pearson Correlation	0.29387351				
Hypothesized Mean Difference	0				
df	90				
t Stat	4.120				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

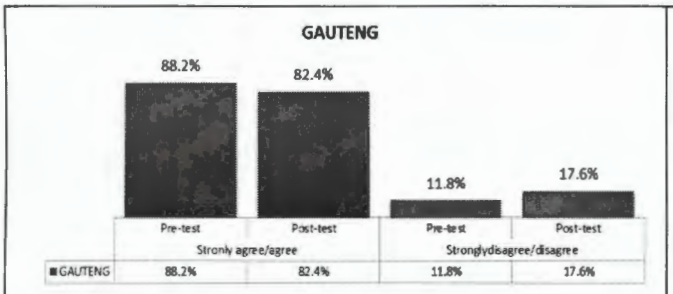


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ6	*POSTQ6*	diff	95% Confidence Interval	
Mean	1.91666667	1.5	0.417	0.005	0.828
Variance	1.03623188	0.43478261			
Observations	24	24			
Pearson Correlation	0.38865017				
Hypothesized Mean Difference	0				
df	23				
t Stat	2.095				
P(T<=t) one-tail	0.024				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.047				
T Critical Two-tail	2.069				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

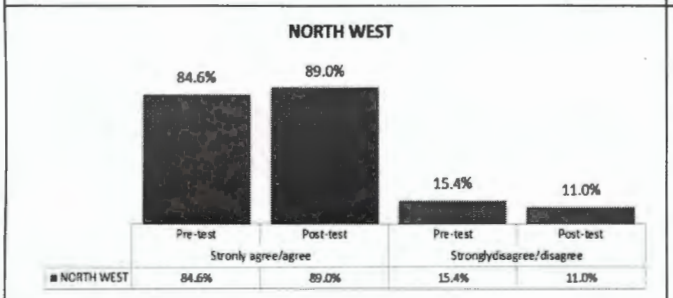
Graph 5.8: Poor communications between staff and patients lead to patient aggression

With reference to the diagram, it is notable that in all three groups the majority of the respondents agreed with the statement.

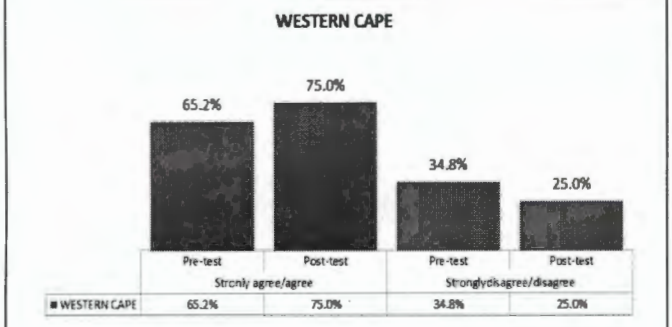
5.5.2.7 *Question seven (7). There appears to be types of patients who frequently become aggressive towards staff*



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ7	*POSTQ7*	diff	95% Confidence Interval		
Mean	1.70588235	2.11764706	-0.412	-0.730	-0.094	
Variance	0.47058824	0.48529412				
Observations	17	17				
Pearson Correlation	0.60007102					
Hypothesized Mean Difference	0					
df	16					
t Stat	-2.746					
P(T<=t) one-tail	0.007					
T Critical one-tail	1.746					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.014					
T Critical Two-tail	2.120					
Reject Null Hypothesis because p < 0.05 (Means are Different)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ7	*POSTQ7*	diff	95% Confidence Interval		
Mean	1.92307692	1.74725275	0.176	-0.012	0.364	
Variance	0.60512821	0.54652015				
Observations	91	91				
Pearson Correlation	0.29427444					
Hypothesized Mean Difference	0					
df	90					
t Stat	1.860					
P(T<=t) one-tail	0.033					
T Critical one-tail	1.662					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.066					
T Critical Two-tail	1.987					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

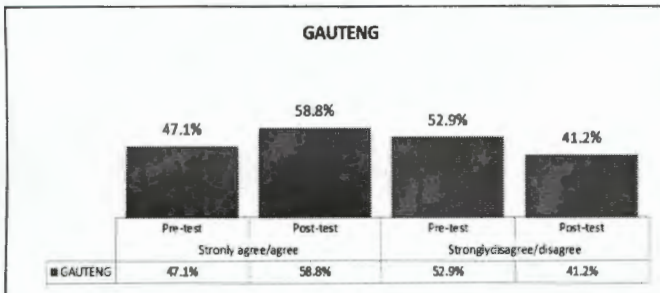


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ7	*POSTQ7*	diff	95% Confidence Interval		
Mean	2.08333333	1.95833333	0.125	-0.422	0.672	
Variance	1.55797101	0.5634058				
Observations	24	24				
Pearson Correlation	0.23590134					
Hypothesized Mean Difference	0					
df	23					
t Stat	0.473					
P(T<=t) one-tail	0.320					
T Critical one-tail	1.714					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.641					
T Critical Two-tail	2.069					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

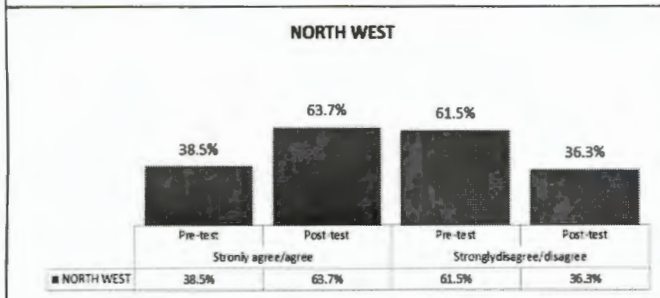
Graph 5.9: There appears to be types of patients who frequently become aggressive towards staff

All respondents answered this question. Gauteng was the only group which showed a decrease in agreement with the statement in the post-test, namely a decrease from 88.2% to 82.4%, North West and Western Cape showed an increased agreement, namely 84.6% to 89% for North West and 65.2% to 89.0%.

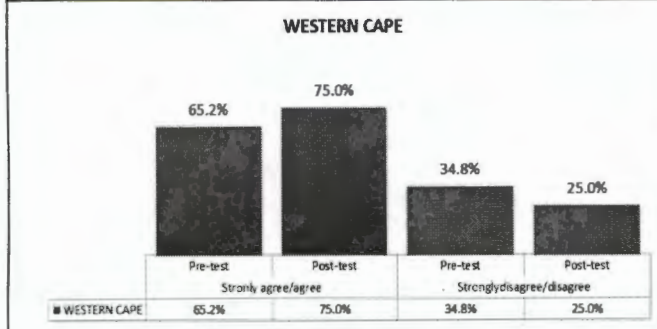
5.5.2.8 Question eight (8). Different approaches to suit different cultural groups are used on this ward to manage patient aggression and violence



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	*diff*	*95% Confidence Interval*	
Mean	2.58823529	2.35294118	0.235	-0.054	0.524
Variance	0.63235294	0.61764706			
Observations	17	17			
Pearson Correlation	0.74711053				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.725				
P(T<=t) one-tail	0.052				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.104				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	*diff*	*95% Confidence Interval*	
Mean	2.75824176	2.1978022	0.560	0.336	0.785
Variance	0.91868132	0.98266178			
Observations	91	91			
Pearson Correlation	0.39002309				
Hypothesized Mean Difference	0				
df	90				
t Stat	4.963				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

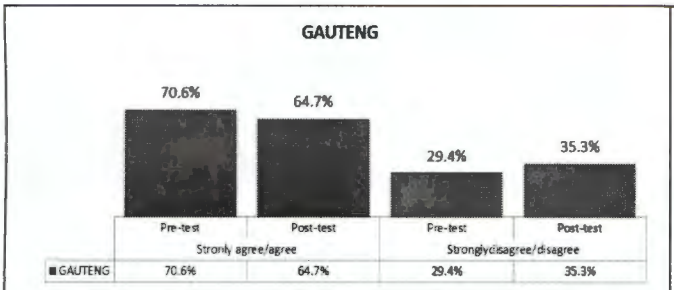


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	*diff*	*95% Confidence Interval*	
Mean	2.125	1.875	0.250	-0.267	0.767
Variance	1.33152174	0.98369565			
Observations	24	24			
Pearson Correlation	0.35615491				
Hypothesized Mean Difference	0				
df	23				
t Stat	1.000				
P(T<=t) one-tail	0.164				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.328				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

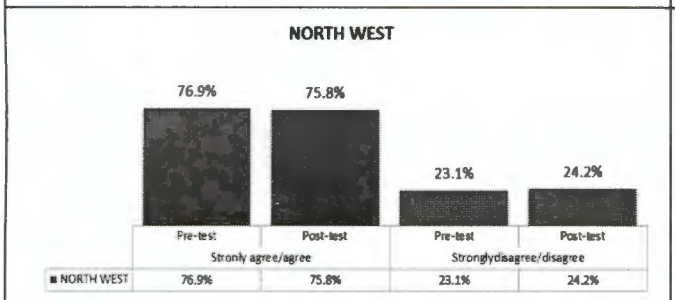
Graph 5.10: Different approaches to suit different cultural groups are used on this ward to manage patient aggression and violence

The majority of the respondents agreed that they use different approaches on the ward.

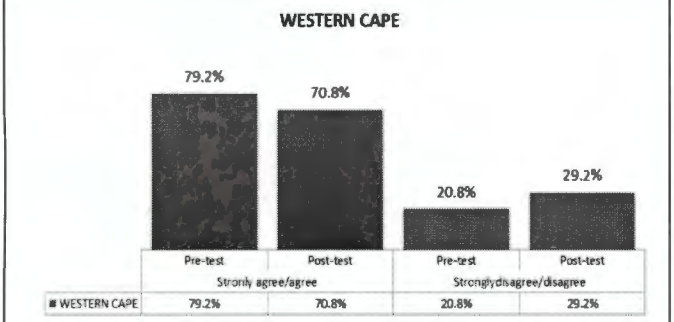
5.5.2.9 *Question nine (9). Patients who are aggressive towards staff should try to control their feelings*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ9	*POSTQ9*	diff	95% Confidence Interval	
Mean	2.05882353	2.35294118	-0.294	-0.691	0.103
Variance	0.55882353	0.49264706			
Observations	17	17			
Pearson Correlation	0.43442769				
Hypothesized Mean Difference	0				
df	16				
t Stat	-1.571				
P(T<=t) one-tail	0.068				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.136				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ9	*POSTQ9*	diff	95% Confidence Interval	
Mean	2.07692308	2.12087912	-0.044	-0.265	0.178
Variance	0.69401709	0.61855922			
Observations	91	91			
Pearson Correlation	0.13827519				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.394				
P(T<=t) one-tail	0.347				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.694				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

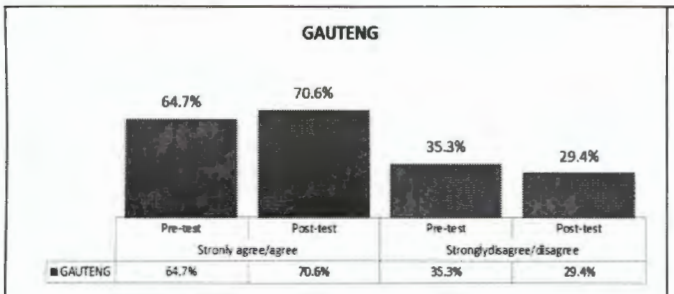


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ9	*POSTQ9*	diff	95% Confidence Interval	
Mean	1.875	2.125	-0.250	-0.561	0.061
Variance	0.72282609	0.46195652			
Observations	24	24			
Pearson Correlation	0.55490256				
Hypothesized Mean Difference	0				
df	23				
t Stat	-1.661				
P(T<=t) one-tail	0.055				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.110				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

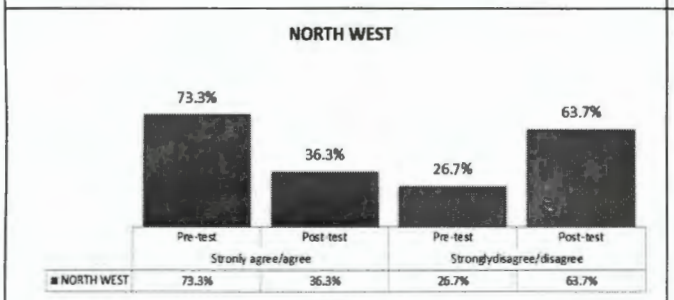
Graph 5.11: Patients who are aggressive should try and control their feelings

All respondents answered all questions. The majority of respondents were in agreement with this statement, that 70.6% for Gauteng, 76.9% for North West and 79.2% respondents felt that patients who are aggressive towards staff should try and control their feelings. This will be discussed in section.5.6.1.1

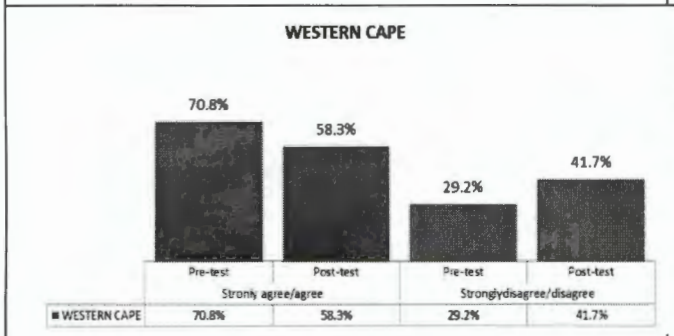
5.5.2.10 Question 10. When a patient is violent, seclusion is one of the most effective approaches to use



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	*diff*	*95% Confidence Interval*	
Mean	2.11764706	2	0.118	-0.191	0.426
Variance	0.86029412	0.625			
Observations	17	17			
Pearson Correlation	0.76711247				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.808				
P(T<=t) one-tail	0.215				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.431				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	*diff*	*95% Confidence Interval*	
Mean	1.98901099	2.76923077	-0.780	-1.022	-0.538
Variance	0.83321123	1.02393162			
Observations	91	91			
Pearson Correlation	0.27390049				
Hypothesized Mean Difference	0				
df	90				
t Stat	-6.403				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

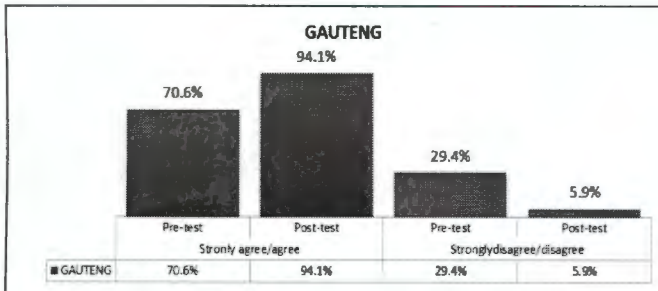


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	*diff*	*95% Confidence Interval*	
Mean	2.125	2.20833333	-0.083	-0.434	0.267
Variance	0.98369565	1.12862319			
Observations	24	24			
Pearson Correlation	0.67569174				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.492				
P(T<=t) one-tail	0.314				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.627				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

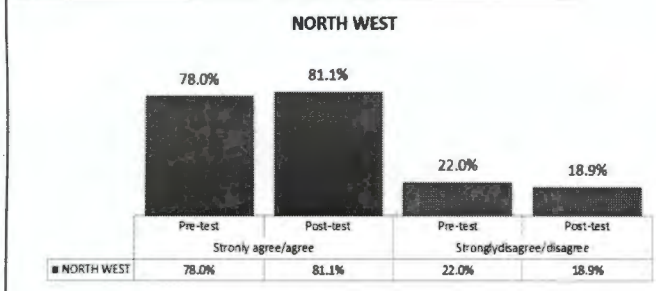
Graph 5.12: When a patient is violent, seclusion is one of the most effective approaches to use

All respondents answered this question and it is observed that the majority of the respondents held firm beliefs that this is one of the most effective methods to use.

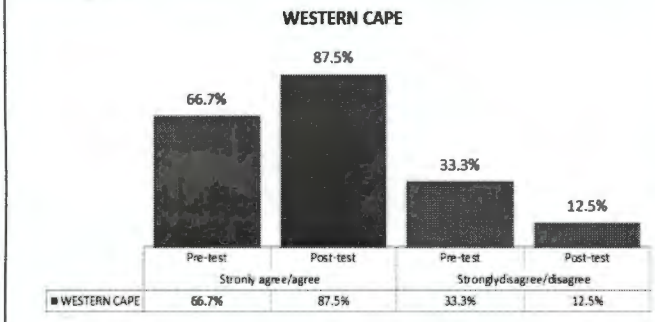
5.5.2.11 Question 11. Patients who are violent are often physically restrained to administer sedation



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	*diff*	*95% Confidence Interval*	
Mean	2.05882353	1.76470588	0.294	-0.179	0.767
Variance	0.55882353	0.31617647			
Observations	17	17			
Pearson Correlation	0.03498557				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.319				
P(T<=t) one-tail	0.103				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.206				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	*diff*	*95% Confidence Interval*	
Mean	1.98901099	1.92307692	0.066	-0.162	0.294
Variance	0.81098901	0.69401709			
Observations	91	91			
Pearson Correlation	0.20620545				
Hypothesized Mean Difference	0				
df	90				
t Stat	0.575				
P(T<=t) one-tail	0.283				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.567				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

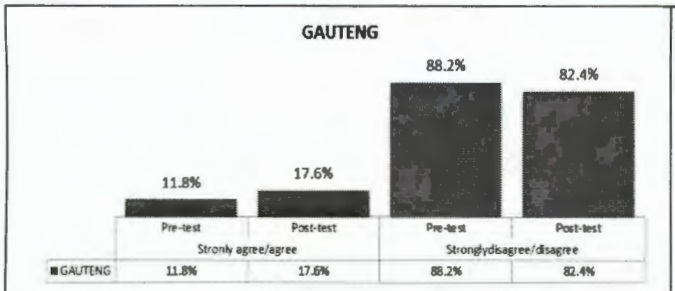


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	*diff*	*95% Confidence Interval*	
Mean	2.04166667	1.66666667	0.375	-0.088	0.838
Variance	1.34601449	0.84057971			
Observations	24	24			
Pearson Correlation	0.46325008				
Hypothesized Mean Difference	0				
df	23				
t Stat	1.676				
P(T<=t) one-tail	0.054				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.107				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

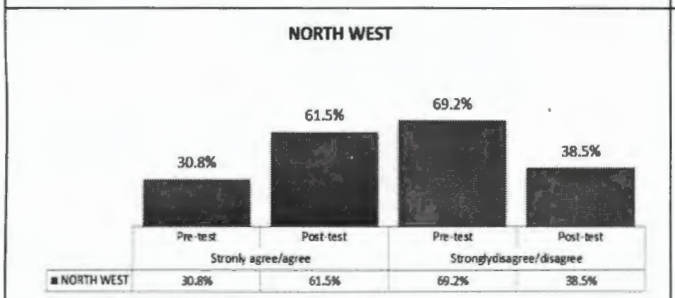
Graph 5.13: Patients who are violent are often physically restrained to administer sedation

All three groups agreed that they agree with this statement in both the pre-test and post-test.

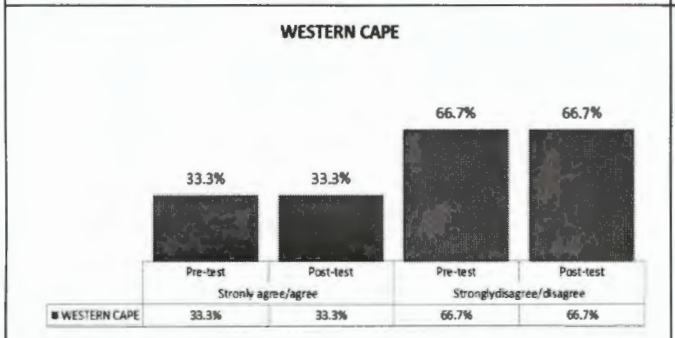
5.5.2.12 Question 12. The practice of secluding violent patients should be discontinued



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ12	*POSTQ12*	*diff*	*95% Confidence Interval*	
Mean	3.29411765	3.17647059	0.118	-0.191	0.426
Variance	0.47058824	0.52941176			
Observations	17	17			
Pearson Correlation	0.64081552				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.808				
P(T<=t) one-tail	0.215				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.431				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ12	*POSTQ12*	*diff*	*95% Confidence Interval*	
Mean	2.81318681	2.25274725	0.560	0.288	0.833
Variance	0.97582418	1.05763126			
Observations	91	91			
Pearson Correlation	0.15636533				
Hypothesized Mean Difference	0				
df	90				
t Stat	4.082				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.000				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

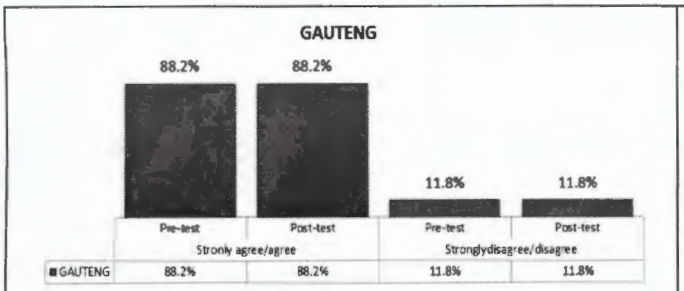


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ12	*POSTQ12*	*diff*	*95% Confidence Interval*	
Mean	2.875	2.79166667	0.083	-0.526	0.692
Variance	1.07065217	1.12862319			
Observations	24	24			
Pearson Correlation	0.05438463				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.283				
P(T<=t) one-tail	0.390				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.780				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

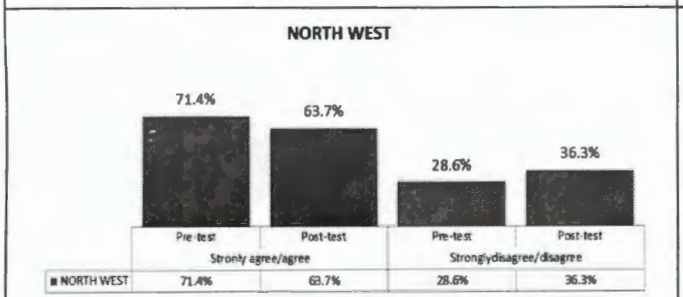
Graph 5.14: The practice of secluding violent patients should be discontinued

The question of whether seclusion must be discontinued was met with disagreement by a majority in Gauteng, North West and the Western Cape. Interestingly, the North West shows a decrease in disagreement on the post-test, which will be discussed in section 5.6.1.4.

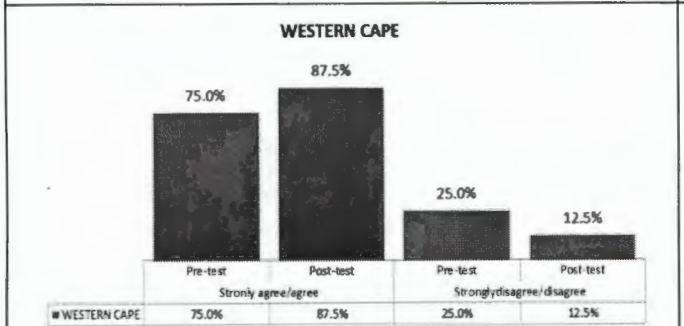
5.5.2.13 *Question 13. Medication is a valuable approach for treating aggressive and violent behaviour*



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean		1.94117647	1.94117647	0.000	-0.182	0.182
Variance		0.30882353	0.30882353			
Observations		17	17			
Pearson Correlation		0.79761905				
Hypothesized Mean Difference		0				
df		16				
t Stat		0.000				
P(T<=t) one-tail		0.500				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		1.000				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean		2.03296703	2.16483516	-0.132	-0.331	0.067
Variance		0.76556777	0.76141636			
Observations		91	91			
Pearson Correlation		0.40028934				
Hypothesized Mean Difference		0				
df		90				
t Stat		-1.315				
P(T<=t) one-tail		0.096				
T Critical one-tail		1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.192				
T Critical Two-tail		1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

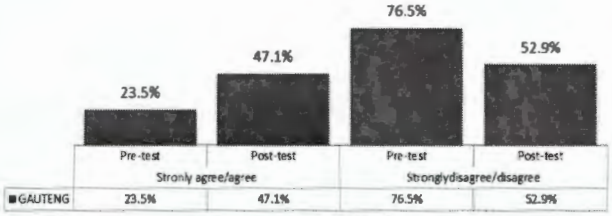


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean		1.83333333	1.66666667	0.167	-0.130	0.463
Variance		1.01449275	0.66666667			
Observations		24	24			
Pearson Correlation		0.72253006				
Hypothesized Mean Difference		0				
df		23				
t Stat		1.163				
P(T<=t) one-tail		0.128				
T Critical one-tail		1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.257				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

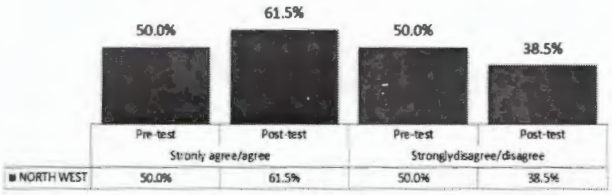
Graph 5.15: Medication is a valuable approach for treating aggressive and violent behaviour

On the whole, all three (3) experimental groups agreed that medicines are a valuable approach to managing behaviour.

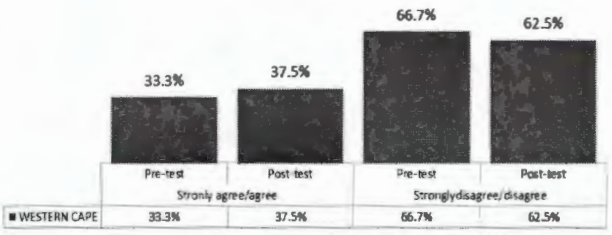
5.5.2.14 Question 14. Aggressive patients will calm down automatically if left alone



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean		2.82352941	2.58823529	0.235	-0.152	0.622
Variance		0.52941176	0.88235294			
Observations		17	17			
Pearson Correlation		0.61860151				
Hypothesized Mean Difference		0				
df		16				
t Stat		1.289				
P(T<=t) one-tail		0.108				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.216				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean		2.53846154	2.24175824	0.297	0.034	0.559
Variance		0.8957265	0.91868132			
Observations		91	91			
Pearson Correlation		0.12437065				
Hypothesized Mean Difference		0				
df		90				
t Stat		2.245				
P(T<=t) one-tail		0.014				
T Critical one-tail		1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.027				
T Critical Two-tail		1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)						

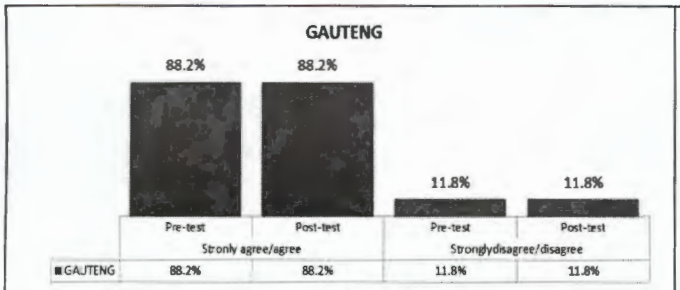


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean		2.91666667	2.625	0.292	-0.165	0.749
Variance		0.94927536	0.76630435			
Observations		24	24			
Pearson Correlation		0.31860709				
Hypothesized Mean Difference		0				
df		23				
t Stat		1.320				
P(T<=t) one-tail		0.100				
T Critical one-tail		1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.200				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

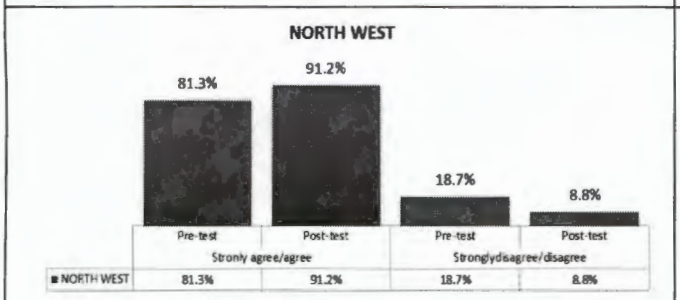
Graph 5.16: Aggressive patients will calm down automatically if left alone

All respondents answered this question and across all three groups there were overwhelming disagreements with this statement. Notably, after the training programme there were changes in attitudes observed, with Gauteng registering decreasing disagreement from 76.5% to 52.9%, North West from 50% to 38.5% and Western Cape 66.7% to 62.5%.

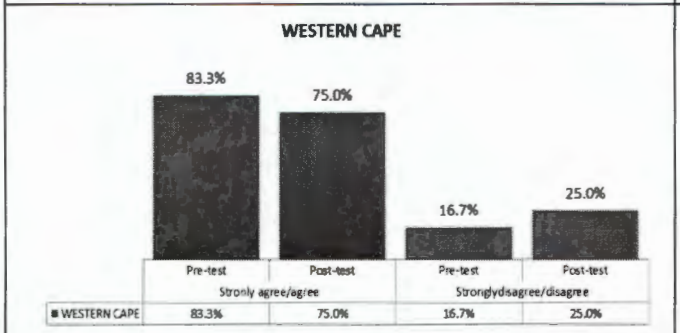
5.5.2.15 *Question 15. The use of negotiation could be used more effectively when managing aggression and violence*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ15	*POSTQ15*	*diff*	*95% Confidence Interval*	
Mean	1.64705882	1.64705882	0.000	-0.257	0.257
Variance	0.49264706	0.49264706			
Observations	17	17			
Pearson Correlation	0.74626866				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ15	*POSTQ15*	*diff*	*95% Confidence Interval*	
Mean	1.92307692	1.65934066	0.264	0.054	0.474
Variance	0.76068376	0.49377289			
Observations	91	91			
Pearson Correlation	0.19245426				
Hypothesized Mean Difference	0				
df	90				
t Stat	2.493				
P(T<=t) one-tail	0.007				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.015				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

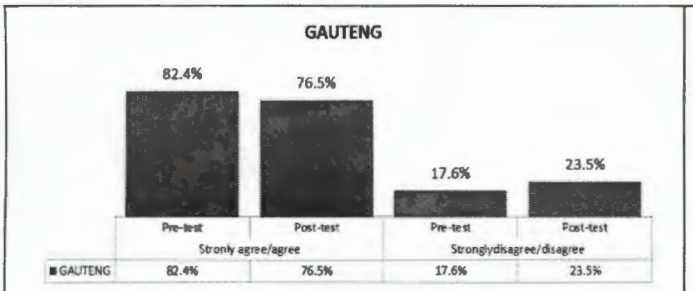


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ15	*POSTQ15*	*diff*	*95% Confidence Interval*	
Mean	1.91666667	2	-0.083	-0.653	0.486
Variance	0.94927536	1.39130435			
Observations	24	24			
Pearson Correlation	0.22699497				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.303				
P(T<=t) one-tail	0.382				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.765				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

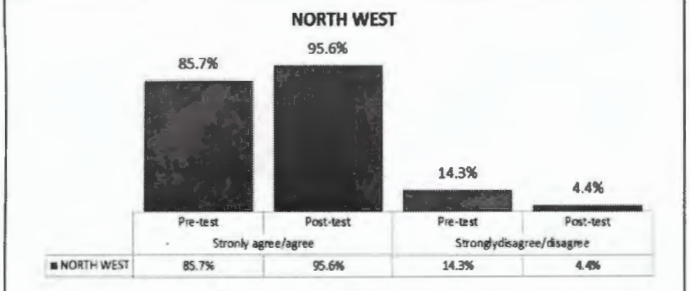
Graph 5.17: The use of negotiation could be used more effectively when managing aggression and violence

There was consensus in all groups as all respondents agreed with this statement.

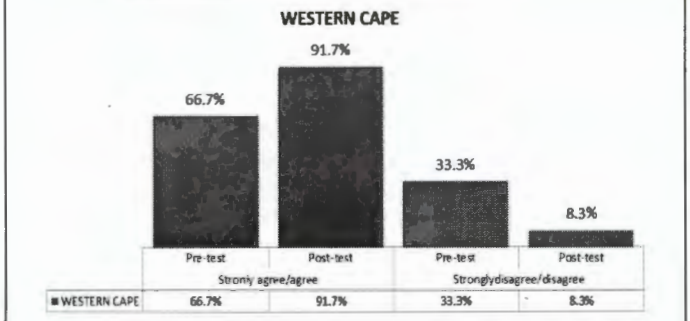
5.5.2.16 Question 16. Restrictive care environments can contribute towards patient aggression and violence



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16		*POSTQ16*	*diff*	*95% Confidence Interval*	
Mean	2		2.11764706	-0.118	-0.519	0.284
Variance	0.375		0.61029412			
Observations	17		17			
Pearson Correlation	0.3919368					
Hypothesized Mean Difference	0					
df	16					
t Stat	-0.621					
P(T<=t) one-tail	0.272					
T Critical one-tail	1.746					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.543					
T Critical Two-tail	2.120					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16		*POSTQ16*	*diff*	*95% Confidence Interval*	
Mean	1.83516484		1.56043956	0.275	0.057	0.492
Variance	0.60586081		0.38241758			
Observations	91		91			
Pearson Correlation	-0.10603202					
Hypothesized Mean Difference	0					
df	90					
t Stat	2.510					
P(T<=t) one-tail	0.007					
T Critical one-tail	1.662					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.014					
T Critical Two-tail	1.987					
Reject Null Hypothesis because p < 0.05 (Means are Different)						

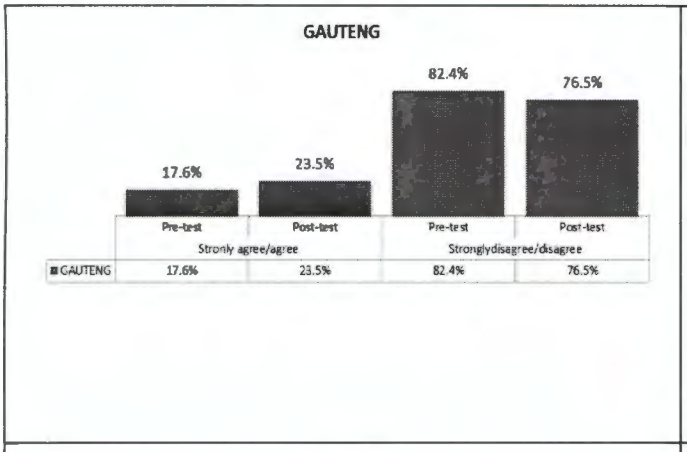


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16		*POSTQ16*	*diff*	*95% Confidence Interval*	
Mean	2.125		1.5	0.625	0.162	1.088
Variance	0.89673913		0.60869565			
Observations	24		24			
Pearson Correlation	0.20597146					
Hypothesized Mean Difference	0					
df	23					
t Stat	2.794					
P(T<=t) one-tail	0.005					
T Critical one-tail	1.714					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.010					
T Critical Two-tail	2.069					
Reject Null Hypothesis because p < 0.05 (Means are Different)						

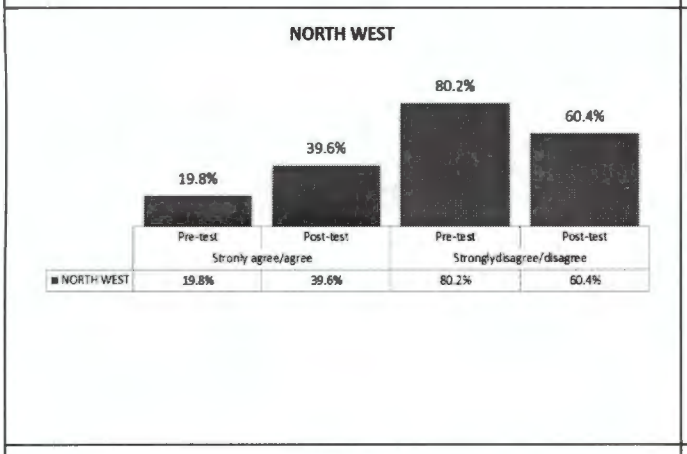
Graph 5.18: Restrictive care environments can contribute towards patient aggression and violence

All respondents answered this question and the majority of the respondents agreed with this statement, that is 82.4% for Gauteng, 85.7% for North West and 66.7% for Western Cape.

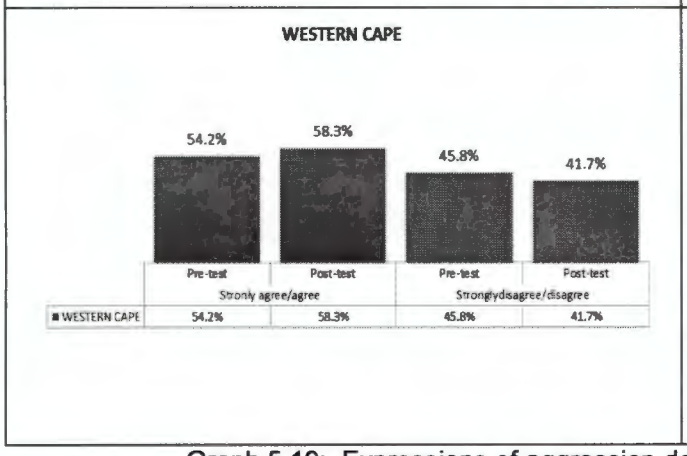
5.5.2.17 Question 17. Expression of aggression does not always require staff intervention



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ17	*POSTQ17*	*diff*	*95% Confidence Interval*	
Mean	3.05882353	3	0.059	-0.227	0.345
Variance	0.43382353	0.5			
Observations	17	17			
Pearson Correlation	0.67097829				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.436				
P(T<=t) one-tail	0.334				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.668				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ17	*POSTQ17*	*diff*	*95% Confidence Interval*	
Mean	3.13186813	2.74725275	0.385	0.143	0.627
Variance	0.6046398	0.94652015			
Observations	91	91			
Pearson Correlation	0.13267058				
Hypothesized Mean Difference	0				
df	90				
t Stat	3.157				
P(T<=t) one-tail	0.001				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.002				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

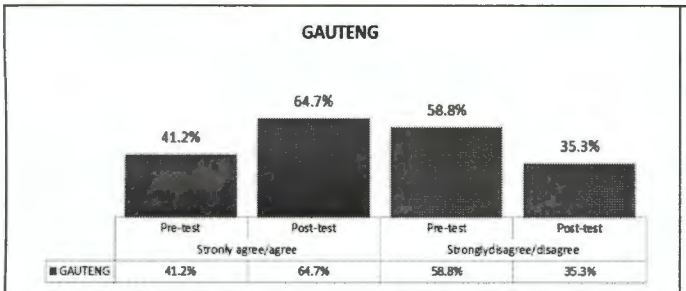


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ17	*POSTQ17*	*diff*	*95% Confidence Interval*	
Mean	2.45833333	2.29166667	0.167	-0.386	0.719
Variance	1.12862319	0.65036232			
Observations	24	24			
Pearson Correlation	0.0401756				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.624				
P(T<=t) one-tail	0.269				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.539				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

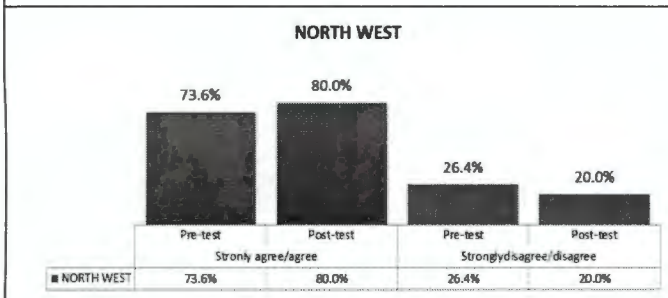
Graph 5.19: Expressions of aggression do not always require staff intervention

The majority of respondents did not agree with the statement and felt that patient aggression requires staff attention. In Gauteng, 82.4% of respondents did not agree with this statement, Whilst in North West 80.2% and in the Western Cape 45.8% did not agree with his statement.

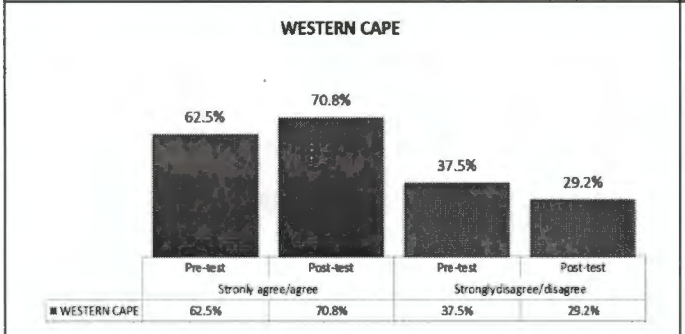
5.5.2.18 Question 18. Physical restraint is sometimes used more than necessary



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	2.70588235	2.41176471	0.294	-0.059	0.647
Variance	0.72058824	0.38235294			
Observations	17	17			
Pearson Correlation	0.6023567				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.768				
P(T<=t) one-tail	0.048				
T Critical one-tail	1.746				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.096				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	1.95604396	1.87912088	0.077	-0.150	0.303
Variance	0.84249084	0.81855922			
Observations	91	91			
Pearson Correlation	0.28788639				
Hypothesized Mean Difference	0				
df	90				
t Stat	0.675				
P(T<=t) one-tail	0.251				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.502				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

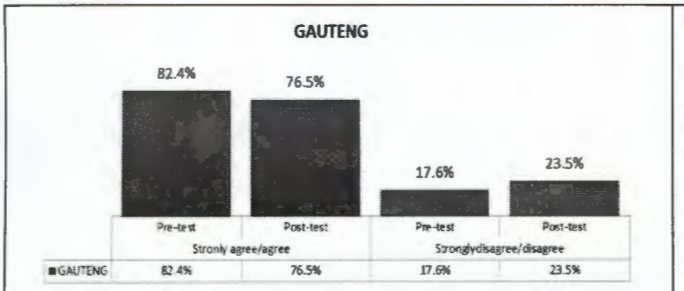


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	2.29166667	2.08333333	0.208	-0.257	0.674
Variance	0.5634058	1.03623188			
Observations	24	24			
Pearson Correlation	0.25132035				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.926				
P(T<=t) one-tail	0.182				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.364				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

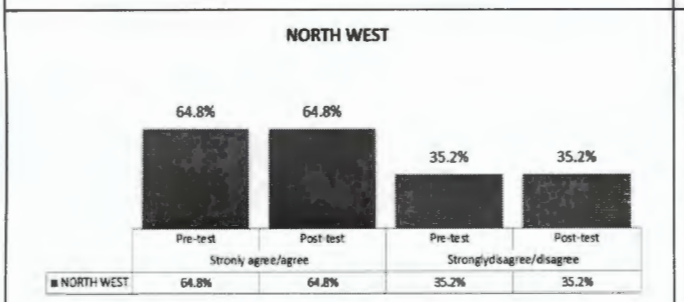
Graph 5.20: Physical restraint is sometimes used more than necessary

All the respondents agreed with this statement and there is an increase in agreement with this statement observable in the post-test. In Gauteng, agreement increased from 41.2% to 64.7%, as in North West it increased from 73.6% to 80% and the Western Cape from 62.5% to 70.8%

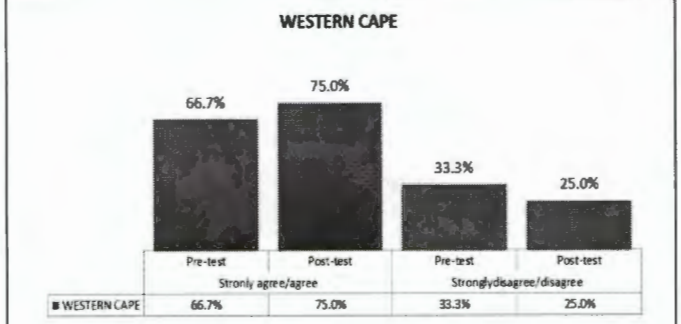
5.5.2.19 Question 19. Alternatives to the use of containment and sedation to manage violence could be used more frequently



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	2.05882353	2.23529412	-0.176	-0.630	0.277
Variance	0.55882353	0.19117647			
Observations	17	17			
Pearson Correlation	-0.04499213				
Hypothesized Mean Difference	0				
df	16				
t Stat	-0.824				
P(T<=t) one-tail	0.211				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.422				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	2.14285714	2.1978022	-0.055	-0.273	0.163
Variance	0.81269841	0.69377289			
Observations	91	91			
Pearson Correlation	0.27269413				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.500				
P(T<=t) one-tail	0.309				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.618				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

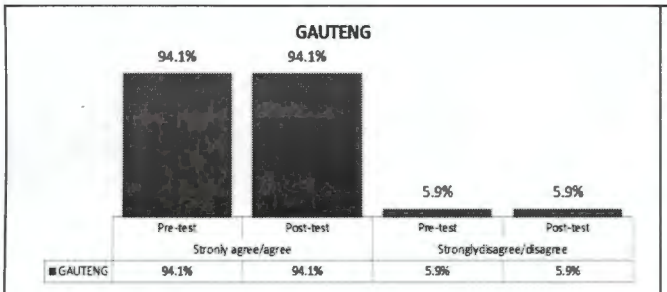


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	2.25	2.125	0.125	-0.393	0.643
Variance	0.7173913	1.07065217			
Observations	24	24			
Pearson Correlation	0.16123275				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.499				
P(T<=t) one-tail	0.311				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.622				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

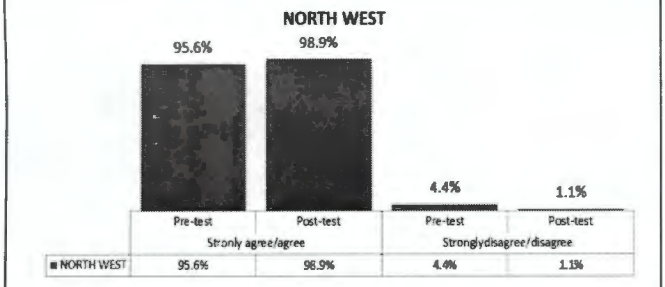
Graph 5.21: Alternatives to the use of containment and sedation to manage patient violence could be used more frequently

This question was answered by all respondents and it met with an overwhelming majority agreeing with this submission during both the pre-test and the post-test. Gauteng is the only group which showed a very slight decrease in agreement with the statement during the post-test.

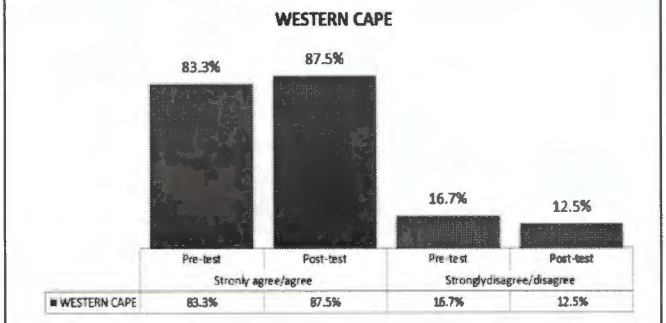
5.5.2.20 Question 20. Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	1.58823529	1.58823529	0.000	-0.257	0.257
Variance	0.63235294	0.63235294			
Observations	17	17			
Pearson Correlation	0.80232558				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	1.38461538	1.23076923	0.154	0.008	0.299
Variance	0.41709402	0.24615385			
Observations	91	91			
Pearson Correlation	0.2747458				
Hypothesized Mean Difference	0				
df	90				
t Stat	2.103				
P(T<=t) one-tail	0.019				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.038				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

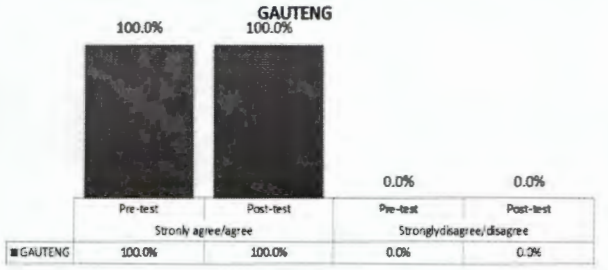


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	1.75	1.58333333	0.167	-0.399	0.733
Variance	1.06521739	1.03623188			
Observations	24	24			
Pearson Correlation	0.14484136				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.609				
P(T<=t) one-tail	0.274				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.548				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

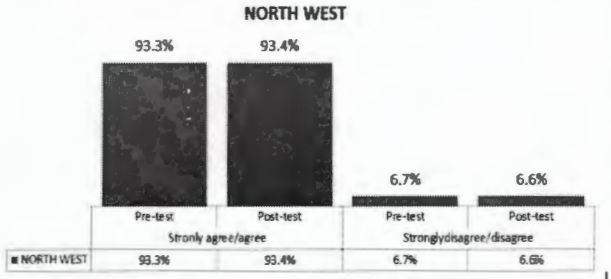
Graph 5.22: Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence

All experimental groups showed an overwhelming agreement with this statement and the post test for North West and Western Cape shows a 4% increase in agreement.

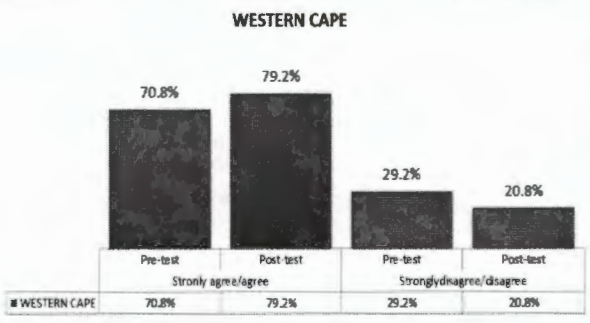
5.5.2.21 Question 21. Patient aggression could be handled more effectively on this ward



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*		
Mean	1.76470588	1.58823529	0.176	-0.095	0.448	
Variance	0.19117647	0.25735294				
Observations	17	17				
Pearson Correlation	0.38122129					
Hypothesized Mean Difference	0					
df	16					
t Stat	1.376					
P(T<=t) one-tail	0.094					
T Critical one-tail	1.746					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.188					
T Critical Two-tail	2.120					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*		
Mean	1.78021978	1.52747253	0.253	0.108	0.397	
Variance	0.46227106	0.42979243				
Observations	91	91				
Pearson Correlation	0.46239253					
Hypothesized Mean Difference	0					
df	90					
t Stat	3.481					
P(T<=t) one-tail	0.000					
T Critical one-tail	1.662					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.001					
T Critical Two-tail	1.987					
Reject Null Hypothesis because p < 0.05 (Means are Different)						

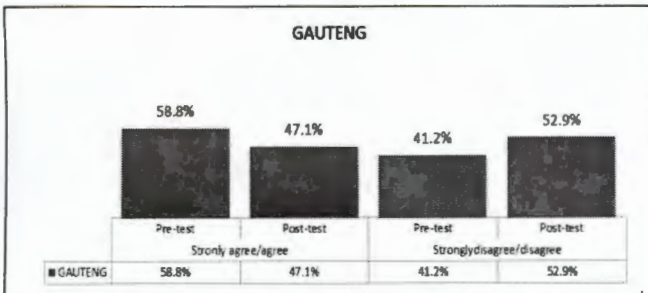


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*		
Mean	2	1.91666667	0.083	-0.309	0.475	
Variance	0.60869565	0.86231884				
Observations	24	24				
Pearson Correlation	0.42008403					
Hypothesized Mean Difference	0					
df	23					
t Stat	0.440					
P(T<=t) one-tail	0.332					
T Critical one-tail	1.714					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.664					
T Critical Two-tail	2.069					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

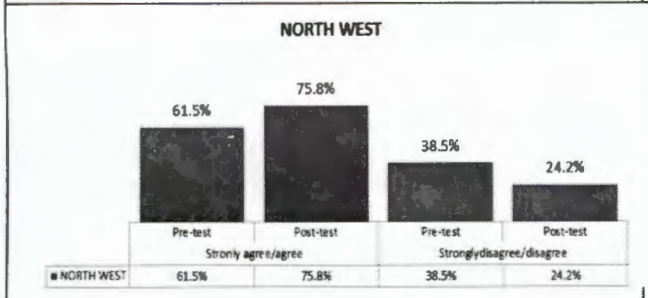
Graph 5.23: Patient aggression could be handled more effectively on this ward

There was a 100% agreement with this statement by Gauteng in both the pre-test and the post-test. North West had a 93.3% agreement in the pre-test and a 93.4% agreement in the post-test. Western Cape had a 70.8% agreement in the pre-test and a 79.2% agreement with the statement on the post-test.

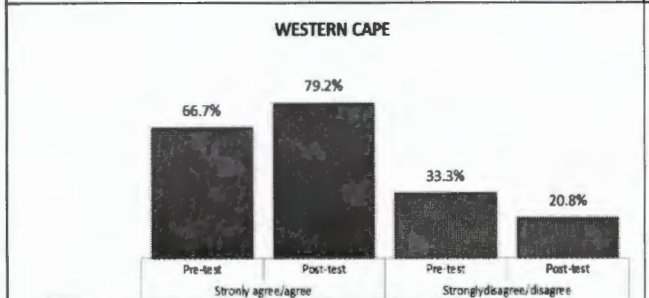
5.5.2.22 Question 22. Prescribed medication can in some instances lead to patient aggression and violence



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ22	*POSTQ22*	diff	95% Confidence Interval	
Mean		2.41176471	2.58823529	-0.176	-0.592	0.239
Variance		1.00735294	0.63235294			
Observations		17	17			
Pearson Correlation		0.61725596				
Hypothesized Mean Difference		0				
df		16				
t Stat		-0.899				
P(T<=t) one-tail		0.191				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.382				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ22	*POSTQ22*	diff	95% Confidence Interval	
Mean		2.27472527	2.02197802	0.253	0.036	0.469
Variance		0.82368742	0.84395604			
Observations		91	91			
Pearson Correlation		0.35249345				
Hypothesized Mean Difference		0				
df		90				
t Stat		2.320				
P(T<=t) one-tail		0.011				
T Critical one-tail		1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.023				
T Critical Two-tail		1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)						

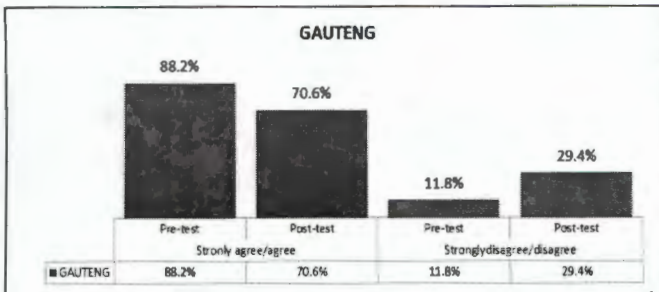


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ22	*POSTQ22*	diff	95% Confidence Interval	
Mean		2.29166667	1.91666667	0.375	-0.245	0.995
Variance		0.82427536	1.03623188			
Observations		24	24			
Pearson Correlation		-0.16073488				
Hypothesized Mean Difference		0				
df		23				
t Stat		1.251				
P(T<=t) one-tail		0.112				
T Critical one-tail		1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.224				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

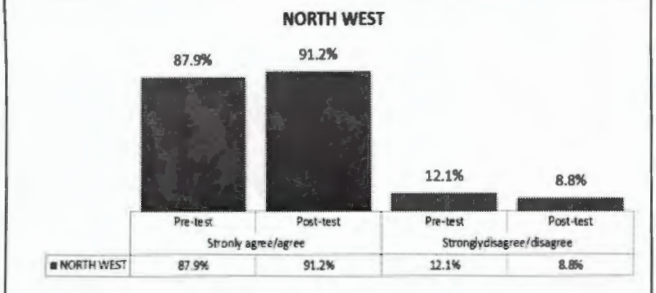
Graph 5.24: Prescribed medications can in some instances lead to patient aggression and violence

All experimental groups showed a majority agreement with this statement which increased after the training programmes, with Gauteng being the exception to the rule.

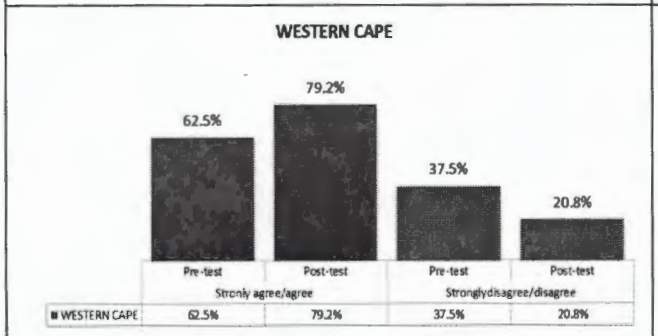
5.5.2.23 *Question 23. It is largely situations that contribute towards the expression of aggression by patients*



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean		1.88235294	2.23529412	-0.353	-0.796	0.090
Variance		0.36029412	0.56617647			
Observations		17	17			
Pearson Correlation		0.20350103				
Hypothesized Mean Difference		0				
df		16				
t Stat		-1.689				
P(T<=t) one-tail		0.055				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.111				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean		1.73626374	1.69230769	0.044	-0.131	0.219
Variance		0.48522589	0.48205128			
Observations		91	91			
Pearson Correlation		0.26685324				
Hypothesized Mean Difference		0				
df		90				
t Stat		0.498				
P(T<=t) one-tail		0.310				
T Critical one-tail		1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.620				
T Critical Two-tail		1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

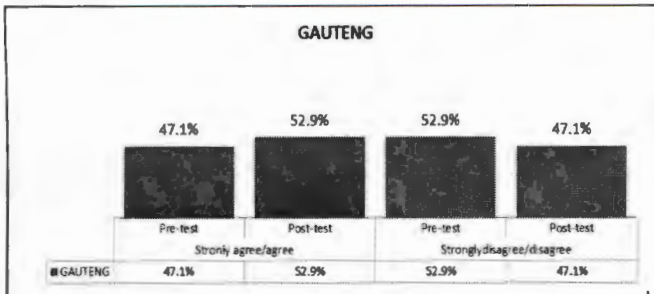


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean		2.16666667	1.875	0.292	-0.111	0.695
Variance		0.57971014	0.72282609			
Observations		24	24			
Pearson Correlation		0.30224722				
Hypothesized Mean Difference		0				
df		23				
t Stat		1.497				
P(T<=t) one-tail		0.074				
T Critical one-tail		1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.148				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

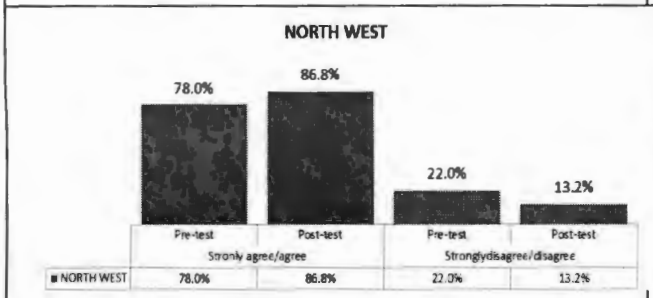
Graph 5.25: It is largely situations that contribute towards the expression of aggression by patients

All three experimental groups agreed with this statement in both the pre-test and the post-test and the null hypothesis (H_0) could not be rejected for any of the three experimental groups. Therefore, it is evident that the training programme had no statistically significant impact on any of the experimental groups.

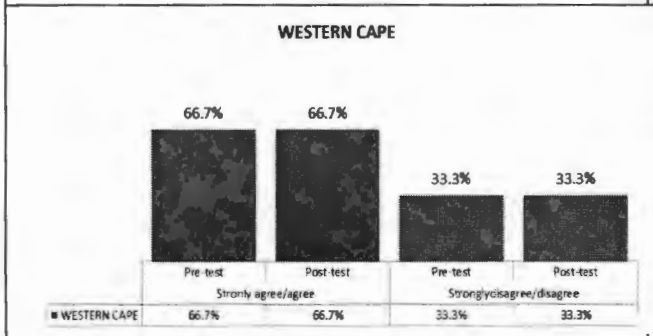
5.5.2.24 Question 24. Seclusion is sometimes used more than necessary



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ24	POSTQ24	diff	95% Confidence Interval	
Mean		2.52941176	2.58823529	-0.059	-0.484	0.366
Variance		0.51470588	0.75735294			
Observations		17	17			
Pearson Correlation		0.4710775				
Hypothesized Mean Difference		0				
df		16				
t Stat		-0.293				
P(T<=t) one-tail		0.387				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.773				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ24	POSTQ24	diff	95% Confidence Interval	
Mean		1.93406593	1.62637363	0.308	0.107	0.508
Variance		0.81782662	0.59218559			
Observations		91	91			
Pearson Correlation		0.34739355				
Hypothesized Mean Difference		0				
df		90				
t Stat		3.049				
P(T<=t) one-tail		0.002				
T Critical one-tail		1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.003				
T Critical Two-tail		1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)						

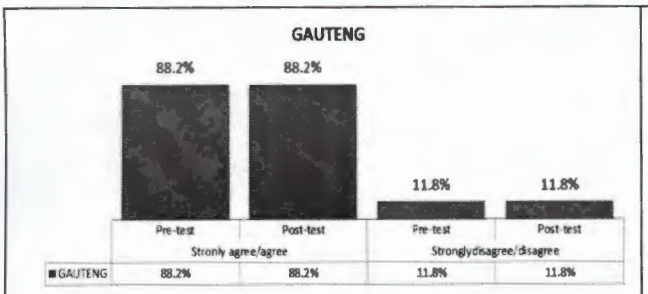


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ24	POSTQ24	diff	95% Confidence Interval	
Mean		2.125	2.25	-0.125	-0.612	0.362
Variance		0.89673913	1.23913043			
Observations		24	24			
Pearson Correlation		0.38152441				
Hypothesized Mean Difference		0				
df		23				
t Stat		-0.531				
P(T<=t) one-tail		0.300				
T Critical one-tail		1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.601				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

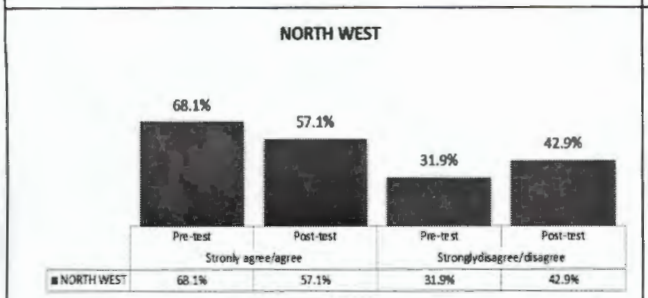
Graph 5.26: Seclusion is sometimes used more than necessary

The majority of all respondents agreed with this statement. All respondents answered this question.

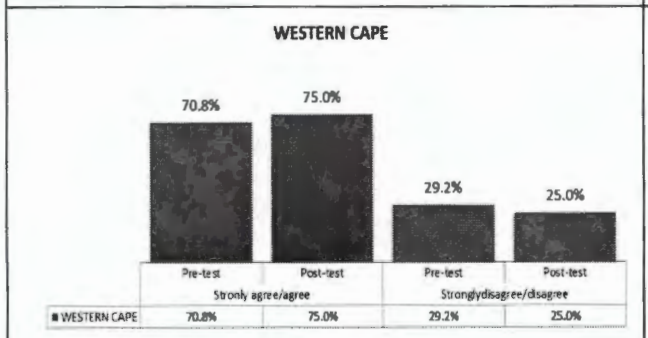
5.5.2.25 Question 25. Prescribed medication should be used more frequently to help patients who are aggressive and violent



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ25	*POSTQ25*	*diff*	*95% Confidence Interval*	
Mean	1.82352941	2	-0.176	-0.379	0.026
Variance	0.65441176	0.5			
Observations	17	17			
Pearson Correlation	0.87409664				
Hypothesized Mean Difference	0				
df	16				
t Stat	-1.852				
P(T<=t) one-tail	0.041				
T Critical one-tail	1.746				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.083				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ25	*POSTQ25*	*diff*	*95% Confidence Interval*	
Mean	2.10989011	2.21978022	-0.110	-0.333	0.113
Variance	0.8989011	0.81782662			
Observations	91	91			
Pearson Correlation	0.33437024				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.980				
P(T<=t) one-tail	0.165				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.330				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

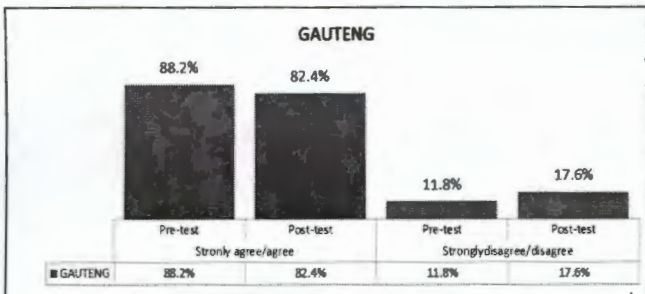


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ25	*POSTQ25*	*diff*	*95% Confidence Interval*	
Mean	2.08333333	1.91666667	0.167	-0.326	0.660
Variance	0.86231884	0.77536232			
Observations	24	24			
Pearson Correlation	0.16837912				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.700				
P(T<=t) one-tail	0.246				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.491				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

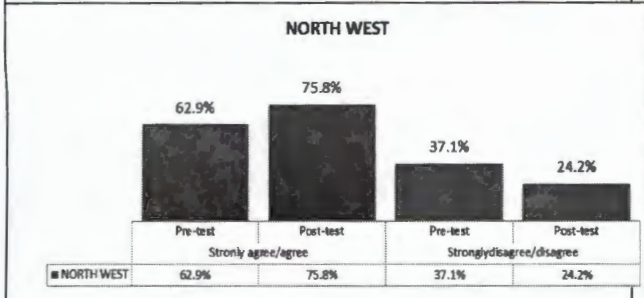
Graph 5.27: Prescribed medication should be used more frequently to help patients who are aggressive and violent

All three experimental groups agreed with this statement in both the pre-test and the post-test and the null hypothesis (H_0) could not be rejected for any of the three experimental groups. Therefore, it is evident that the training programme had no statistically significant impact on any of the experimental groups.

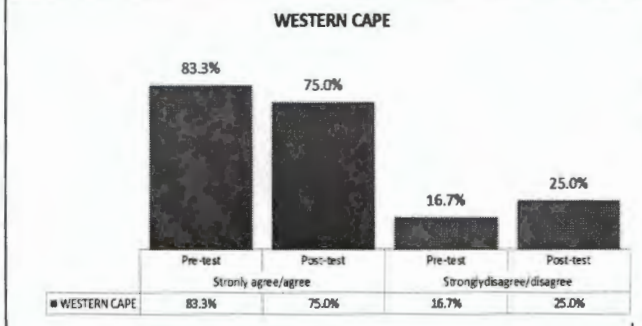
5.5.2.26 Question 26.The use of de-escalation is successful in preventing violence



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ26	*POSTQ26*	diff	95% Confidence Interval	
Mean	1.94117647	1.94117647	0.000	-0.406	0.406
Variance	0.30882353	0.68382353			
Observations	17	17			
Pearson Correlation	0.4000128				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ26	*POSTQ26*	diff	95% Confidence Interval	
Mean	2.13186813	1.96703297	0.165	-0.068	0.398
Variance	0.62686203	0.6989011			
Observations	91	91			
Pearson Correlation	0.05700077				
Hypothesized Mean Difference	0				
df	90				
t Stat	1.406				
P(T<=t) one-tail	0.082				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.163				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

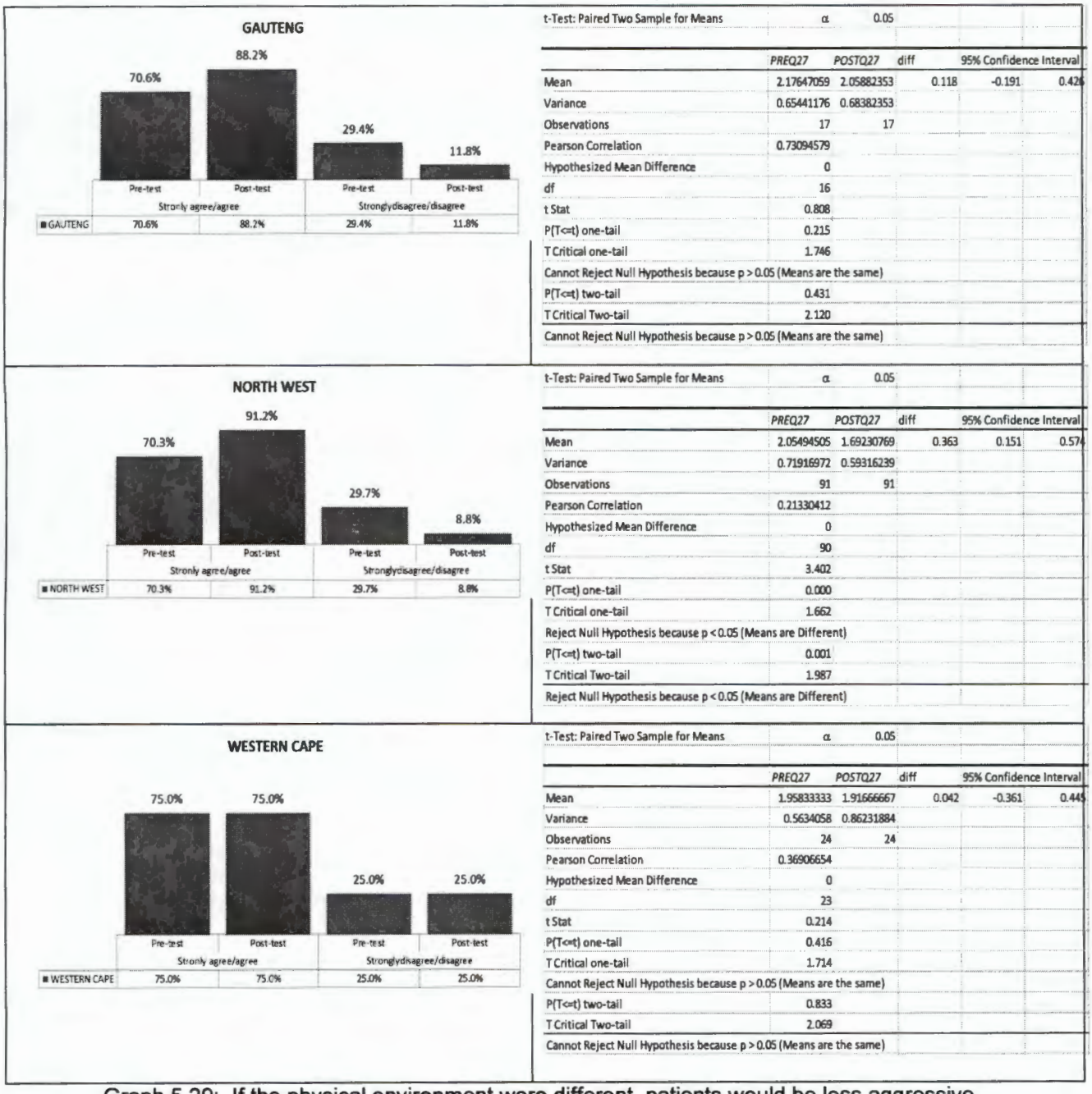


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ26	*POSTQ26*	diff	95% Confidence Interval	
Mean	1.83333333	1.875	-0.042	-0.464	0.380
Variance	0.49275362	0.80978261			
Observations	24	24			
Pearson Correlation	0.24090237				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.204				
P(T<=t) one-tail	0.420				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.840				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

Graph 5.28: The use of de-escalation is successful in preventing violence

All three experimental groups agreed with this statement in both the pretest and the posttest and the null hypothesis (H_0) could not be rejected for any of the three experimental groups. Therefore, it is evident that the training programme had no statistically significant impact on any of the experimental groups.

5.5.2.27 *Question 27. If the physical environment were different, patients would be less aggressive*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ27	*POSTQ27*	diff	95% Confidence Interval	
Mean	2.17647059	2.05882353	0.118	-0.191	0.426
Variance	0.65441176	0.68382353			
Observations	17	17			
Pearson Correlation	0.73094579				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.808				
P(T<=t) one-tail	0.215				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.431				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

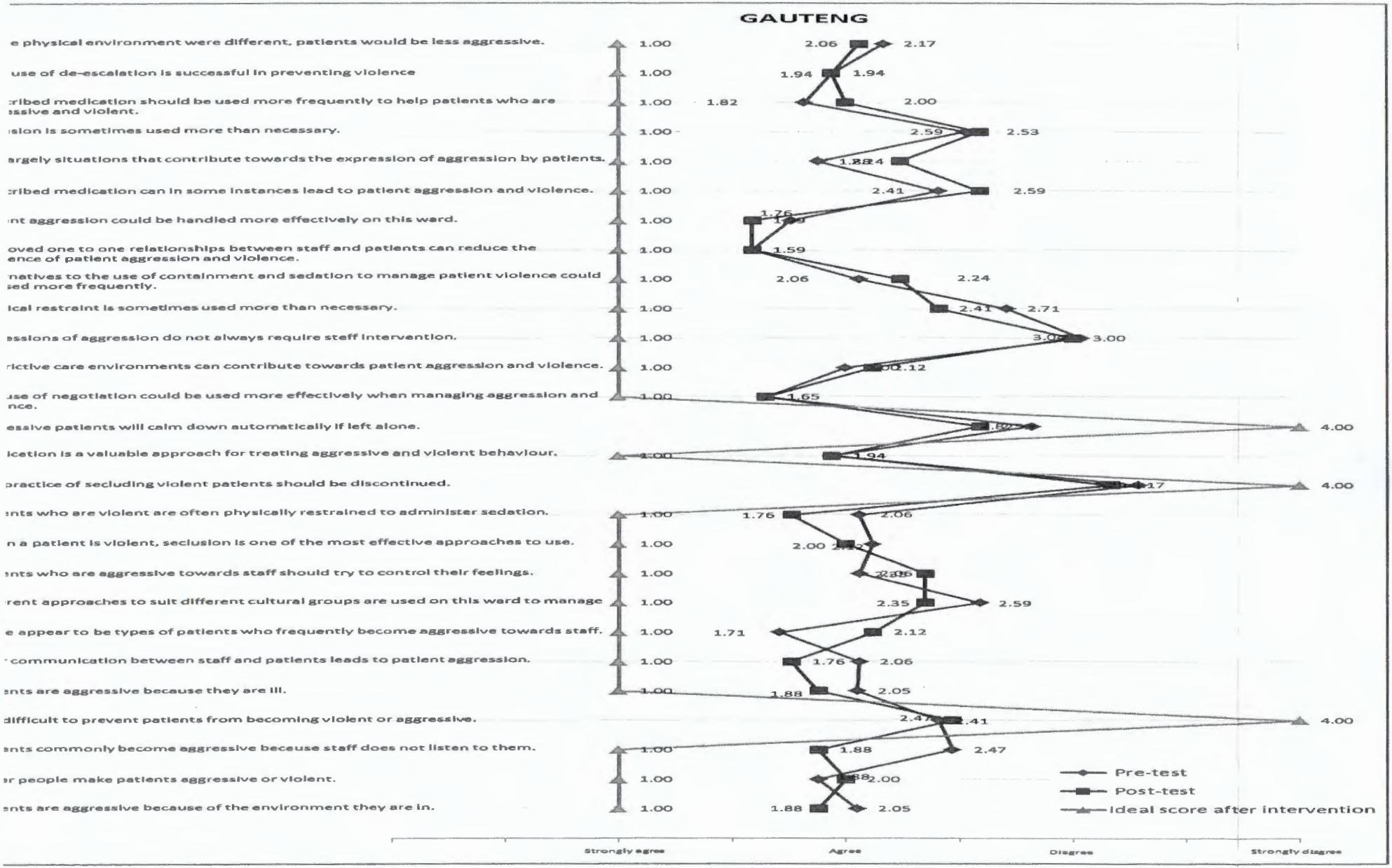
t-Test: Paired Two Sample for Means		α	0.05		
	PREQ27	*POSTQ27*	diff	95% Confidence Interval	
Mean	2.05494505	1.69230769	0.363	0.151	0.574
Variance	0.71916972	0.59316239			
Observations	91	91			
Pearson Correlation	0.21330412				
Hypothesized Mean Difference	0				
df	90				
t Stat	3.402				
P(T<=t) one-tail	0.000				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.001				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

t-Test: Paired Two Sample for Means		α	0.05		
	PREQ27	*POSTQ27*	diff	95% Confidence Interval	
Mean	1.95833333	1.91666667	0.042	-0.361	0.445
Variance	0.5634058	0.86231884			
Observations	24	24			
Pearson Correlation	0.36906654				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.214				
P(T<=t) one-tail	0.416				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.833				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

Graph 5.29: If the physical environment were different, patients would be less aggressive

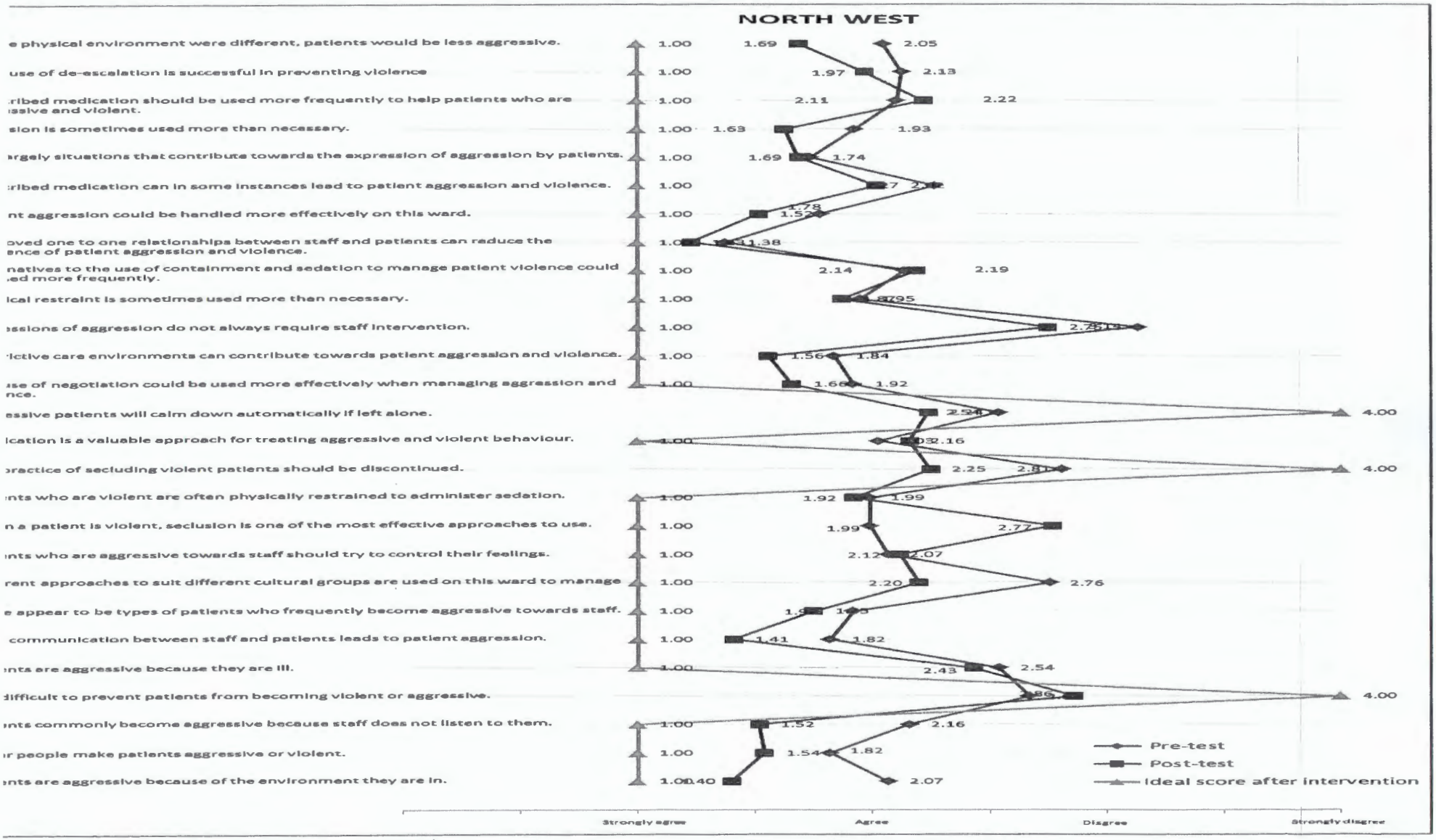
All three experimental groups strongly agree with this statement, and this agreement increased after training programmes. For Gauteng, we observe an increase from 70.6% to 88.2%, whilst North West registers an increase from 70.3 % to 91.2% with the Western Cape having the exact pre- and post-test agreement at 75.

The following three (3) graphs display the overall view of mean scores pre- and post-test per statement compared to the expected mean. It makes a visual representation of how the treatment intervention impacted on the respondents.



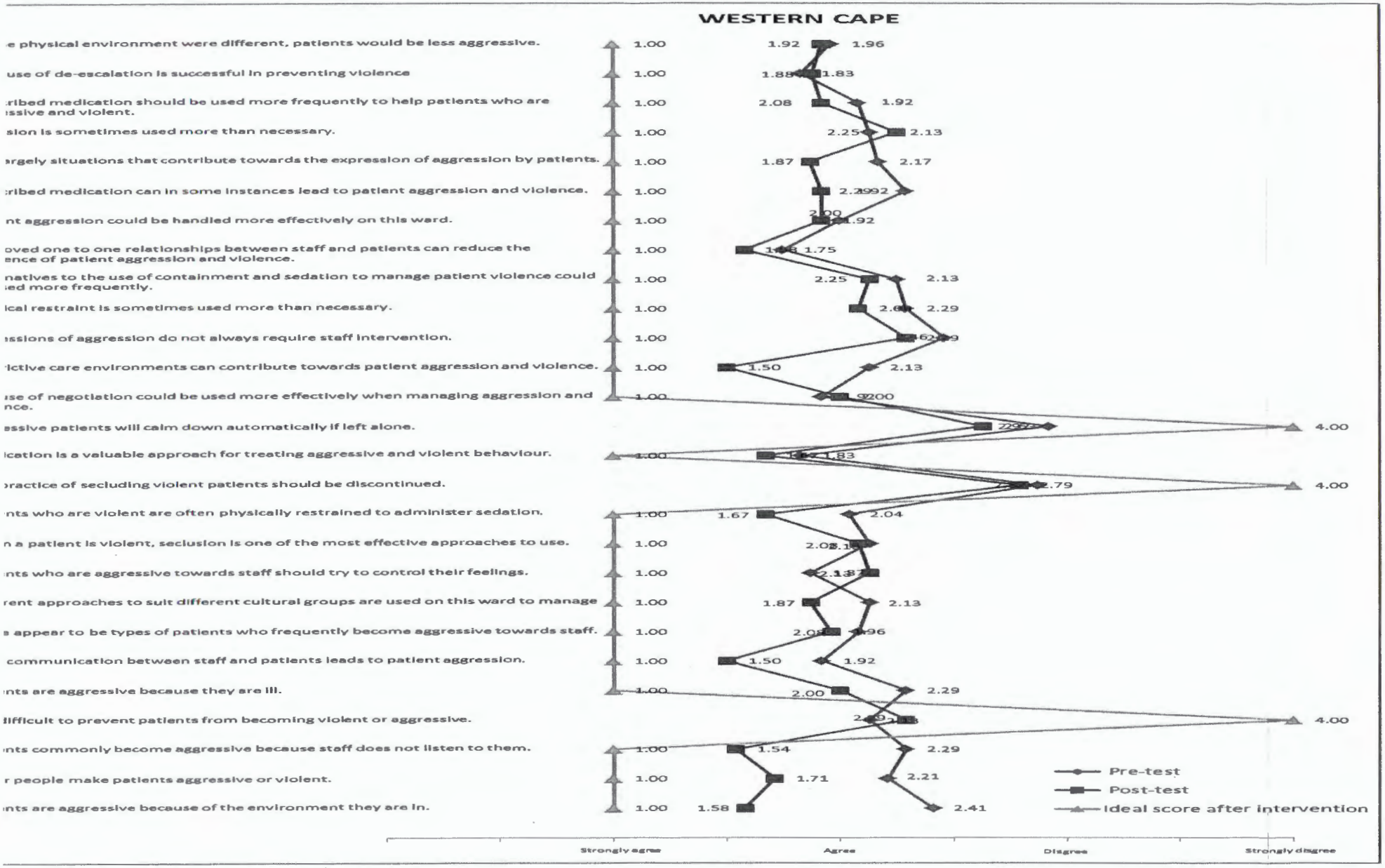
0 Overall graph for Gauteng

In the Gauteng experimental group where the respondents had training on theories of aggression and cultural sensitivity prior to the post-test, it shows that there is an improved agreement with the statements around accepting that patients could be treated more effectively, that poor communication and staff not listening to patients contribute to patient related aggression. An interesting manifestation is that during the post-test, the respondents more readily agreed with the statement that patients are often restrained to administer medication.



I Overall graph for North West

The experimental group from the North West Province included Psychiatric Nursing students in their third and fourth years of training. The North West experimental group had training only in cultural sensitivity and awareness prior to the posttest. This observation is quite interesting because it seems as though the either cultural sensitivity questionnaire or the MAVAS questionnaire played a role in their attitudes.



Overall graph for Western Cape

The experimental group from the Western Cape underwent the total training programme before the post-test. When looking at the results from the Western Cape, there is a more observable change in attitudes on certain of the responses on the MAVAS questionnaire. With specific reference to the pre-test and the post-test scores, more respondents were in agreement with the involvement of the environment and poor communication as possible causes for mental health care user related violence.

Both Gauteng and the Western Cape experimental groups more readily admitted to the use of physical restraint to administer medication. This response is not visible in the North West experimental group and the researcher attributes this to the level of experience in psychiatric nursing, where 97% of the respondents had between one (1) and five (5) years of experience in the field.

These observations are noted whilst observing the within group responses when looking at the one tailed posttest result. In the between group responses with the two tailed results, these differences are balanced out. Therefore, within a group a result may show statistical significance, whilst between groups it does not show statistical significance.

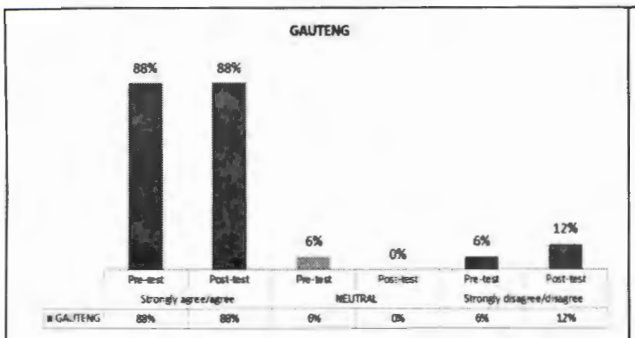
5.5.3 ANALYSIS OF THE INTER CULTURAL SENSITIVITY AND AWARENESS QUESTIONNAIRE

The Intercultural sensitivity questionnaire was the second questionnaire added to address the efficacy of combining cultural sensitivity and awareness as part of the training programme in the culturally safe management of aggression and violence. The following sections will deal with the findings on the questionnaire and a similar question by question approach will be followed as with the discussion in the MAVAS questionnaire. The Intercultural sensitivity questionnaire consists of 24 questions with a five (5) point Likert scale rating whereas one (1) reflects strong disagreement, two (2) indicates disagreement, three (3) is neutral/uncertainty, four (4) indicates agreement and five (5) reflects strong agreement with the statements.

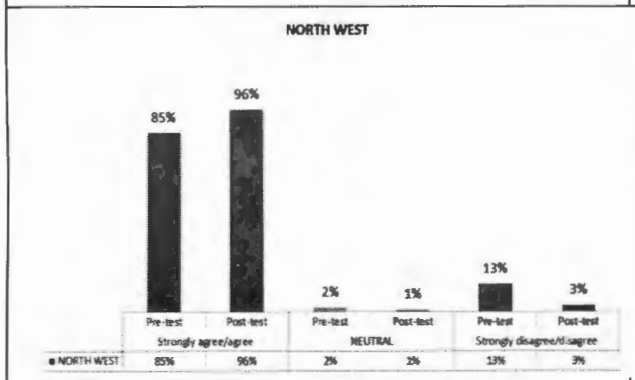
The researcher proposed a non-directional hypothesis (N_1), namely that a training programme will have an effect on the attitudes of respondents with regards to cultural sensitivity and awareness. This effect will be tested by means of a pre-test and a post-test, where the Intercultural sensitivity scale will be used to test for any possible changes in the respondents with regards to their responses on the 24 questions in this questionnaire.

The following section will analyse the findings on each of the 24 questions.

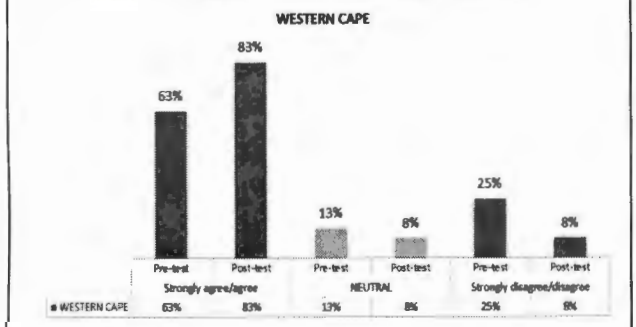
5.5.3.1 I enjoy interacting with people from different cultures



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	*diff*	*95% Confidence Interval*	
Mean	4.17647059	4	0.176	-0.095	0.448
Variance	1.02941176	1.5			
Observations	17	17			
Pearson Correlation	0.90534129				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.376				
P(T<=t) one-tail	0.094				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.188				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	*diff*	*95% Confidence Interval*	
Mean	4.14285714	4.49450549	-0.352	-0.661	-0.042
Variance	1.7015873	0.67496947			
Observations	91	91			
Pearson Correlation	0.07849936				
Hypothesized Mean Difference	0				
df	90				
t Stat	-2.257				
P(T<=t) one-tail	0.013				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.026				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

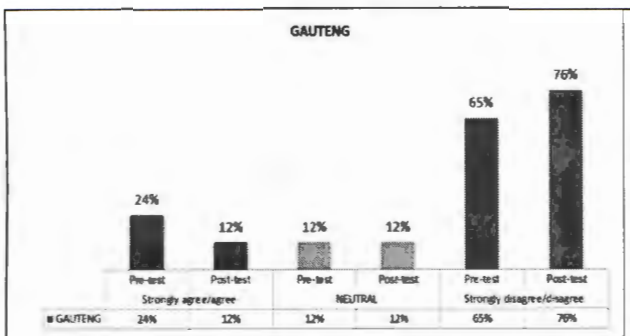


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ1	*POSTQ1*	*diff*	*95% Confidence Interval*	
Mean	3.54166667	4.20833333	-0.667	-1.345	0.012
Variance	1.99818841	1.38949275			
Observations	24	24			
Pearson Correlation	0.24244846				
Hypothesized Mean Difference	0				
df	23				
t Stat	-2.033				
P(T<=t) one-tail	0.027				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.054				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

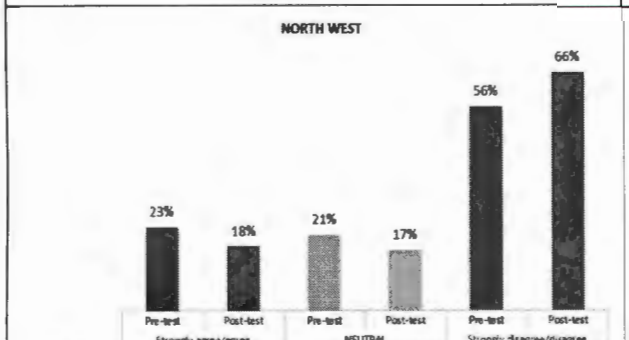
Graph 5.33: I enjoy interacting with people from different cultures

The three experimental groups all agreed with this statement and the percentages were quite high, namely 88% agreement for Gauteng, *5% agreement in the pre-test and 96% agreement in the post-test for North West, Western Cape showed 63% agreement in the pre-test and 83% agreement in the post-test.

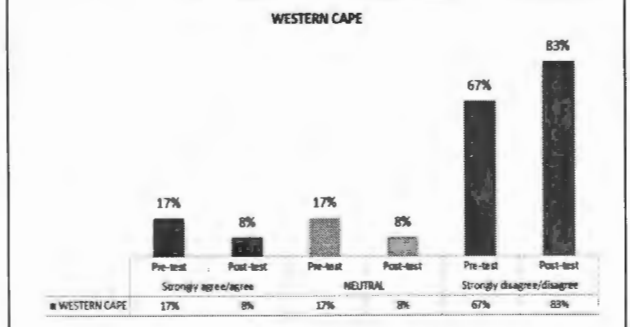
5.5.3.2 *I think people from other cultures are narrow-minded*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ2	POSTQ2	diff	95% Confidence Interval	
Mean	2.29411765	2	0.294	-0.059	0.647
Variance	1.34558824	1			
Observations	17	17			
Pearson Correlation	0.80819319				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.768				
P(T<=t) one-tail	0.048				
T Critical one-tail	1.746				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.096				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ2	POSTQ2	diff	95% Confidence Interval	
Mean	2.43956044	2.28571429	0.154	-0.111	0.419
Variance	1.51575092	1.45079365			
Observations	91	91			
Pearson Correlation	0.45384605				
Hypothesized Mean Difference	0				
df	90				
t Stat	1.153				
P(T<=t) one-tail	0.126				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.252				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

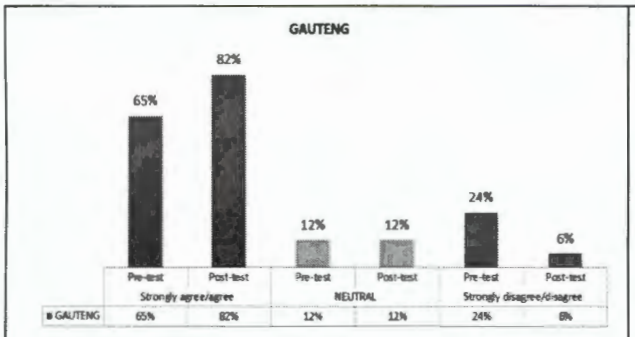


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ2	POSTQ2	diff	95% Confidence	Interval
Mean	1.70833333	1.91666667	-0.208	-0.482	0.765
Variance	1.12862319	1.29710145			
Observations	24	24			
Pearson Correlation	0.48212021				
Hypothesized Mean Difference	0				
df	23				
t Stat	1.273				
P(T<=t) one-tail	0.108				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.216				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

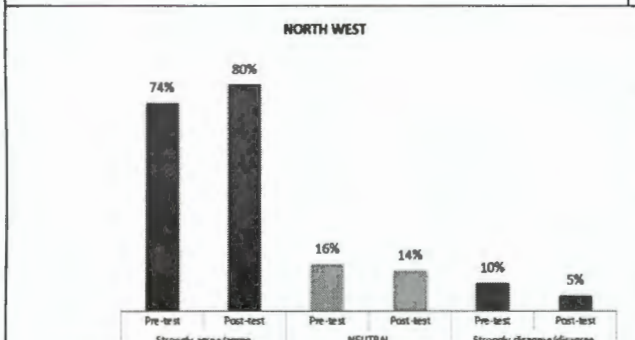
Graph 5.34: I think people from other cultures is narrow-minded

All three experimental groups with an overwhelming majority were in disagreement with this statement in both the pretest and Posttest. For all of the experimental groups, the means were similar.

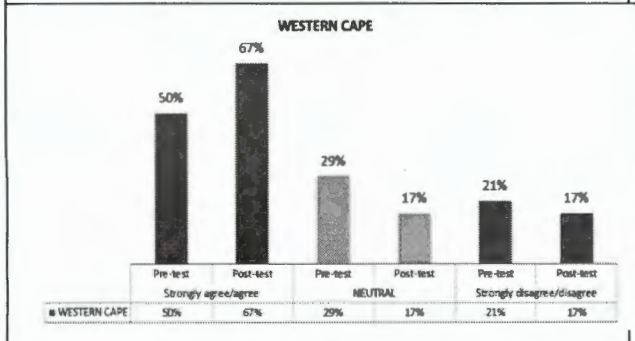
5.5.3.3 *I am pretty sure of myself in interacting with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ3	*POSTQ3*	diff	95% Confidence Interval
Mean		3.58823529	4.05882353	-0.471	-1.154 0.212
Variance		2.25735294	0.68382353		
Observations		17	17		
Pearson Correlation		0.47345567			
Hypothesized Mean Difference		0			
df		16			
t Stat		-1.461			
P(T<=t) one-tail		0.082			
T Critical one-tail		1.746			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.163			
T Critical Two-tail		2.120			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ3	*POSTQ3*	diff	95% Confidence Interval
Mean		3.92307692	4.06593407	-0.143	-0.423 0.138
Variance		1.31623932	0.88449328		
Observations		91	91		
Pearson Correlation		0.17981474			
Hypothesized Mean Difference		0			
df		90			
t Stat		-1.012			
P(T<=t) one-tail		0.157			
T Critical one-tail		1.662			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.314			
T Critical Two-tail		1.987			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

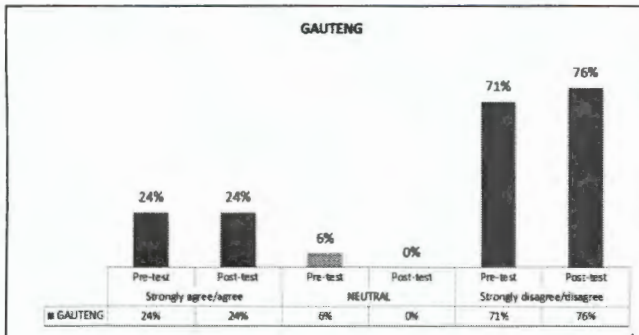


t-Test: Paired Two Sample for Means		α	0.05		
		PREQ3	*POSTQ3*	diff	95% Confidence Interval
Mean		3.375	3.58333333	-0.208	-0.736 0.320
Variance		1.375	1.29710145		
Observations		24	24		
Pearson Correlation		0.41509168			
Hypothesized Mean Difference		0			
df		23			
t Stat		-0.816			
P(T<=t) one-tail		0.211			
T Critical one-tail		1.714			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.423			
T Critical Two-tail		2.069			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

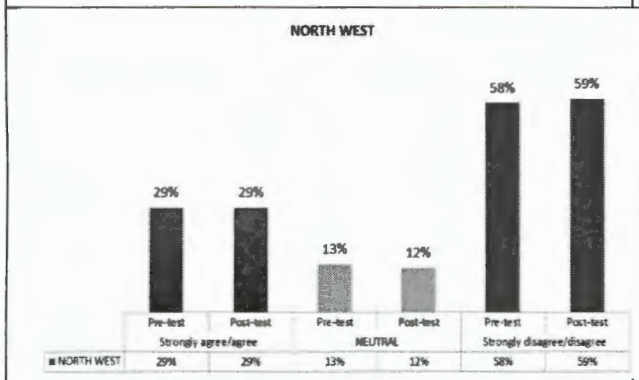
Graph 5.35: I am pretty sure of myself in interacting with people from different cultures

All respondents agreed with this statement and in the post test there was an observed increased agreement, namely Gauteng improved from 65% to 82%, North West from 74% to 80% and Western Cape from 50% to 67%.

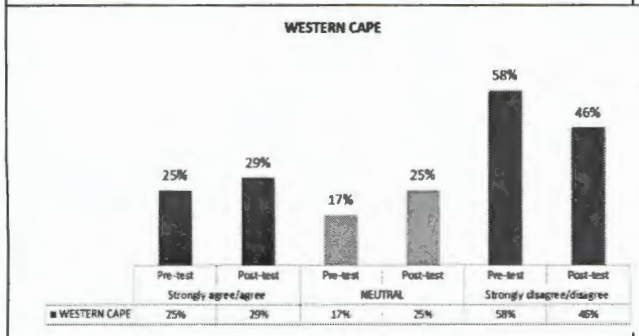
5.5.3.4 *I find it very difficult to talk in front of people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ4	*POSTQ4*	diff	95% Confidence Interval
Mean		2.23529412	2.29411765	-0.059	-0.726 0.608
Variance		1.31617647	1.47058824		
Observations		17	17		
Pearson Correlation		0.39638732			
Hypothesized Mean Difference		0			
df		16			
t Stat		-0.187			
P(T<=t) one-tail		0.427			
T Critical one-tail		1.746			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.854			
T Critical Two-tail		2.120			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ4	*POSTQ4*	diff	95% Confidence Interval
Mean		2.47252747	2.48351648	-0.011	-0.272 0.250
Variance		1.58534799	1.47472527		
Observations		91	91		
Pearson Correlation		0.48838882			
Hypothesized Mean Difference		0			
df		90			
t Stat		-0.084			
P(T<=t) one-tail		0.467			
T Critical one-tail		1.662			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.933			
T Critical Two-tail		1.987			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

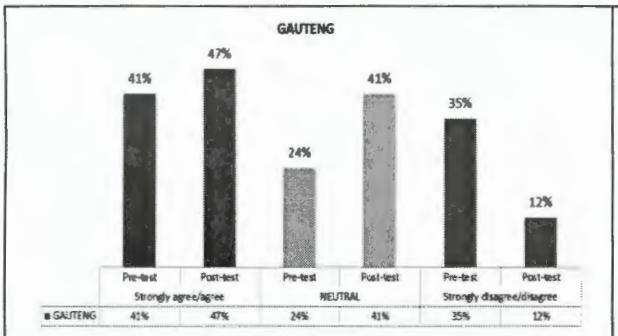


t-Test: Paired Two Sample for Means		α	0.05		
		PREQ4	*POSTQ4*	diff	95% Confidence Interval
Mean		2.625	2.75	-0.125	-0.672 0.422
Variance		1.375	1.23913043		
Observations		24	24		
Pearson Correlation		0.35807233			
Hypothesized Mean Difference		0			
df		23			
t Stat		-0.473			
P(T<=t) one-tail		0.320			
T Critical one-tail		1.714			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.641			
T Critical Two-tail		2.069			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

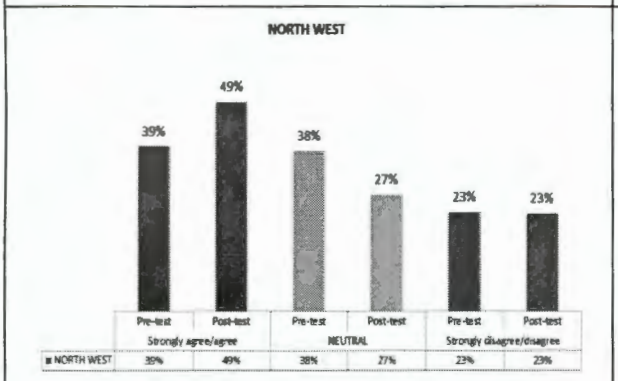
Graph 5.36: I find it very difficult to talk in front of people from different cultures

All respondents answered this question and the majority disagreed with it. Gauteng and North West seemed to have shown increased agreement with this statement from 71% to 76% for Gauteng and a marginal 1% increase in agreement for North West; Western Cape to the contrary showed a decrease from 58% to 46%.

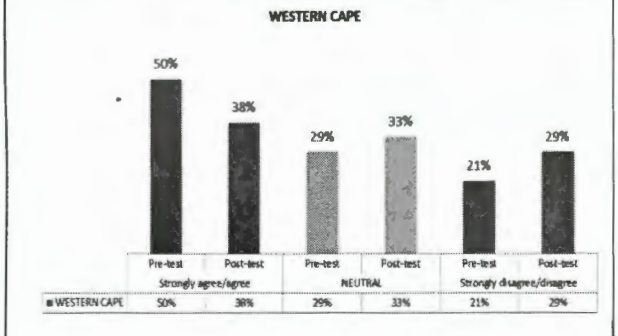
5.5.3.5 *I always know what to say when interacting with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ5	*POSTQ5*	diff	95% Confidence Interval	
Mean		3.23529412	3.47058824	-0.235	-0.766	0.296
Variance		1.31617647	0.76470588			
Observations		17	17			
Pearson Correlation		0.50571508				
Hypothesized Mean Difference		0				
df		16				
t Stat		-0.940				
P(T<=t) one-tail		0.181				
T Critical one-tail		1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.361				
T Critical Two-tail		2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
		PREQ5	*POSTQ5*	diff	95% Confidence Interval	
Mean		3.23076923	3.30769231	-0.077	-0.353	0.199
Variance		1.2017094	1.37094017			
Observations		91	91			
Pearson Correlation		0.31629969				
Hypothesized Mean Difference		0				
df		90				
t Stat		-0.553				
P(T<=t) one-tail		0.291				
T Critical one-tail		1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail		0.582				
T Critical Two-tail		1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

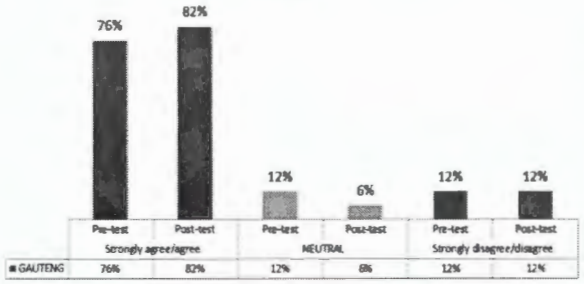


t-Test: Paired Two Sample for Means		α	0.05			
		PREQ5	*POSTQ5*	diff	95% Confidence Interval	
Mean		3.375	2.95833333	0.417	-0.031	0.864
Variance		1.11413043	1.08514493			
Observations		24	24			
Pearson Correlation		0.4893341				
Hypothesized Mean Difference		0				
df		23				
t Stat		1.926				
P(T<=t) one-tail		0.033				
T Critical one-tail		1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail		0.067				
T Critical Two-tail		2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

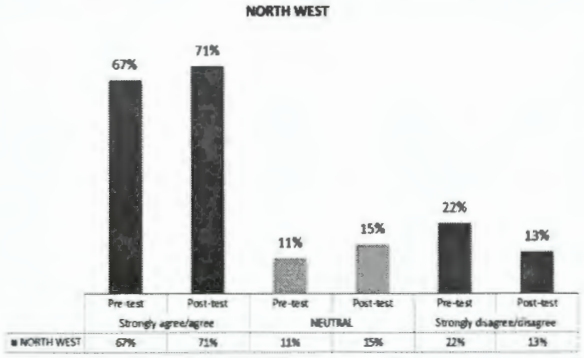
Graph 5.37: I always know what to say when interacting with people from different cultures

All respondents answered this question and it seems as though almost ⅓ of the respondents in each of the experimental groups reported uncertainty on this particular question.

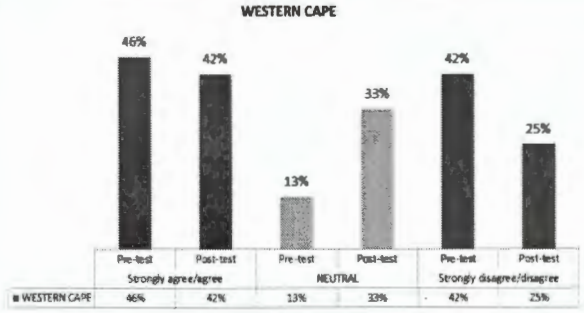
5.5.3.6 I can be as sociable as I want to be when interacting with people from different cultures



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ6	*POSTQ6*	diff	95% Confidence Interval		
Mean	3.94117647	3.88235294	0.059	-0.470	0.588	
Variance	0.93382353	0.73529412				
Observations	17	17				
Pearson Correlation	0.36825295					
Hypothesized Mean Difference	0					
df	16					
t Stat	0.236					
P(T<=t) one-tail	0.408					
T Critical one-tail	1.746					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.817					
T Critical Two-tail	2.120					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ6	*POSTQ6*	diff	95% Confidence Interval		
Mean	3.6043956	3.78021978	-0.176	-0.440	0.089	
Variance	1.33064713	1.04004884				
Observations	91	91				
Pearson Correlation	0.32195826					
Hypothesized Mean Difference	0					
df	90					
t Stat	-1.321					
P(T<=t) one-tail	0.095					
T Critical one-tail	1.662					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.190					
T Critical Two-tail	1.987					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

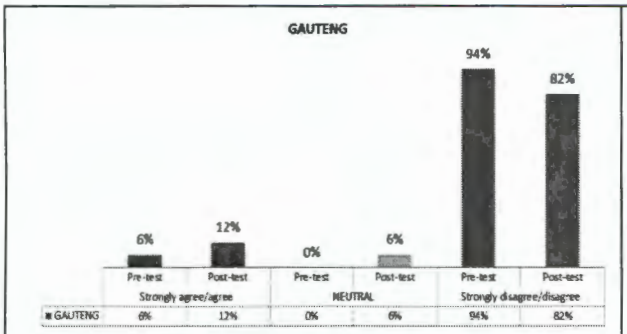


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ6	*POSTQ6*	diff	95% Confidence Interval		
Mean	3.16666667	3.16666667	0.000	-0.623	0.623	
Variance	1.27536232	1.1884058				
Observations	24	24				
Pearson Correlation	0.1177204					
Hypothesized Mean Difference	0					
df	23					
t Stat	0.000					
P(T<=t) one-tail	0.500					
T Critical one-tail	1.714					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	1.000					
T Critical Two-tail	2.069					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

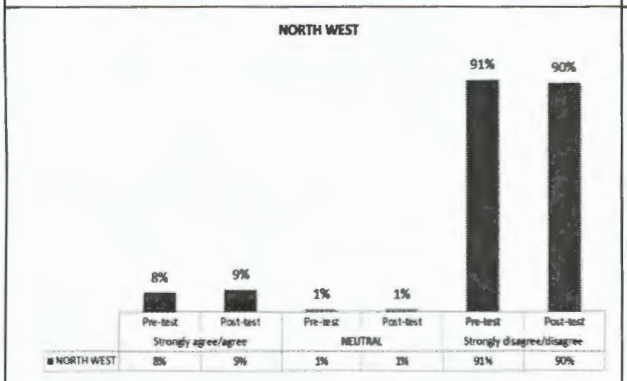
Graph 5.38: I can be as sociable as I want to be when interacting with people from different cultures

The pre and post-tests did not differ significantly for any of the three experimental groups. As a matter of fact, in all three groups the majority of the respondents agreed with the statement. Remarkably, the Western Cape had lower agreement responses with this statement in comparison with the other two experimental groups and during the post-test, there was a slight decrease in the agreement response during the post-test in comparison with the pre-test, namely a decrease from 46% to 42%.

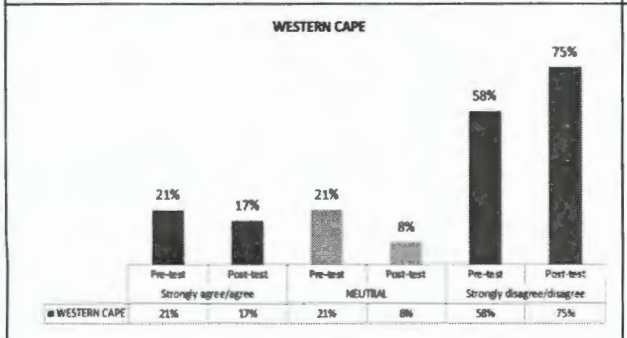
5.5.3.7 *I don't like to be with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ7	*POSTQ7*	diff	95% Confidence Interval	
Mean	1.70588235	1.94117647	-0.235	-0.996	0.526
Variance	0.97058824	0.93382353			
Observations	17	17			
Pearson Correlation	-0.15060722				
Hypothesized Mean Difference	0				
df	16				
t Stat	-0.655				
P(T<=t) one-tail	0.261				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.522				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ7	*POSTQ7*	diff	95% Confidence Interval	
Mean	1.61538462	1.75824176	-0.143	-0.386	0.101
Variance	0.86153846	1.07423687			
Observations	91	91			
Pearson Correlation	0.29496118				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.165				
P(T<=t) one-tail	0.124				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.247				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

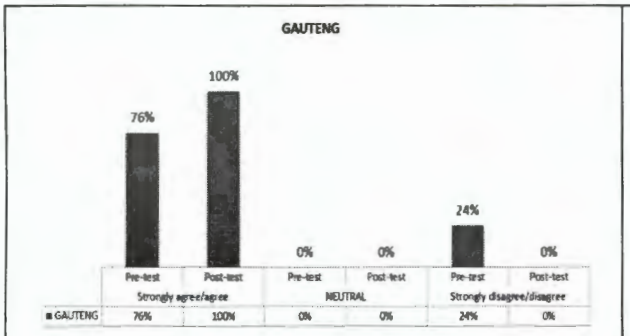


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ7	*POSTQ7*	diff	95% Confidence Interval	
Mean	2.45833333	2.16666667	0.292	-0.373	0.956
Variance	1.5634058	1.53623188			
Observations	24	24			
Pearson Correlation	0.20105974				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.908				
P(T<=t) one-tail	0.187				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.373				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

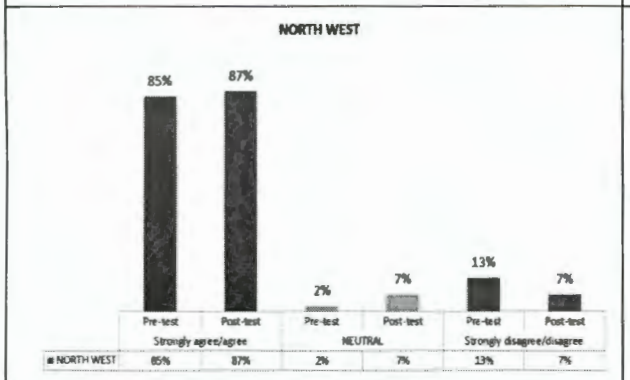
Graph 5.39: I don't like to be with people from different cultures

All three experimental groups disagreed with this statement and during the post-test, only Gauteng showed an ever so small decrease in disagreement with the statement, namely a decrease from 92% to 82%.

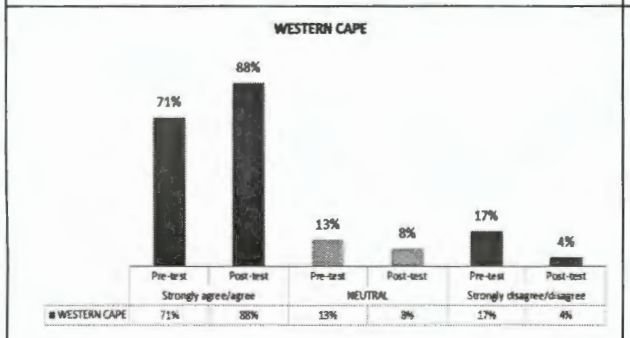
5.5.3.8 I respect the values of people from different cultures



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	diff	95% Confidence Interval	
Mean	3.94117647	4.41176471	-0.471	-1.286	0.345
Variance	2.18382353	0.25735294			
Observations	17	17			
Pearson Correlation	-0.04904082				
Hypothesized Mean Difference	0				
df	16				
t Stat	-1.224				
P(T<=t) one-tail	0.119				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.239				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	diff	95% Confidence Interval	
Mean	4.16483516	4.34065934	-0.176	-0.473	0.121
Variance	1.58363858	0.89377289			
Observations	91	91			
Pearson Correlation	0.18576036				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.176				
P(T<=t) one-tail	0.121				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.243				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

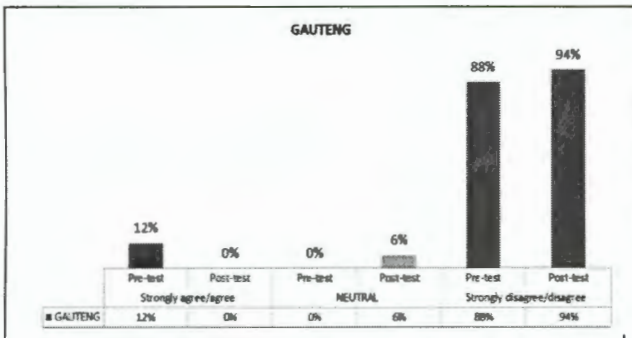


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ8	*POSTQ8*	diff	95% Confidence Interval	
Mean	3.79166667	4.33333333	-0.542	-1.084	0.001
Variance	1.30253623	0.92753623			
Observations	24	24			
Pearson Correlation	0.26370633				
Hypothesized Mean Difference	0				
df	23				
t Stat	-2.066				
P(T<=t) one-tail	0.025				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.050				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

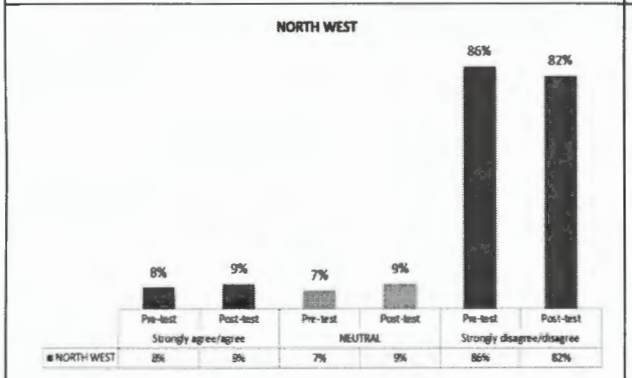
Graph 5.40: I respect the values of people from different cultures

All the three experimental groups agreed strongly with this statement, with a slight increase in agreement observed in the post-test score

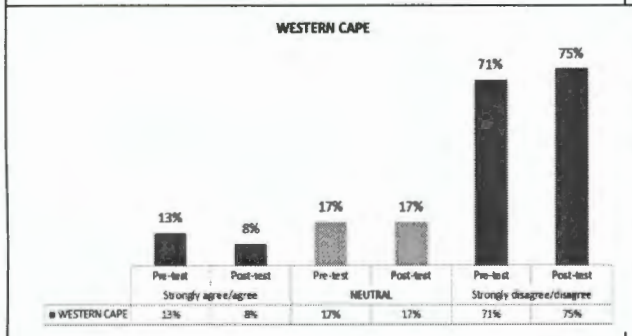
5.5.3.9 I get upset easily when interacting with people from different cultures



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ9	POSTQ9	diff	95% Confidence Interval
Mean		1.76470588	1.76470588	0.000	-0.481 0.481
Variance		0.94117647	0.31617647		
Observations		17	17		
Pearson Correlation		0.35045651			
Hypothesized Mean Difference		0			
df		16			
t Stat		0.000			
P(T<=t) one-tail		0.500			
T Critical one-tail		1.746			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		1.000			
T Critical Two-tail		2.120			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
		PREQ9	POSTQ9	diff	95% Confidence Interval
Mean		1.76923077	1.86813187	-0.099	-0.335 0.138
Variance		0.97948718	1.02686203		
Observations		91	91		
Pearson Correlation		0.35708593			
Hypothesized Mean Difference		0			
df		90			
t Stat		-0.831			
P(T<=t) one-tail		0.204			
T Critical one-tail		1.662			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.408			
T Critical Two-tail		1.987			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

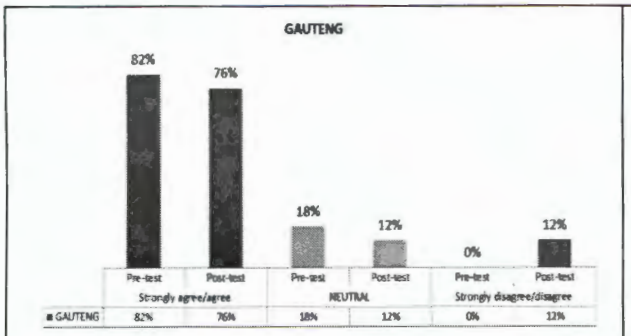


t-Test: Paired Two Sample for Means		α	0.05		
		PREQ9	POSTQ9	diff	95% Confidence Interval
Mean		2.04166667	2	0.042	-0.398 0.482
Variance		1.08514493	1.13043478		
Observations		24	24		
Pearson Correlation		0.5103274			
Hypothesized Mean Difference		0			
df		23			
t Stat		0.196			
P(T<=t) one-tail		0.423			
T Critical one-tail		1.714			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail		0.846			
T Critical Two-tail		2.069			
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

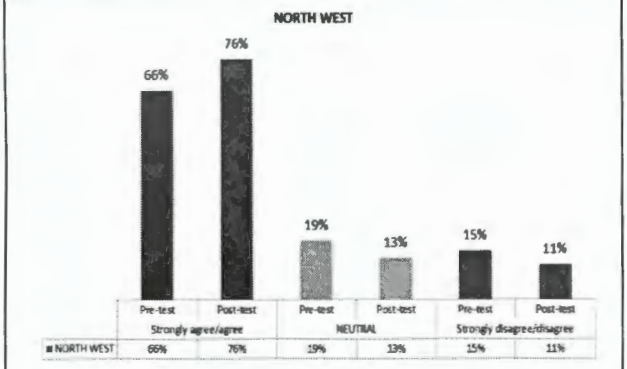
Graph 5.41: I get upset easily when interacting with people from different cultures

All the three experimental groups disagreed with this statement and the training programme did not persuade them otherwise. Because all the means are more or less similar, the null hypothesis (N_0) cannot be rejected.

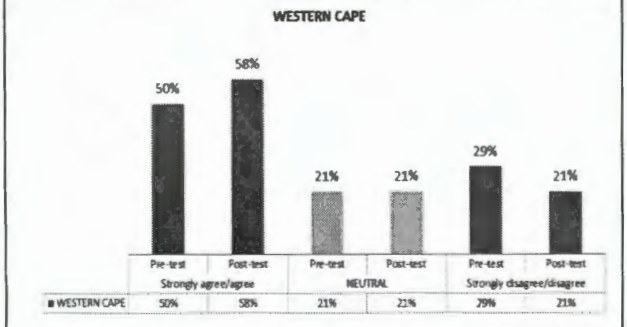
5.5.3.10 *I feel confident when interacting with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	diff	95% Confidence Interval	
Mean	3.94117647	3.82352941	0.118	-0.323	0.559
Variance	0.30882353	0.77941176			
Observations	17	17			
Pearson Correlation	0.35969439				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.566				
P(T<=t) one-tail	0.290				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.579				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	diff	95% Confidence Interval	
Mean	3.65934066	3.93406593	-0.275	-0.554	0.005
Variance	1.38266178	0.9956044			
Observations	91	91			
Pearson Correlation	0.24580721				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.953				
P(T<=t) one-tail	0.027				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.054				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

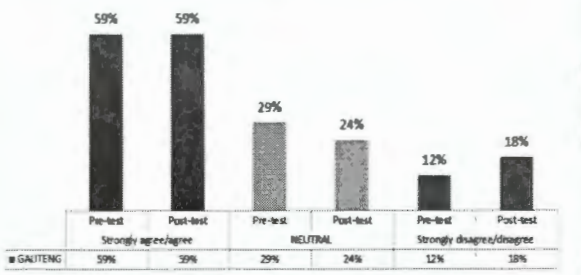


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ10	*POSTQ10*	diff	95% Confidence Interval	
Mean	3.41666667	3.45833333	-0.042	-0.658	0.574
Variance	1.55797101	1.12862319			
Observations	24	24			
Pearson Correlation	0.21039115				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.140				
P(T<=t) one-tail	0.445				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.890				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

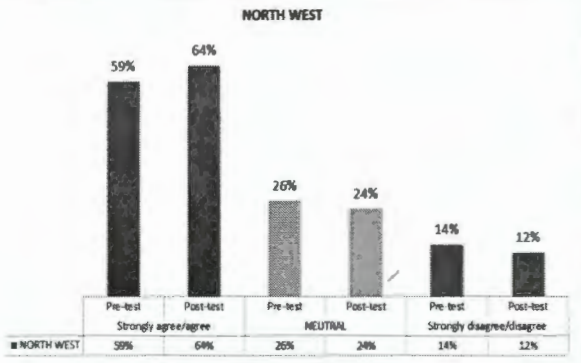
Graph 5.42: I feel confident when interacting with people from different cultures

This question was met by agreement by all three experimental groups. It is observed that the pre and post-test agreement with this statement decrease in Gauteng from 82% to 76%, in the North West it increased by 10% and an 8% increased agreement is observed for the Western Cape.

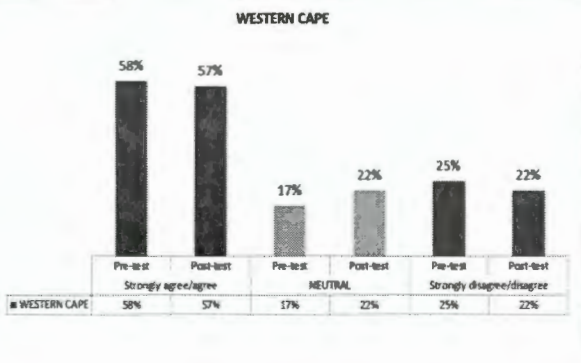
5.5.3.11 I tend to wait before forming an impression of culturally-distinct counterparts



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	diff	95% Confidence Interval	
Mean	3.52941176	3.47058824	0.059	-0.404	0.521
Variance	0.63970588	1.13970588			
Observations	17	17			
Pearson Correlation	0.5683534				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.270				
P(T<=t) one-tail	0.395				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.791				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	diff	95% Confidence Interval	
Mean	3.57142857	3.63736264	-0.066	-0.294	0.162
Variance	0.91428571	0.98925519			
Observations	91	91			
Pearson Correlation	0.37219384				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.575				
P(T<=t) one-tail	0.283				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.567				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

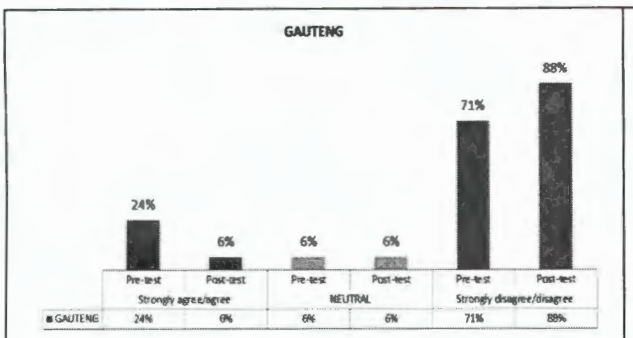


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ11	*POSTQ11*	diff	95% Confidence Interval	
Mean	3.41666667	3.125	0.292	-0.349	0.932
Variance	1.47101449	1.67934783			
Observations	24	24			
Pearson Correlation	0.26971058				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.942				
P(T<=t) one-tail	0.178				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.356				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

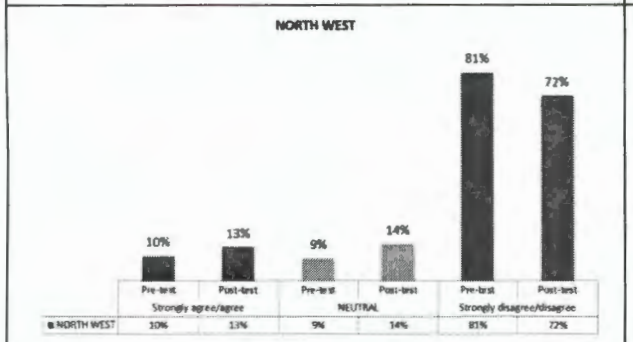
Graph 5.43: I tend to wait before forming an impression of culturally-distinct counterparts

All the three experimental groups remained consistent in their pre- and post-test reporting of this statement.

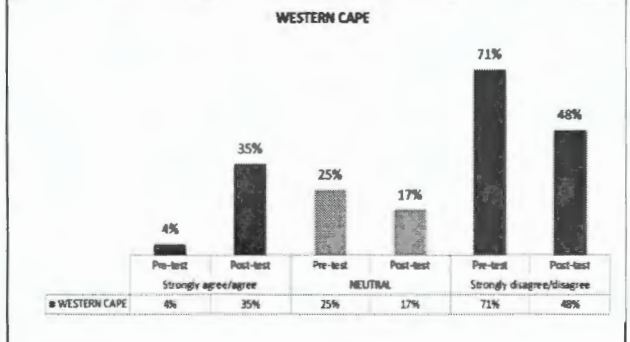
5.5.3.12 *I often get discouraged when I am with people from different cultures*



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ12	*POSTQ12*	diff	95% Confidence Interval	
Mean	2.35294118	1.82352941	0.529	-0.129	1.188
Variance	1.49264706	0.65441176			
Observations	17	17			
Pearson Correlation	0.25667057				
Hypothesized Mean Difference	0				
df	16				
t Stat	1.705				
P(T<=t) one-tail	0.054				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.108				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ12	*POSTQ12*	diff	95% Confidence Interval	
Mean	1.92307692	2.21978022	-0.297	-0.603	0.010
Variance	1.18290598	1.37338217			
Observations	91	91			
Pearson Correlation	0.15288968				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.923				
P(T<=t) one-tail	0.029				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.058				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

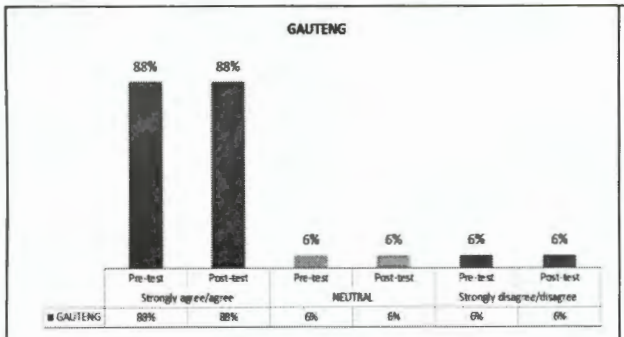


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ12	*POSTQ12*	diff	95% Confidence Interval	
Mean	2.16666667	2.66666667	-0.500	-1.097	0.097
Variance	0.57971014	2.4057971			
Observations	24	24			
Pearson Correlation	0.41724859				
Hypothesized Mean Difference	0				
df	23				
t Stat	-1.732				
P(T<=t) one-tail	0.048				
T Critical one-tail	1.714				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.097				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

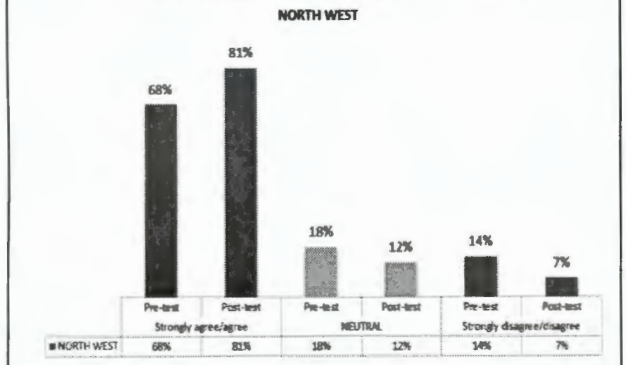
Graph 5.44: I often get discouraged when I am with people from different cultures

Disagreement with this question is observed in all three experimental groups. Gauteng shows an increased disagreement in the post-test, namely from 71% to 88%. There were significant statistical changes observed for North West and the Western Cape, which will be elaborated on in section 5.6.2.12.

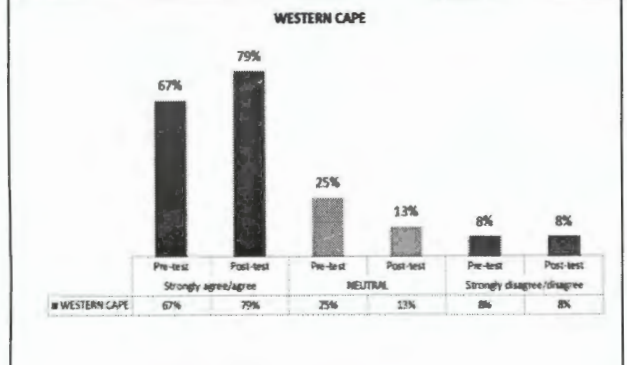
5.5.3.13 *I am open-minded to people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean	3.94117647	3.88235294	0.059	-0.633	0.750
Variance	0.80882353	0.73529412			
Observations	17	17			
Pearson Correlation	-0.17162327				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.180				
P(T<=t) one-tail	0.430				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.859				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean	3.79120879	3.98901099	-0.198	-0.502	0.107
Variance	1.5003663	1.05543346			
Observations	91	91			
Pearson Correlation	0.16591977				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.290				
P(T<=t) one-tail	0.100				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.200				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

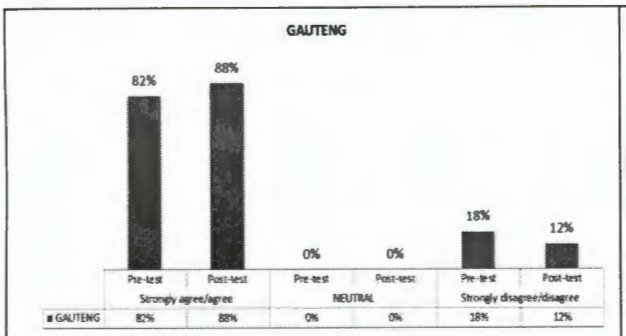


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ13	*POSTQ13*	diff	95% Confidence Interval	
Mean	3.79166667	4.04166667	-0.250	-0.736	0.236
Variance	1.04166667	1.34601449			
Observations	24	24			
Pearson Correlation	0.4482696				
Hypothesized Mean Difference	0				
df	23				
t Stat	-1.064				
P(T<=t) one-tail	0.149				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.299				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

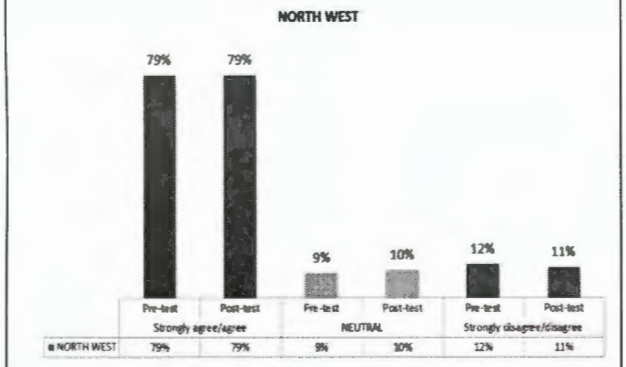
Graph 5.45: I am open minded to people from different cultures

This question, similar to question 14, indicates that the null hypothesis cannot be rejected and that the training programme had no influence on the respondents.

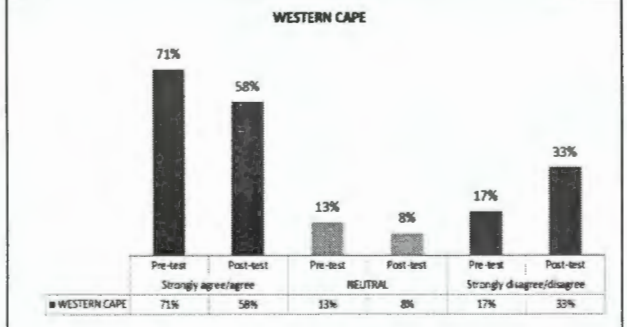
5.5.3.14 *I am very observant when interacting with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean	3.82352941	3.88235294	-0.059	-0.921	0.803
Variance	0.90441176	0.98529412			
Observations	17	17			
Pearson Correlation	-0.48682745				
Hypothesized Mean Difference	0				
df	16				
t Stat	-0.145				
P(T<=t) one-tail	0.443				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.887				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean	4	4.04395604	-0.044	-0.325	0.237
Variance	1.31111111	1.17582418			
Observations	91	91			
Pearson Correlation	0.26846508				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.311				
P(T<=t) one-tail	0.378				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.757				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

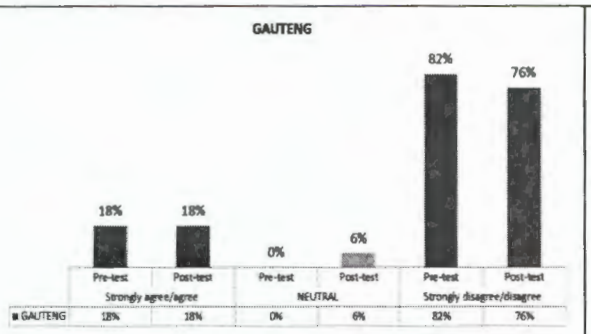


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ14	*POSTQ14*	diff	95% Confidence Interval	
Mean	3.625	3.29166667	0.333	-0.333	1.000
Variance	1.02717391	2.30253623			
Observations	24	24			
Pearson Correlation	0.27211199				
Hypothesized Mean Difference	0				
df	23				
t Stat	1.034				
P(T<=t) one-tail	0.156				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.312				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

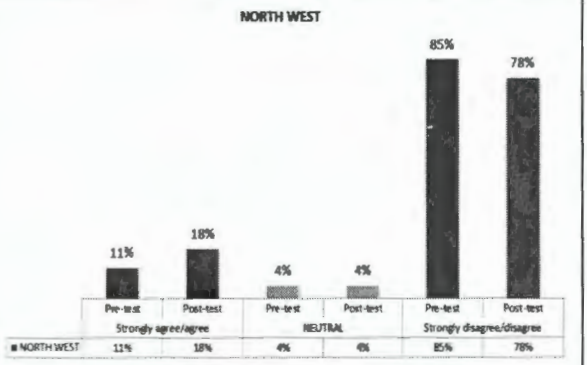
Graph 5.46: I am very observant when interacting with people from different cultures

Respondents in all three experimental groups agreed with being observant when interacting with people from other cultures, even though the Western Cape group shows a reconsideration of the response during the post-test. This minimal difference from 71% down to 58% is of no statistical significance, albeit an interesting observation.

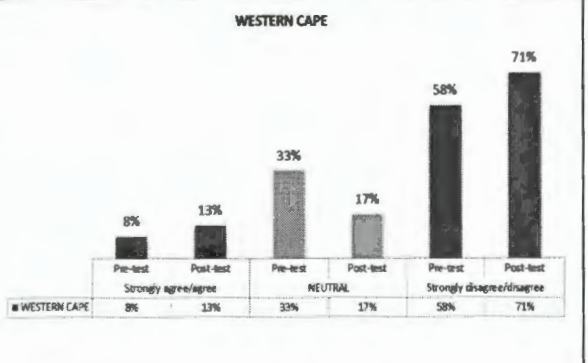
5.5.3.15 I often feel useless when I am interacting with people from different cultures



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ15	*POSTQ15*	diff	95% Confidence Interval	
Mean	2.11764706	2.17647059	-0.059	-0.647	0.529
Variance	1.36029412	1.02941176			
Observations	17	17			
Pearson Correlation	0.45670678				
Hypothesized Mean Difference	0				
df	16				
t Stat	-0.212				
P(T<=t) one-tail	0.417				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.835				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means	α	0.05			
	PREQ15	*POSTQ15*	diff	95% Confidence Interval	
Mean	1.8021978	2.03296703	-0.231	-0.540	0.078
Variance	1.24932845	1.45445665			
Observations	91	91			
Pearson Correlation	0.18623037				
Hypothesized Mean Difference	0				
df	90				
t Stat	-1.484				
P(T<=t) one-tail	0.071				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.141				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

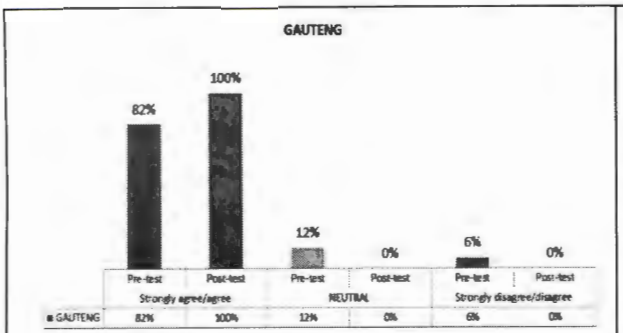


t-Test: Paired Two Sample for Means	α	0.05			
	PREQ15	*POSTQ15*	diff	95% Confidence Interval	
Mean	2.33333333	2.125	0.208	-0.274	0.690
Variance	1.01449275	1.24456522			
Observations	24	24			
Pearson Correlation	0.42562933				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.894				
P(T<=t) one-tail	0.190				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.380				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

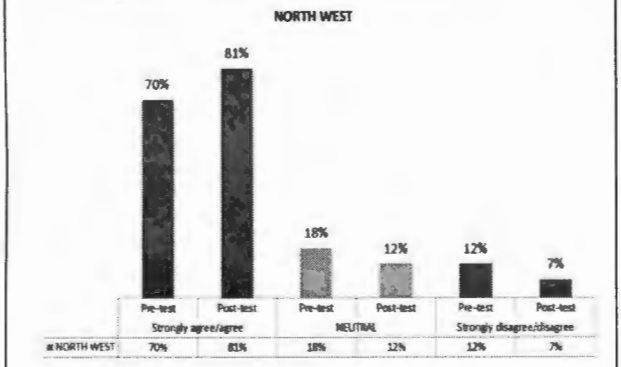
Graph 5.47: I often feel useless when interacting with people from different cultures

All respondents showed similar disagreement with this statement during the pre-test and the post-test. Gauteng and North West reported a slight decrease in the reported disagreement with the statement during the post-test, namely for Gauteng the scores from pre-test to post-test decreased from 82% to 76% and for North West, it decreased from 85% to 78%.

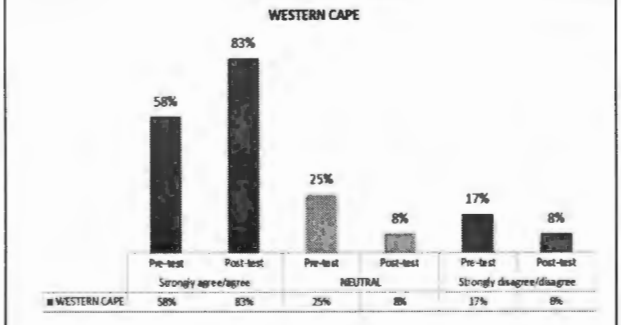
5.5.3.16 *I respect the ways people from different cultures behave*



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16	POSTQ16	diff		95% Confidence Interval	
Mean	4.11764706	4.29411765		-0.176	-0.630	0.277
Variance	0.73529412	0.22058824				
Observations	17	17				
Pearson Correlation	0.21908902					
Hypothesized Mean Difference	0					
df	16					
t Stat	-0.824					
P(T<=t) one-tail	0.211					
T Critical one-tail	1.746					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.422					
T Critical Two-tail	2.120					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						



t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16	POSTQ16	diff		95% Confidence Interval	
Mean	3.91208791	4.13186813		-0.220	-0.485	0.045
Variance	1.39218559	0.96019536				
Observations	91	91				
Pearson Correlation	0.31766222					
Hypothesized Mean Difference	0					
df	90					
t Stat	-1.648					
P(T<=t) one-tail	0.051					
T Critical one-tail	1.662					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						
P(T<=t) two-tail	0.103					
T Critical Two-tail	1.987					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

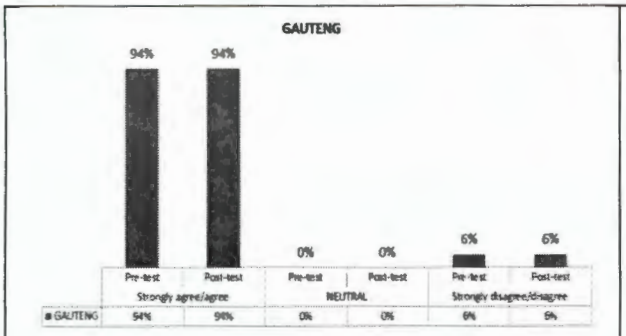


t-Test: Paired Two Sample for Means		α	0.05			
	PREQ16	POSTQ16	diff		95% Confidence Interval	
Mean	3.54166667	4.125		-0.583	-1.179	0.013
Variance	1.38949275	1.07065217				
Observations	24	24				
Pearson Correlation	0.19160123					
Hypothesized Mean Difference	0					
df	23					
t Stat	-2.024					
P(T<=t) one-tail	0.027					
T Critical one-tail	1.714					
Reject Null Hypothesis because p < 0.05 (Means are Different)						
P(T<=t) two-tail	0.055					
T Critical Two-tail	2.069					
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)						

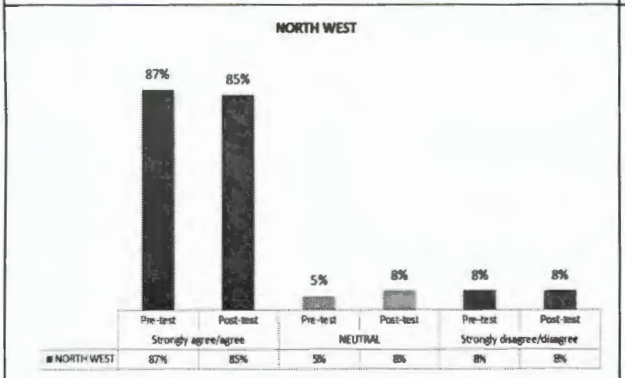
Graph 5.48: I respect the way people from different cultures behave

There is strong agreement with this statement in all experimental groups. Gauteng registered increased agreement from 82% to 100%, North West increased from 70% to 81% and Western Cape from 58% to 83%.

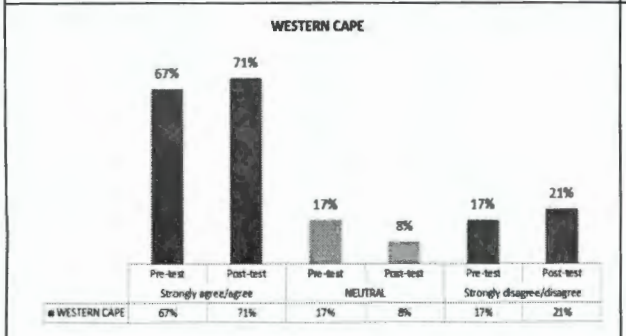
5.5.3.17 *I try to obtain as much information as I can when interacting with people from different cultures*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ17	*POSTQ17*	diff	95% Confidence Interval	
Mean	4.29411765	4.17647059	0.118	-0.482	0.717
Variance	0.59558824	0.90441176			
Observations	17	17			
Pearson Correlation	0.09517624				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.416				
P(T<=t) one-tail	0.342				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.683				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ17	*POSTQ17*	diff	95% Confidence Interval	
Mean	4.20879121	4.21978022	-0.011	-0.248	0.226
Variance	0.87814408	0.86227106			
Observations	91	91			
Pearson Correlation	0.25313246				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.092				
P(T<=t) one-tail	0.463				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.927				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

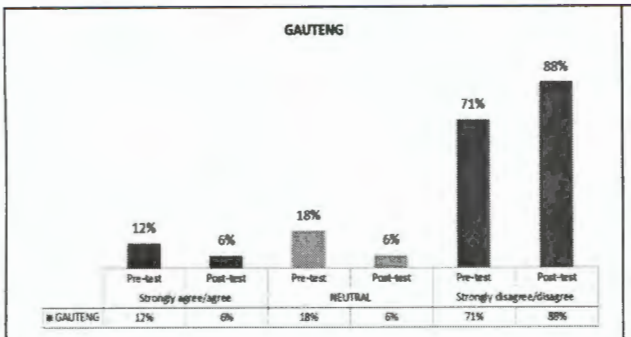


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ17	*POSTQ17*	diff	95% Confidence Interval	
Mean	3.58333333	3.875	-0.292	-0.882	0.299
Variance	1.29710145	2.11413043			
Observations	24	24			
Pearson Correlation	0.43977862				
Hypothesized Mean Difference	0				
df	23				
t Stat	-1.022				
P(T<=t) one-tail	0.159				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.317				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

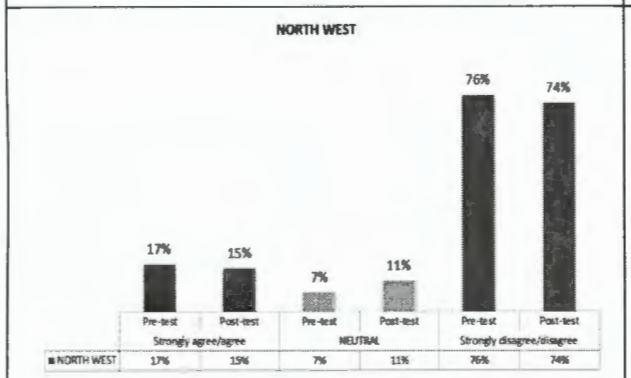
Graph 5.49: I try to obtain as much information as I can when interacting with people from different cultures

The majority of respondents agreed with this statement and this agreement stayed more or less consistent throughout.

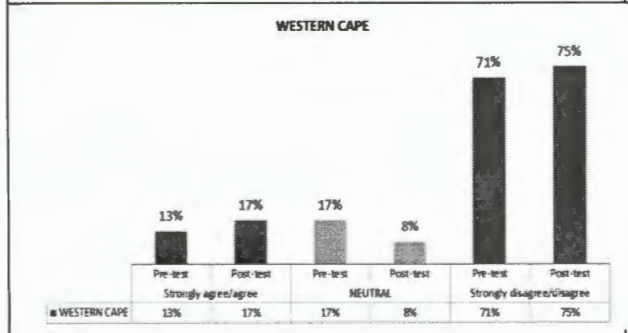
5.5.3.18 I would not accept the opinions of people from different cultures



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	2.05882353	1.82352941	0.235	-0.355	0.825
Variance	1.43382353	0.65441176			
Observations	17	17			
Pearson Correlation	0.39851713				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.846				
P(T<=t) one-tail	0.205				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.410				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	2	2.05494505	-0.055	-0.416	0.306
Variance	1.51111111	1.6969475			
Observations	91	91			
Pearson Correlation	0.06244787				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.302				
P(T<=t) one-tail	0.382				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.763				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

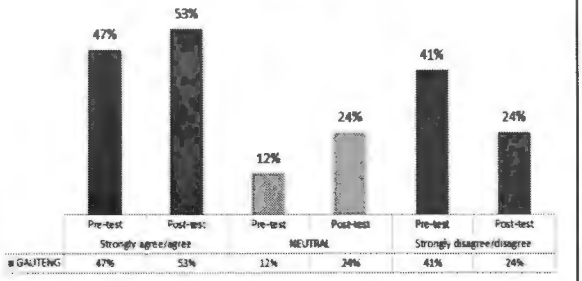


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ18	*POSTQ18*	diff	95% Confidence Interval	
Mean	2.125	2.20833333	-0.083	-0.705	0.538
Variance	1.24456522	1.73731884			
Observations	24	24			
Pearson Correlation	0.27720103				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.277				
P(T<=t) one-tail	0.392				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.784				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

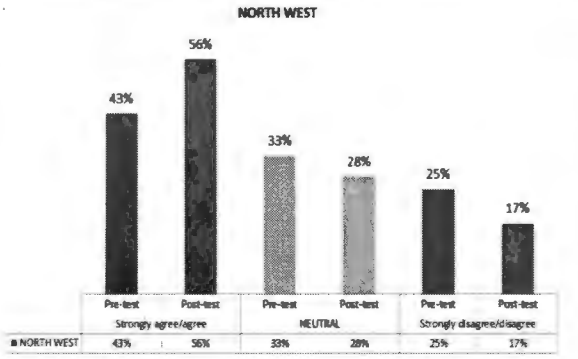
Graph 5.50: I would not accept the opinions of people from different cultures

A minority of respondents actually admitted that they do not accept the opinions of other people from different cultures, and after the training programme, these opinions changed as follows: Gauteng in the pretest 12% which decreased to 6% for the posttest, North West 17% which decreased to 15% and Western Cape 13% actually increased to 17%.

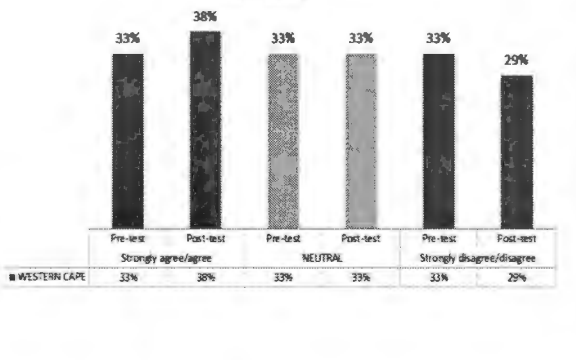
5.5.3.19 I am sensitive to my culturally-distinct counterpart's subtle meanings during our interaction



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	3.11764706	3.35294118	-0.235	-0.974	0.504
Variance	1.48529412	1.24264706			
Observations	17	17			
Pearson Correlation	0.243553				
Hypothesized Mean Difference	0				
df	16				
t Stat	-0.675				
P(T<=t) one-tail	0.255				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.509				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	3.12087912	3.48351648	-0.363	-0.672	-0.053
Variance	1.68522589	1.31916972			
Observations	91	91			
Pearson Correlation	0.2659004				
Hypothesized Mean Difference	0				
df	90				
t Stat	-2.326				
P(T<=t) one-tail	0.011				
T Critical one-tail	1.662				
Reject Null Hypothesis because p < 0.05 (Means are Different)					
P(T<=t) two-tail	0.022				
T Critical Two-tail	1.987				
Reject Null Hypothesis because p < 0.05 (Means are Different)					

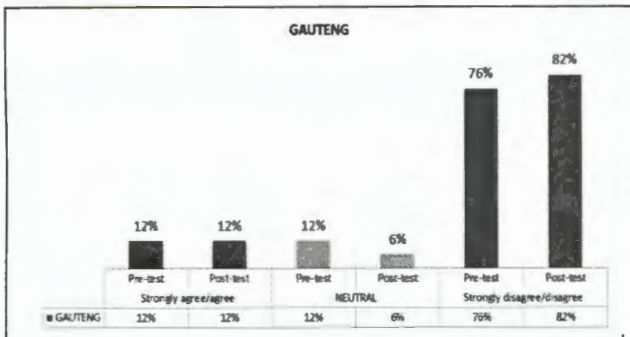


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ19	*POSTQ19*	diff	95% Confidence Interval	
Mean	3.04166667	3	0.042	-0.668	0.751
Variance	1.34601449	1.47826087			
Observations	24	24			
Pearson Correlation	0				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.121				
P(T<=t) one-tail	0.452				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.904				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

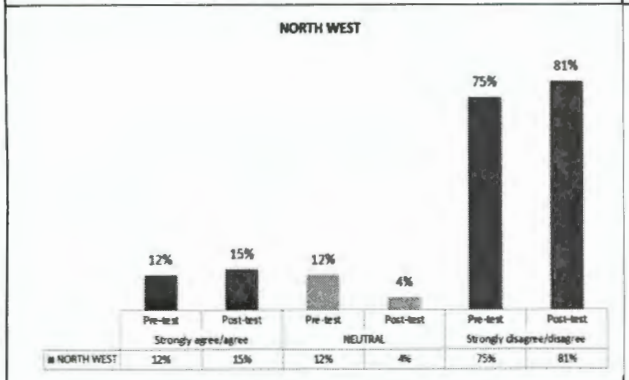
Graph 5.51: I am sensitive to my culturally-distinct counterpart's subtle meanings during our interaction

Similar to the observation in question 5, almost ⅓ of the respondents in each of the experimental groups reported uncertainty on this particular question.

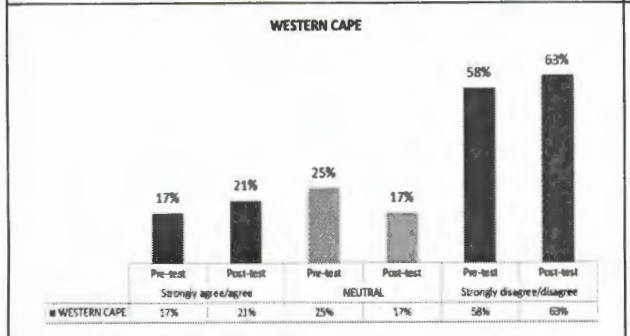
5.5.3.20 I think my culture is better than other cultures



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	2.11764706	2.05882353	0.059	-0.679	0.797
Variance	1.23529412	1.18382353			
Observations	17	17			
Pearson Correlation	0.14896989				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.169				
P(T<=t) one-tail	0.434				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.868				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	1.86813187	1.85714286	0.011	-0.327	0.349
Variance	1.53797314	1.59047619			
Observations	91	91			
Pearson Correlation	0.15832376				
Hypothesized Mean Difference	0				
df	90				
t Stat	0.065				
P(T<=t) one-tail	0.474				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.949				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

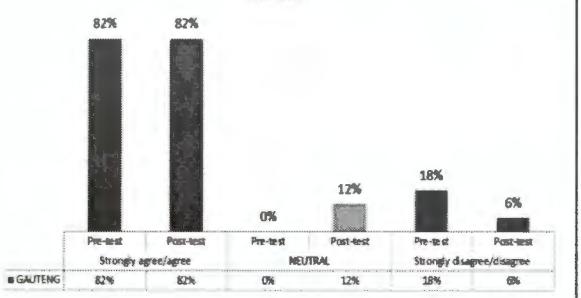


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ20	*POSTQ20*	diff	95% Confidence Interval	
Mean	2.29166667	2.25	0.042	-0.415	0.499
Variance	1.43297101	1.58695652			
Observations	24	24			
Pearson Correlation	0.61267461				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.189				
P(T<=t) one-tail	0.426				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.852				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

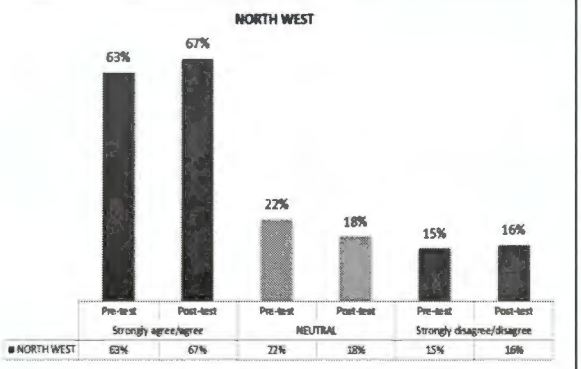
Graph 5.52: I think my culture is better than other cultures

All three experimental groups showed disagreement with this statement and after the training programme, this disagreement grew as follows: From 76% to 82% for Gauteng, 75% to 81% for North West and an increase from 58% to 63% for the Western Cape.

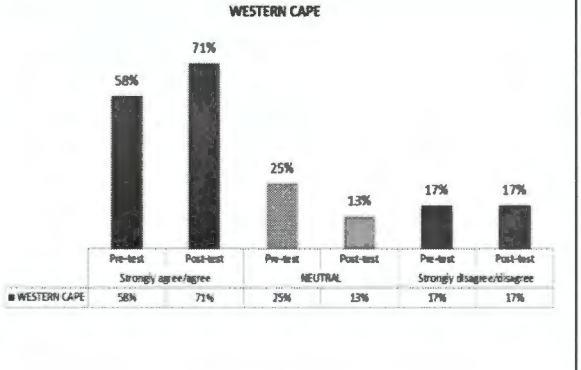
5.5.3.21 I often give positive responses to my culturally-different counterpart during our interaction



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*	
Mean	3.94117647	3.82352941	0.118	-0.359	0.595
Variance	1.05882353	0.77941176			
Observations	17	17			
Pearson Correlation	0.53825425				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.523				
P(T<=t) one-tail	0.304				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.608				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*	
Mean	3.6043956	3.64835165	-0.044	-0.371	0.283
Variance	1.53064713	1.4971917			
Observations	91	91			
Pearson Correlation	0.18599409				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.267				
P(T<=t) one-tail	0.395				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.790				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

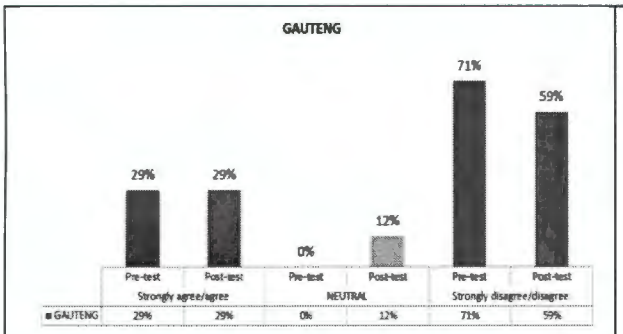


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ21	*POSTQ21*	*diff*	*95% Confidence Interval*	
Mean	3.58333333	3.79166667	-0.208	-0.831	0.414
Variance	1.21014493	1.5634058			
Observations	24	24			
Pearson Correlation	0.21863237				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.693				
P(T<=t) one-tail	0.248				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.496				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

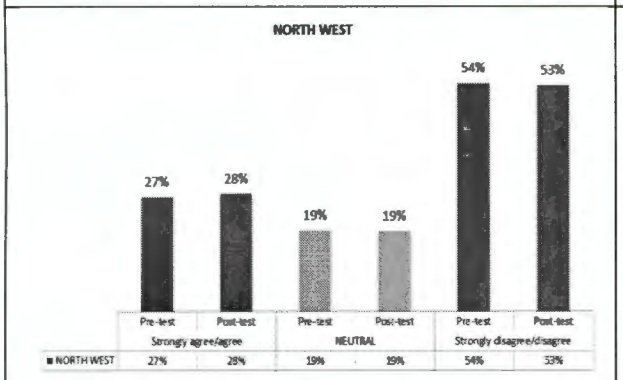
Graph 5.53: I often give positive responses to my culturally-different counterpart during our interaction

All three experimental groups had the same responses for both the pre-test and the post-test and these responses did not change after the administration of the pre-test. Notably, these are the expected norms for the responses on this particular statement, one which a person would not wish to change through a training programme.

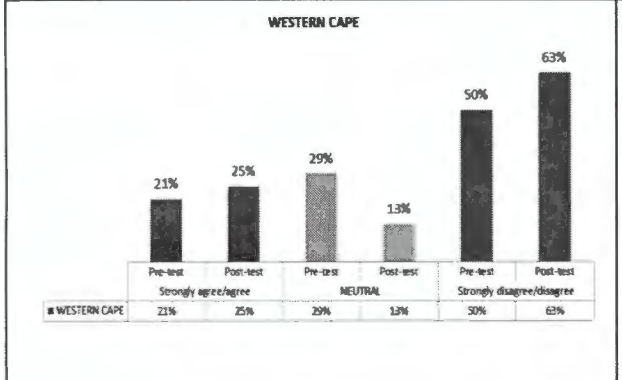
5.5.3.22 I avoid those situations where I will have to deal with culturally distinct persons



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ22	*POSTQ22*	*diff*	*95% Confidence Interval*	
Mean	2.47058824	2.47058824	0.000	-0.792	0.792
Variance	1.51470588	1.38970588			
Observations	17	17			
Pearson Correlation	0.18244753				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ22	*POSTQ22*	*diff*	*95% Confidence Interval*	
Mean	2.53846154	2.61538462	-0.077	-0.389	0.235
Variance	1.78461538	1.66153846			
Observations	91	91			
Pearson Correlation	0.34744388				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.489				
P(T<=t) one-tail	0.313				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.626				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

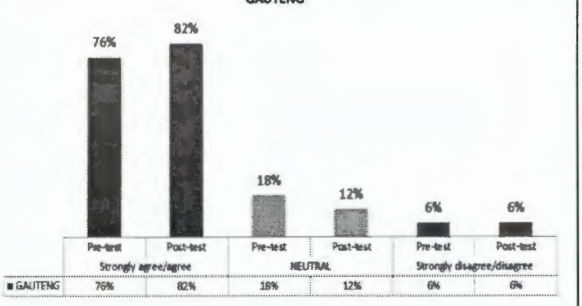


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ22	*POSTQ22*	*diff*	*95% Confidence Interval*	
Mean	2.41666667	2.41666667	0.000	-0.693	0.693
Variance	1.29710145	1.73188406			
Observations	24	24			
Pearson Correlation	0.11119938				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

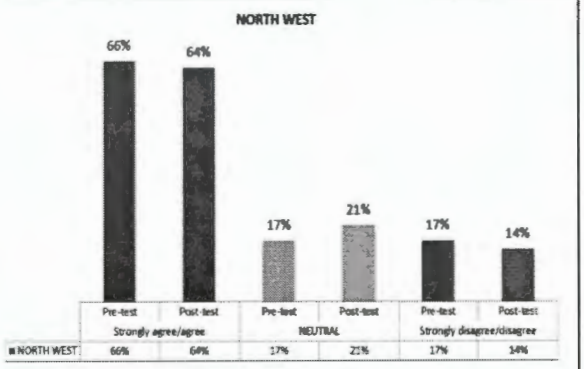
Graph 5.54: I avoid those situations where I have to deal with culturally-distinct persons

There is overall disagreement with this statement. In Gauteng, there was a slight decrease in disagreement from 71% to 59%, North West stayed consistent and the Western Cape increased disagreement from 50% to 63%.

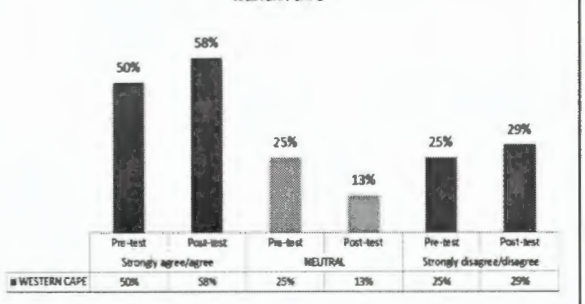
5.5.3.23 *I often show my culturally-distinct counterpart my understanding through verbal or nonverbal cues*



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean	3.88235294	3.88235294	0.000	-0.364	0.364
Variance	0.61029412	0.48529412			
Observations	17	17			
Pearson Correlation	0.54719738				
Hypothesized Mean Difference	0				
df	16				
t Stat	0.000				
P(T<=t) one-tail	0.500				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	1.000				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean	3.50549451	3.63736264	-0.132	-0.430	0.166
Variance	1.56385836	1.41147741			
Observations	91	91			
Pearson Correlation	0.31171899				
Hypothesized Mean Difference	0				
df	90				
t Stat	-0.879				
P(T<=t) one-tail	0.191				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.382				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

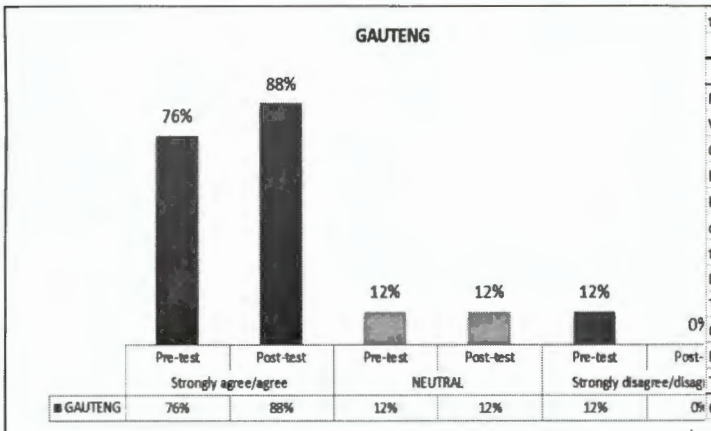


t-Test: Paired Two Sample for Means		α	0.05		
	PREQ23	*POSTQ23*	diff	95% Confidence Interval	
Mean	3.41666667	3.20833333	0.208	-0.450	0.867
Variance	1.38405797	1.91123188			
Observations	24	24			
Pearson Correlation	0.26509653				
Hypothesized Mean Difference	0				
df	23				
t Stat	0.654				
P(T<=t) one-tail	0.260				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.519				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

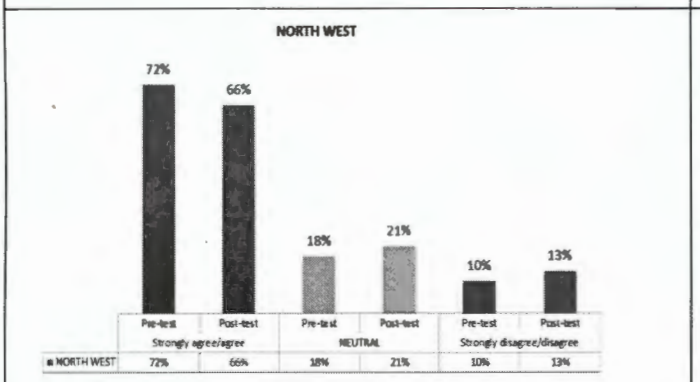
Graph 5.55: I often show my culturally-distinct counterpart my understanding through verbal or non-verbal cues

The reported responses for both the pre-test and the post-test were one of overwhelming agreement across all three experimental groups.

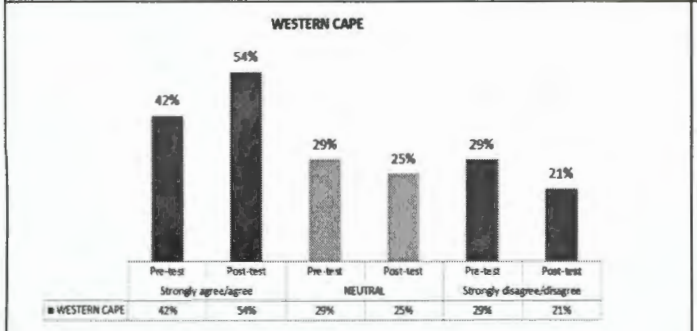
5.5.3.24 I have a feeling of enjoyment toward differences between my culturally-distinct counterpart and me



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ24	*POSTQ24*	*diff*		95% Confidence
Mean	3.82352941	4.05882353	-0.235		-0.622
Variance	0.77941176	0.30882353			
Observations	17	17			
Pearson Correlation	0.53204795				
Hypothesized Mean Difference	0				
df	16				
t Stat	-1.289				
P(T<=t) one-tail	0.108				
T Critical one-tail	1.746				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.216				
T Critical Two-tail	2.120				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



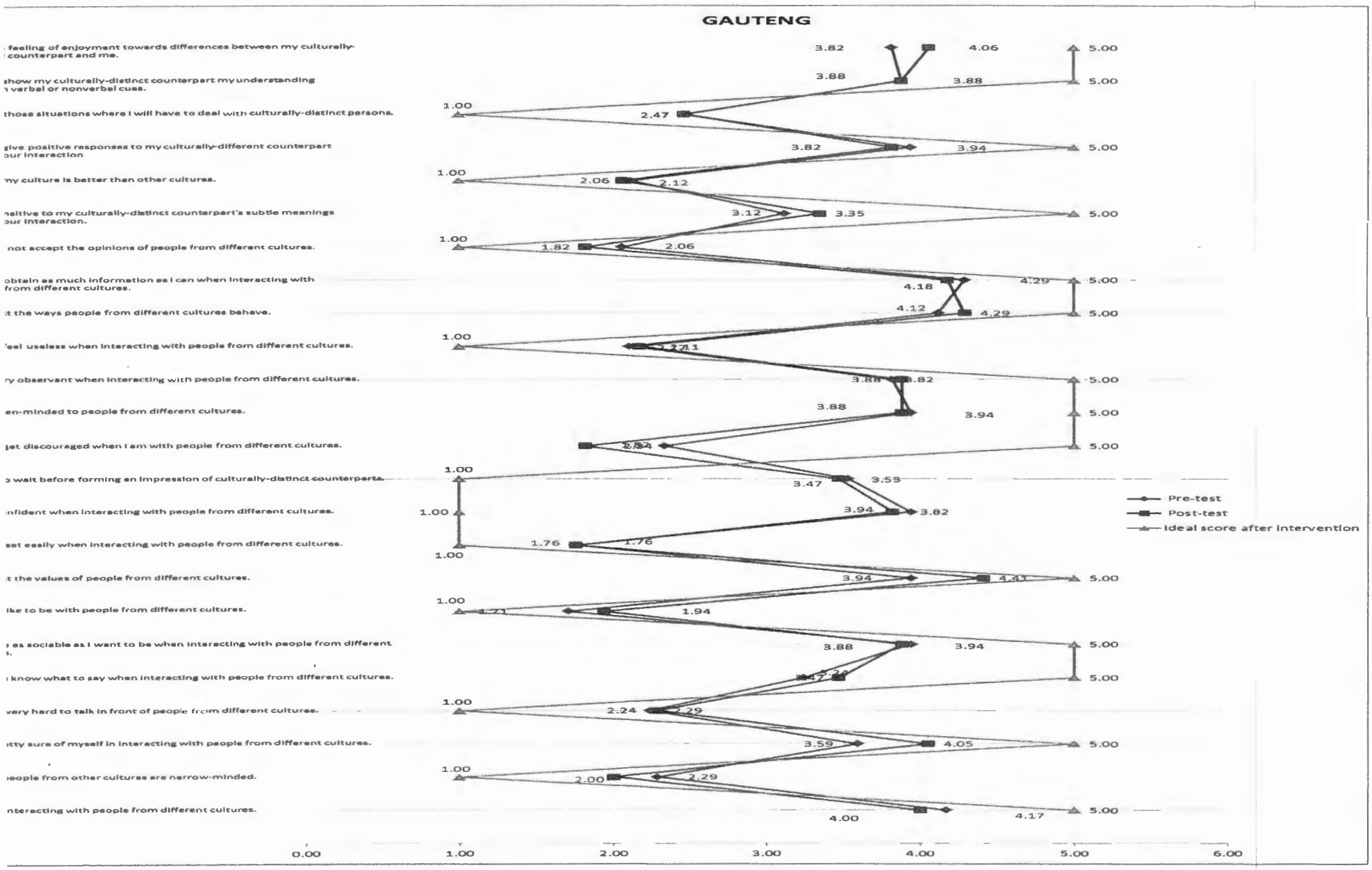
t-Test: Paired Two Sample for Means		α	0.05		
	PREQ24	*POSTQ24*	*diff*		95% Confidence
Mean	3.86813187	3.76923077	0.099		-0.241
Variance	1.44908425	1.49059829			
Observations	91	91			
Pearson Correlation	0.09246644				
Hypothesized Mean Difference	0				
df	90				
t Stat	0.578				
P(T<=t) one-tail	0.282				
T Critical one-tail	1.662				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.565				
T Critical Two-tail	1.987				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					



t-Test: Paired Two Sample for Means		α	0.05		
	PREQ24	*POSTQ24*	*diff*		95% Confidence
Mean	3.20833333	3.375	-0.167		-0.910
Variance	1.47644928	1.80978261			
Observations	24	24			
Pearson Correlation	0.05652084				
Hypothesized Mean Difference	0				
df	23				
t Stat	-0.464				
P(T<=t) one-tail	0.324				
T Critical one-tail	1.714				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					
P(T<=t) two-tail	0.647				
T Critical Two-tail	2.069				
Cannot Reject Null Hypothesis because p > 0.05 (Means are the same)					

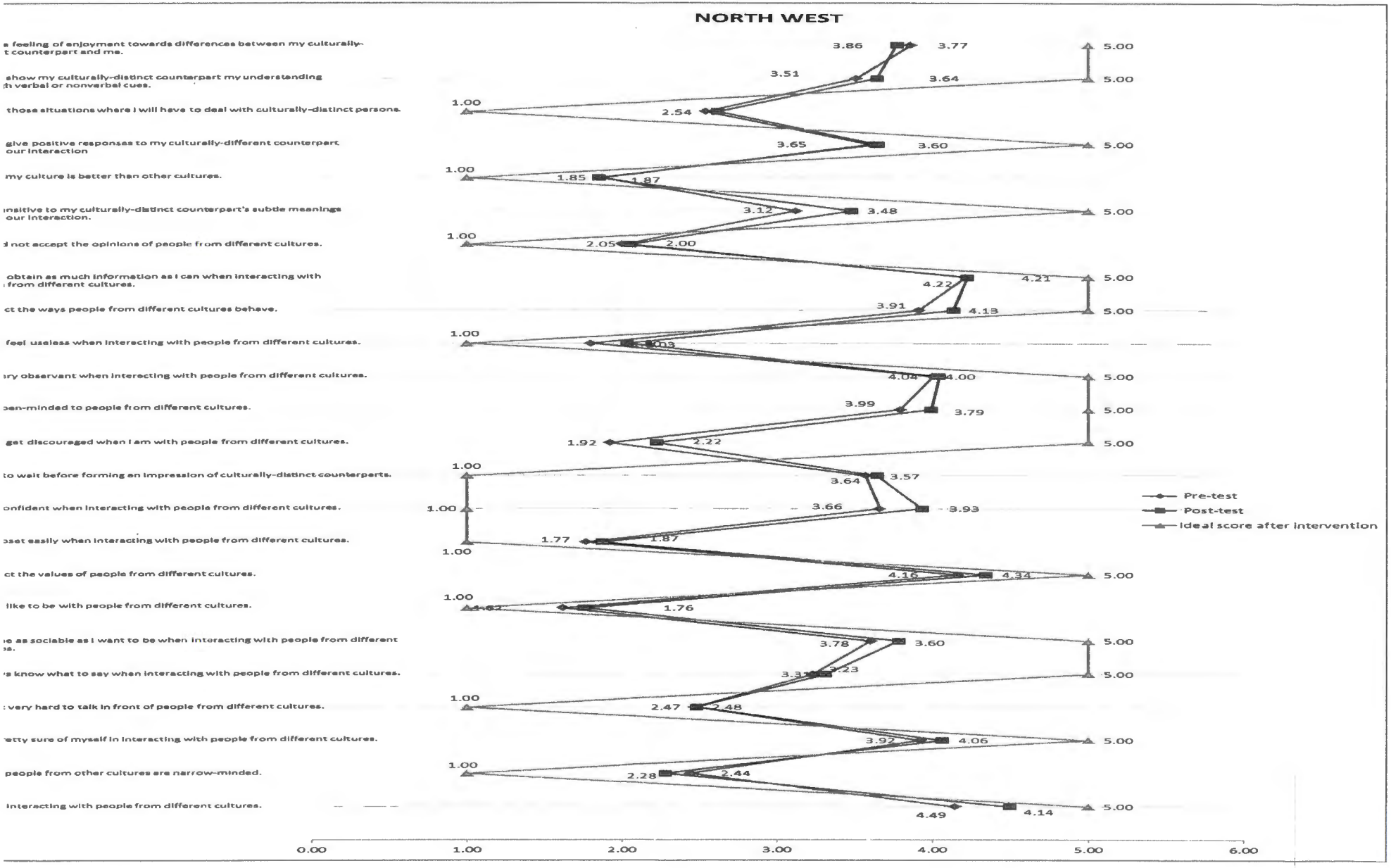
Graph 5.56: I have a feeling of enjoyment towards differences between my culturally-distinct counterpart and me

The respondents across the board agreed with this statement. Upon the training programme, Gauteng shows increased agreement from 76% to 82%, as Western Cape follows suit with an increased agreement from 50% to 58%.



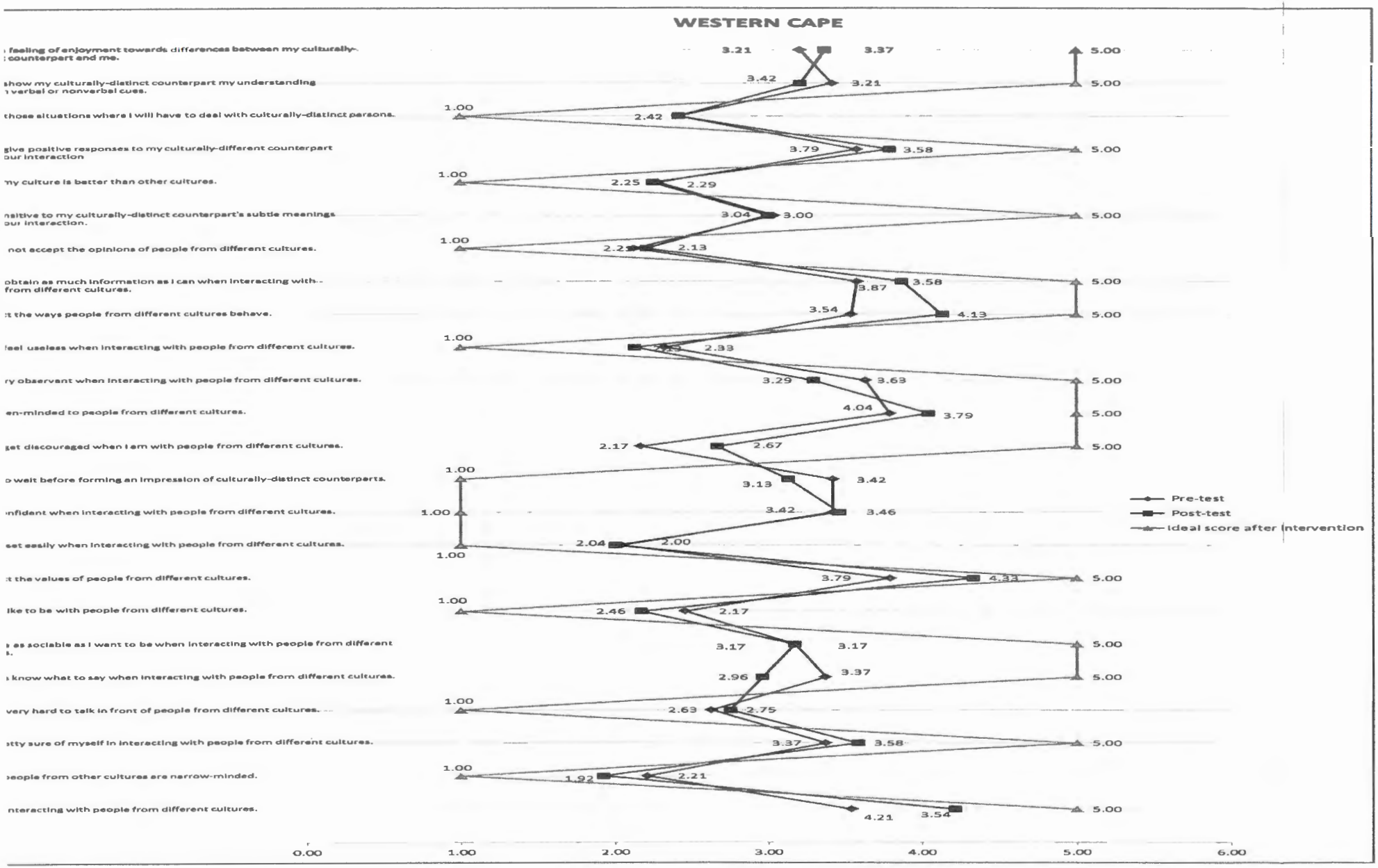
Overall graphs for Gauteng

The graph for Gauteng shows no attitudinal changes between the pre-test and the post-test responses after the training programme with regards to sensitivity towards other cultures. All questions followed the curve of the ideal responses as depicted in green on the graph above.



3 Overall graphs for North West

From this graph, it is evident that the treatment intervention had very limited impact on the North West experimental group. There seems to be a very slight change in the reported feelings of competence when dealing with persons from another culture, but it is statistically insignificant.



Overall graphs for Western Cape

The Western Cape showed a statistically significant change in attitude after the training programme, with reference to showing respect to other cultures and knowing what to say to persons from another culture. The Western Cape, during the post-test, admitted more readily that they do not always wait before they form an opinion about persons from another culture.

5.6 DISCUSSION OF THE RESULTS

This section will discuss the findings and relate it to the literature review. The synthesis and clarification of the findings will be according to the research objectives.

5.6.1 MAVAS questionnaire

The MAVAS questionnaire has certain themes identified with the different questions, and these themes are internal causes of aggression and violence, External causes of aggression and violence, Situational causes of aggression and violence and management of aggression and violence. The treatment administered to the respondents as training programme incorporated all of these themes in the curriculum as set out in section 5.2.4.3. The researcher performed the pretest prior to the treatment, with the post-test administered after the treatment in order to see if there is an attitudinal change in respondents with regards to these themes on the MAVAS questionnaire. After the perusal and analysis of the responses, the following conclusions are made.

5.6.1.1 Internal causes of aggression and violence

Questions (4) four, (5) five, (7) seven, (9) nine, 14 and 17 relate to the internal causes of aggression, i.e. causes within the patient.

- **Question four: It is difficult to prevent patients from becoming violent or aggressive**

  Notably, at least 52.9% of the respondents reported that it is difficult to prevent patients from becoming aggressive. In the post-test after the training programme, this percentage decreased to 47.1%, the p – value being (p=0.750). As such, p>0.05 shows that the training programme had no significant statistical effect on the Gauteng group. North West experimental group had a low indication of 39, 6% agreement with the statement and it decreased to 31.9%. The (p=1.987) also appears statistically insignificant, with a similar

finding for Western Cape, namely (p=0.382). Therefore, the training programme did not affect any significant statistical changes in the attitudes towards this statement.

Observably, the attitudes within all three groups remained stable, regardless of whether the training was done or not. Therefore, the null hypothesis (H_0) is accepted and the training programme made no change in the attitudes of the respondents with reference to their perceived difficulty in the prevention of violence and aggression.

- **Question five: Patients are aggressive because they are ill**

All respondents were in agreement with the statement that patients are aggressive because of their illness. Albeit statistically insignificant, it is noted however that scores for all experimental groups did change with regards to the percentage of who agrees with this statement during the post-test. The differences are as follows: Gauteng 76.5% to 82.4%, North West 53.8% to 54.9% and Western Cape from 58.3% to 70.8%. The expected ideal response for this question also points towards agreement with this statement.

The majority of the respondents were in agreement with this statement and subsequently, because this is an accurate perception of the respondents, the training did not change their attitudes, thus the null hypothesis (H_0) is accepted. Therefore, it can be stated that the training programme had no effect on the respondents. All probability values exceeding 0.05 namely Gauteng (p=0.422), North West (p=0.334) and Western Cape (p=0.216) lead the researcher to accept the null hypothesis (N_0), indicating a statistically insignificant relationship between the training programme and the attitudes in the post-test. The strong agreement with this statement corresponds well with findings wherein Duxbury and Whittington (2005:474) reported that nurses clearly see mental illness as a good indicator of aggression and violence,

- **Question seven: There appear to be types of patients who frequently become aggressive towards staff**

All the respondents were in overwhelming agreement with this statement based on the one tail t-test; Gauteng was the only group which showed a statistical insignificant change between the groups on the posttest Gauteng (p=0.014) leads to a rejection of the null hypothesis (N_0),. An interesting phenomenon on this question is that within the groups when

computing the one-tailed test, both North West and Western Cape showed a statistically significant change. The probability values for this test are reflected as follows, for North West (p=0.066) and for Western Cape (p=0.641). Because p>0.05, it is stated that the null hypothesis (N_0) cannot be rejected and the training made I significant statistical difference.

- **Question nine (9): Patients who are aggressive towards staff should try to control their feelings**

With the probability values for the three experimental groups reportedly being Gauteng (p =0.136), North West (p =0.694) and Western Cape (p=0.110) none of the three experimental groups showed any statistically significant changes in attitudes in this question. Therefore, the null hypothesis (H_0) could not be rejected for this response; hence the training programme had no significant statistical effect on the three groups.

It, however, remains observable that agreement with this statement did decrease between the pre-test, administration of treatment and the post-test, Gauteng showed a decrease in agreement from 70.6% to 64.7%, North West from 76.9% to75.8% and Western Cape 79.2% to 70.8%.

- **Question 14: Aggressive patients will calm down automatically if left alone**

The majority of respondents disagreed with the statement that respondents will automatically calm down if left alone. The North West province showed a statistically significant change in attitude. However, it is remarkable that they did not receive the training programme which dealt with aggression or the management of aggression. They only received training in cultural awareness and sensitivity. This group, in terms of demographics, is also the youngest group in comparison with the other groups.

The training programme only affected the attitudes of the North West experimental group. However, for the Western Cape and the Gauteng groups, the null hypothesis (H_0) could not be rejected. Upon closer inspection, it is however evident that for both Gauteng and the Western Cape, the post-test showed minimal higher agreement with the statement. After the training programme for Gauteng, the agreement in the Post-test increased to 47.1% from the initial 23.5% in the pre-test. Similarly, the Western Cape response increased to 37.5% in the post-test after an initial 33.3% agreement in the pre-test. The p values being p>0.05 for

Gauteng (p=0.216) and Western Cape (p=0.200) show no relationship between the training programme and the attitudes in the post-test of Gauteng and Western Cape.

This is observation in contrast with the perception of the indigenous healers in section 4.7.3.1, where they recommend that the calmness of the mental health care provider should rub off on the aggressive person and that it is not always necessary to intervene. The aggression can be easily managed if the cause is removed.

- **Question 17: Expressions of aggression do not always require staff intervention**

Question 17 was met with an overwhelming response rate indicating disagreement with this statement.

The post-test showed a slight decline in disagreement with the statement, namely Gauteng now reported 76.5% disagreement as opposed to the 82.4% disagreement before the training. North West dropped from 80.2% down to 60.4% and at a $p<0.05$, namely (p =0.002), this is the only group which shows a significant relationship between the training programme and the post-test scores. Disagreement in the post-test in the Western Cape dropped from 45.8% to 41.7%, and shows no statistical significance as (p =0.539). Therefore, it can be deduced that only the North West experimental group showed a significant difference in response after the treatment.

The posttest also showed that the treatment intervention could not persuade the respondents otherwise. This attitude proves to be very tenacious in comparison with the North West experimental group, where their conviction of disagreement changed from 80% during the pretest to lower to 60.4% during the posttest even though they only received training in cultural sensitivity and awareness. The outcomes of the qualitative research in chapter four (4) section 4.10.4.3 show that the indigenous healers, both the *Khoisan* and *Basotho,* informed that often no interaction is necessary. McCann *et al.* (2014:2) and Brodaty *et al.* (2007) reported similar conflicting feelings in staff as to when intervention is necessary.

5.6.1.2 External causes of aggression.

This theme is observed in questions 1, 16 and 27.

- **Question one (1) Patients are aggressive because of the environment they are in**

The statement in question one (1) refers to the environment being a cause of patient related violence. As observable in graph and table 5.3, Gauteng showed no statistically significant change in their attitudes towards this question $p>0.05$ at ($p=0.422$) the probability level exceeding the set p level indicating a statistical insignificant relationship between the training programme and the post-test results. This might possibly be explained by the fact that Gauteng reported that 82% of their respondents had training in the management of aggression and violence.

North West and Western Cape, on the other hand, showed a significant change in attitude towards this question, with North West showing a significant increased agreement between post and pre-test from 73.6% to 94.5%. Even though they only received training in cultural sensitivity and awareness, the Western Cape experimental group on the other hand underwent the total training programme and showed an increased response of agreement from 45.8% during the pre-test to 83.3% during the post-test. For the North West group, the p value is ($p=0.000$) which indicates a statistical significant difference in scores for the pre-test and the post-test. Similarly, the Western Cape who received the total training programme had a post-test p value of ($p=0.030$), also showing a statistically significant difference.

Therefore, the null hypothesis (H_0) is accepted for Gauteng but rejected for the North West and the Western Cape, the conclusion being that the training programme had a statistically significant effect on the North West and the Western Cape, and had a positive attitudinal change.

This finding echoes what was observed by Duxbury and Whittington (2005:474), where both staff and patients recognise the role of the environment in adding to mental health care user related violence and aggression.

- **Question 16: Restrictive care environments can contribute towards patient aggression and violence**

All of the respondents recognised how the restrictive care environments can contribute towards patient related aggression and violence, and the training programme brought about a statistically significant change in attitude in the Western Cape ($p=0.010$) and the North West

(p=0.014) experimental groups, indicating that the null hypothesis can be rejected. Gauteng, who previously had training, maintained their positive agreement with his statement. Western Cape showed the highest post-test agreement with this statement, namely an increase from 66.7% to 91.5%. North West did not show such a large margin of growth, which is to be expected if it is considered that they were not exposed to the training programme. It is uncertain what might have affected such an attitudinal change in the absence of the training course.

This observation of agreement is consistent with a finding by Duxbury and Whittington (2005:474), whereby they reported that staff and patients both identified the environment as a contributing factor in the manifestation of aggression and violence.

- **Question 27: If the physical environment were different, patients would be less aggressive**

Similar observations were made with reference to the responses of the North West group to a question of changes in the physical environment, where they only received training on cultural sensitivity and awareness, yet they are the only group who showed a significant difference in response in the post-test (p=0.001). Gauteng showed increased agreement with the statement, namely an agreement rate of 70.6% in the pre-test and an increase to 88.2% in the post-test, although they received training in theories around aggression. This proves that re-confirmation of prior knowledge may result in attitudinal changes.

5.6.1.3 Situational causes of aggression

Situational causes are reported in questions two (2), three (3), six(6), 15, 20 and 23, where there is reference to communication between staff and patients, actions of people, relationships and situations which might all contribute to patient related aggression.

- **Question two (2)** *Other people make patients aggressive or violent*

Question two (2) specifically refers to people causing aggression in patients. Even though Gauteng showed an insignificant decrease in agreement with this statement from 88.2% to 82.4% (the cause of which is uncertain), the majority still agrees with other persons contributing and causing aggression. North West and the Western Cape showed a change in

attitude towards this statement and increased agreement with this statement after the training programme and subsequently. The null hypothesis (H_0) cannot be rejected for Gauteng, due to the probability for Gauteng being (p=1.608) thus p>0.05.

The contrary is noted for both North West and Western Cape, the respective probability values being (p=0.003 and p=0.031) p<0.05. Therefore, it can be inferred there is a statistically significant relationship in the training for North West and Western Cape in the post-test attitudes.

This kind of agreement, especially when referring to the word "other" in the statement, is part of what is referred to as the attributional theory (Duxbury & Whittington, 2005:470), where it takes the responsibility away from the nurse and attributes it towards either the patient or the situation. The researcher, therefore, assumes that being equipped with knowledge and also the strong presence of attributing responsibility elsewhere makes it easier for respondents to agree with this statement.

- **Question three (3) Patients commonly become aggressive because staff does not listen to them.**

All three groups showed a statistically significant increased agreement with the statement in question three (3) which states that patients become aggressive because staff do not listen to them. This response is very important as it shows that the training programme made staff more aware of the importance of communication between them and the mental health care user and how poor communication leads to patient aggression, as is seen in question six (6) The statistical significant observation is observed in the probability value for the respective experimental groups, namely, Gauteng (p=0.004), North West (p=0.000) and Western Cape (p=0.002) The null hypothesis is rejected because p<0.05 and therefore the training programme is deemed to have had a significant influence on attitudes.

- **Question six (6) Poor communication between staff and patients leads to patient aggression**

The three experimental groups all strongly agreed with this statement in the pre-test. During the post-test, it is observed that the perception increased in Gauteng from 76.5% to 88.2%, but due to the p-value being p>0.05, the training programme made no statistically significant

difference in Gauteng. The two other experimental groups on the other hand show a statistically significant relationship between the post-test and the training programme, as the $p<0.05$ in the North West and Western Cape. The values are ($p=0.000$) for North West and ($p=0.047$) for the Western Cape. The null hypothesis (H_0) is therefore rejected and it is deduced that the training made a statistically significant difference in North West and the Western Cape. For Gauteng, the null hypothesis (H_0) is accepted and the training made no difference there.

- **Question 15: The use of negotiation could be used more effectively when managing aggression and violence**

Although all respondents agreed with this statement and it is not expected to sway attitudes and opinions in any other direction, it is noted that there is a statistically significant difference in the North West experimental group in terms of their post-test p-value, with ($p=0.015$) showing that the training programme impacted on their response to show an even higher agreement from an initial 81.3% to 91.2%.

The Gauteng response remained exactly constant. However, there was a slight decline in the post-test agreement observed for the Western Cape. With $p=0.765$ there is no relationship between this observation and the training programme. This observation, however, remains unexplained. Therefore, based on the observed p-values for both Gauteng and Western Cape $p>0.05$, the null hypothesis (N_0) cannot be rejected and therefore it is concluded that the training made no difference in these two provinces.

- **Question 20: Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence**

Ninety percent of respondents across the three experimental groups felt that improved one to one relationships between staff and patients will reduce the incidence of violence in the wards. The training programme also addressed this aspect and the agreement remained in the high 90%. All three groups recognised the role situations play in the expression of anger and aggression by patients and this was the ideal response. Therefore, the researcher did not foresee that attitudes will change on this question, and indeed it did not.

- **Question 23: It is largely situations that contribute towards the expression of aggression by patients**

None of the three experimental groups shows any significant change in attitude after the training programme. Gauteng shows a decreased confidence in agreement with this statement from 88.2% down to 70.6%. This decrease is not statistically significant as $p>0.05$ namely ($p=0.111$). Even though North West increased agreement with this statement from 87.9% to 91.2%, this too is not statistically significant ($p=0.620$) and the same holds true for the Western Cape ($p=0.620$) after an increase in agreement from 62.5% to 79.2%. The responses here correspond well with previous agreement in question two (2) stating that other people make patients aggressive or violent.

This is a similar observation as seen in the study by Duxbury and Whittington (2005:470) who refer to a finding by Whittington and Wykes (1994b), where the authors observed that institutional pressures compelling staff to enforce rules may lead to an increase in institutional factors, thereby confounding mental health care user related aggression. Often these situations might not be in the control of the mental health care provider. Currently, the researcher observes in the Western Cape that the mental health care institutions are forced to become smoke-free areas. This policy, which is being implemented at ward level, has led to a reported increase in incidences of mental health care user related violence.

5.6.1.4 Management of aggression and violence

Questions 8, 10, 11, 12, 13, 18, 19, 21, 22, 24, 25, and 26 dealt with staff attitudes towards the management of aggression and violence.

]

- **Question 8: Different approaches are used on this ward to manage patient aggression and violence.**

North West province was the only experimental group who showed statistical significance with $p=0.00$ where $p<0.05$. The null hypothesis (H_0) is rejected. The other two experimental groups showed no change in attitude regarding the response on this question. It is, however, evident that there was a slight increase in agreement with this statement after the training programme for all provinces, albeit not statistically significant. Gauteng increased the positive

response from 47.1% to 58.8%, North West 38.5% to 63.7% and the Western Cape from 65.2% to 75%.

The training programme focused on how it is beneficial to adapt the ward to suit the needs of the client. Therefore, this change in the post-test response leads the researcher to conclude that the respondents are in agreement with this proposal.

- **Question 10: When a patient is violent, seclusion is one of the most effective approaches to use**

Seclusion and the use of medication remains the method of choice to deal with patient related aggression and violence, as reported by the majority of the respondents. North West province was the only experimental group showing a statistically significant change in attitude during the post-test, namely (p=0.000). It is, however, uncertain what caused this change in attitude as they did not receive training in the management of aggression and violence; they merely received training in cultural sensitivity and awareness. Similarly, this group from North West has the fewest years of experience in mental health nursing, so it seems the logical conclusion to make is that due to this lack of experience, they have not been exposed to as much seclusion of MHCU as the other groups, hence this response.

- **Question 11: Patients who are violent are often physically restrained to administer sedation**

The posttest for all three groups showed no statistically significant differences. Therefore, it can be safely assumed that the training programme did not affect the attitudes of the respondents to this statement. The practice of sedating MHCU's in order to manage violence and aggression is common course in mental health care nursing, and a practice which will never be abolished. Duxbury and Whittington (2005:470) note that Wright (1999) found that staff is reportedly uncomfortable with these practices, yet they accept that it is part of the management strategy in dealing with aggression and violence. The researcher concurs with this finding and agrees that these practices will continue but that there is a need for policy guidelines regarding the practice of restraint and seclusion.

- **Question 12: The practice of secluding violent patients should be discontinued**

North West showed a significant change in attitude from an initial 30.8% agreement with the statement to a 61.5% agreement with the statement. The calculation of p=0.00 thus p<0.05 requires a rejection of the null hypothesis (H_0), with evidence that the training programme influenced the attitudes of respondents with regards to the practice of seclusion. The other experimental groups maintained the attitude that these practices cannot be discontinued. The researcher proposes approaches for question 12. This practice will be more acceptable if it is guided by policy guidelines.

A possible reason why the respondents had a change of attitude cannot be linked with the training as they had not received training on the management of aggression and violence. It might be due to the influence of having received cultural sensitivity and awareness training that this influenced their response. It is important to note that the responses of the other groups are close to the ideal responses for this statement. Therefore, there was no attempt to change their attitudes through the training programme. The responses about not discontinuing the practices of seclusion in this study echo findings by McCann *et al.* (2014:5)

- **Question 13: Medication is a valuable approach for treating aggressive and violent behaviour.**

The use of medicine remains a valuable method. All the respondents agreed with this statement and it is observed that the training programme did not change the attitudes of the participants at all. The null hypothesis (H_0) is therefore not rejected, based on the probability values for Gauteng (p=1.00), North West (p=0.192) and Western Cape (p=0.257) i.e. all p-values p>0.05.

Noteworthy is that the North West group had an insignificant increased disagreement during the posttest namely from a 28.6% disagreement in the pre-test to a 36.3% increase during the post-test. This is inexplicable.

- **Question 18: Physical restraint is sometimes used more than necessary**

The majority of the respondents admitted that restraint is used more than necessary. This response correlates well with the response in question four (4), whereby the respondents

found it difficult to prevent patient related aggression. The slight increase in the self- reported response on this question bore no statistical significance. It is, however, disconcerting that this practice still happens in mental health care facilities. The researcher notes how Duxbury and Whittington (2005:470) and McCann *et al.* (2014:5) also observed that it is commonly reported.

- **Question 19: Alternatives to the use of containment and sedation to manage patient violence could be used more frequently**

This question had similar strong responses in agreement with the statement by all respondents and the post-test means were similar to those of the pre-test. As all of these means were $p>0.05$, the null hypothesis (H_0) could not be rejected and therefore training had no effect on this response.

Respondents in this research project felt that alternatives to the use of containment and sedation could be used more frequently. This is important for presenters of training programme, as it implies mental health care providers are ready to change the way in which things are being done.

- **Question 21: Patient aggression could be handled more effectively on this ward**

Gauteng showed a 100% response that aggression could be handled more effectively. This stayed constant as did North West on 93.3%. The Western Cape increased this opinion from 70.85 to 79.2%. Even though this was the ideal response in all groups, the presence of an increase of 8.35% in the Western Cape shows that the training programme succeeded in confirming opinions and swaying some opinions towards the ideal response. Similar responses were noted with regards to the use of medicine, as previously stated.

- **Question 22: Prescribed medication can in some instances lead to patient aggression and violence**

The training programme included literature explaining paradoxical effects caused by medication and how this can often increase levels of aggression in MHCU. This training had no statistically significant effect on Gauteng or the Western Cape. It however had a statistical effect on North West with a probability level of ($p=0.023$) $p>0.05$.

It is uncertain what caused this attitudinal effect, as the respondents did not receive this training programme prior to the posttest.

- **Question 24: Seclusion is sometimes used more than necessary**

Even though the majority of the respondents in all experimental groups agreed with this statement, only the North West experimental group showed a statistically significant difference in attitude between the pretest and the posttest scores, with a *p* value p=0.003 directing the researcher to reject the null hypothesis (H_0) and accepting that either the training programme on cultural sensitivity and awareness or the MAVAS questionnaire itself effected an attitudinal change in the respondents. McCann *et al.* (2014:3) confirms this finding, where negative attitudes of staff are linked to an increase in the use of containment methods to manage aggression

- **Question 25: Prescribed medication should be used more frequently to help patients who are aggressive and violent**

All three experimental groups agreed with this statement in both the pre-test and the post-test and the null hypothesis (H_0) could not be rejected for any of the three experimental groups. Therefore, it is evident that the training programme had no statistically significant impact on any of the experimental groups.

This is a similar finding as observed by Duxbury and Whittington (2005:475) and McCann *et al.* (2014:5) and it is being referred to as the therapeutic modality and biomedical model. Duxbury and Whittington (2005:475) continue to report that the use of medication and "rapid tranquilisation" is being followed in the United Kingdom.

Due to staff shortages, and when it is observed that the majority of the respondents as can be seen in having between one (1) and five (5) years of experience. It may be a bit premature to recommend practices such as rapid tranquilisation in South Africa due to the lack of experience of staff. Graph 5.2 shows that the majority of the respondents in this research are students, nursing auxiliaries, enrolled nurses, registered nurses and psychiatric nurses. These categories are not allowed to administer rapid tranquilisation and in South Africa, this can only be administered by a medical doctor. Therefore, based on the categories of staff

employed in mental health care facilities, it is not a feasible practice at this stage. This practice is more suitable in the 72-hour facilities which are situated in the general hospitals. The qualified staff available in these facilities is more readily available, as is the equipment should it be necessary to resuscitate a mental health care user. The mental health care facilities in South Africa are not geared to deal with this type of MHCU who requires intense and rapid sedation. These MHCU's would be referred to general hospitals for such management.

- **Question 26: The use of de-escalation is successful in preventing violence**

It is observed that from the outset, all groups agreed with this statement. As this is the ideal response, it was not anticipated that the respondents would change their opinion from agreement to disagreement.

These responses make it clear that respondents are prepared to use these techniques as from the responses in questions 3, 6, 8, 15, 19 and 21. It is evident that respondents are not entirely satisfied with the way things are currently done in the respective mental health care facilities.

Duxbury and Whittington (2005:476), mention that the use of de-escalation is not easy, the researcher concurs with this finding because the use of de-escalation is not a one cure fits all solution. It must be tailored to suit the individual client. Patients reported during a study done by Cowin *et al.* (2003) as mentioned by Duxbury and Whittington (2005:476) that they were not satisfied by the way staff used de-escalation; they rather promoted more therapeutic relationships.

This observation by the patients echoes what the respondents in this research agreed with, namely that there could be an improvement in the communication between staff and patients and negotiations could be used more effectively.

5.6.1.5 Concluding remarks

The preceding sections discussed the findings of the MAVAS questionnaire, and the inferences made by the researcher, with comparison to existing literature. The next section will deal with the findings of the inter cultural sensitivity scale when observing the pre-test and post-test results.

5.6.2 Inter cultural sensitivity and awareness questionnaire

This section will address the responses question by question, and inferences will be made based on the findings in combination with the literature as found in chapter two (2)

5.6.2.1 I enjoy interacting with people from different cultures

The statistics shows that the intervention proved to be effective in changing attitudes with reference to interacting with persons from a different culture. For the North West province, both the other provinces scored $p>0.05$, noteworthy the one tail test for the Western Cape regarding the within group scoring shows $p>0.05$ namely $p=1.714$, but it does not show a similar effect for the between group comparison. Subsequently, North West shows a statistically significant response which allows for the researcher to reject the null hypothesis (H_o), and for the within group Western Cape follows suit with a subsequent rejection of the null hypothesis (H_o). It can therefore be stated that the training programme had an effect on the attitudes of the respondents with regards to whether they enjoy interaction with people from a different culture. All the experimental groups were exposed to the training programme, but at different stages. The response in North West who had the youngest group of respondents, leads the researcher to conclude that the younger persons might be more amenable to change attitudes.

5.6.2.2 I think people from other cultures are narrow-minded

All three experimental groups with an overwhelming majority were in disagreement with this statement in both the pre-test and post-test. For all of the experimental groups, the means were the same, whereas $p>0.05$, therefore the null hypothesis (H_o) could not be rejected and it is evident that the training programme had no impact.

All experimental groups already showed a positive regard for persons from other cultures

It is, however, observed that after the training programme there was a slight increase in disagreement with the statement that other cultures are narrow minded. 10% more respondents disagreed with this statement in the post-test for Gauteng and North West. The largest margin of observable difference is in the Western Cape, where the pre-test disagreement was at 67% and this increased to 83%. Even if this is not statistically significant, it is observed that there is an

attitudinal change after the presentation of the training programme for cultural sensitivity and awareness.

5.6.2.3 I am pretty sure of myself in interacting with people from different cultures

All three experimental groups had a strong agreement with this statement. Notably, even though it is not statistically significant, all three experimental groups showed a slight increase in the reported agreement with this statement. Gauteng increased from 65% agreement in the pre-test to 82% agreement during the post-test. North West increased from 74% agreement to 80% agreement and the Western Cape from 50% to 67%. Reflected as percentages, it makes this observation more visible yet it is not statistically significant and, therefore, the null hypothesis (N_0) cannot be rejected.

5.6.2.4 I find it very hard to talk in front of people from different cultures

Due to the means of the three experimental groups being similar, the null hypothesis (N_0) cannot be rejected. The training, therefore, had no effect on the different groups. The Western Cape is the only group with a slight change in the level of disagreement with this statement, namely from a 58% disagreement, it decreased to a 46% disagreement with the statement. The deduction that the researcher makes is that the Western Cape possibly felt more at ease to reveal how they actually felt about this response after rapport was built between them and the researcher who presented the training course.

5.6.2.5 I always know what to say when interacting with people from different cultures

The overall means show no difference and calls for an acceptance of the null hypothesis (N_0). However, a closer observation of the data reveals the one tail p value for the Western Cape to be<0.05 namely $p=0.033$, therefore the within group analysis shows a statistically significant difference for the Western Cape on this response and therefore the null hypothesis (N_0) is rejected for the Western Cape. At the set confidence interval of 95% there is therefore a 5% possibility that this phenomenon might not be linked to the training programme. Some possibilities for this phenomenon might be due to, the presence of the researcher, the possible influence of the treatment intervention or an unidentified variable.

It is noted that the responses on the previous question referring to "talking in front" of other persons are deemed to be vastly different from knowing what to say "to" other cultures. This is an interesting, almost contradictory, observation with no obvious explanation as to the cause.

5.6.2.6 I can be as sociable as I want to be when interacting with people from different cultures

The pre and post-test did not differ significantly for any of the three experimental groups. As a matter of fact, in all three groups the majority of the respondents agreed with the statement. Remarkably, the Western Cape had lower agreement responses with this statement in comparison with the other two experimental groups and there was a slight decrease in the agreement response during the post-test in comparison with the pre-test, namely a decrease from 46% to 42%.

The researcher has made a similar observation on questions four (4), five (5) and six (6) contradicting each other in terms of the responses. An inference is that if one reportedly has difficulty in knowing what to say to other cultures, it would make it difficult to be as sociable as you want to be, when interacting with them.

5.6.2.7 I don't like to be with people from different cultures

All three experimental groups reported overwhelming disagreement with the statement. The Western Cape experimental group was again the exception to the rule and, whereas there was an ever so slight decrease in the level of agreement observable, the opposite held true for the Western Cape. The groups showed a 58% disagreement with the statement during the pre-test and a 75% disagreement with the statement during the post-test. This phenomenon might possibly be explained by the fact that the post-test in the Western Cape was conducted after the presentation of the total training programme, as opposed to Gauteng who only had training on theories of aggression and cultural sensitivity and North West who only had training on cultural sensitivity and awareness.

5.6.2.8 I respect the values of people from different cultures

All three groups reported agreement and a slightly higher level of agreement with this statement is observed in the post-test for all three groups. These were, however, statistically insignificant and

the null hypothesis (N_0) cannot be rejected. Therefore, it is evident that the training programme had no impact on the respondents' attitudes towards this statement.

5.6.2.9 I get upset easily when interacting with people from different cultures

All three experimental groups agreed with this statement. Gauteng reported 88% agreement in the pre-test and 94% agreement in the post-test, North West showed 86% agreement in the pre-test and 82% agreement in the post-test. Western Cape reported 71% agreement in the pre-test which increased to 75% agreement in the post-test. All the *p* values >0.05. There is no evidence of relationship between the variables and, therefore, the null hypothesis (N_0) is accepted.

5.6.2.10 I feel confident when interacting with people from different cultures

The statistical analysis of the one tail analysis for the North West experimental group shows up as p=0.027 because p< 0.05. The null hypothesis for this within group test cannot be rejected and the researcher can assume that the training programme influenced this response. Therefore, the non-directional hypothesis (H_1) is accepted. The difference of 10% for this group could not be attributed to erroneous response capturing by the respondents as it is too large a percentage. During the pre-test, the North West experimental group had a 66% agreement with the statement and, during the post-test after the treatment, this increased to a 76% agreement within the group. The one tail and two tail results for the Gauteng and Western Cape experimental groups were all p>0.05 and based on this finding, the null hypothesis for these two groups cannot be rejected and it can be assumed that the training had no effect on these two groups.

5.6.2.11 I tend to wait before forming an impression of culturally-distinct counterparts

Response rates for all three experimental groups remained constant during both the pre-test and the post-test, thus the null hypothesis cannot be rejected due to the similar means observed for the one tail and two tailed calculations.

5.6.2.12 I often get discouraged when I am with people from different cultures

Statistical analysis indicates through the two-tail test that the null hypothesis cannot be rejected for all groups. However, the p (T<=t) one-tail test for North West computes as 0.029 resulting in p<0.05

which shows up as acceptance of the non-directional hypothesis (N_1), indicating that the treatment intervention has indeed significantly influenced the group. Similarly the p (T<=t) one-tail test for Western Cape computes as 0.048 and therefore the same holds true for this group in terms of acceptance of the (H_1), namely the training programme influenced the respondents.

5.6.2.13 I am open-minded to people from different cultures

This question, similar to question 14, reflects agreement with the statement in both the pre-test and post-test scores for all three experimental groups, yet these changes have no statistical significance and are not due to the influence of the training programme.

5.6.2.14 I am very observant when interacting with people from different cultures

The result for this question is addressed by the statement in section 5.6.2.13.

5.6.2.15 I often feel useless when interacting with people from different cultures

All respondents showed similar disagreement with this statement during the pre-test and post-test. Gauteng and North West reported a slight decrease in the reported disagreement with the statement during the post-test, namely for Gauteng the scores from pre-test to post-test decreased from 82% to 76% and for North West it decreased from 85% to 78%. This slight difference stimulates thinking that perhaps the respondents were more comfortable to report actual feelings during the post-test as opposed to during the pre-test when they just met the researcher for the first time.

5.6.2.16 I respect the ways people from different cultures behave

After consultation with the statistician, the conclusion is that the Western Cape shows a statistically significant difference in their response rate as was seen during questions 5, 10 and 12 and forth coming question 19. These findings are made basing on the one-tail t-test hypothesis testing. This shows statistically significant difference for the specific group but on the contrary the two-tail t-test does not show this up in the between test. The assumption is therefore correct if it is deduced that the training programme influenced the response during the post-test.

It is important to note that Western Cape received the complete training programme as opposed to the other two experimental groups who received partial training programme before the administration of the post-test. This might have played an influence on the respondents and due to the nature of the training programme, the Western Cape were exposed to diverse cultural interactions for a longer period, prior to the administration of the posttest.

5.6.2.17 I try to obtain as much information as I can when interacting with people from different cultures

The responses for all three provinces stayed consistent during the pre-test and the post-test, with the only possible conclusion being that the training programme had no influence on the responses of any of the three experimental groups.

Taking into cognisance that this is a sensitive topic and that this is a self-administered questionnaire, it is possible that this might have biased the respondents in their responses.

5.6.2.18 I would not accept the opinions of people from different cultures

Observation of the pre-test and post-test means of all three experiment groups shows that the within and in-between means of these groups show no statistical difference and due to the means being more or less the same, the only logical conclusion being that the null hypothesis (N_0) cannot be rejected. Therefore, the training programme had no influence on the respondents.

5.6.2.19 I am sensitive to my culturally-distinct counterpart's subtle meanings during our interaction

Regardless of the graphs showing that the majority of the respondents agreed with this statement and that these perceptions stayed more or less consistent and were not at all affected by the training programme, the interesting phenomenon which shows up is the high self-reported uncertainty with regards to this question. None of the other questions had a similar 33% response of being uncertain. This is especially true for the experimental groups from North West and the Western Cape.

5.6.2.20 I think my culture is better than other cultures

The attitudes towards this question remained firm and respondents reported that they disagree with this statement. A similar observation is made for Question 21.

5.6.2.21 I often give positive responses to my culturally-different counterpart during our interaction

The respondents reported with agreement on this question in all three experimental groups. It is necessary to elaborate that this is an expected response or an ideal response which the researcher would not wish to change.

5.6.2.22 I avoid those situations where I will have to deal with culturally-distinct persons

Whereas the responses were constantly overwhelming in agreement with question 21, for this particular question there was overwhelming disagreement with the statement, admittedly the type of response one would wish for. These responses did not change with the post-test and due to the means being very similar and all of them are >0.05, it allows for the acceptance of the null hypothesis (N_0). Therefore, the conclusion is that the training programme did not affect the respondents to change their opinion.

5.6.2.23 I often show my culturally-distinct counterpart my understanding through verbal or nonverbal cues

Whereas Gauteng and the Western Cape experimental groups show 7% to 8% increase in agreement with this statement during their post-test responses, the response rate stayed constant for the North West group. This 7% to 8% increase in agreement is of no statistical significance. It is, however, observable when looking at the percentages scored for the different groups.

5.6.2.24 I have a feeling of enjoyment towards differences between my culturally-distinct counterpart and me

There is an observed positive response amongst all three experimental groups, with Gauteng and the Western Cape showing an insignificant increase in this positive response. However, North West to the contrary showed a 2% decrease in the response, depicting agreement with this statement. Even though this is insignificant and overall does not allow the researcher to reject the null hypothesis (N_0), it is nevertheless regarded as an interesting reaction from 2% of the respondents. Therefore, the training programme seems to have had no impact on the respondents.

5.6.1.25 Concluding remarks

The cultural sensitivity and training programme has been noted to have no effect on the responses in the self-reported Intercultural sensitivity scale. The only statistically significant changes observed were noted in question 5 for the Western Cape, question 10 for North West and question 12 for both North West and the Western Cape. When considering that the majority of the respondents in Gauteng had between 16 and 25 years of experience as opposed to the average work experience being one to five years for North West and the Western Cape, the researcher makes the inference that their attitudes are more set and tenacious and would therefore be difficult to sway. This will be further discussed in section 6.2. to highlight the observation that there are definite factors which will impact on changing attitudes.

5.7 CONCLUSION

This chapter presented the analysis of the data which were obtained through self-administered questionnaires during a pre-test and a post-test after the administration of a training programme. Frequency tables and histograms represented the data with a short description of all results. The results of correlation statistics in the form of one- and two-tailed *t*-tests were also reported and discussed in detail.

The following chapter will entail the conclusions and recommendations arising. The limitations of this study will also be declared.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The purpose of this study was to determine if a training programme in the culturally safe management of aggression and violence which includes training in cultural sensitivity and awareness will have an effect on the attitudes of mental health care practitioners in the management of mental health care user related violence and aggression. Chapter one (1) described the background and rationale for this study, highlighting why it is significant to obtain insights from indigenous healers in order to determine what is deemed culturally safe in our dealings with MHCU from very diverse cultural groups.

Chapter two (2) elaborated in depth on the dichotomous nature of health care in South Africa with two diametrically opposing views, namely Western Based Knowledge Systems and Indigenous Knowledge Systems being the foundation upon which these different health care approaches rest.

This research project, being an exploratory sequential mixed method research described in chapter three (3), covered a novel data collection methodology, namely the use of *makgotla*, which was instrumental in augmenting current knowledge and literature, with knowledge as used by Indigenous healers. This newly acquired information was built into the curriculum for the training course in the management of aggression and violence, which formed the training programme (treatment) in this quasi-experimental design. The research methodology was further presented in chapter four (4) focusing on the qualitative phase of this project, as chapter five (5) followed with the quantitative phase.

Chapter 6, being the final chapter, will elaborate on the conclusions and recommendations which arose from this research. The foundation for the recommendations will be the outcomes of this research and the literature review followed.

6.2 CONCLUSIONS FROM THE OUTCOMES

The overall aim of this study was to determine, as stated in section 1.5, if a training programme focussing on the management of aggression, within a multi-cultural context effects attitudinal changes in the cultural awareness, sensitivity, and safety with reference to the attitudes of mental health care practitioners, towards the management of aggression and violence? Furthermore, the researchers wished to answer some broader objectives, thus the following section will deal with whether the research questions were answered

6.1.1 What are the attitudes of Mental Health Care Practitioners towards the management of aggression and violence?

Baseline data was created by means of a pretest and after the administration of a training programme, the posttest was conducted and the attitudes were confirmed for these respondents. Furthermore, a previous baseline experimental research project determined the attitudes of staff towards the management of aggression and violence in a former study (Bock & Pienaar, 2013:109).

6.1.2 An exploration of African Indigenous Knowledge Systems used to manage mental health care user related aggression

Through the conducting of *makgotla*, it transpired that the indigenous healers without formal training have the ability to recognise the signs and the cultural causes for aggression and violence. Depending on the possible cause for the aggression and violence in section 4.9.2, the indigenous healer will decide on the appropriate action to take for each individual client. These findings are evident in sections 4.8 and 4.9. Action taken will vary from the use of verbal skills, physical interventions and de-escalation or diversionary techniques. These constructive actions and the use of diversionary techniques were included in the training programme as is evident in annexure two (2).

6.1.3 The establishment of base-line data on the level of cultural sensitivity and awareness of mental health care practitioners

Base line data was established but this is only applicable to the respondents and cannot be generalised to the larger population. The self-reported data must be viewed with some suspicion as it contains sensitive information, and although it was done anonymously, it may still be biased.

It is interesting to note that the experimental group from the North West province had no previous training in the management of aggression and violence, yet the presentation on cultural sensitivity and awareness played a role in effecting attitudinal changes in light of the management of aggression and violence attitudinal scale.

6.1.4 Discussion of the efficacy of a training programme/ intervention (treatment)

From this research, it is evident that neither the completion of the MAVAS questionnaire nor the training in cultural sensitivity had any significant effect on the Gauteng experimental group and this can be linked to the fact that Gauteng had an 80% previous attendance of a course on the management of aggression and violence and their responses on the MAVAS questionnaire was already as close to the ideal response as can be expected. Therefore it can be deduced that the MAVAS questionnaire alone and training in cultural sensitivity did not change the attitudes of this particular experimental group towards the management of aggression and violence in view of the fact that they had previous training.

However, the training programme in the North West experimental group seems to have influenced their perception of the mental health care user as is reflected on their responses on the MAVAS questionnaire. The majority of the responses were of statistical significance in the post-test. Therefore, it is observed that the training programme had a bigger impact on the younger less experienced group when compared.

The experimental group from the Western Cape showed statistically significant changes in attitudes on the MAVAS questionnaire on questions pertaining to causes of aggression, the environment and communication. The rest of the questions were answered as close to the ideal response as can be expected and therefore the researcher did not expect attitudinal changes in this regard.

The three experimental groups all showed persistent attitudes when responses on the Intercultural sensitivity scale are compared for both the pre-test and the post-test scoring and it can be reported that the training in cultural sensitivity and awareness did not have any effect on the attitudes of the respondents with reference to intercultural awareness and sensitivity. In the North West experimental group, however, it is evident that this training most definitely played a role in their attitudes towards the management of aggression and violence, but not in their Intercultural sensitivity, as their responses were already close to the ideal responses.

The training programme is observed to have the most observable effect on the group from the North West. This group included third and fourth year psychiatric nursing students and it is also the group with the youngest respondents with between one (1) to five (5) years of experience in mental health care. The researcher is thus left with the impression that the younger respondents might be more suggestible with regards to changing attitudes as opposed to the groups with the older respondents.

The above can be explained at the hand of the reported enduring nature of attitudes. Attitude was defined in 1860 by Herbert Spencer and Alexander Bain (as referenced by Cacioppo *et al.*, 1994:261) as an internal state of readiness for action which includes affect. Cacioppo *et al.* (1994:622) elaborates that attitude can become more favourable or less favourable towards a stimulus if it is associated with pleasure or unpleasant contexts and that attitudes are shaped and formed by ideas and consequences that the recipients shape and generate by themselves (Cacioppo *et al.*, 1994:265). Lakkaraju and Speed (2010:76) quotes Visser and Cooper (2003) who observed that individuals tend to hold sets of attitudes which are consistent with each other.

Therefore, the researcher concludes that the person who fears the psychiatric patient and does not understand his culture may have a certain attitude towards him which might influence the way they feel about the management of aggression and violence, as found in MHCU.

6.1.4.1 Understanding regarding the internal causes of aggression and violence

Attitudes with regards to the difficulty of preventing patients from becoming aggressive remained constant and respondents continue to find this difficult to do. Based on the findings in this section, the respondents are aware of the role of mental illness in the manifestation of mental health care user related aggression and violence. The understanding that there are certain types of patients who are more prone to aggression and the fact that the training showed a statistically significant difference for Gauteng proves that the respondents in Gauteng may possibly be better equipped to predict violence in the wards.

The slight decrease in the perception that MHCU should try and control their aggression, as observed in all three experimental groups, shows that staff are more aware of their role and responsibility in preventing aggression, and that aggression is not under the control of the mental health care user.

6.1.4.2 Understanding of the situational causes of aggression and violence

There is statistical support that the training programme effected attitudinal changes in the participants, which showed that they have gained insight into how situations and communication can lead to misunderstandings which increase mental health care user related aggression and violence. The respondents have taken responsibility for their role in the situational causes which may contribute to aggression.

6.2 RECOMMENDATIONS

The recommendations ensuing from this study focus on equipping the neophyte who is still impressionable with the necessary skills to create and sustain a culturally safe environment in which to manage the aggressive and violent mental health care user. The quintessential part of the management of aggression and violence is being able to prevent it from occurring, and this is where the training would be most beneficial for all staff members. Staff should be regularly updated with therapeutic communication skills, as the staff reported they are aware that this is an area where their skills lack.

6.2.1 Suggestions for mental health care facilities

The training of staff in the management of aggression and violence should be linked to the individual performance plans of the staff and should form part of the continuous professional development of employees and link to their annual performance agreements.

Mental health care providers are aware of the role of the environment and confined areas in causing and leading to aggression. They, however, require training in order to make the environment more therapeutic even if it is in a closed unit. The hospitals could possibly invest in breakaway rooms, where a mental health care user could retire to voluntarily to calm down if feeling irate.

The practice of nursing staff restraining patients should be reconsidered and one recommendation would be the appointment of mid-level workers, trained in safe restraint of the aggressive mental health care user as this would add to alleviating the fear of the nursing personnel regarding restraint, and the possibility of sustaining injuries. This procedure requires skilled employees and a recommendation would be specially trained persons to deal with the matter of restraint. If persons

other than the nursing staff are used for restraint it might have appositive impact on therapeutic nursing care. This approach might contribute to nursing staff adopting their role as primary care givers and primary therapists, as opposed to merely delivering custodial care. This will add to the creation of more therapeutic ward environments with MHCU as the nursing staff's attention will be on therapeutic interaction as opposed to fearing the clientele they serve. It is however noted that not all the facilities where the researcher conducted this research is as keen on using security officers to restrain violent MHCU, therefore it is perhaps advisable that this trained person be a mid-level worker but not a care giver.

6.2.2 Suggestions for nursing curricula

Nursing curricula should include management of aggression and violence and transcultural nursing as this phenomenon is not restricted to mental health care only but it is also very common in trauma and emergency units, labour ward and reportedly also among visitors. The management of aggression and violence is beneficial to all medical professionals, regardless of the type of unit where they are employed.

One of the hospitals in Gauteng informed the researcher that they provide training on the management of aggression and violence to all new appointees upon orientation of the neophytes, furthermore they reportedly do not use security officers to assist in the management of mental health care user related aggression.
Nursing curricula should include both IKS and WBKS in the curricula as this will contribute towards sensitising nurses to be culturally aware, sensitive and safe.

6.2.3 Suggestions for the content of training programme for MHCU

As observed in section 5.6.1.2 mental health care providers are often conflicted as to when it is necessary to intervene, they often miss the opportune golden period for de-escalation and aggression flares out of hand. This then necessitates more traditional methods to manage aggression such as restraint, sedation and seclusion. It is, therefore, proposed that guidelines be drawn up for staff in the form as a protocol to indicate what type of intervention is advised at the different manifestations of aggression and violence. In combination with the traditional methods of the biomedical system, the inclusion of practices by indigenous healers such as allowing a person to calm down on their own if there is no imminent danger involve, and practices such as not intimidating and rather making the aggressor feel welcome should also be encourages as this

harbors trust in the mental health care provider, as opposed to the too often coercive methods employed as referred to by Steinert *et al.* (2014:6).

The training programme for mental health care providers, who are experienced in mental health care, cannot be the same as those of the foundational programme. These training packages should be geared at re-affirming existing knowledge and skills and teaching ethical principles in the use of restraint and sedation, Duxbury and Whittington (2005:471) made similar recommendations.

The rationale behind this recommendation by the researcher is found in the following: creating an improved understanding of mental illness.

Exposure to mental health care user's aggression and violence will influence a person's judgment and becomes part of the experience of the mental health care provider. Experiences lead to the formation of attitudes; therefore it is possible that previous experience might add to the enduring nature of attitudes. This deduction is confirmed by Cacioppo *et al.* (1994:263). In resonance with the abovementioned is also the attributional theory which postulates that the inference a person makes about the cause of behaviour directly influences attitude.

These theories made the researcher to assume that with more exposure to mental health care user related violence, attitudes may possibly be less favourable towards the management of aggression and violence, which might possibly impact on training programmes, especially when considering attitudes are deemed to be enduring in nature, therefore creating an understanding of the motives of behaviour, might positively influences a person's attitude.

6.2.4 Suggestions for the community

The makgotla in the community exposed the existence of destructive practices such as beating the mentally ill when they are aggressive and violent, throwing stones and displaying attacking behaviour due to fearing the mentally ill community member. It is proposed that the researcher return to these communities and highlight the effective practices they have, but also give more health education on mental illness and how destructive practices will lead to an increase in the violent behaviour.

6.3 RECOMMENDATIONS FOR FURTHER STUDIES

A proposed sequel to this study would be an immediate follow up in one of the hospitals utilised for this study, however the proposal is that one ward will be used and all of the staff working in this specific ward be exposed to the training programme with a follow up posttest to be conducted after four weeks and then repeated six months later to determine if there are any long-term sustained attitudinal changes.

Further studies could also perhaps focus on other avenues:

- The perspective of patients with reference to the efficacy of training programmes on staff attitudes.
- The perception of the mental health care user with regards to cultural safety in mental health care
- The characteristics of a culturally safe mental health care environment.
- Research on "unlearning" destructive attitudes in the mental health care worker with more experience and longer exposure to MHCU.

6.4 STUDY LIMITATIONS

The limitations identified in this study are mostly related to aspects around the research methodology. The use of a self-reported questionnaire, albeit anonymous can still be very biased especially so if it deals with sensitive issues such as self-reported with regards to cultural sensitivity, which is a very contentious matter in South Africa.

Quasi experiments are not as strong as randomised experiments (Rosnow & Rosenthal, 1999:157), therefore a randomised experiment is proposed for future research.

This study focused on short-term attitudinal changes after the presentation of a training programme to equip participants with the knowledge to manage mental health care user related aggression and violence, however some limitations are observed.

Further limitations in this study is identified to be the duration of the training course which was originally planned for a minimum of three days, but ultimately being fitted into one day. The content load of the training programme (treatment) was very high for a one day course, regardless of

justification through alluding to limited time available due to the operational requirements of the respective hospitals felt outside the control of the researcher.

The researcher recommends a longer time lapse between the administration of the training programme (treatment) and the conduct of the posttest. Unfortunately through direct experience of the poor response rate in the small control group, the researcher had to ensure an improved response rate to render credibility to the findings of the study and had to resort to collecting posttest data whilst still in the field.

Due to reported staff shortages as can be seen in the e-mail correspondence in Annexure seven (7), the researcher had to rely on the availability of respondents to be set free by their respective managers in order to attend the training programme, subsequently this impacted on the size of the different experimental groups, therefore this research cannot be generalised to the general population but only to the respondents in this research.

6.5 SUMMARY

An exploratory sequential mixed method research was conducted, investigating the effect of a training programme including culturally safety and awareness and the management of aggression and violence on the attitudes of mental health care providers. The setting for this study was mental health care facilities with acute admission units in four different provinces in South Africa, namely the North West Province, Gauteng, Western Cape and the Northern Cape and indigenous healers in two of the provinces where the mental health care providers from the same cultural group as the indigenous healers are referred to in the event of a suspected mental illness.

The overall conclusion from this study is that indigenous healers without any official training in the management of aggression and violence have skills which are beneficial for mental health care providers. These skills should be included in training programmes and curricula to skill mental health care providers in the management of aggression and violence. From this research, it is observed that the training course during which some of these skills were demonstrated proofed to be more readily adopted by the mental health care providers with the least amount of experience as mental health care providers. This stems from the more tenacious nature of prolonged attitudes as observed in persons who adopted these attitudes through more years of work experience in mental health care facilities.

The overall recommendation is that in order to influence attitudes training in the management of aggression and violence should commence during the foundational programme on under graduate level and this must be reinforced annually and form a crucial part of the orientation of all neophytes.

Therefore, the contribution of this thesis is the combination of IKS practices and biomedical methods included in curricula for the management of aggression and violence is most effective to use in training focused on undergraduate and at neophyte level, where the participants are more impressionable. This not only increases cultural sensitivity and awareness but also makes mental health care providers more aware of their own attitudes and how it contributes or prevents aggression and violence in MHCU.

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ANNEXURE 1

Transcript of the Makgotla

Transcript of the Lekgotla with the Khoisan community in a Khoi village 2013/12/20

Background

The Khoisan village is quiet and humble, on arrival one could hear a cock crowing and see goats' running across the veld, the goats and the ants scurrying on the ground is an early sign of imminent rain along with the thunder clouds collecting in the distance. At the house of one of the elders a big pot of food was bubbling over an open fire spilling the appetising aroma of food cooking, ladies were busy kneeing dough for "rooster brood" (a type of bread in the form of a bun, which will be baked over the warm coals), the whole of the community is in preparation of the feast to held after the *Lekgotla.*

The *Lekgotla* took place after the researchers negotiated the proceedings with The Chief of A Khoisan village.

Negotiations for the Lekgotla

Negotiations for the *Lekgotla* took place in the humble residence of The Chief and his wife Mama C. On arrival of the research team at The Chief's house the researchers enjoyed the view of the hills and the soccer field on which a few goats were grazing. The researchers were awaiting the arrival of The Chief, as he was down at the community centre making sure everything is ready for the research team. While waiting for The Chief the researchers sat on the stoop in conversation with Mama C the Chief's wife.

When the King arrived the researchers were invited into the Chief's house (a welcome cool relieve from the humid heat outside. After introductions and being offered cool drink the researchers and The Chief discussed the aims of the *lekgotla*, and what the researchers wish to discuss with the community. The topic disclosed by the researcher is the management of aggression and violence in the community and the methods the community would use when a person with a mental illness becomes aggressive and violent.

The Chief agreed to lead all proceedings which took place in the A Khoisan village Community centre, and gave the necessary permission for the *lekgotla* to be captured via video recording and permission was also granted to take still photos of the proceedings. The Chief requested that the material be made available to him and that the material captured be used for the purpose of the research only and not for commercial purposes. The researchers agreed to this request.

Personal conversation with The Chief prior to the *lekgotla*

The community has experienced some of the psychiatric patients to be "aspris" (Acting out on purpose) because their behaviour is often a means to an end. Some of the mentally ill patients differ from day to day, one minute they cannot do anything for themselves and the next minute they know how to work with money. **"Vandag is hy reg en more is hy gxau/mal" (The vernacular for mental illness in Khoisan is Gxau and in Afrikaans is mal.)**

The Chief continued to paint a picture (which is descriptive of mania) of one of the ladies who has since passed away. She will all of a sudden dress flamboyantly in very high heels and go visit the "English" church, and then during the sermon she would develop the "loop siekte" (wandering illness) get up from the pew and walk out of church mid-sermon. The community tolerated this behaviour well and ignored these symptoms as it will soon pass and she will be back to her old self. All of the members of the community are welcome to attend groups and activities hosted by the "Council of Elders, Administrative council and the group for the elderly as community involvement is important to the community as a whole.

The Chief is concerned that aggression is on the rise in the community due to the influence of hard core drugs which has filtered into this quiet community. The Chief warned that the influence of drugs should not be raised with the community yet during this Lekgotla as it is a sensitive matter at this stage. There is currently a *sub judice* court case where a member of the community was murdered by an outsider (non-A Khoisan community member) this makes violence and aggression a very real phenomenon in this humble community.

Proceedings during the Lekgotla

The Khoisan tribe is a deep religious tribe and opened the *lekgotla* with the signing of a hymn and a prayer by the pastor, requesting that the eyes, ears and thoughts of the members of the *lekgotla* be opened. The Pastor then blessed the members of the research team and participants in the name

of Jesus Christ, and thanked God that the members arrived safely and that the researchers and research assistants will have a safe return journey.

The proceedings of *lekgotla* allows for members of the community to enter and leave during the proceedings. As each participant enters he/she is welcomed by the rest of the community. In total 35 members attended the *lekgotla*.

The Chief spoke about the use of Indigenous medicines and the role of the university in determining the efficacy of the indigenous medicine but that the purpose is not to make "*gxeigas*" (healers) out of the community but to shed more light on the medicines that the community but to explore how the community uses and prepares the medicines which they (community) have been using for so long.

The Chief introduced Prof Pienaar so that he can introduce the members of the research team.

"Hoe werk ons met mal mense tussen ons?" *('How do we work with the mentally ill people in our community?")*

The researcher experienced the *lekgotla* as very emotional as this very poor community is very religious and extremely accepting of the researchers through the blessing they bestowed on the research team. The community showed an interest in the team and is very eager to learn how they could benefit through the research and how their knowledge could be validated. Adding to the ambience of spirituality during the *lekgotla* was the rain and thunder that started during the *lekgotla*, for the Khoisan tribe rain is seen as a blessing, this then added to the Lekgotla being perceived as blessed. (This rain and thunder is audible on the video recording.) During the negotiations for the *lekgotla* the Chief made it very clear that they have been using indigenous medicines for many years and that they have not been killed by these medicines.

A logistic committee is to be established along with the A Khoisan village community for future visits of researchers to the community.

Antie C Baie dankie vir die goeie gebaar vir die grafstene, applous mooi ding wees as dit deur ons gaan.

Members of the research team each introduced themselves to the community members and elders.

thanked the researchers for trying to let the world understand the Khoisan village and the Khoisan community.

Needs of the community stated were as follows: Computers and training to use computers, First Aid Courses as this particular Khoisan village is far from Douglas and Kimberley where the closest hospitals are in the event of an emergency. Training is estimated at R8000, 00 for courses and the village does not have access to financial resources, training in computer literacy would greatly benefit the Khoisan community. The King emphasised that it is important to train the youth so that they can become leaders and not be led by others.

Concerns addressed by The Chief is the protection of the indigenous knowledge of the community which need to be protected, in example the King used the experience of the community through the use of aloe, the sharing of this indigenous knowledge around the aloe plant has led to their aloe resources being depleted by WBKS. The Chief used the Afrikaans word for patent "patent reg" and used this word as a double innuendo by breaking it down into "patent" (patent) and "reg" (right) and reiterated that the Khoisan has the patent for the use of the veld pharmacy but their rights thereto has not been acknowledged. The Chief cautioned the community in sharing their knowledge willy-nilly with researchers because money can be seen as an impetus "geel wortel" (golden carrot) to share knowledge but there is no guarantee that money will be ploughed back into the community without legal binding contracts. Without contracts the people exploiting the medicinal plants get millions of Rands but the community without the patent and the right gets noting. The community is assured that the aim of this *lekgotla* is not to make any money and that Patent lawyers will engage with the community and that the research team will not waver from this agreement with the community and that the community will always be the owners of this indigenous knowledge and the patent will lie within the community. The Chief summarised that, "What is yours you do not give away" this specifically applies to the Indigenous Knowledge of the community and that none of the community members must be tempted by money to "give away their knowledge" The Chief used the analogy o **"My bootjie seil al nader aan die kis"** ("My ship is sailing towards my grave") to emphasise that "how we deal with our indigenous knowledge today will determine the legacy left behind for the younger generation." "Let us protect the plants and use it to our benefit."

The members of the *lekgotla* emphasised the exclusivity of veld medicine in the Khoisan community and therefore the patent and right of these veld medicines are the property of the Khoisan.

The Chief introduced the topic of the researcher as follows: "Xgau"

The Chief "Nou mense ons het nou gehoor dat hierdie mense is hier met twee verskillende portefeuljes. "Ek wil nou nie die gevaarlike woorde gebruik nie maar elkeen het sy eie amp. Ons het gehoor dat Theresa daar werk so met die xgau mense, mense wie se koppe nie so lekker werk nie. Ons het gehoor dat David in die waakeenheid werk Ek wil eerste by Theresa se storie kom. U weet kom ek lees gou hier iets. Hoe beheer ons aggressie in die gemeenskap. Nou aggressie is waneer mense so vining op hulle se perdjies is, vir niks kwaad word nie. En dan praat ons nou pure in die kryt stap. Nou maar daar was ń manier gewees hoe die ouer mense altyd hierdie mense gekalmeer het. Hoe hulle, hulle kalm maak en sê hierdie ding werk nie, jy is besig om jou eie ondergang te bewerkstellig. So die vraag is dan nou hoe, en dit gaan die oumense nou vir ons beantwoord. Hoe word daar met hierdie mense gewerk wat so opstandig is? Wat sommer ewe skielik hy sit nog so dan vind hy uit hy moet sommer nou dan besluit hy hierdie outjie is lank verby, hy moet speel hy moet hom nou sommer tug vir niks. Nou ons will sommer nou weet hoe word daai aggressie binne die gemeenskap gehanteer." Dan die tweede vraag daar uh kom ons kom nou terug na haar (researcher) protefeulje toe, is ok oor aggressie is ok oor kwaad word maar ons weet mos mense wat se koppe deurmekaar word is oor die algemeen half aggressief. Hulle wil net maak of breek en baklei en tekere gaan hoe hanteer ons as gemeenskap hulle. Gaan ons ook in en beantwoord ons aggressie met aggressie of is daar iets anders wat ons doen om hierdie mense te laat afsien van hulle aggressie, wat doen ons. Ek dink julle kan vir haar help deur daardie vrae te beantwoord. Kom ons gaan na die eerste vraag toe, hoe hanteer ons aggressie binne ons gemeenskap. Die opstandigheid, wat doen ons as mense opstandig raak.

"People we hear why these people are here the two have different portfolios. I do not want to use dangerous words but each of them has their own offices. We heard that Theresa works with xgau people, people whose heads are not working so well. We heard that David works in ICU. I want to first address Theresa's question. Let me read. How do we manage aggression in the community" Now aggression is when a person gets on his high horse for nothing and get upset for no reason. Here we refer to them getting into the "boxing ring" quickly. There was a way in which the Elders calmed these people. How did they calm them and convinced them that what they are doing is not working and that their behaviour is causing their downfall? So the question and if the Elders could reply is: How do we work with people who become so obstinate? The person who would sit and then all of a sudden feel he must punish another person for no apparent reason? We want to know

how we deal with this person as a community. The second question would be, and here we refer to her portfolio, it is also about aggression but those people who do not have all their faculties, we know that in general they are more or less always aggressive and they just want to make and break things. You can help her (Theresa) by answering those questions. Let us answer the first question, How do we manage aggression inside our communities?

Member One (Elder in the community): "Jammer ek het laat ingekom, Nou vir hierdie man "Jy moet verstandig wees. Want waneer iemand opstandig word dan moet jy hom nie krag gee om op te klim nie. Hy soek trap plekke om op te klim. (Showing climbing steps with his hands) Maar as hy nie kry nie dan moet hy bedaar. Nou wat ek daarby bedoel is dat waneer jyself ook hoog word dan gee jy hom trap plekke. Maar uh as mens nou verstandig handel dan is dit dat jyself nou sien maar ek moet klein word ek moet minder word as die person. Ek moet hom op n manier paai met my gesindheid sodat hy ook self kan sien hy is verkeerd. Want jy sal hom nooit tot bedaring kry as jy ok daai selfde gees inhom inblaas nie. A fellow member confirms audibly "Ja aggressie" Nou dit is een manier wat ek nou geleer het hoe jy daardie person in die gemeenskap gaan optree om dan nou daardie aggressie te bekamp. Kort en saaklik.

"I am sorry I came late. Now to deal with this person you need to be wise. When a person becomes obstinate you need to be wise, if a person is aggressive you must not provide him with a step. He is looking for a step, however if he does not get a step to climb on he will calm down. If you act wisely in this situation, you will notice that you have to get smaller than that person. You can calm him with your attitude so that he will see his wrongs. If you blow the same spirit as what he is in into him you will never be able to calm him down. This is one method which I have learned. Short and to the point."

The community applauds the contribution of each attendee who participates.

The Chief: Is daar nog ander mense wat ander idees het? Al is dit net hoe jy gesien het ander mense hanteer hom ons praat mos maar nou kom ons gesels hieroor. *Are there any other ideas, even if it is only something you have witnessed, let us talk about this? (This comment of The Chief allowed more members to share in their own experience and the one member shared her own domestic experience. Any other contribution even if you have only witnessed how others treat them.*

Are there any other people who would like to share their ideas? Even if it is what you witnessed how others dealt with this person. Let us talk about this."

Member Two. Hierdie person met aggressie. Jy moet kalm praat, jy moet kalm praat. Dis die sleutel daai.

"This person with aggression. You must speak in a calm voice; you must speak in a calm voice. This is the key."

Member Three seated in the last row in the hall quietly mumbled "Jy fok hom op, Jy fok hom op.

"You fuck him up, you fuck him up"

Member One: Die vroue moet weet as die man so opstaan ons sien mos nou dis vroue en kinders maar hulle weet mos nou die man is mos altyd bevoeterds hoe tree hulle op om dit te kalmeer dis dieselfde. Elkeen weet na daai man so kwaai is om hom te hanteer en te laat bedaar maar ek weet nie soms kan ons seerkry deur die moeilikgeit van hulle maar die vroue hanteer hulle.

"The ladies can answer; they know what they do when the husband is acting so upset. What do they do to calm him down? They do something because they can get injured by the men, yet they seem to manage them."

Member four (Lady Elder) "Van my kant af goeie middag mense. Van my kant af weet ek by my weet ek, ek het n man wat bietjie nie lekkerrig is nie wat bietjie opstanderig is, kwaai is en so aan maar my antwoord vir hom is om net my mond toe te hou en kalmeergeit te doen."

"From my side: Good afternoon." "I know with me I have a husband who is not always well and can get upset, my answer to him is to not backchat and this I do with calmness."

Prof Pienaar took over when The Chief left Prof Pienaar ek sien daar n hand "Julle jong mense wat het julle gesien doen die oumense?"

"And you young ones, have you ever witnessed how the elders deal with this?"

Member five (Young lady) "As die een stroom op gaan, probeer maar kalm bly en moenie praat nie (demonstrating with her hands a person who raises high). Want jy gee die person krag en as jy wil hierdie kant toe gaan wil die person daardie kant toe gaan dan is dit mos nou ń lelike ding."

"If a person goes up the stream (vernacular for becoming aggressive) stay calm and do not speak because if you do you give him power, you think you will go this way, which person will then just go the other way and this will only lead to ugliness."

Member six (Elderly lady) "Ek het nou nie eintlik veel om te se nie maar jou manier van praat met mekaar as die een bietjie hoog is en jy kom met ń kalm mooi gees en stemtoon wat hom bietjie laat afbring en veral as dit in die huis is sê jy "ag my skat of my engeltjie (demonstrating touching the person gently on the shoulder) ek ken jou mos nie so nie. Dit bring hom ok ń bietjie af. Maar ek noem my man engel ek het nie ń ander word vir hom nie ek het ń wonderlike man. Niemand sal verstaan nie regtig ek sal nooit my man prys gee nie. (applauded by the community). My man het so ń mooi gesindheid en ek kan hom nie eintlik beskryf nie ek het nie woorde vir hom nie maar as ek ń bietjie kwaad is dan ag my ou ding dan is daar nou weer vrede ons gaan slaap nooit kwaad nie. Ons praat dit uit voordat ons bed toe gaan. My man is baie beskeie ek verwag nie iemand van buite moet my man disrespekteer nie. As daar iemand van buite is wat my man disrespekteer dan raak ek regtig opstandig want hy is nie iemand wat opstandig raak nie, hy praat nooit lelik van ander mense nie. Hy sal nie vergadering kom hou met iemand anders se naam nie hy sal hou die vergadering vir die doel daarvoor sal hy dit hou en hy sal nooit in iemand anders se pad staan nie ek is werklik met aggressie. (Demonstrating with her hands a motion of moving from a higher level to a lower level.)

"I do not have much to say but the way in which you speak to a person who is a bit high (upset) If you speak with calmness and in good spirit and tone of voice this will bring the person down. Especially at home if you say "O my darling or angel I do not know you like this it will bring him down a little bit. I call my husband "my angel" I have a wonderful husband and I will not give him up for anything, I do not have enough words to describe him. When I get upset he has such a beautiful personality he would just say "Oh my sweetheart" and then I calm down. My husband is a very humble person and people from outside must never disrespect him he never talks badly about others and never gets upset. My husband will never stand in the way of another person, he will

never host a meeting in another person's name, and he will only host a meeting for the intended purpose of the meeting.

Prof Pienaar "Is hier iemand van die ouer mense wat kan wys van die word wat ek gehoor het die Xarare die Khoisan Xarare is wanneer jy die een wat so is kalmeer. Wat is die word wat jy sê as jy die een so xarrare?"

Are there any of the Elders here who can explain the word xarrare? The Khoisan "xararre "that you do when you calm a person who is like that?"

Member seven (Female Elder in the community) " So ǹ iemand as jy regtigwaar nou sien so ǹ iemand is nou baie, baie, baie dan moet jy nederig raak jy moet klein raak en met respek met hom saam praat .Jy moet hom sê (Demonstrating a lowering of the voice) Sê "Nxau" kalm die mense daar buite het ore wat hoor. Dan xarrare jy hom so (Demonstrating how you would calm a person in a swaying motion). Dan voel jy hy word sommer so kalm dan sit jy by hom en jy praat met hom en sê vir hom die kinders loop ook hier rond en as jy so opstandig raak môre raak die kinders ook teen jou omdat jy opstandig raak. En dan voel jy ook bietjie beter. (Softly saying) "So kalm nou."

"A person like that, if you see he is very, very, very (aggressive) you need to be very, very, very humble and calm and talk to him with respect. You must tell him to calm down because there are people out there who might hear him you can touch him and gently hold him. You will then feel his body become calm. When he is calm you can tell him that when the children notice his aggression they will stand up against him one day. Once you have calmed him down, you yourself will also feel calmer."

Member Two: "As een so kwaai is ... (inaudible due to background noise) verander jy eerder die onderwerp."

"When a person is as angry as that it is better to change the topic."

The Chief "Die tweede vraag is min of meer dieselfde, hier kom nou net die "gxau-geid" by. Dis nou ǹ geval van ǹ man wat nie "all there" is nie. As hy nou aggressief raak iemand wat mal is wat doen jy as daai person sommer kom uitdaging. Die man is nie reg nie."

"The second question is basically the same but here there is madness involved. This is the case of a man who is not "all there" If he becomes aggressive what do you do if he comes and challenges you?"

Member seven: (Member seven demonstrates with her hands you calm him but verbalises) As jy nie nou vir jou reg ruk nie dan gaan jy nou met die ambulans Bloemfontein toe (Bloemfontein referring to the Free State Psychiatric Complex). Community laughed at this description. "As jy nie nou rustig raak nie vat hulle jou Weseinde toe. Jy hou jou mal jy is nie mal nie."

"*If you do not pull yourself together they will take you with the ambulance to Bloemfontein. You must calm down or you will be taken to Weseinde hospital. You act as though you are mad but you are not mad."*

Member Two: "Stuur so een dat hy eerder gaan water haal."

"*Rather send a person like that to go fetch water"*

The Chief "Ons het mos al hier mense gehad wat uitgehaak het wat is daardie tyd gedoen? Hoe is hulle hanteer as hulle bietjie wild geraak het; hulle was tog deur ons gekalmeer. Die man is ń proses deur gegaan. Is hy maar net so gekyk dat hy sommer weer regkom of was daar iets gedoen? Hoe het julle gemaak met die geweldadigheid? Ons het mos maar dieselfde gewerk om hom te kalmeer en het ok met hom mooi woordjies gepraat so maar partykeer moet jy maar los dat Gods water oor Gods akker loop "

"We have had people like that in our community, people who "lost" it, what did you do in that case? How did you mange than when they became a bit wild? Did you just look at that person and let him be until he was ok or did you do something? Did you work the same to calm him as the others or did you just let it be?

Member One (Male Elder) Jy werk anders want dit is ń opstandige gees wat so in daai mens ingaan. En uh vra vir die Here hoe jy ok geestelik moet optree, Jy moet die Here eers geestelik innooi by jouself om op te tree teen die opstandige gees. Vra hoe nou Here hoe maak ek nou gee vir my leiding om daai woorde wat jy van die Here vra is geseën met die Gees van God. En ek glo mos daar is by die Here niks onmoontlik nie. En daai woorde as dit

in die ore kom dan is dit dat dit daar mos so kalmeer. Want daai bose gees moet ook na die stem van die Here luister. God is magtig in die hemel en selfs op die aarde om wondere te doen. So dit is nie net sekere tye of by sommige mense wat Hy dit doen nie. Hy besoek jou waneer jy dit nodig het op die daad waneer jy Hom vra Here help my tot U goedertierendheid."

"You work with him in a different manner because it is a restless spirit inside him doing it. You ask God how you must react. Spiritually you need to invite God into yourself to counteract the upset spirit in the other man. You ask God for guidance and which words you must use. Nothing is impossible with God even the evil spirit is compelled to listen to the voice of God. God is almighty in heaven and on earth and God will visit you when you need him and give you strength and guidance.

The Chief: "Ons het nou ǹ antwoord gekry uit ǹ Geestelike oogpunt ons het nou nie gxeigas hier nie want hulle sou ons ook goedjies kon gese het oor hoe maak hulle dan kon ons hierdie goed gekombineer het tot ǹ sterker gedagte."

"*We have received an answer from a spiritual point of view; we do not have gxeigas here who would have been able to give more information, to make our thoughts stronger with more information."*

Validation during the one-on-one group discussions with the community members.

Member Three: Ek het al gesien dat waneer die gxau mens so kwaai is en jy is kalm help dit partykeer om nie te praat nie maar net saggies te sit en fluit tot daai person kalm is. Waneer hy kalm is dan kan ons praat want jy moet weet hoekom hy so kwaad was. "Jy kan eers na die tyd redeneer." "Dit help nie jy praat terwyl hy opstandig is nie."

"I have witnessed when the mad person is so angry and you stay calm it does not help to argue, just sit down and whistle softly until that person is calm. When he is calm then we can talk. You can only reason afterwards, it is no good to reason while he is angry."

Member eight: (Middle aged lady who did not speak during the Lekgotla). "Somtyds raak hulle so kwaad omdat hulle stemme hoor of ǹ innerlike pyn het wat net God kan genees. Jy

gee een suikerwater as jy nie medisyne het nie lat hy net kalmeer." "Jy kan hulle duwweltjie stamp- of grashout trek en tee maak sodat hulle ook kalmeer."

"They sometimes get so angry because they hear voices talking to them or they get angry because of some inner pain which can only be healed by God. You can give him sugar water if you haven't got medicine to help them calm down. You can even give them duwweltjie stamphout or grashout (Dianthus micropetalus), (tea brewed from indigenous plants) to help them calm down."

Member nine: (Elder) "Ek het al gesien dat as die person so kwaad is dan gooi hulle hom met water nat dat hy homself uit die kwaad skrik. Maar dit werk nie altyd nie partykeer maak dit die gxau mens nog kwaaier. "Kyk daar daai is een van die gxau mense daai kind daar, hy het nie meer ǹ ma nie en sy boetie vat sy pensioen. Die kind kan nie praat nie maar nou kom staan hy so voor die vrouens met ǹ vyf rand en beduie hy will by die vroue wees. Iemand het hom dit geleer en dit kan nie deug nie. Die jong kinders is bang vir hom want hy het dom krag en as hy hulle so pla dan gooi hulle hom met die klippe."

"I have witnessed people pouring water over the mad person, who is so angry, but it does not always work, sometimes it makes them more aggressive. See that child there is one of the mad people, he is without a mother and father and his younger brother takes his pension money. This child cannot speak but he comes with a five rand coin to the women and shows that he wants to have sex with them. Somebody must have shown him that and that won't do. The younger children are scared of him because he is very strong; when he bothers them they throw stones at him.

Member seven (Lady) "Ja die kind weet wat hy wil he maar hy kan nie praat nie. Ek het hom al gevat om inkopies te gaan doen dan vat hy die regte goed op die rakke. Maar die winkel baas wil hom nie daar hê nie hulle se hy is mal en steel. Die kind is nou al twee keer deur ǹ kar omgery en hy raak kwaai, ons weet nie eintlik hoe om met hom te maak nie buiten om kalm met hom te praat en hom af te bring as hy so hoog raak."

"Yes the child knows what he wants but he cannot speak. I have taken him to the shop to shop for groceries and he takes all the correct stuff from the shelves. The shop owner does not want him there because he says the child steals and is mad. He has been knocked over by a car twice and he gets aggressive. We do not really know how to deal with him except to talk to him calmly and calm him down when he gets so upset."

Lekgotla in A rural village in Lesotho

Background

The Lekgotla was negotiated in terms of the standard protocol whereby the researchers negotiated with the different Chiefs and informed said chiefs of the intent and nature of the *lekgotla*. The Chiefs called upon the Head of the indigenous healers in Lesotho, who in turn called all the indigenous healers in and around a rural village in Lesotho and Maseru together for the intended *lekgotla*. The researchers attended as quiet observers and the Chief of the Indigenous healers was coached regarding the aim of the questions and he was subsequently requested to chair the *lekgotla*. The chief and members of the *lekgotla* was assured that anonymity would be ensured and that there is no need to share information deemed to be sacred.

During the negotiations the three researchers discussed the aims of the *lekgotla* with the Chief Traditional Healer, namely to answer their respective questions.

For the purpose of this research the researcher posed the following question: "How do you manage violence and aggression in the mentally ill person?

A rural village in Lesotho, about 50km from Maseru (the capital of Lesotho). It is a quaint little neat village with several huts and the community centre where the *lekgotla* took place is on the premises of one of the senior secondary schools.

This transcript is a verbatim report and translation from seSotho to English. The researchers colleague Mr. David Mphuthi who is a Mosotho man translated from seSotho to English and back from English to seSotho to ensure a valid reflection of the verbatim content of this transcript.

The Lekgotla

The Chief Traditional Healer welcomed everybody present and posed the questions to the *lekgotla*. Apart from the 12 members of the Research team there were 30 Indigenous healers who attended the *lekgotla*. A *lekgotla* is open for any member of the community to attend and all members have equal input into the question posed, noteworthy the researcher observed that there were male and female Indigenous Healers present.

The male indigenous healers were the first persons to respond to the questions, and the elders replied first, after the youngest male responded the female indigenous healers would take their turn, also in ranking of the elders first.

The observation of the researcher is that everything is dealt with in a respectful manner and that all inputs were welcomed. The indigenous healers were all dressed in Traditional clothing with different goatskin headbands and head coverings made out of beads. During a one-on-one conversation the indigenous healers said that those wearing the goatskin head gear received their calling to become a traditional healer during a dream and those who were wearing the beds received their calling via a vision while they were awake.

The Chief of the Indigenous healers in Lesotho opened the proceedings by welcoming all present, and explain the nature of the questions which will be posed.

The first question raised was that by fellow researcher Mhpoofolo who queried how knowledge is transferred from one generation to a next.

How can our knowledge be translated to the forthcoming generations about the medicinal plants?

Chief Healer: "I would like each and every one of you to give an answer" (silence)... The Chief Healer then repeated the same question.

Respondent one: "The question difficult to understand. The Chief Healer then rephrased: "What do we do to take our knowledge to the young ones not only medicinal plants but life in general? How do we make sure the following generation get the information as it was with the older generations?

One of the young members a young male said: It is now we do not have time for the family the older generations do not have the night time stories with us as young people. We look at the TV and do not have time and sit with the elders as to what has been happening in the olden days." Chief Healer interrupts and says: "This is not what is wanted. But the question is we as Basotho, how do we take things back? It can be done via negotiations and sitting around the table. How can we pass the knowledge to the forthcoming generation?

Young man started to reply but is interrupted by the Chief Healer: The Chief healer "No what do we do as people to take the knowledge to the younger generation? (laughter)

What do we do as Basotho, older people to meet the younger generation halfway in terms of knowledge? The first researcher Mhpoofolo clarifies: "Important that we get old or we die and now the knowledge we have goes down to the grave with us. We want to know this knowledge what do we do to take it to the next generation? (Silence mumbling)

A Healer replies: "I have three children, boys that I am pressuring and making sure they get the knowledge I have, because I also get it from the older people.

Chief healer: Apart from the knowledge transferred to you what will happen with the passing of knowledge to other children?

Response from Healer:" It is up to an individual I do not discriminate against any child who comes in for knowledge as a Mosotho child the children must be taught the medicinal plants we make use of and when they are taught about the medicinal plants this is Lekhala (aloe) and when they play they would share the knowledge with one-another. (Laughter).

Third healer: "This is very clear that it can be just one aim of the culture to be a better culture." "When it comes to nationality or culture I understand as Chief Healer the most important thing is my kids in my house must live according to what we as Basotho are doing. If the family knows what they are made of they will influence other families in the community even good and bad things can be copied. These days unfortunately a Mosotho or Basotho is ashamed to be called Mosotho, Sotho as it is deemed inferior everybody should know who they are." (Coughing).

Chief Healer interrupts: "The question is as the Basotho people how do we make sure that what we know does not only end up with us but can be transferred to other generations? What I think so that we do not find our things fading, our children must be taught from a young age about cultural things and knowledge which should also be taken to schools if it can be translated from schools it will be a good partnership and a good thing".

Chief Healer: "Does it mean children will be together in the school and have this knowledge?"

Younger Healer: (speaking very animatedly) "The young man must be given a chance to say what he thinks he was trying to say how they as youth find there is no time for night time stories and maybe the young man said the TV can be used effectively through programmes with cultural knowledge. I also think those things and knowledge can be translated and we want our mothers

and fathers to understand it is not a competition, between them and the media. Everybody is entitled to have their own opinion." Mhpoofolo says: The old man does not mean one is wrong and one is right I am writing what you are saying. (Everybody agrees)

Chief healer:" Can you please make your speech to be strong. (Everybody laughs) As a young man you said a lot of things please put it in way for us as older people to understand."

Young healer: "We still have older people helping us because older people in community I am of the opinion they can be consulted and give us advice. We can sit with them in their own huts they must actually have time for: Women for ladies, Men for the young boys, that would actually improve the knowledge generated in a culture and whoever attended will be able to inform other people." (Inaudible) "As a young man I think our old people, even I would not like to call them old people but rather elders... (Members of the *lekgotla* said it is fine to refer to or use the word old people) They should be visited not in urban areas but in villages and huts where they still have the information you can share. Boys should be taken to the kraal (similar to the process of *lekgotla)* by men to be taught what men do culturally. Ladies are taken by older women to a sacred place to be taught what is expected by women. Information should be conjoined (sic) to the chief and elders so that the information agreed upon can be shared with the young ones."

"It is very important that our elder people teach us about life at least even they play important role because as you sit and watch you are learning about aspects of life, make sure you learn and apply this. Most of the time we are expected to do things we are not sure about how to do."

Researcher one: "Do you mean that this information to be kept by the old ladies and men only, and when we go to them, they can give us the information. (Silence) Chief said yes (mumble).

Indigenous healer with dread locks dressed in a grey blanket: (Becomes very excited as he speaks with almost an bewildered expression) "You know what there is something that when I tell it to you now, I grew up in village, some older boys in the field they had something called toloki and this toloki is something used by older boys to treat younger boys. (Sic) The bigger boys will send the younger boys to dig up potatoes. The big potatoes are then taken by older boys and the smaller boys are to take small potatoes it was toloki, and a way in which information was transferred to the younger boys." These big potatoes eaten by big boys.... someone interrupts. "You have missed the point here." Chief of the indigenous healers: "Please sit down and let the older man finish first and clarify this point for us."

Older man: "This issue about toloki it is the potatoes, smaller potatoes the way he is putting it I know the word "*mampudi*" is the biggest head boy... Chief healer interrupts: "We need to understand as a healer working with mental health people where does this toloki comes in with people, it has no impact on what we want to do." Let us try and make sure we do not waste time about things not asked. Researcher one: "What is this toloki? Let this old man say how toloki can help growing men to understand the issues."

Chief Healer replies: "Mhpoofolo I do not think it is relevant because if toloki is just a potato I do not understand how it comes into the picture what we understand to answer today. We are taught by old people what is toloki and what it leads us to understand."

Chief Healer interrupts: (Mumbling) (Inaudible response). "There are so many things; wild medicinal plants that we can use to cure some other diseases especially mental illnesses. This information must not be a secret, younger people must know what we use to cure sickness. It must stay in the family and parents must make it part of knowledge in the family, plants do give healing and cleansing aspects and this must be taught in the household. Some of them (plants) are dangerous and people must be made aware even though the plants are good and useful for healing it can be very dangerous. Some of the plants can be said just in the open others not." (Mumbling)

Lady Healer 1: "Before we do anything we take our culture to our ancestors there is a lot of things we are owing to our ancestors following the type of life we lead nowadays. I still support and belief that yes info to be taught at school also in our villages and in small groups (*thakaneng*) where there are older people staying with the little ones teaching them about life and showing them where life starts. This is where the boys are grouped according to their ages each and every group taught to what is expect from that age group. You cannot say anything to anyone at any time. Do not give info beyond the age of child when they reach a certain age. You can begin to start speaking open about things especially in indigenous healing there are different beliefs. People are not the same some go for the improved way of healing even though we have our own ways of healing we lose hope and do not believe that our own things work well. Most people go for the western way of western medicine. Western medicine comes from the same medicinal plants we get from the veld. It is therefore important to know sometimes as it happens, I know a certain medicine plant can cure certain disease, and in conversation I say this to someone and he uses the same information to help someone else. We will make sure our children have knowledge about it but some information which is sacred because we fear of losing our own knowledge." (Silence and mumbling)

Lady Healer 2: "I am saying go back to our culture. I am an elderly lady bringing up grandchildren not my own as their own mother father is not there. They know what is good and bad because I sit down with them and tell them, even the boys, I tell them what the consequences is. I have children who will not eat eggs or sheep intestines (a cultural taboo for different genders and age groups) even now you can go to my hut all children from the village come to my hut I sit with them and teach them. I do not own a child now, he is 33years old. I teach other children in the village. I call them together and teach them about our cultural beliefs. I tell the girls the moral aspects how to sit with boys as to not be revealing themselves I tell them point blank. But nowadays when I tell them to go back in cultural ways things have changed a lot.

Nowadays we as old people are termed witches and we are unlikely to take a child and talk to them as they will call you a witch we are very far from each other but I do not care I do everything and tell everybody. There is a tree in my yard all children come and eat leaves of my tree, they say this is the tree of healing from my grandmother and we will make use of it. Even at the school I do have teachers who come to me and say these children do not eat. I tell them if my children do not want to eat leave them we must make sure we grow up to use the same values. We were not asked anything as a child, you were taught this child comes from the river. Nowadays the children ask anything and you have to tell them the truth because they don't believe you.

We should not be scared or embarrassed to talk about these things to the children now at my house a lot of children are waiting for me to talk to them even though their parents are against it." (Laughter) It is very important that this people come here important to talk and understand the importance of having meetings like this."

Healer 2: "Nowadays it is so unusual in the families, men and women are the same in the house boy, girl does not know what role to play, in the olden days everybody knew what they were doing.

Lady Healer 3: "I came in the same. Now that you say these days the girls are wearing pants when they sit they just sit with the boys what are the things we do? We want to understand how to bring back old values we talk about. Very important you sit down and teach it. Yes sit down and tell I tell you in my house no girl wears trousers, the trousers are for men girls have many things happening around them and life. In my house the girls will wear the "*thethana*" (Laughter)

Chief Interrupts: "Mapana we should take some things and modernise so we all understand what is said here." (Laughter) "It is important that each and every one participate, do not exclude people who do not understand our language; please interpret so all can understand what is said."

Chief Healer: (Mumbling in between) "These things when I think backwards were very much easier when elder people can help in making our world to be healed because when I look at the world now, our world is sick. There are things that these chiefs grow and the Basotho boys are taught. Previously old ladies get young boys and girls and hold their private parts in their hands and say they (the children) are smoking. They will then sniff their hands and pretend to sneeze from the alleged smoking. Nowadays it cannot be done, because it is molestation of a child "*ho Tsuba*" Except for harassment the people in the village especially parents must be taught who do not know if they are doing right or wrong If people can be educated where and what was done initially in the olden days I still think most of our youth can be better nation tomorrow. Olden days no trousers. Girls wore *thethana.* Girls and boys nowadays have no respect if taught how to respect elders they will be a good nation tomorrow. Teach them the respect. Thank you very much I am closing this point."

Chief Healer: We are now going to move further. Nowadays we are still having a problem as parents we cannot talk to kids even if they arrive in the middle of the night they will go out." "Now we move on to next point.""

Lady Healer 1: "Let me just say something on the previous point which is very important what want to say now. (Disagreement between researcher 1 and Lady Healer 1) (mumbling, inaudible and laughter) Researcher 1: "I want to come back to you to make sure what I have written is true. I understand from the elderly people things came up:

1) Education should start at home in house in family,
2) Parents teach their own children cultural issues and moral values
3) This education goes to schools and this education also goes from village to village
4) We are living in a changing world this affects the youth and it was suggested a TV programme could be used so that youth can go sit and watch the TV programme slotted for them to educate them in this way we can help in taking forward cultural education to the young ones.

Chief Healer: "The next point little bit higher strong point. This is strong it affects you directly as healers so please listen carefully and answer what is asked. Make sure you answer what asked.

"When person has mental illness and show aggression how do you assist that person? To put under control is it clear?" (Laughter and mumbling) Question repeated by the Chief Healer.

Lady healer 1: "I can say from my side... (trying to answer but the chief healer interrupted her) "Because you answer outside of the question I am trying to help you."

Chief healer: "It is very important to understand the question and be trained so that we understand what is asked. Now you as healer how do you say you will treat this person mental illness? You understand how violent they are, you are aware they can kill you.

Lady Healer 1: "Yes, you as person need to be above this person remember not everybody with mental illness is violent. Do not be violent, be calm when working with them they are sick. To get them there (calm), you have to *qekisa* (beg), them to be calm. It is very important that with these people you are calm when you approach them because in their mind they are already aggressive. If you come in with aggression you are aggravating what is happening in their mind already as a healer you need to make sure you make them sit down. Talk to this person and beg before you give them any medication.

Chief Healer" I was just asking this question, I happened to be there when someone was treated. I saw someone with mental illness when taken out of the car there was the medicine that was burnt, and this person had to go through the smoke of this medicine and you have to make sure you control him.

Lady Healer 2: "In most of the time you find this person is allowed to go through the smoke and most of the time when they come they ask: Can I kiss this women? As a lady you do not allow this to happen to you."

Lady Healer 1: You must keep asking if he understands that you are not fighting him, he is sick even if he wants to kiss you. Do not look at what they are doing bring back their mind so that it can come back from what he doing. At this point if he wants to hit you do not take a stick to hit them back. I do not agree with this treatment you will make him mad worse (sic).

Lady Healer 2: I want to make sure how we treat mental illness I hear you say this thing burnt there...

Chief Healer: "No no! do not talk about what burnt there I have things written down to talk about, what burnt I just gave example about what I saw."

The chief healer repeats question again: When somebody with mental illness and signs of aggression and violence comes to you, how do you assist them to come back to normality?

Lady Healer 3: I am saying I helped these mad people a lot because it is believed the mad are coming from the caves. Now I help them. When they come in my yard tied up I say "Untie him!" When he gets into my hut I come to him. I go to them and give them a hand of mercy protection and hand that calms them down these things I have I cannot say here I can only say it when we are in a sacred place. I touch this man with a sacred hand and he will sit down and listen to what I say. I don't give them anything. Now he sits. Even if violent after I give them a hand they become calm because I am calm. It could happen that when I am touching them with my hand I am also mad but my hand is calm Don't just work with people sick I even cure mad people (*Mahlanya)* really mad ones.

Even if they are from Mohlomi (Psychiatric Hospital in Lesotho) before I am told they are from Mohlomi I can cure them.

Once they get into my yard they become very calm. Somebody that knows what it is to be an indigenous healer and those tremendous initiations of the traditional healer; they will know how to deal with mad people.

The only thing I would do is to take a mug and give him water and say "Sit here my love" and immediately the person becomes calm and sits down. Even if the person came in being tied with ropes, the only thing I do is to be calm and show no sign violence because you will make them mad. (Silence)

Chief healer: "Give other man chance to say what want.

Female Healer 4: in response to a question by researcher 1: "I am asking once you touch with the hand does this mean everything now done and he is healed? Is there no medicine to give? "No I do not give medicine when he is violent I only give medicine once everything has calmed down. When cool and calm then start giving medicine. (Echoed by all) I just instruct to sit down give them my hand then they become very soft I will do everything by hand (claps)

Researcher two asks: "Now that you say these people; Chief said medicine burnt when a person comes in aggressive. Is it possible to tell which medicines you burn and decoction for drinking?

Chief Healer: "No, No, No! You are now asking me to teach you how to do indigenous healing without being an indigenous healer (Mumbling)

Lady healer 2: "This medicinal plant they are there and there are medicines we use even though they are different I will give only these I believe would help. When done everything fine with this person. According to me no person is mad they just have problems which they are not able sort out. I need to calm them down to think straight It is very important that I do that but I will not tell you what we burn.

Researcher 2: We respect that as Research team thank you very much

Male Healer 1: I am sorry will not be able tell you the names of medicines we burn when somebody is sick. Not on all mad people you will give something to smoke or drink. There are mad people who are very mad and they take some stuff orally others need to smoke something. Some of the mad just need medicine for cleansing. They use this when bathing, that will help them out of the state they are in. It all depends on how madness got onto this person. Some of the mad people are just mad and just want someone to sit and talk with them then the madness is gone. Some must be removed from the place where they are because they are mad because of surroundings they find themselves in. (Mumbling)

Chief Healer: In Gauteng I have seen that there are huge walls around the hospital for mad people when you are a visitor there it looks as though you are in prison. Now all of a sudden when visiting there I saw someone jump over the wall around houses so this man that was jumping was coming from another house where he was dumped by his girlfriend people thought he was mad and started calling ambulances. They captured him and said he must be taken to the hospital. This issue when I listen to it, there is something that happened it looks like it is different but it is not I am trying to say in the issue of saying what kind of medicine like e.g. *Hloenya* What is it used for. Chief Healer: "Stop the question is not appropriate. I want you speak to this question not anything else."

Older male healer: "You can help in different ways let me answer what you ask When this man comes here he will find medicine burnt as he is coming through. Others will find medicine they must sniff there is medicine burnt when he comes into house it will make him drowsy and then when he

is mad, it is not mad it is the nerves and when the medicine makes him drowsy, this calms down the nerve break, and he will be soft and calm and sleep.

Chief Healer: "If continues to be mad what do you do e.g. you are the fourth Indigenous Healer and payments were made to all consulted now last payment that is there, what is the easiest way that can be done so that the family can be assisted so this person be healed with the payment of the last cow or payment? This person starts here from being helped but again we must make sure he understands and family understands the situation he is in. Thank you very much. Let us talk about this.

Researcher 2: "What can I say, I really like this people they also refuse to come to the doctor you just handcuff him and give tablets.

Male healer 2: "As for me this type of sick person they way I treat them depends on what caused the madness. If I have to meet them at the gate I will go to the gate and inside my hand I will be having some medicinal plants I will not touch him but I will throw this medicine on the ground where he is and we will be fighting with him to step over the medicine. I will try to get him inside the yard or hut; the fight will be to get him to step over the medicine. When he is in the house I will touch him with medicine in my hands and the medicine in my hands will cause him to listen to everything I want to say or do. Then give him medicine to drink. When he takes the medication I will talk to the family about what happens I will talk to the family he will not talk. He will fall asleep in his dreams when he wake up I will give "can say In Sesotho we say back of mad person is corrected by smacking them" Is that so? (Laughter and mumbling)

Male Healer 3: "Let me say to you it differs according to the indigenous healers."

Female Healer 3: "There was another female indigenous healer who would get into the house of the mad person and she would beat him to the extent that he would become tired, but it differs from one indigenous healer to another. I heal most people say when give them a hand they become soft but we still believe to give them a whip then give him medicine prepared when he slept. Now it will be him and me alone I will ask him what he sees and what he hears. This is how I treat the mad people who are violent and want to run away. I have achieved this status because I befriend them I am his friend. I work in hospital Mohlomi with the western doctors. When I am in Mohlomi I have seen several mad people. Some of them I only touch with my hand and they are fine. Most people when I touch they even agree to be injected even though they were very violent towards the nurses who want to inject them. When they want to give them injection that is when the fight starts. In my

presence it does not have to be violent since I have been in Mohlomi I give them my hand and touch and they become calm and controlled I then take them to the place where they are going to lie and rest. That is what I do.

Chief Healer: "Can you explain have these people not been so mad that you feel there is nothing I can do but give them force.

Female Healer 2: "Fortunately I have not met such a person; have not met such persons in my whole life. One person who is about a year ill (Sic) come from another village, they found him in the caves. I was told he is so violent he could kill, when I arrive he is not so aggressive. He became so happy that people asked me what happened. When he comes to my house I untie him. If I am not there they take him to his house and give him help. This person with no family at all; I asked he has person who he works with. Maybe this is the problem that caused him into this state therefore we need to assist him. He went up and down the whole Lesotho but has not been helped. He is now in Maseru and with me; I ask the person who he is with and ask him is there anything you can help with? He said no I didn't know what to do I give in. This mad person has wife and children he is mad .There is something now that is difficult (inaudible)... I fell in love with this man to help him, now he is in this state there is something impossible you cannot make. A branch in health department it is not allowed in any way that I arrive at the directors of the branches of Department of Health. And now unfortunately I am not allowed to go in the wards to help with sick persons. I haven't met such a person the one that I have met when I arrived at this person, I was told he is sick but he was very soft when I spoke to him I only talked to him. Some I met I saw they only became violent when other people were around them. Once given medication they get better. Thank you very much.

Questions by the researcher conducting research on medicinal plants

Chief Healer: "Can you just say in few words how did these medicinal plants come into being?" Most people think these plants were planted by "Other" people. When God created man He instructed what animals should eat He instructed man to eat everything grown in the world. Therefore plants from earth are the best treatment to use.

Chief Healer: Now we will speak about the last questions I was given to discuss with you, these questions relate to the plants directly. The first question is:

"How important are the medicinal herbs in this community and what are they used for"

"How do you prepare these medicinal herbs, and which ones do you frequently use?"

Healer number 1: The medicinal plants in this country are very important because we believe in them and these plants they make us healthy and in most of the cases we use them in mixtures.

Types of plants that we use *Lengana*, *hloenya, Phate ea ngaka,* Aloe and *Poho tshehla* and *lero la tlholeho.* And then we have *kwena* (mint). *Lengana* we have three types of *Lengana* but all of them are called *Lengana* because there are no different names for them. You must know which one you want to use because some of them are very dangerous as it can kill you.

Researcher: How do you prepare this *Lengana*? Healer 2: Normally we boil them, we sometimes use green leaves and put them on the painful part. When somebody has common cold we put the green leaves in the nostrils or under the pillow. Some people will even smoke the dried leaves single as *Lengana* or mixed with *Kwena* leaves.

What conditions are commonly treated with the medicinal plants?
Common cold, treating of the intestinal worms, so we do deworming, menstrual pains, malaria, killing of germs. These plants they also help the drivers and people doing sedentary type of work with their kidneys. We also use these plants against witchcraft.

Measurement: How do you use measurements about this plant? We use the fingers to measure how much we need. Sometimes we make use of a full hand or a half-a-hand, once the decoction is prepared the measurement is done with teaspoon, tablespoon and/or cups. These medicinal plants should not be used more than a week for the same condition. You need to change your herbs if there is no improvement. The leaves are boiled until the water changes its colour and the person that is preparing the decoction is the one that will decide when the decoction is ready for use.

ANNEXURE 2

Curriculum for the cultural safe management of aggression and violence

1 Introduction

The management of aggression and violence is an anxiety provoking situation for all mental health care providers and is identified by Bjørkly (199:57) to be "one of the most distressing and disruptive obstacles to effective treatment in modern psychiatry." The incidences of aggression and violence often goes under reported, however the implementation of an aggression report scale has proven successful in previous research to prevent under reporting.

Nursing staff are the victims of aggression and violence in 90% of incidences of aggression as reported by Bjørkly (1999:62) and Ukpong, Owoeye, Udofia et al (2011:46), Fottrell (1980:216) and Gudjonsson, Rabe-Hesketh and Szmukler (2004:261).

James, Isa and Oud (2011:130) made a very interesting observation, namely; the older nurse are less frequently the center of an verbal or physical attach, this the authors associate with more experience gained in psychiatric nursing.

As is evident in research by Bock: (2010), James et al (2011:133) also concludes that there is a need to train nurses in the management of aggression and violence in order to change their attitudes towards managing aggression as associated with the mentally.

2 Objective of the curriculum

- On completion of this training programme the learner will be able to diagnose the early signs of mental health care user related aggression before it escalates into violence.
- The learner will be able to identify potential causes of aggression.
- The learner will be aware of their own perception of the management of aggression and violence.
- The learner will be able to deal with a mental health care user in a culturally aware and sensitive manner,
- The learner will be able to de-escalate aggression to a manageable level.
- The learner will be able to apply break away techniques and will be able to apply safe restraining techniques.

3 Curriculum content

The content of this curriculum is based on inputs as received during a previous research project where base line data was created to determine staff attitudes towards the management of

aggression and violence. The researcher used this information and the knowledge generated through a lekgotla with indigenous healers to determine how aggression is managed. The researcher therefore incorporated the social knowledge from the community with scientific knowledge generated through research as referred to throughout this curriculum.

This knowledge led to the creation of a conceptual framework for the management of aggression and violence.

In turn this conceptual framework further guided the curriculum content

3.1 Target group for this curriculum

This course will be presented over the duration of one week and will be on NQF level 5.

The credits for this course are allocated as follows:

3.2 Broad content of the curriculum

20 periods=3 credits and 6 periods=1 credit (!hour=1.5 notional hours)

Topic	Periods 45 min.	Notional hours	Credit
Determine the attitudes of staff towards the management of aggression and violence	4	2	0.66
Identify the early signs of aggression and violence	4	2	0.66
Identifying causes of aggression and violence	4	2	0.66
Predicting violence	4	2	0.66
De-escalation techniques	16	8	2.66
Break away techniques	8	4	1.33
Safe restraint	8	4	1.33
Cultural sensitivity awareness and safety	8	4	1.33
Total	56	28	**9.2**

4 MICRO CURRICULUM

4.1 Perception of the management of aggression and violence

4.1.1 Learners will complete the MAVAS Management of aggression and violence Questionnaire; this will determine their perception of the management of aggression and violence and their cultural sensitivity and awareness.

4.1.2 Learners will also be required to give their definition of aggression and violence

4.1.3 The attitudes of nurses towards the management of aggression is influenced by the amount of exposure to aggression, nature of the incident, their thoughts and beliefs about aggression and acts towards a person as highlighted by James Isa & Oud (2011:130)

4.2 Early signs of aggression

The early warning signs of aggression are very unique to each patient therefore it is imperative that the nursing staff get to know their MHCU's very well. Culture is influential in setting the norms for behavior as mentioned by Tjale and De Villiers (2004:69). Therefore it is essential that the nursing staff also take into consideration the culture of the patient when deciding upon utilizing the Model as developed by Fluttert *et al.* (2008: 214) as it might lead to ethnocentrism if the nurse wants to interpret the behavior of a patient in terms of her own cultural norms (Tjale & De Villiers, 2004:69).

4.2.1 Verbal aggression is the most common form of aggression James, *et al* (2011:130), Hills. 2008:24). However the occurrence of verbal aggression might often be at a later stage, aggression must be detected as early as possible in order to either manage or de-escalate it. To accomplish early detection of aggression the nurse must be aware or the recognition of the subjective causes for aggressive behavior (Fluttert *et al.*, 2008:213). Therefore it is essential that nurses and the security staff in the wards are equipped with the necessary skills to help them detect early signs of aggression as manifested through subtle behavioral

changes. The researcher concurs with Fluttert *et al.* (2008:213 that training on early detection will also help the staff to assist the client with their self-management skills.

Fluttert *et al* (2008:215) continues to site Birchwood (1992, 2000) who refers to the "personal signature" of a person with respect to the manifestation and causes of aggression. This Signature implies that patients are extremely unique in terms of aggression and needs to be evaluated and managed as an individual and not merely according to set protocols.

4.2.2 Early recognition model

Fluttert *et al.* (2008:213) developed an early recognition model for identifying aggression and simultaneously preventing severe incidences. The aim of this model was to identify the subtle signs during activities such as delivering daily care. This model consists of four distinctive areas that focus on acquainting the client with the model and stipulating the expected behavior. The nurse patient and all of his support system are involved and asked to list e patient is taught how to monitor their own behavior and to recognize the warning signs. During phase four the preventative measures are identified and the client is advised to utilize these measures in the event of detecting the early warning signs of aggression. (Fluttert *et al.* 2008:213).

Importantly all staff must be made aware of this protocol and how to apply this. Furthermore this recognition model concurs with the perception of indigenous healers, namely that the client who is aggressive must have input and recognise the factors which leads to his own aggression, he must form part of the management of his own behaviour and not be merely a passive recipient of care.

Thus Fluttert *et al.* (2008:214) identified that the success of this model rests on the development of rapport between the nursing staff and patients.

4.3 Causes of aggression

4.3.1 Situational vulnerability

- The increased probability of a person to become aggressive due to: Physical contact, Limit setting, Problems of communication, Changes or re-adjustment, Persons, High risk contact, Drugs and stimulants as per the REFA (Report form for aggressive episodes) scale (Bjørkly, 1999:58). Bjørkly (1999:59) reports that often there are more than one precipitant for a single episode of aggression and that 64% incidents of aggression was caused by limit setting.
- 25% (twenty five percent) of incidences occurred due to delusional states, hallucinations or difficulty in communication this finding is similar to what the indigenous healers reported in terms of the association of mental illness and aggression, therefore the nurse must guard against the perception that [all mentally ill persons are prone to violence]..

- There is no reported difference in the rates of aggression between male and female patients but noteworthy there is a reported trend for male psychiatric patients to engage in more serious violence than their female counterparts.
- There was no statistically significant difference in rates of aggression during different seasons.
- Often the same patients are involved in numerous incidences of violence and aggression.
- In the ward setting where access to alcohol, stimulants and drugs are controlled there is often a decrease in incidences of aggression and violence.
- Staff refusal of patient requests Gudjonsson *et al.* (2004:259).
- Patients refusing medication as cited by Gudjonsson et al (2004:259
- Closed-ward systems (James et al., 2011:133), (Mavundla, 2000:1576).
- Conflicts with staff, certain staff have been identified to be more prone to attacks indicating problematic relationships, Duxbury & Whittington 2005:470)
- Shift changes, admissions and discharges have also been linked with escalation in aggression (Delaney & Johnson, 2007: 43).
- Past experience of being "rewarded" for violent behaviour
- Cramped over crowded spaces
- Very hot spaces
- Fear and anxiety
- Too little or too much stimulation

4.4 Warning of imminent violence as per NHSLA Risk management standards

- Increase in pitch and volume of the voice
- Dilatation of the pupils
- Abrupt answers to questions
- Towering posture
- Tensing of limbs and facial muscles
- Sustained prolonged eye contact
- Restlessness
- Clenching and unclenching of fists
- Threatening gestures and provocative behaviour'
- Repeating the same thing over and over

4.5 Predictors of violence

- Diagnosis of schizophrenia and co-morbid substance abuse (Duxbury & Whittington 2004:470).
- Younger men with a psychiatric illness and co-morbid substance abuse problem are most likely to become aggressive (Duxbury & Whittington 2005:470).
- Conflicts between Patients and staff. (Duxbury & Whittington 2005
- During meal-and shower time in the mornings have all been associated with an increase in the incidence of aggression.

- Patients who are unknown to the nursing staff may proof to be very unpredictable and often poses a higher risk to staff than known patients according to Delaney and Johnson (2007:42), the indigenous healers also reported that extra caution must be taken where the person is unknown to the healer, where there is no collateral information available all persons must be dealt with as though they are unpredictable.
- The better the staff are acquainted with the patient, the more equipped they are in terms of predicting the outcome of a situation as per Delaney and Johnson (2007:43). Therefore this will allow staff not only to anticipate behaviour but to focus on the best mode of action to de-escalate potentially dangerous behaviour.
- History of violent behaviour and the severity of previous acts
- Previous use of weapons
- Known personal triggers.
- Threatening with violence
- History of frontal lobe damage

The Brøset Violence Checklist has proven to be extremely accurate in predicting violence and aggression in a health care setting. This scale has proven to be successful in decreasing the amounts of seclusion due to the occurrence of aggression, as found in a study by Clarke *et al.* (2010). According to Clarke *et al.* (2010) the Brøset Violence Checklist (BVC) consists of six items and can be completed either within the presence or absence of the patient. This tool has subsequently been implemented in different hospital settings as a basic part of routine patient care (Clarke *et al.*, 2010:615).

"The BVC assesses three patient characteristics (confusion, irritability and boisterousness) and three patient behaviours (verbal threats, physical threats and attacks on objects) as present or absent. It is hypothesized that an individual displaying two or more of these behaviours is more likely to become violent within the subsequent 24-h period than the patient who does not display these behaviours." (Clarke *et al.*, 2010:215). The BVC have proven to be accurate in the use on unknown and unfamiliar patients, (Clarke *et al.*, 2010:617).

4.6 De-escalation techniques

In order to manage aggression it is essential that the therapist and patient both understand the onset of aggression and identifies the feelings experienced directly prior to an aggressive incident. (Fluttert *et al.*, 2008:212). This in essence will assist both the therapist and client to gain an in-depth understanding of the behavior of the client.

- Once a staff member is acquainted with a patient they will get to understand what the "typical" behaviour of a patient would be during a situation.
- Understand why a person would behave in a particular fashion
- Respond immediately when a situation is particularly unsafe
- Remember not all escalating situations will be dangerous; this is where knowing a patient is particularly helpful. (Delaney & Johnson. 2007:44).
- All incidences of aggression follows a trajectory, however often the persons involved are not aware of the beginning of the incident. Early appropriate intervention is of extreme importance

as to be able to stop further escalation. This is supported by Hill (2008:28) as he found during his study that it is important to contain patient aggression at the level of verbal abuse and that aggression management training should focus on de-escalation strategies.

- The intensity of the incident is a good point to determine the nature of the intervention required.
- Aim of de-escalation is to reduce violent behaviour through the use of verbal and non-verbal communication skills (Price & Baker, 2012:310)
-

4.6.1 Characteristics of effective de-escalators (Price & Baker, 2008:312)

- Open, honest, supportive, self-aware, coherent, non-judgemental and confident without appearing arrogant.
- Express genuine concern for the patient, are non-threatening and permissive in a non-authoritarian manner.
- Empathize
- The above qualities will help the care giver to gain the client's trust and this will make the appeal from the care giver for the client to maintain self-control more accepted.

4.6.1.1 Personal control

Price and Baker (2008:312) refers to Duperouzel (2008) and Gertz (1980) by citing, when it appears as though a person is calm in dealing with an aggressive client the sense of calm will rub off on the client. This creates a perception in the client that the staff is not aggressive and in control of the situation. To accomplish this calmness a strategy proposed is to focus your attention on the patient rather than how you as a care giver feel about the situation. However be constantly aware of the propensity for violence. This technique will demand a certain amount of self-control from both the therapist and the patient. Even though aggression is learned behaviour so is self-control according to Geen and Donnerstein (1998:Loc2016)

4.6.1.2 Verbal and Non-verbal skills (Price & Baker, 2008:313)

Calm gentle tone of voice The indigenous healers reports the importance of calmness and a calm hand because they say that the use of an aggressive tone will b\"Blow the same spirit back into the patient, and will give the patient a "step to climb higher" this means to become more aggressive"

Tactful use of language and sensitive humour as long as it is not seen by the client as sarcasm or belittling him.

Focus on your own body language, eye contact, facial cues and focus on expressing concern for the patient.

Be aware of the appropriateness of eye contact and that it should not become a stare down which can be perceived as challenge or aggression. Culturally it is not appropriate for a younger person especially a female, to make eye contact with some older male patients. A possible method to deal with this is to make fleeting eye contact but avert your eyes to about the height of the chest of the person (this way you will be able to observe any movement from hands or legs in your direction)

This will put you in the ideal position to not be caught off guard by a sudden attack from the patient ton you.

4.6.1.3 Safe conditions for de-escalation (Price & Baker, 2008:314)

Determine the level of support which might be required
Determine the presence of weapons or potential weapons
Be aware of exits for staff to leave the area safely
If possible move the patient to a quieter area or remove fellow patients to a safer area.

4.6.2 De-escalation (Price & Baker, 2008:315)

Find out what caused the patient to feel the way he/she does.
Find out their immediate need and what can be done to solve the problem
Avoid sanctions or threats or entering into power struggles, the making of threats will immediately lead to resistance and it will worsen the situation
Do not make unreasonable concessions or appear to be uncompromising

4.6.2.1 Facilitate expression (Price & Baker, 2008:315)

The patient should be allowed to communicate his/her feelings without being judged, the patient must be left with the perception you understand his/her pain and that you are there to assist. In order for a patient to be able to express how he feels he must be able to monitor their own actions (Geen & Donnerstein, 1998:Loc. 2022), failure will ultimately lead to loss of self-control and the display of aggression. This failure can be caused by delusional states, being under the influence of some or other substance, de-individuation as seen when one loses one's own identity in a group such as a gang or lack of strength such as when admitted against your own wishes, which leads to emotional distress as explained by Geen and Donnerstein (1998:Loc. 2028)

Give alternatives to the expression of anger

Acquiescence is expected from MHCU, this is however not very reasonable as adults we are supposed to be self-deterministic and not overwhelmed by our situation, the mental health care user who feels overwhelmed might be resolved to a fight or flight reaction determined by his circumstances if there are no alternatives posed to him/her. Provide options the patient must feel they have a certain amount of control even if the options are limited, such as which staff member they want to talk to, where they want the injection administered buttock or arm.

Use distraction techniques this is especially helpful in the person with a cognitive disorder, a person under the influence of alcohol or in children with intellectual disorders (Gallagher & Parrott 2011:326). Through the use of this technique you can maneuver the client away from the person or the situation that resulted in his feelings of anger in the first place.

If a person becomes violent it is often necessary to use a firmer approach and to limit their behaviour, in such instances it is often necessary to take a person to a safer area in order to administer medication after which de-escalation would continue, where there are other patients

present it is often more feasible to remove the "spectators" and have them leave the area. This will buy some time and give the patient the opportunity to possibly think about his feelings and re-contemplate his actions i.e. calm down without any intervention necessary from the staff members.

4.7 Break away techniques

Break away techniques are used when a care provider is attacked by a patient, the use of these techniques will allow the nurse to escape the attack from the patient without injury to herself or the patient and to obtain the necessary help from colleagues

The important point to remember is that there are different techniques to be used for different types of attacks.

The focus of break-away techniques is to always focus on safety without harm to the patient. The element of surprise is the principle to be applied where the patient will not be able to anticipate the nurse's reaction.

Types of attacks most frequently occurring

- Bite
- Hair grab
- Hold arm with one hand
- Hold arm with two hands
  - Bear hug (Full Nelson)
  - Strangle hold from the front using two hands
  - Strangle hold from behind using two hands
  - Strangle hold from behind using the arm

4.7.1 General principles to keep in mind when using break away techniques

- Never pull away from a hold or bite, this will result in more injury, moving in towards the patient always comes as a surprise as the patient would normally expect the nurse to attempt to pull away. Pulling away is usually the normal behaviour in humans.
- The thumbs on the human hands are the weakest points and easiest digit to break free from.
- Once you break free, run and get help.

Applying the techniques will be practiced and demonstrated during physical demonstrations.

4.7.2 Break-away techniques to apply when in the following situations

4.7.2.1 Bites

- Push the area being bitten towards the patient's mouth and push with you finger of the free hand hard into the buchal area where the joint of the jaw is. This pressure point will trigger an automatic response in the form of the opening of the jaw of the person biting.

- Alternately use the side of your first two fingers push onto the upper lip and vibrate hard against the area where the septum joins the upper jaw this will cause a parasympathetic response forcing the patient to release the bit hold

3.7.2.2 Hair grab from behind

- Grab a hold of patient's wrist with both your hands
- Pull patient's hands towards your skull this will relieve the pulling on your hair.
- Step backwards towards the patient
- Quickly bend knees move downwards with whole body while holding on to arms
- Twist your body away (outwards) from the patient (downwards and outwards)
- If hold breaks get out of the way

4.7.2.3 Hair grab from the front

- Grab a hold of patient's wrist with both hands
- Push patients hands towards your skull
- Step towards the patient
- Turn your body inwards while holding onto the patient's arm forcing your outside elbow over the arm with which the patient is pulling your hair.
- This will force the patient's body downwards and rotate his arm outwards which will result in a release of the hold on your hair.
- If the hold breaks get out of the way

4.7.2.4 A hold on your wrist with the patient holding your right wrist with his left hand or your left hand with his right hand

- Notice where the patient's thumb is as this is the weakest point on the human hand
- Make the hand on your arm being hold into a tight fist.
- Place your free hand over your own fist (to help with extra leverage and strength)
- If the thumb of the hand with which the patient is holding is uppermost you must step in towards the patient and pull the arm being hold upwards with a sudden sharp movement out of the hold.
- As the patient releases move away

4.7.2.5 Wrist-hold when the patient is using both hands

- Notice where the patient's thumbs are as these are the weakest points on the human hands.
- Make the hand on your arm being hold into a tight fist.
- Place your free hand over your own fist (to help with extra leverage and strength) in this case your free hand and arm will grab your own fist on the am which is being held (over the arms in the middle between the hands of the patient.)
- Step in towards the patient and pull the arm being hold upwards with a sudden sharp movement out of the hold.
- As the patient releases move away

4.7.2.6 Bear Hug from behind

The patient will expect the nurse to lean forward to attempt to break free.

The surprise element here is to catch the patient off guard. (Children use this technique very effectively when they do not want their parents to dress them.) They simply go limp.

The technique works best when the person being held takes a deep breath and then simply suddenly leans backwards, throw their arms up in the air, go limp and literally falls backwards and slips down against the patient. Often this might knock the patient off balance and gives the nurse time to escape and call for help.

4.7.2.7 Strangle-hold from the front with the patient using two hands

All strangle holds are extremely dangerous in the sense that it might be lethal and therefore justifies the use of some force. Additionally it requires protection of the trachea so that a degree of airway can be maintained.

- To maintain a patent airway, push your jaw down as far as possible
- Clasp your hands together in-front of your body as though you are holding an axe.
- With as much force and speed as you can muster swing your arms with the clenched hands upwards and outwards while giving one step towards the patient.
- As you swing your arms through the arms of the patient the force you use should break the hold on your neck.
- Run away and immediately get help.
- If you do not succeed in breaking the hold at a first attempt especially if you are a female being held by a male. You can use the heel of your hand and with a sudden upwards thrust you can punch the person on the nose. This is extremely painful but very successful in releasing a grip on a neck. It will temporarily put a person out of action long enough to allow the nurse to run and get help.

4.7.2.8 Strangle-hold from behind using two hands

- Push your jaw down notice where the thumbs are.
- Grab a hold of both of the patient's pinkies and pull the pinkies outwards towards the patient this will also break the hold.
- As the patient releases move away

4.7.2.9 Strangle-hold from behind using the arm

- Push down with your chin to try and maintain a patent airway.
- Notice which arm the patient is using
- Make a fist with your hand on the same side as the arm the patient is using.
- Grab your own fist with the other hand (this will give you more strength)
- In one motion extend the fisted arm forward and jab back with your elbow hitting into the solar plexus of the patient holding you

- As the patient releases move away and get help

IN ALL INSTANCES WHERE YOU WERE COMPELLED TO USE JUSTIFIABLE FORCE REPORT AND DOCUMENT THIS AND WHERE NECESSARY HAVE THE PATIENT EXAMINED BY A MEDICAL PRACTITIONER FOR POSSIBLE

4.8 SAFE RESTRAINING TECHNIQUES

Different authors have pointed out that the use of chemical and physical restraint and even seclusion often leads to more violence and injuries (Wynn, Kvalvik & Hunnekleiv, 2011:133), yet there is a definite place for such measures if a person is extremely violent and poses a danger to self and others.

4.8.1 Dangerous Techniques

Basket holds restraint/hobble tying as this can lead to asphyxiation.

Restraint on a soft surface a person can asphyxiate in this position especially if the face is forced into a soft mattress.

Face down prone position any pressure on the back will restrict breathing and cause asphyxiation.

Pressure on the chest, abdomen restricts movement of the diaphragm necessary for breathing.

Pressure on the neck area can lead to asphyxiation or over the carotid area can lead to arrhythmia and death.

Kneeling position with his knees on the floor torso lying face down across a bed restricts movement of the diaphragm and can also lead to traumatic asphyxiation.

Take extra caution in the following patients

- Obese patients
- Cardiac problems
- Asthmatics
- Sedation with phenothiazines and benzodiazepines

4.8.2 Safe Technique in Restraining

3 to 5 people is required for safe restraining

One person will be the ***team leader***, this is the person who will communicate with the patient and give the cue to the rest of the team that they will move in to restrain the patient.

This person will use a towel to throw towards the patient's face to elicit the reflex whereby the patient will raise his arms to ward off the towel flying in towards his face.

The next two persons in the team will make a grab for the patient's arms. Grab the arm by the wrist (While facing the patient) curl your arm closest to the body of the patient under his axilla and pull the patient close to you while pushing on the wrist with the arm extended. As per photo below.

Photo 3.1

In this position place your leg behind that of the patient. You will now have the patient in an off balance position walk forward and gently put the patient down on the floor on his back. As seen in the next photo.

Photo 3.2

Immobilize arms with pressure on shoulder joint and extension of the arm holding the wrist down. In this position it is difficult for the patient to attempt to bite the staff member, the worst this person can do is spit at the staff.

Photo 3.3

The third and fourth persons will:

Immobilize the legs with restraint over the ankle or by sitting astride the leg and maintaining pressure over the area just above the knee joint. In this position the person cannot flex the knee to execute a kick. One or two persons can do this i.e. either one person over either the patient's legs; or one person per leg of the patient. See picture underneath

Photo 3.4

The ***leader*** will administer sedation in either the deltoid or in the leg. Do not attempt to turn the patient on his side to administer in the buttock as this will contribute to injuries of either the patient or the staff.

In this restraint position there is no pressure anywhere on the chest or the thorax of the patient to compromise breathing and it will therefore eliminate the risk of asphyxia

The ***leader*** will administer sedation in either the deltoid or in the leg. Do not attempt to turn the patient on his side to administer in the buttock as this will contribute to injuries of either the patient or the staff.

5. CULTURAL SENSITIVITY, AWARENESS AND SAFETY

Culture according to Leininger as cited in George (2002:491) defines the way in which a person perceives care, and they will relate these experiences to their general health belief and practices.

"An understanding of culture is essential for competent nursing care as culture is interwoven throughout health care" (Lancellotti 2007:180). The Nurse must be able to get to know the client within the context of his or her culture Lancellotti 2007:180 refers to this as what researchers term the "Stranger to Trusted Friend Enabler" This allows the nurse to value and respect similarities and differences.

Lancelotti (2007:181) confirms that this movement can only start when the nurse develops consciousness (awareness) and take action. One such observation is highlighted by Geen and Donnerstein (1998: Loc. 2080), where the authors point out that culture and socialization determines lines beyond which internal restraint against aggression is set aside and what the extend thereof is, therefore people learn from their culture at which point it is acceptable and even expected to become violent.

Therefore the author can safely say culture will determine at which point it is acceptable to become aggressive and it is imperative that therapists therefore understand the cultural background of a client.

- There is also some evidence that Black patients may be managed differently by nursing staff when involved in an 'untoward incident' as quoted by Gudjonsson, *et al.* (2004:259).
- James et al 2011:131) reports that nurses often show stigmatization and discriminatory dispositions towards the mentally ill. The researcher views the mentally ill as a sub culture in health care and is therefore of the opinion that this sub-cultural grouping needs nursing care which is culturally aware and sensitive.
- Health care professionals often view the psychiatrically ill as more prone to violence, malevolent and unpredictable according to James et al. (2011:131).
- Culture is universal. It is also diverse, as Leininger (1991, 1995a, 1995b, 1997) refers culture to the specific pattern of behaviour which distinguishes any society from others.
- care (caring) is essential to curing and healing, for there can be no curing without caring
- every human culture has lay (generic, folk or indigenous) care knowledge and practices and usually some professional care knowledge and practices, which vary transculturally
- Culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological ethno-historical, and environmental contexts of cultures.
- a client who experiences nursing care that fails to be reasonably congruent with his/her beliefs, values, and caring life ways will show signs of cultural conflict, noncompliance, stress and ethical or moral concern
- Culturally based care if fully known can greatly advance nursing knowledge (Leininger 2001:38)
- Prejudice is explained by Lancellotti (2007:179) to dehumanize people and deny them their individuality. This can be seen in the application of a one cure fits all approach when managing aggression and violence by means of traditional western based methods.

5.1 Cultural safety

Fulcher (2002:689) refers to cultural safety as the acknowledgement of and attendance to a person's needs to according to their cultural frame of reference even if it is not fully understood. Fuller (2002:699) further points out that Indigenous people (referring to Maori's in Nieu Zealand) have often been subjected to "cultural racism" in the allocation of health and social services. This often happens unintentionally when health services makes assumptions or places as example WBKS's superior to Indigenous Knowledge systems, and renders care without full consideration of the IKS of a person from a different cultural background.

Ramsden and Papps (1996: 491) defines cultural safety as "The effective nursing of a person from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on own nursing practice." Cultural safety also implies that the nurse will care for a patient taking cognizance of those things which makes a patient unique according to Ramsden and Papps (1996:493).

In order for the nurse to recognise the individuality of her patient she/he must however be aware of her own reality and attitude which she/he brings to the practice.

Ramsden & Papps (1996:493) identify safety as the competent practice a nurse practices in order to prevent risk and harm to the patient, this includes physical, mental, social, spiritual and cultural components of the client/patient relationship. With this in mind it reinforces the idea of the researcher that the traditional western based methods of managing violence and aggression as a one cure fits all approach does not guarantee cultural safe practices to all MHCU.

6. CONCLUSION

The management of aggression and violence is extremely difficult to do however the researcher concurs with Fluttert *et al.* (2008:215), namely that well trained nursing staff should have the ability to detect the very subtle signs of imminent aggression and instability and that they should have the necessary skill to turn these warning signs favourably to the therapeutic advantage of the patient.

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Goetz & Huckshorn, 2003. Creating Violence Free and Coercion Free Service Environments for the Reduction of Seclusion and Restraint: Presenting a U.S. Initiative: *Debriefing Activities A Core Strategy © A Tertiary Prevention Tool.* http://www.google.co.za/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0CEIQFjAD&url=http%3A%2F%2Fwww.hogg.utexas.edu%2Fuploads%2Fdocuments%2Fdebrief_activities.ppt&ei=Tb9TU7PxL8GI7Aav8IDIDA&usg=AFQjCNHlzVknKvt55U9L7eOwdzmowJ4E2w Accessed 20 April 2014 [PowerPoint presentation]. 10

ANNEXURE 3

Permission to use the MAVAS questionnaire

Happy to help Teresa
There are two versions - you may have a preference for layout but the content is the same.
My permission is granted subject to you citing me in any papers/docs you produce. If you ever would like to share your data to do some comparisons that would also be helpful but not a requirement.

Kind regards
Good luck

Joy
Dr Joy A Duxbury
Reader in Mental Health Nursing
Divisional Leader for Mental Health
Tel: 01772 895110
JDuxbury@uclan.ac.uk
>>> "Teresa Bock" <Terebock@pgwc.gov.za> 2/25/2010 6:56 pm >>>
** High Priority **
Dear Dr Duxbury

My name is Theresa Bock; I am a registered Psychiatric Nurse working in Stikland hospital (a Psychiatric hospital near Cape Town in South Africa). I have been employed as a registered psychiatric Nurse for 24 years.

I am currently registered as a PhD candidate with the North-West University in the North-West province of South Africa. I have submitted a research proposal to Stellenbosch University titled: "The effectiveness of policy implementation as strategy to manage Mental Health Care User related aggression.

I am proposing a quantitative study with an experimental group and a control group with a post-test only design. I intended to draw up a questionnaire to test if the policy and guidelines (in the form of a training course outlining theories with regards to aggression, calming strategies, break away techniques and restraining techniques) have changed the perception and attitudes of staff with regards to aggressive mental health care users. My supervisor Dr Abel Pienaar however advised that I make use of existing questionnaires.

I have read through your research titled "The Management of Aggression and Violence Attitude Scale (MAVAS): a cross-national comparative study" Published 23 January 2008. The scale you designed would suit the purpose of my study.

I herewith request your official permission to use your scale. Acknowledgement of use thereof will be done according to the University Stellenbosch plagiarism policy. If permission is granted could you kindly indicate any other information required prior to the use of your scale.

The situation in the Psychiatric Hospitals in the Western Cape: South Africa is a cause of great concern with regards to staff and occasionally patient related injuries due to aggression and violence and a lack of policies and guidelines directing staff in the management of aggression and violence.

Subsequently I am currently in the process of designing a training programme for which we will obtain continuous professional development accreditation; furthermore I am part of a team of psychiatrists and managers trying to influence the development of Provincial Policy that would make attendance of this course and bi-annual updates compulsory for all staff dealing with MHCU and all other potential violent patients. Through my proposed research I wish to determine the efficacy of the proposed training programme and where possible make the necessary changes to the proposed programme after analysis of the data collected.

I have developed a keen interest in the phenomenon of aggression as I have witnessed several occasions where it was my perception that incidences of aggression was either caused by the way a client was managed by staff or due to environmental factors that must definitely be adapted.

I am an admirer of your work.

Yours faithfully

Theresa M Bock
Head of Campus
Metro East Campus of the Western Cape College of Nursing
Tel 021 940 4567
Fax 021 940 4543
Terebock@pgwc.gov.za
"A love affair with knowledge will never end in heartbreak."

ANNEXURE 4

QUESTIONNAIRE ON THE MANAGEMENT OF MENTAL HEALTH CARE USER RELATED AGGRESSION.

NB Participation in this research project is **anonymous and voluntary**.
Findings of the research project will be made available to the four psychiatric hospitals included in the study; no hospital name shall be mentioned.

Highest level of education		**Tick off √**
Current rank	Auxiliary Nurse	
	Enrolled Nurse	
	Registered Nurse	
	Registered Psychiatric Nurse	
	Registered Advanced Psychiatric Nurse	
Other		

Male	**Female**

Gender **Tick off √**

Yes	**No**

Have you received training with regards to the management of patient related aggression?

Tick off relevant experience in years working in a psychiatric Unit with a √

Less than 1 year	1 to 5 years	6 to 10 years	11 to 15 years
16 to 20 years	21 to 25 years	26 to 30 years	More than 30 years

The Management of Aggression and Violence Attitude Scale (MAVAS)

- The purpose of this questionnaire is to obtain your perceptions of aggression and the management of aggression at this facility.
- For each item, please darken the circle that reflects your opinion about the statement. If you wish to change your rating, place an X completely through the circle and then darken another circle.

		Strongly Agree	Agree	Disagree	Strongly Disagree
1	Patients are aggressive because of the environment they are in.	○	○	○	○
2	Other people make patients aggressive or violent.	○	○	○	○
3	Patients commonly become aggressive because staff does not listen to them.	○	○	○	○
4	It is difficult to prevent patients from becoming violent or aggressive.	○	○	○	○
5	Patients are aggressive because they are ill.	○	○	○	○
6	Poor communication between staff and patients leads to patient aggression.	○	○	○	○
7	There appear to be types of patients who frequently become aggressive towards staff.	○	○	○	○
8	Different approaches are used on this ward to manage patient aggression and violence.	○	○	○	○
9.	Patients who are aggressive towards staff should try to control their feelings.	○	○	○	○
10	When a patient is violent, seclusion is one of the most effective approaches to use.	○	○	○	○
11	Patients who are violent are often physically restrained to administer sedation.	○	○	○	○

		Strongly Agree	Agree	Disagree	Strongly Disagree
12	The practice of secluding violent patients should be discontinued.	O	O	O	O
13	Medication is a valuable approach for treating aggressive and violent behaviour.	O	O	O	O
14	Aggressive patients will calm down automatically if left alone.	O	O	O	O
15	The use of negotiation could be used more effectively when managing aggression and violence.	O	O	O	O
16	Restrictive care environments can contribute towards patient aggression and violence.	O	O	O	O
17	Expressions of aggression do not always require staff intervention.	O	O	O	O
18	Physical restraint is sometimes used more than necessary.	O	O	O	O
19	Alternatives to the use of containment and sedation to manage patient violence could be used more frequently.	O	O	O	O
20	Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence.	O	O	O	O
21	Patient aggression could be handled more effectively on this ward.	O	O	O	O
22	Prescribed medication can in some instances lead to patient aggression and violence.	O	O	O	O
23	It is largely situations that contribute towards the expression of aggression by patients.	O	O	O	O
24	Seclusion is sometimes used more than necessary.	O	O	O	O
25	Prescribed medication should be used more frequently to help patients who are aggressive and violent.	O	O	O	O
26	The use of de-escalation is successful in preventing violence	O	O	O	O

		Strongly Agree	Agree	Disagree	Strongly Disagree
27	If the physical environment were different, patients would be less aggressive.	○	○	○	○

Thank you for your participation in this research project.

ANNEXURE 5

Intercultural Sensitivity Scale

Intercultural Sensitivity Scale

Below is a series of statements concerning intercultural communication. There are no right or wrong answers. Please work quickly and record your first impression by indicating the degree to which you agree or disagree with the statement. Thank you for your cooperation.

		1 strongly disagree	2 disagree	3 uncertain	4 Agree	5 Strongly Agree
1	I enjoy interacting with people from different cultures.					
2	I think people from other cultures are narrow-minded.					
3	I am pretty sure of myself in interacting with people from different cultures.					
4	I find it very hard to talk in front of people from different cultures.					
5	I always know what to say when interacting with people from different cultures.					
6	I can be as sociable as I want to be when interacting with people from different cultures.					
7	I don't like to be with people from different cultures.					
8	I respect the values of people from different cultures.					
9	I get upset easily when interacting with people from different cultures.					
10	I feel confident when interacting with people from different cultures.					
11	I tend to wait before forming an impression of culturally-distinct counterparts.					
12	I often get discouraged when I am with people from different cultures.					

13	I am open-minded to people from different cultures.					
14	I am very observant when interacting with people from different cultures.					
15	I often feel useless when interacting with people from different cultures.					
16	I respect the ways people from different cultures behave.					
17	I try to obtain as much information as I can when interacting with people from different cultures.					
18	I would not accept the opinions of people from different cultures.					
19	I am sensitive to my culturally-distinct counterpart's subtle meanings during our interaction.					
20	I think my culture is better than other cultures.					
21	I often give positive responses to my culturally-different counterpart during our interaction					
22	I avoid those situations where I will have to deal with culturally-distinct persons.					
23	I often show my culturally-distinct counterpart my understanding through verbal or nonverbal cues.					
24	I have a feeling of enjoyment towards differences between my culturally-distinct counterpart and me.					

Chen and Starosta (2000) first developed an instrument to explore the concept of intercultural sensitivity

ANNEXURE 6

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: "Culturally safe management of aggression and violence in mental health care institutions."

REFERENCE NUMBER: NWU-00051-13-S1
PRINCIPAL INVESTIGATOR: Theresa Melodie Bock
ADDRESS: 89 Joubert Street, Joubert Park, Bellville
CONTACT NUMBER: 0836027097

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project which you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails, and how you would be involved. Also note that your participation is entirely voluntary and that you are free to decline to participate. If you say no, this will not affect you negatively in any manner whatsoever. You are also free to withdraw from the study at any point, even if you agreed to take part.

This study has been approved by the Health Research Ethics Committee at North West University and will be conducted according to the ethical guidelines and principals of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- The study will be conducted in four randomly selected hospitals located in South Africa and Lesotho. The Acute admission units of the hospital where you are employed have been selected, as aggression and violence is higher in acute admission units as opposed to long term units. This study will include all staff of the multi-disciplinary team in the acute admission unit.
- This research study will describe the attitudes of the staff towards the management of aggression and violence, the cultural awareness and sensitivity, by asking you to complete a questionnaire.
- If you are randomly selected to undergo training in the management of aggression and violence you will be invited to attend a training course.
- After the training course was presented the researcher will provide you with a similar questionnaire as the one completed previously.
- The answers on the two questionnaires will be compared in order for the researcher to determine how effective the training course presented and attended was.
- All research participants will be provided with this letter and a consent form to be completed prior to their participation in this research project.
- Once the consent form has been completed the research participant will place it in a sealed envelope. The participation is entirely voluntary and anonymous. The participant will place both the questionnaire and the consent form in different boxes provided by the researcher, so that questionnaires and consent forms cannot be linked with each other. No names or hospital names will be attached to the questionnaires.

Why have you specifically been invited to take part in this research project?

- As a nurse you are employed and are working in a mental health care institution, where you are exposed to MHCU with often aggressive behaviour. Your perception of how we are managing these patients, are very important and you can provide valuable input into suggestions on how to empower staff to deal with these patients.

What will your responsibilities be?

- You will be requested to complete a consent form and a questionnaire to be completed and placed in the boxes marked "consent" and "questionnaire" as provided by the researcher.
- You will then be invited to attend training on the management of aggression and violence
- After the course you will be given a final questionnaire to complete and place in the boxes a described above.

Will you benefit from taking part in this research?

- The data collected during this research will be used to develop a curriculum to assist staff to manage aggression and violence as associated with MHCU, in a culturally safe manner. Therefore your participation will benefit you and your colleagues and future mental health care nurses.

Are there any risks involved in taking part in this research project?

- No risks have been identified for this project. However if you should feel discomfort when answering the questionnaire due to recollection of an event where you possibly were the victim of aggression and violence, the researcher encourages you to phone her at 021 940 4567 or 083 6027 097 and she will arrange a formal referral to your employee wellness programme ICAS, where you can speak to a qualified therapist about any unresolved trauma.

If you do not agree to take part, what alternatives do you have?

- Your participation is entirely voluntary, if you select not to participate you will not be penalised in any manner.

Will you be paid to participate in this research project?

- No, you will not be paid to take part, nor will you incur any cost. The training received is entirely free.

Is there anything else you should do or know?

- You can contact the NWU Health Research Ethics committee at 018 299 1111/2222 and the Faculty of Health Sciences at 018 299 2092.
- You will receive a copy of this Information leaflet and consent form for your own records.

DECLARATION BY THE PARTICIPANT

By signing below, I

..... Agree to take part in this research study entitled, "Culturally safe management of aggression and violence in mental health care institutions"

I declare that:

- I have read or had read to me the information and consent for, and it is written in a language with which I am fluent and comfortable
- I have had a chance to ask questions and all my questions have been adequately answered
- I understand that taking part in this study is voluntary and I have not been pressured to take part
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interest.

Signed at (place) ..... On (date).....

Signature of participant Witness.....

DECLARATION BY THE RESEARCHER

I Theresa Melodie Bock declare that:

- I explained the information in this document to the participant
- I encouraged the participant to ask questions and took adequate time to answer them
- I am satisfied that the participant adequately understands all aspects of the research, as discussed above.
- I did/did not, use an interpreter. (If an interpreter is use the interpreter will sign the declaration below)

Signed at (place) ..... On (date)...../

Signature of researcher.....Witness.....

DECLARATION BY THE INTERPRETER

I, ...declare that:

- I assisted the researcher Theresa Melodie Bock to explain the information in this document to the participant using the language medium of .....
- We encouraged the participant to ask questions and took time to answer them
- I conveyed a factually correct version of what was related to me
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her questions answered.

Signed at (place) ..... On (date).....

Signature of interpreter.....Witness.....

ANNEXURE 7

Ethical clearance for study from NWU

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

To whom it may concern

Faculty of Health Sciences
Tel: 018 2992092
Fax: 018 2992088
Email: Minrie.Greeff@nwu.ac.za

5 August 2013

Dear Prof. Pienaar

Ethics Application: NWU-00051-13-S1 "Culturally safe management of aggression and violence in mental health care institutions"

All ethical concerns have been addressed and ethical approval is recommended.

Yours sincerely

Prof. Minrie Greeff
Ethics Sub-committee Vice Chairperson

Original docs: Prof. Minrie Greeff(10187308) C:\Users\13210672\Documents\ETIEK\2013 ETHICS\NWU-00051-13-S1c.docx
19 July 2013

File reference: NWU-00051-13-S1

ANNEXURE 8

Permissions from the respective health care institutions and provinces

DEPARTMENT OF HEALTH
LEFAPHA LA BOITEKANELO
ISEBE LEZEMPILO
DEPARTEMENT VAN GESONDHEID

Department of Health
Private Bag X5049
KIMBERLEY
8301

Enquiries : Dr. Eshetu Worku
Reference : Tel: 053 830 2122
Fax: 086 541 7122

Date : 18 June 2015

Ms. TM Bock
Western Cape College of Nursing
Metro East Campus
C/O Stikland de la Haye Road
Bellville

Dear Ms. TM Bock

TITLE: **Culturally safe management of aggression and violence in mental health care Institutions.**

Reference Number: NC2015/0016

The application to conduct the study was received and has been reviewed by the Provincial Health Research and Ethics Committee (PHREC)

Approval is hereby granted to conduct the above-mentioned study in the Northern Cape Province

Please note: This approval is valid for a period of one year from the date of approval.

The following conditions have to be noted:

1. The research project shall be conducted at no cost to the Northern Cape Department of Health.
2. The approval is limited to the research proposal as submitted in the application.
3. Variation or modification on the research must be notified formally to PHREC for further consideration.
4. The PHREC may monitor the project at any time.

We are committed to achieving our vision through a decentralized, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence-based, informative health care and nurturing partnerships for the benefit of our clients and patients.

Dear Mr. Moyo

With reference to my telephone calls on Friday 2015/25 and today I requested Mme Nkwenza to provide me with the necessary e-mail address to submit substantiating documents to you. I have the necessary permission from Dr Worku and ethical clearance e from both the North West province and the North West University please find attached.

I would love to come and present the training course on the management of aggression and violence at your facility on 10 September and administer a pre and post test to determine the efficacy of the training programme.

The training programme is free of charge with no cost to the institution. The target population would be the Multidisciplinary staff working with MHCU. Participation is voluntary. I have rolled out this training in all four hospitals in the Western Cape and we present this on a continuous basis, participant In the Western Cape vary from security officers to all categories of nursing staff. Psychologists and doctors.

I will guarantee the anonymity of the staff and the hospital.
I would only require a venue to present the training course.
Included in the training is the following:

1. Understanding aggression
2. De-escalation techniques
3. Dignified break away techniques
4. Safe restraining
5. Cultural sensitivity

I would appreciate your feedback.

Yours faithfully

"A marriage with Knowledge will never end in heartbreak."

Theresa M Bock
Head of Campus/Deputy Director
Western Cape College of Nursing: Metro East
Western Cape government
Address: CO Stikland Hospital, De La Haye Road, Bellville
Tel 021 940 4567
Cell: 0836027097
e-mail Theresa.Bock@westerncape.gov.za

health and social development

Department: Health and Social Development
GAUTENG PROVINCE

STERKFONTEIN HOSPITAL
CLINICAL DEPARTMENT
Enquiries: *Prof. Subramoney*
Telephone : *(011)951-8341*
Facsimile : *(011) 951 8331*
e-Mail: [redacted]

Mrs. C. Makutulela
Acting Chief Executive Officer
Sterkfontein Hospital
KRUGERSDORP

Dear Mrs. Makutulela

STUDY : THE CULTURALLY SAFE MANAGEMENT OF AGGRESSION AND VIOLENCE
RESEARCHER: THERESA BOCK

The above study was discussed at the Research Committee meeting. We recommend that permission be granted that Sterkfontein Hospital be used as a site for the above research.

However, since this is a research project involving voluntary participation, we cannot guarantee participation of individuals/staff members

Upon completion of the study, a copy thereof should be submitted to Sterkfontein Hospital

The researcher should contact Mr. H. Shuping (Tel. 011 951-8344) to arrange your visits to Sterkfontein Hospital.

Thank you.

PROF. U. SUBRAMANEY
CHAIRPERSON: RESEARCH COMMITTEE
07/10/2013

Approved.

MRS. C. MAKUTULELA
ACTING CHIEF EXECUTIVE OFFICER

Thank you Mr Shuping and Theresa.

Mr Jimmy Mapunya

Chief Executive Officer

Sterkfontein Hospital

Tel: 011951 8376tel:011951%208376

Fax: 0866225261tel:0866225261

Email: Jimmy.Mapunya@gauteng.gov.za<mailto:Jimmy.Mapunya@gauteng.gov.za>

——— Original message -------

From: Theresa Bock Theresa.Bock@westerncape.gov.za

Date:31/07/2015 07:13 (GMT+02:00)

To: "Shuping, Herbert (gphealth)" Herbert.Shuping@gauteng.gov.za

Cc: Abel Pienaar <abel.pienaar@gmail.com>, Ugasvaree Subramaney <Ugasvaree.Subramaney@wits.ac.za>, "Mapunya, Jimmy J. (GPHEALTH)" <Jimmy.Mapunya@gauteng.gov.za>
Subject: RE: Training programme in the management of aggression and violence

Dear Ntate Shupping

Thank you very much for your prompt response.

There need not be a fixed number of candidates I would love to have at least a minimum of 20 respondents if at all possible.

Fortunately there are statistical methods available to accurately do inferential statistics should the numbers be smaller.

I am indeed looking forward to meeting up with you.

I respect your position in terms of security officers. The course normally starts at 09:00 until 15:00.

Yours faithfully

Theresa
"A marriage with Knowledge will never end in heartbreak."

Theresa M Bock

Head of Campus/Deputy Director

Western Cape College of Nursing: Metro East

Western Cape government

Address: CO Stikland Hospital, De La Haye Road, Bellville

Tel 021 940 4567

Cell: 0836027097

e-mail Theresa.Bock@westerncape.gov.za<mailto:Theresa.Bock@westerncape.gov.za>

[cid:_com_android_email_attachmentprovider_1_5017_RAW@sec.galaxytab]
From: Shuping, Herbert (gphealth) [mailto:Herbert.Shuping@gauteng.gov.za]

Sent: 31 July 2015 07:00 AM

To: Theresa Bock

Cc: Abel Pienaar; Ugasvaree Subramaney; Mapunya, Jimmy J. (GPHEALTH)

Subject: RE: Training programme in the management of aggression and violence

Dear Theresa

I confirm receiving your email, 8th September will be ok but let me know how many candidates you will be looking for your training also be aware that our security is not allowed to have contact with our MHCU and thus they will not be part of the training. Looking forward to see you.

Kind regards

Boitumelo Herbert Shuping

Assistant Manager: Staff Development Nursing Department

Sterkfontein Hospital

Switchboard: +27 11 951 8000 Mobile: +27 82 502 1590

Direct Line: +27 11 951 8344 E-Mail:
herbert.shuping@gauteng.gov.za<mailto:herbert.shuping@gauteng.gov.za>
Fax: +27 11 951 8391

Address: Sterkfontein Psych Hospital, Sterkfontein Road, Krugersdorp 1739.

[cid:image001.png@01CD69A6.7B538090] [cid:image002.png@01CD69A6.7B538090]
<http://commons.wikimedia.org/wiki/File:World_Aids_Day_Ribbon.svg>
Department of Health and Social Development Back to Basics to Make Health and Social Services Work Better
From: Theresa Bock [mailto:Theresa.Bock@westerncape.gov.za]

Sent: 30 July 2015 10:46 AM

To: Shuping, Herbert (gphealth)

Cc: Abel Pienaar (abel.pienaar@gmail.com<mailto:abel.pienaar@gmail.com>)

Subject: Training programme in the management of aggression and violence

UID09duf63i2bd

Dear Mr Shuping

I have tried phoning as advised by Dr Subramaney.

I am a PhD student doing research on the culturally safe management of aggression and violence, my supervisor is Professor Abel Pienaar. I am presenting a one day training course on the management of aggression, dignified break away techniques, de-escalation techniques and safe restraining. Dr Subramaney advised me to contact you to make the necessary arrangements to present the course and administer the questionnaire.

I would love to be able to come and collect data on 8 September, and would require a venue to present the training. The training is free of charge and staff and Hospital anonymity is guaranteed.

The target population is typically the all members of multi-disciplinary team such as all categories of nursing staff, social workers, medical staff, and security staff who deal with the mental health care user.

Please find attached my proof of ethical clearance and permission to use Sterkfontein hospital.

Warm greetings from a very cold Cape Town

Yours faithfully

"A marriage with Knowledge will never end in heartbreak."

Theresa M Bock

Head of Campus/Deputy Director

Western Cape College of Nursing: Metro East

Western Cape government

Address: CO Stikland Hospital, De La Haye Road, Bellville

Tel 021 940 4567

Cell: 0836027097

e-mail Theresa.Bock@westerncape.gov.za<mailto:Theresa.Bock@westerncape.gov.za

DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING
Terebock@pgwc.gov.za
Enquiries: Ms T M Bock
Cell 0826027007

Western Cape Government
Health

Date: 2014/09/03

The CEO Sterkfontein Hospital

RE: Request permission to present a training course on the management of aggression and violence at Sterkfontein Hospital

Dear Sir

I Theresa Melodie Bock am a student Registered at the North West University. I am a PhD Candidate doing research on the Culturally safe management of aggression and violence in Mental Health Care Institutions.

I have received ethical clearance for this low risk study, which entails the presentation of a curriculum for the management of aggression and violence with a pre and post test to determine the efficacy of this programme.

This programme is presented to staff in acute admission units.

Please find attached the proposal and proof of the ethical clearance

Sincerely

Theresa M. Bock

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

3801 First Street
New Office Park
MAHIKENG, 2735

Enq: Keitumetse Shogwe
Tel: 018 391 4504
kshogwe@nwpg.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : **Ms T.M Bock**
North West University

Physical Address (Work/ Institution) WCCN: METRO EAST
LO STIKLAND HOSP BELLVILLE
DE LA HAYE RD, BELLVILLE, 7530

Subject : **Research Approval Letter- Culturally safe management of aggression and violence in mental health care institutions.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the Department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

Dr. FRM Reichel
Director: PPRM&E

07/07/2015
Date

LEPAPHA LA BOITEKANELO
DEPARTMENT OF HEALTH
Kgetsana Peso Private Bag X2068
Mmabatho,2735
07 JUL 2015
NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

Researcher

2015/07/13
Date

1

Healthy Living for All

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP36_912
ENQUIRIES: Ms Charlene Roderick

Albert Luthuli & University Drive
Mahikeng
2790

For attention: **MS Theresa Bock**

Re: CULTURALLY SAFE MANAGEMENT OF AGGRESSION AND VIOLENCE IN MENTAL HEALTH CARE INSTITUTIONS.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Vredenburg Hospital **N Fortuin** **Contact No: 022 709 7287**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

A HAWKRIDGE.

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 16/10/2015.
CC **C BESTER** **DIRECTOR: WEST COAST**

From: Sinazo Vikilahle**Sent:** 16 September 2015 11:54 AM

To: Theresa Bock

Cc: Charlene Roderick

Subject: WC_2015RP36_912

Dear Theresa

Please find the attached document to access your facilities and also the Mutual Courtesy Guide and Report.

Regards
Sinazo Vikilahle
Intern : Health Research
Directorate: Health Impact Assessment
Western Cape Government : Department of Health
Address : 5th Floor, 8 Riebeek Street, Cape Town
Tel: (021) 483 0881
Email : Sinazo.Vikilahle@westerncape.gov.za
Website : www.westerncape.gov.za

Goeie dag Sr

Baie dankie dat u in Weskus in Vredenburg die aanbieding gaan doen. Ek wil graag as Psigiatrie koordineerder versoek of u nie asseblief selfde aanbieding ook in Clanwilliam of Vredendal kan aanbied nie asseblief. Agv personeel sonder rybewyse is dit moeilik vir verste areas om opleiding by te woon.

Kan u asseblief met my skakel oor beskikbare datums indien u u weg oopsien om ons behulpsaam te wees.

Groete

Alta Davids

From: Zeta Roodt

Sent: 28 July 2015 10:16 AM

To: Theresa Bock

Subject: RE: Psychiatric course 5&6 Aug 2015

Dear Mrs Bock

The course is held at the Vredenburg Provincial hospital, in the Multi Purpose Hall.
Thank you, I will convey the starting times to Mrs Oosthuizen.

Kind regards

Zeta Roodt

From: Theresa Bock

Sent: 28 July 2015 10:14

To: Zeta Roodt

Subject: RE: Psychiatric course 5&6 Aug 2015

Dear Mrs Roodt

The course will start at 09:00 until 15:00, can you possibly indicate where exactly the venue is?

Sincerely

"A marriage with Knowledge will never end in heartbreak."

Theresa M Bock

Head of Campus/Deputy Director

Western Cape College of Nursing: Metro East

Western Cape government

Address: CO Stikland Hospital, De La Haye Road, Bellville

Tel 021 940 4567

Cell: 0836027097

e-mail: Theresa.Bock@westerncape.gov.za

From: Zeta Roodt
Sent: 28 July 2015 10:11 AM
To: Theresa Bock
Subject: Psychiatric course 5&6 Aug 2015

Dear Mrs Bock

Mrs Oosthuizen has asked me to confirm with you a time that the course will be starting in Vredenburg on 5 and 6 August 2015.

Kind regards

Zeta Roodt
Admin Clerk: Nursing Services Manager
Vredenburg Provincial Hospital
Saldanha Bay Sub-District
Address: Voortrekker Road, Private Bag x 3, Vredenburg, 7380.

Tel nr: 022 709 7214
Fax nr: 086 564 6817
Email : Zeta.Roodt@westerncape.gov.za

ANNEXURE 9

Inter-coder protocol and letter of authenticity

PROTOCOL FOR THE INTER-CODER

TITLE OF THE RESEARCH: The Culturally safe management of aggression and violence

AIM OF THE RESEARCH:

- What are the attitudes of Mental Health Care Practitioners towards the management of aggression and violence?
- Are Mental Health Care Practitioners culturally aware and sensitive?
- How effective is a proposed programme on management of aggression and violence, in combination with cultural sensitivity and awareness to bring about attitudinal changes in Mental HealthCare Providers?

THE OBJECTIVE OF THE QUALITATIVE PHASE OF THIS RESEARCH

- An exploration of African Indigenous Knowledge Systems used to manage mental health care user related aggression.

The researcher collected the data via Lekgotla and from the audio and video recordings made verbatim transcripts. These transcripts were analysed by the researcher and certain themes and categories were identified, with the aim of answering the question "How does indigenous healers manage aggression and violence in the mentally ill?

The researcher used the phenomenological analysis technique of Coliazzi (1978) as cited by Polit and Beck (2012:566) for data analysis.

Ullswater Street 14
Pinelands,

7405.

8/10/2015.

To whom it concern,

Since I have a vast amount of knowledge of qualitative research and the analysis of qualitative data, I was requested by Miss. T. Bock to be the independed coder of the qualitative data of her Doctoral Manuscript. On 2014/07/19 I received three randomly selected full sets of unmarked interview transcripts, accompanied by the purpose and objectives of the study. In order to evaluate and ensure inter- coder reliability, me and the internal researcher of the current study used different colour highlighters to code the same sets of data independently, using the same coding scheme. We later met to check for consistency and to compare the descriptive and interpretive codes.

Since it was qualitative data, inductive reasoning was used because it does not allow for coding of themes to fit the researcher's pre-conceptions. Thus, codes are data driven.

During the process we had regular discussions regarding the difficulties we experienced as well as the meaning of each code. Although we had some minor differences in interpretation, we revised the codes before reaching a point of agreement. This was done in an attempt to enhance the credibility of the process.

Dr. Ev Wijk
Senior Lecturer Advanced Psychiatric Nursing Science, Western Cape College of Nursing.
0827842417

EvWijK

ANNEXURE 10

Confirmation letter from statistician

November 2015

To whom it may concern

A few months ago, Theresa Bock approached me to assist her with the statistical analysis of the data she has collected for her PHD. Another PHD student whom I have also successfully assisted referred me to Theresa.

I gained my 15 years of experience in statistical analysis of data through working as a researcher for two global research companies (Research International and IPSOS/Markinor), as well as currently for SARS. The software I use and have experience in, is SAS, updated to the latest version.

My qualifications are as follows:

BSc(Hons) Genetics – UP

BA(Hons) Psychology – UP

MBA Strategic Marketing – University of Hull

Continuous training in SAS, i.e. Enterprise guide, JMP.

Sincerely

Ilja de Boer

BSc(Hons), BA(Hons)Psych, MBAStratMkt(Hull,UK)

ANNEXURE 11

Confirmation letter from the language editor

pd
performancedynamix
'generating value through communication'

497 Lot 2A Adylin, Lomagundi Road, Westgate, Harare
+263 772 347 689 ; +263 8644201592
nembawareshadic@aol.com ; performancedynamix@aol.com
shadreckmembaware

DECLARATION OF LANGUAGE EDITING

November 2015

To Whom It May Concern

Dear Sir/Madam

This is to certify that I have fully edited the PhD thesis of Ms. Theresa M. Bock entitled CULTURALLY SAFE MANAGEMENT OF AGGRESSION AND VIOLENCE IN MENTAL HEALTH CARE INSTITUTIONS (North-West University). The text was checked for style, clarity and ease of reading, grammar and usage, spelling and punctuation, consistency in the use of text and figures in illustrations and tables, completeness and consistency in references, as well as consistency in page numbering. Headers and footers and suggestions were offered. The editor makes no pretension to have improved the intellectual content of the thesis and did not re-write any text. The editor's suggestions are to be accepted or rejected by the author. The author effected the final changes by him- or herself.

Yours sincerely,

SHADRECK NEMBAWARE: Corporate communications Consultant – Performance Dynamix

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