CAREGIVERS' EXPERIENCES OF VIOLENCE BY MENTALLY ILL PETIENTS DISCHARGED FROM CHAINAMA HOSPITAL ATTENDING REVIEWS AT FILTER CLINIC, LUSAKA-ZAMBIA

BY

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ADissertation Submitted IN PARTIAL fulfillment of the requirement for the award of the Digreeof Masters of Science in Nursing.

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DECLARATION

I hereby declare that the work presented in this research study report as a requirement for the award of the Master Degree in Mental Health Nursing and psychiatric nursing at the University of Zambia, has not been presented anywhere, either partially or wholly, for any other Master degree course and is not currently being presented for any other master degree award except where acknowledged.

Signature:..... Date:……

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APPROVAL

The University of Zambia has approved this research report of 5th April, 2017 in partial fulfillment of the award of Master Degree in Nursing.

Examiner 1……. Signature …… Date..…….

Examiner 2..... Signature..... Date.....

Examiner 3..... Signature..... Date .....

Chairperson and Board Examiner Signature…….. Date……

STATEMENT

I Erick Musala Kunda hereby certify that this report is as a result of my own independent investigation that I carried out in the partial fulfillment of the requirements for the award of Master Degree in Nursing. The various sources of information to which I am indebted are indicated in the text and references.

Signed……Date……

ABSTRACT

Background:

Caring for Mentally ill patients is a major task many Caregivers face globally. Many people have argued that caring for such a group of patients is followed with unique challenges. Despite the information about caring for patients suffering from mental illness, little information is available and known about lived experiences of caregivers at filter clinic coming for reviews and admitted in wards at Chainama Hills Hospital Lusaka Zambia, worse in the community where such cases are occur.This study deals with an exploration of caregives' experiences of physical violence from discharged mentally ill patients at Chainama Hills Hospital.The purpose is to explore the aggressiveness of violent behavior by discharged mentally ill patients from Chainama Hills Hospital towards the caregivers.

This study'objective is to discover and describe the lived experiences of caregivers who care for mentally ill patient at home but attending reviews at Chainama hills Hospital Lusaka Zambia.

The study employed a descriptive survey design in which qualitative techniques, phenomelogical were used to conduct the research and collect the required data. A purpose sampling process was applied.The sample population was the caregivers of discharged mentally ill patients coming for reviews at the hospital. A sample of 40 Caregivers was used and divided into 4 focus groups with 10 people in each group. The focus group discussions was conducted by the researcher using guidelines. The group were homogenous sampled to participate in the discussions. The

data was analyzed using content analysis and thematic analysis by using emerging themes. In-depth, individual, semi-structured interviews were conducted and the interviews were recorded and transcribed verbatim and the researcher used vivo method to analyse data.

Both positive and negative experiences were repoted by respondents.The findings of the study :is that physical violence to the caregivers is prevalent. The violence is preceded by disorderly behavior, disobedience, and excessive and irrational demands of things by the patients. Failure to get attention and positive response ignites the violence. The next finding was that the care-givers rarely had escape alternative and protection because of the nature of the illness the patient's suffer from. On the negatives there was lack of support from relatives, government and NGOS, also the feeling of being unappreciated by relatives.

Limitation fo this study only covered only those patients who were coming back for review and those did not come back.

In summary, this study shows that the majority of the patients who are dischanged do not come back for reviews and makes the violence in the community to be on the high side especially when they relapse

Training about management of aggression needs to be provided, debriefing sessions to deal with stress experienced needs to be arranged, and research to quantify the levels of anxiety should be conducted.

Key words: violence, discharged, care-givers.

DEDICATION

My dissertation is dedicated to my dear wife Rhoda, a woman of influence who has been a source of encouragement throughout my training; you have been such a great companion, a wife so rare to find,you are all that I ever wanted for a wife, imagine you never complained that you were financialy broke due to my education. Secondly I would dedicate this dissertation to my late Dad Musala and my Mother Cecilia still alive. My sons Simon, Erick, Kambita, Temwani, Ireen and Cecilia strive to succeed in life. Finally I dedicate to uncle Saidi, for his support.

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ACRONYMS /ABBREVIATIONS

DALY	Disability adjusted life years
FGDs:	Focua group discussion
IDIs:	In-depth interviews

MOH :	Ministry of Health
UNZABREC:	University of Zambia biomedical research Ethics committee
UTH:	University teaching Hospital
UNZA :	University of Zambia
WHO:	World Health Organization
ZDHS	Zambia Demographic and Health Survey

CHAPTER ONE

1.0 Introduction

According to the World Health Organization (2015), caregivers experience violence which causes physical, sexual, or psychological harm. caregivers experience violence by patients suffering from mental illness and this problem is noted worldwide (Garcia-Moreno et al, 2015).

It has a profound and negative impact on caregivers' ability to live happy and productive lives (Kipatrick, 2014). Violence experienced by Caregivers include rape, incest, verbal abuse and physical violence, and emotional abuse (Barnett et al, 2011). Both men and women have been victimized; prevalence rates of violence against women caregivers are higher than in male caregivers 85% to 55% (Johnson, 2008).

Mental illness is common, affecting more than 25% of all people at some time during their lives. Furthermore, mental illness represents 12% of the global disease burden (WHO, 2011). It is also believed that by the year 2020, the burden of these disorders will increase by 15%. An estimated 4 million people alive today suffer from mental illness or from a psychological problem, world number of those presently affected receive any treatment and many suffer in silence and suffer alone (WHO, 2011). According to World Bank estimates, Caregivers' experience of violence and rape cause an annual loss of 9 million disability adjusted life years (DALYs), higher than the number of DALYs lost to cancer. The financial burden of Caregivers' experience of violence on health systems is significant, with research in the United States estimating Internal Prevention of Violence alone to be responsible for $19.3 million per year in healthcare costs.

Such violence has also been associated with unwanted pregnancies and post-natal depression. Caregivers who have experienced violence during pregnancy have children who are more likely to have diarrhoea and respiratory infections. It further has shown to compromise children's growth, and unwanted pregnancies often result in a suboptimal family environment for child development (Kipatrick, 2014).

1.2 Background Information

Data from the most recent Zambia Demographic and Health Survey indicates that over 50% of caregivers interviewed reported experiencing some form of violence, while over 15% reported sexual violence from mentally ill patients (Nalungwe, 2013). Caregivers who have experienced

violence have been at increased risk of medical conditions including acute musculoskeletal injuries, chronic pain, reproductive and gastrointestinal problems, and depression (Barnett et al, 2011). The link between caregiver's violence and suicide is well established. indicates that over 50% of caregivers interviewed reported experiencing some form of violence, while over 15% reported sexual violence from mentally ill patients. The high prevalence of violence that are experienced by caregivers in Zambia makes it both a challenging and critical topic for programming. Studies show that many caregivers perceive violence to be both normal and acceptable, which is linked to the social and cultural norms.

The reported rates of caregivers' experience of violence have major implications for transmission of HIV, which has a disproportionate effect on women and girls. The latest research from UNAIDS suggest that caregivers who experience violence have a 50% increased risk of acquiring the virus. The negative effects of unequal power relations have also been documented. Chainama hospital filter clinic Staff attend to more than 20% of clients who come to attend reviews and the staff reported those patients had an episode of violence to caregivers this means approximately four (4) patients out of ten (10) attended were reported having an episode of violence towards caregivers (Chainama Hospital Records, 2014). Apparently, there is still a critical gap in mental health care, support and knowledge among caregivers. In recent years, a growing number of injuries to the caregivers and destructions of properties due to violence from the patients in the community has become very common.

In 1991; the United Nations General Assembly adopted protecting principles of mental health service users (WHO, 2011). This declaration emphasized that mental health service users should be cared for in the community. It meant close links with families and communities , and that, users, their relatives and the community should participate in the well- being of the users (WHO,2011). The shift in the mental health care paradigm took place largely due to three independent factors: Human rights movements under the united nation became a truly international phenomenon. This resulted in mental health services' users to be with their family in the community rather than in asylums (Barrofsky and Budson, 2009) and Zambia was not spared. Mental health became firmly incorporated into the concept of health, as defined by the newly established World Health Organization, which encourages care in the community backed by the availability of beds in general hospitals for acute cases. These two events

prompted a Shift from care in large custodial institutes to more open and flexible case in the community. Community care includes a wide range of rehabilitation services that address the needs of people with mental illness. These services must be coordinated between mental health workers and the community agencies. However, it must be noted that discharging of long-term institutional patients must be discharged after adequate preparation (Swartz et al, 2009).

In addition, the family and established community facilities, which maintained community, support system for non- institutionalized mental health services' users also required consideration (WHO, 2011). The other functions of community care are proper supervision of drugs and security for society and the mental health services users (Swartz et al, 2009).
Regionally in rural Ethiopia 71%, Caregivers have experienced physical or sexual violence in their lifetime.The 2011 data shows that female caregivers experienced violence fatalities disproportionately compared to the male caregivers. This violence contributed to 21% for females and 9% for male caregiversfatalities. it has been noted that 36% of all the violence that caregivers experienced were perpetrated by patients with mental illness. Most of the violent cases experienced by Caregivers turn out to be non-fatal incidences. About 75% of these cases are considered simple assault, while 19% of cases are considered aggravated assault (Justice Policy Institute, 2009). In most cases caregivers are at high risk of violence from patients under their care. The type of violent attacks include threats, physical assaults, and muggings.

Despite the health workers being trained, caregivers may not be aware of the protective measures when patients are threatening to be violent(World Health Organization, 2014). Experiences also show that caregivers are the target of violence, because of the direct contact, and the first care they give to the client in the community (Abederhalden, 2009:45).

1.3. Statement of the problem

There has been an increasing sensitization of the public about the risk of violence from mentally ill patients health service users living in the community (Swarty, et al.2009).

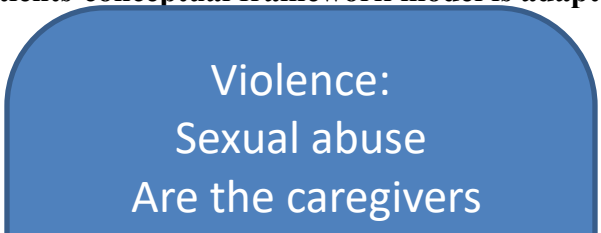
The essence of community based rehabilitation, apart from empowering patients financially has been to also make patients and their relatives participate more fully in community life and to build a stronger relationship with other disadvantaged groups living in the same area (Feuerstein,2008). This is that the users are real people who matter, having ideas, thoughts, opinion and ambitions. They are no different from other people and want the same basic things out of life as others (WHO,2011). Violence to caregivers from patients suffering from mental illness has been found in psychiatric hospitals and is becoming increasingly a public health problem, and this violence has affected the community (Liwack and Webster (2008).

According to Liwack and Webster (2008) the caregivers are exposed to violence from patients discharged from both civil and forensic psychiatric institutions. In line with this, the government of Zambia also has designed a primary health care (PHC) program that includes mental health care services at community level. By shifting the mental health care services into the community, the problems of violence which used to occur in hospitals also shifted to the community (MOH, 2015). According to the Ministry of health OF Zambia the violence prevention is being developed as part of the health reforms process where community participation is the key component. This is emphasised in the primary health care package as stated that communities and Health Workers As such, efforts have been made to facilitate the participation, and empowerment of all heath workers and the caregivers who have been taking care of these clients with mental illness, to improve their safety (WHO, 2015). Despite the all effort by government, the Caregivers are not safe and sure of what will happen to them if the patients become violent, they ask themselves which measures should they take to prevent violence and protect themselves. The violence experienced has bad consequences on Caregivers' lives such as injuries, death, embarrassements and depression to mention few.

A report for Chainama Hospital shows that only in 2014 physical abuse were 1671 cases, verbal abuse 3570 cases, sexual abuse 225 cases, psychological trauma 2,580 cases and these are few cases reported from the community (Chainama records, 2014). This situation is alarming and needs total attention.

THEORETICAL MODEL

Violence by Mentally ill patients'conceptual framework model is adapted from PRECEDE-PRECEDE, 2016



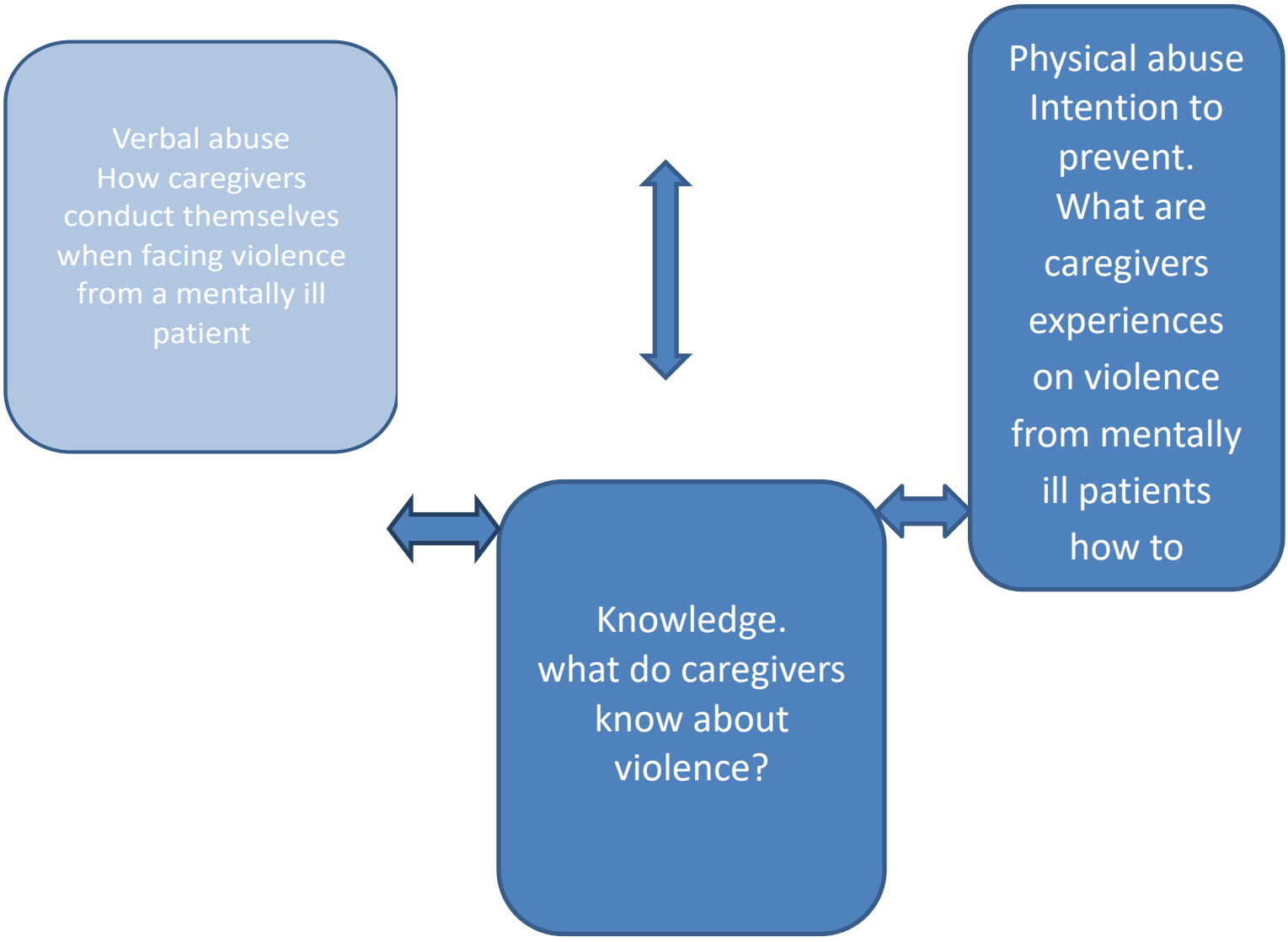

Verbal abuse
How caregivers conduct themselves when facing violence from a mentally ill patient
Physical abuse
Intention to prevent.
What are caregivers experiences on violence from mentally ill patients how to
Knowledge.
what do caregivers know about violence?

Fig 1

1.4 Theoretical Framework

In this study the PRECEDE-PRECEDE Model has been used (Green and Kreuter, 2009) to explain the exact nature of the violence experienced by Caregivers and the bad consequences it brings in their lives. The study used only the PRECEDE part of the modelas it did not focus on designing and implementing appropriate interventions to address the problem. The model was used to learn about the violence experienced by Caregivers.

The PRECEDE component has four steps that social assement, epidemiological assessment, behavoural and environmental assessment, educational and ecological, administrative and policy assessment. (Green and Kreuter, 2009).

The model begins by assessing the environment in which the lives by carrying out a social and epidemiological assessment Social assessment is identifying the social concerns of the community. For instance, the Zambian community is concerned with the increase in violence causing injuries(physical, verbal, sexual arrassement). Epidemiological assessment is using epidemiological data to suggest health problems therefore the study looks at Caregivers' experience of violence by Mentally ill patients and the consequences physical, verbal, sexual abuse. The model considers the risk of such behaviours on people health.

Then the model calls for the identification factors that will help the group to adopt health actions. This is the administrative and policy assessment which involves planning related to heath education and policy regulation. This is discussed in the following steps and how they were applied in this study.

1.4.1 Precede Model Steps

1.4.1.1 Social assessment

The objective for social assessment was to to explore the risk of violence against Caregivers. In this regard the concern of the community is to help them with the police, relatives to support them and the government/NGOS. This study however used data , which is the focus group discussion and interview to describe the the problem from the perpetrators violence. The researcher reviewed documents on reported cases of violence at Chainama Filter clinic

to obtain information on Caregivers experiences' of violence.

Table1 Reported violence against Caregivers'in the period of 2010-2014

Types	**years**				
	2010	**2011**	**2012**	**2013**	**2014**
Physical abuse	**30**	**42**	**65**	**167**	**1671**
Verbal abuse	**70**	**78**	**84**	**187**	**3570**
Sexual abuse	**0**	**1**	**5**	**113**	**225**
Psychological trauma/abuse	**40**	**51**	**65**	**72**	**2580**

The Table shows that Caregivers are vulnerable physical, verbal and psychological trauma or abuse than anyone else in the community by Mental Ill patiens and this is not only high but increasing faster than other cases. However, this situation could be totally different from reported cases and this is one of the limitations of this source of information.

This study carried out social assessment by finding out the most abuse and the type of abuse Caregivers experience from the mentally ill relatives. This was to find out if the community's concern is similar to the abused'view.

1.4.1.2 Epidemiological assessment

The objective of this step wasto identify the health problems caused by violence. This study identified the health problems by finding out from the Caregivers the consequences the violencve or the abuse from the mentally ill relatives. Secondary data from Chainama hospital was used to obtain information on the health problems resulting from violence such as injuries, rape, burning of properties sometimes death. According to Chainama Hospital for 2014, a total of 1671Caregivers were injured with Lusaka recording a highest number of caregivers representing nearly (47%) compared to copperbelt province (18.0%). The statistics are of concern specifically for Lusaka and the copperbelt.

1.4.1.3 Behavioral and Environmental assessment

The objective of this step was to identify the behavioral and environmental correlates of Caregivers abuse or violence. This step was divided into two parts that is behavioral and environmental correlates. The behavioral correlates are behaviors or life styles that contribute to the increase in violence towards Caregivers. The study assessed behavioral contributors by finding out from the respondents the type violence mostly experienced and who was more vulnerable to the abuse and who are predisposed to the violence or abuse. Environmental correlates are social and physical factors that contributes to the abuse or violence. The researcher reviewed literature to identify the behaviors. The study identified the social physical tha contributed to the abuse or violence.

1.4.1.4.Educational and Ecological assessment

The objective of this step was to identify presposing, reinforcing and enabling factors that influence behavioural and environmental correlates. The study identified the predisposing, reinforcing and enabling factors.

1.4.1.4.1 Predisposing Factors

Presposing factors are factors that exert their effects prior to a behavior occurring by increasing or decreasing a person’s motivation to undertake that particular behavior or providing a reason for the behavior. Predisposing factors to the the behavior include knowledge, attitudes, beliefs, personal preferences, existing skills and self efficacy.

1.5 JUSTIFICATION

The Zambian government has taken appropriate legislative (Mental Health CareAct17 of 2012), measures such as physical restraining, chemical restraining and environmental e.g.: seclusion, serene, sedation to protect caregivers from violence. However, despite all measures taken by the government caregivers are still not protected. This is because there is convincing evidence that caregivers are being abused by the patients suffering from mental illness (Victim Support Unit, 2016).This study is being undertaken to establish the extent to which caregivers are exposed to violence from mentally ill patients.This studyis intended to inform policy about strategies to reinforce the law. This study will contribute to mental health nursing knowledge base. It explores the influence of having knowledgeable caregivers who are able to detect risks of violence at community level. This will also protect the caregivers on how to respond to the patients when they are becoming aggressive. There is scarcity of mental health information on the risk of violence assessment guidelines to be used by caregivers. This is crucial knowledge components which the caregivers could use in the care and support to the client with mental illness at community level.

Both the direct and indirect effect of caregivers' knowledge and experiences, risk assessment on the quality of care for patients with mental illness has been examined. The researcher feels strongly that this will improve the care and safety of caregivers experiencing violence by patients suffering from mental illness in the community. The study has given insight on how violence can be prevented timely and effectively. The study has also identified training needs which will assist policy makers to design training packages for caregivers who are nursing clients with mental illness. The training is on how to prevent, identify and manage risks of violence. Consequently, this will reduce violence at the community level, and promote safety of clients, caregivers, health workers. it is hoped that this study will contribute to creating a safe environment for caregivers.The study seeks to explore the caregivers experience of violence from mentally ill patients from Chainama Hospital to contribute to the overall policy on prevention of violence (injuries, expenditure...) and on how to manage Caregivers emotions (physical abuse and psychological abuse experienced while caring for mentally ill patients). These findings of this study would lead to development of strategies to improve prevention of violence towards caregivers.

1.6 Research Objectives

1.6. 1 Main Objectives

1.6.2 To determine the caregivers' experiences of violence by mentally ill patients dischanged from Chainama Hills Hospital

1.6.3 Specific Objectives

1.6.3.1 To explore the risk ofviolence against caregivers from discharged mentally ill patients attending reviews at Chainama hospital.

1.6.3.2 To assess caregivers knowledge of handling violent mentally ill patients at chainama hospital.

1.6.3.3 To explore extent of the support given to care givers in managing mentally ill patients

1.7 Research Questions

What are the caregivers'experiences of violence when caring for mentally ill patients discharged from Chainama Hills Hospital?

1.8 Hypothesis

Mentally Ill patients are unpredictable and are likely to be violent and abuse others.

1.9 Variables

1.9.1 Independent variables

Independent variables are the ones influencing other variables, determining the values of these affected variables (Brink, 1996). That is the factors influencing the problem at hand. Therefore, the independent variables for the study is: Caregivers experiences of violence when caring for mentally ill patient.

1.9.2 Antecedent Variables

The antecedent variable appears before the independent variable and determines it (Bless and Achola, 1990). Therefore antecedent variable for the study will be the environment.

1.9.3 Dependent Variables

Brink (1996) defined dependents variables as factors that are observed and measured to the effect of the independent variable. Therefore, the dependent variable for the study is Caregivers experiences of violence by mentally ill patients.

Caregivers'experiences of violence: (physically, sexually, and verbally).

Age, educational level and employment, security.

1.10 Definition of Terms :

Knowledge about violence: Knowledge is the" information, understanding and skills that you gain through education or experience" (Hornby, 2016).

Socio economic status

Socio economic status is an individual's or group's position within an hierarchical social structure, including occupation, education, income, wealth, and place of residence (Bittman et al (2017).

Social support

Social support assumes many forms and can encompass a variety of relationships and behaviour. It can be best understood as the relationships and interactions that provide individuals with assistance or feelings of attachment to their neighbors, families and the community at large (Berkman et al, 2017)

Stigma

Stigma is a perceived negative attribute that causes someone to devalue or think less of the whole person (Salters-Pedneault , 2009).

Violence

This can be defined as harmful and unlawful use of force or strength; if caused by physical assault. The violent person is commonly understood to be someone who attacks another. A person engaged, or is engaging in assault on another person either with or without the use of weapons (Bittman et al (2017). .

Aggression: Refers more to a disposition to show hostility towards becoming violent, but clearly can also involve assault itself. Aggression is an extremely wide term with both negative and positive connotations. In this context aggression is understood to be an extreme negative tendency towards becoming assaultive (Hornby, 2016).

Verbal abuse

Verbal violence, most often also labeled *verbal abuse*, is a common variety of violence, which encompasses a relatively large spectrum of behaviors, including: accusing, undermining, verbal threatening, ordering, trivializing, constant forgetting, silencing, blaming, name calling, overtly criticizing. (Bittman et al (2017).

Sexual abuse

Sexual abuse is any sort of non-consensual sexual contact. Sexual abuse can happen to men or women of any age. Sexual abuse by a partner/intimate can include derogatory name calling, refusal to use contraception, deliberately causing unwanted physical pain during sex, deliberately passing on sexual diseases or infections and using objects, toys, or other items (e.g. baby oil)(Hornby, 2016).

Physical abuse

One or more episodes of aggressive behaviour, usually resulting in physical injury with possible damage to internal organs, sense organs, the central nervous system, or the musculoskeletal system of another person(Mosby's Medical dictionary, 2009).

CHAPTER TWO

LITTERATURE REVIEW

2.1 Introduction

This chapter focuses on caregivers' experience of violence by mentally ill patients discharged from Chainama Hills Hospital in order to provide a comprensive picture and clues to magnitude of the problem. Literature reviewed is on published articles and accredited books from computerized data base and libraries. The literature will be conducted in each objective of the study.

2.2 Physical and psychological abuse,

2.2.1 Intention to Prevent Violence

Violence has been a worldwide public health problem; societal violence has become a global concern. WHO (2015) reports that violence is costing millions of dollars in hospital care, and in the community set up, and these results in millions of days of loss in work productivity, police involvement. Clark (2015) noticed that violence contributes to a variety of physical and psychological health problems that can be prevented by the community efforts to modify factors that contribute to violence against self or others. Singler (2015) in his study on violence reports that generally, theories which explained violence have been categorized as biological, psychological, sociological, anthropological, and multifactorial theories. Taylor, Leese, Williams, Butwell, and Larkin (2009) conducted a study in England reported that in some cases a past history of violence is regarded as one of the best indicators of future violence. Several studies have demonstrated this empirically, that when psychiatric patients relapse, they become more violent towards guardians and health providers. Taylor et.al, (2011) argued that although past history of violence may be the best indicator of future violence, this in itself may not be very helpful if the risk of future violence is only modestly increased; for example, Harry and Steadman (2011) found that history of previous arrests effectively predict only five percent (5%) of future offending, regardless of what the guardians should be trained in aggression management. Similarly, Needham Danset, Haugh, and Fischer (2014) carried out a study and found that psychopathology in which schizophrenia of paranoid type, substance, dementia, were

strongly associated with aggressive behaviours toward relatives, friends, and health workers. Barnes and Bowl (2011) offer the concept of the black male to be extra-aggressive towards caregivers and nurses. Jansen Etal. , (2015) stated that aggression directed to caregivers by patients is very common at home, and in the hospital. However, this behaviour is not only in the in-patient set-up but also to caregivers outside the hospital environment. Jansen (2015) identified that inadequate knowledge, lack of privacy, lack of freedom at home contributed to violent behaviours. Irritating factors at home could precipitate aggressive behaviour. Secker (2016) in a study agreed with Taylor (2017) that aggressive behaviour are not solely from mental illness but also from social context the patients find in themselves, and the interactions involved in, in the community, even in the hospital.

Ellen, Fagan-Pryor, Harber, Dunlap, Nall Stanley and Wolpert (2009) focused on patients' views on causes of aggression and effective intervention; findings demonstrated that the causes were reflecting interpersonal relationships, conflicts of patient- to-patient and patients to staff of which sixty percent (60%) were of patient to guardian's at home. Torpy and Hall (2009) found that patients who had been placed on a restriction order, following a conviction for a grave offence, were no more likely to be assaultive than non-restricted patients. A restriction order was not in itself found to be a good predictor of aggressive behaviour within hospital, even at community level, there is no consensus about whether staff, patients, and guardians are more commonly assaulted, and both groups are common victims.

Hodgkinson (2011) found that a strange-person to the client was assaulted more frequently, and another study showed that inexperienced strange person in the house was more likely to be injured by assault (Carmel & Hunter 2011). Walker and Seifert (200 9) found that trained guardians were assaulted more frequently. Hodgkinson (2011:985) also found that a small group of guardians were repeatedly assaulted and pointed to the fact that this was either due to particular guardian not using predictive measures at risk at that moment, or because of individual guardian's styles. Some authors suggest that rigid or authoritarian staffs or guardians are assaulted more often (Cooper & Mendonca2015; Durivage 2009). Violence was more common at home when roles were poorly defined, weak guardians and an unpredictable home programs.Needham, AbderhaldenDansent, Haugh, and Fischer (2014); Jansen, Dassen, and Jebbink (2015) had conducted studies in different environment, in which treatment related factors were identified as a cause of aggression. These factors included use of restrictive

measures like use of restraint and seclusion, change of medication, and duration of the hospitalization, which was described to long. This makes a fearful and unpredictable situation to guardians, and hospitals.

Depp (2017) reviewed two hundred and thirty-eight (238) assaults on other relative's handicapped, observed that handicapped relatives were always victims of assault. Assaults occurred more frequently, men tended not to assault women or vice versa, this was observed at home. British study looked at comprehensively at antecedents of violence found that most commonly, a high state of arousal preceded violence in thirty one percent (31%) of cases. Restrictions placed on patients twenty percent (20%) and provocation by other nineteen percent (19%). Pearson (2009) and Deep (2010), and Fottrell (2012) in their several studies suggested that violence is more common, when there are little structured activities, or restrictions at home. Drinkwater (2014) found that violent behaviour was four times high during periods without unplanned activities at home and in the wards. Adler (2008) reported a greater amount of violence when caregivers were busier and could not attend to the client's demands; and there has been discussions about serious assaults occurring when guardians have no helpers at home, or care was poor (Martin 2008; Yaltes 2009). James and Fineberg (2011) reported that increases in violence are strongly associated with the Experiences also show that caregivers are the target of violence, because of the direct contact, and the first care they give to the client in the community (Abederhalden, 2009:45). Noble and Roger (2011:9) reported that violence has tended to show an equal rate between sexes or greater violence in female patients. Binder and McNiel and Larkin (2012:8) observed that women made up twenty-fivepercent (25%) of the patients population and were involved in violence and seventy five percent (75%) of the violent incidents at home where they were coming from.

The factors behind the high rate of female patient's violence, particularly in secure setting, at home may be shared with the factors associated with the higher rate of violence among female prisoners when they come out of prisons (Maden 2009).The use of unfamiliar caregiver person to the client. World Health Organization (2010) estimated the cost of interpersonal violence in the U.S. at more than $300 billion per year. The cost to victims was estimated at more than $500 billion per year. Combined, this is the equivalent to nearly 10% of the country's Gross Domestic Product (The Economic Dimensions of Interpersonal Violence, World Health Organization, 2014).

In 2015, 5,686 young people aged 10 to 24 were murdered an average of 16 each day. [Youth Violence Facts at a Glance, Summer 2008, U.S. (Centers for Disease Control and Prevention (CDC, 2015) The Bureau of Justice reported in 2010 that 25% of Caregivers have experienced violence and 6 million children witness this violence annually (Direct Expenditures by Criminal Justice Function,2009-2015, Bureau of Justice Statistics). An estimated 450million people alive today suffer from mental illness or from a psychological problem, world number of those presently affected receive any treatment and many suffer in silence and suffer alone (WHO, 2011). Certain cultural factors such as ritual cleansing following the death of a spouse may precipitate mental illness). These ceremonies have been implicated in the cause of mental illness, and arise from social punishment or witchcraft (Feuerstein), 2008).

Negative social, political and economic influences, like wars, violence, HIV/AIDS, poor or lack of health services can lead to poor mental health within society.

2.3. caregivers' knowledge about violence

Clark (2009) believed that early life experiences, particularly relationships with parents or lack of them, developed the person's behaviour, and the control for violence. Naturally it has been difficult to predict whether someone is going to harm in a given situation, although in the short term certain warning signs, changes in mood or behaviour, may indicate that a particular person is more likely to do something destructive or violent towards guardians, friends, and health workers. In looking at the longer-term protection of the public we were concerned with the circumstances in which the risk of harm arises (Crichton, 2015). Crichton (2015) also demonstrated that there were more aggressive behaviours in patients with schizophrenia exhibiting psychotic symptoms than those without psychotic symptoms towards caregivers.

2.3.1 verbal abuse

Verbal abuse from mentally ill patients often leads to violent actions. So it is important for relatives to know that verbal abuse mainly leads violent actions. If these relatives are aware of the behaviour, they may develop ways to ignore the verbal abuse from their mentally ill patients and ketner (2008) states that the caregivers often loose trust, develop low self-esteem and embarrassement after being verbally abused by their mentally ill relatives. Stanko (2012) emphasized that patients' verbal abuse provokes negative effects on Caregivers' psychological

and physical well being hence the need for the relatives to acquire knowledge on how to ignore the verbal abuse by not responding to the patient. Ignoring the verbal abuse should be emphasized on as a study in Suitzerland obsrved tha seventy two (72%) of caregivers at home settings feel seriously threatened verbally and seventy (70%) of guardians have reported being attacked at least once during the care. Experiences also have shown that caregivers are the target of violence, because of the direct contact, and the first care they give to the client, since care has been shifted into the community (Abederhalden, 2010). Noble and Roger (2009) also reported that violence has tended to show an equal rate between sexes or greater violence which is manifested in female patients. Binder and McNiel and Larkin (2008) observed that women made up twenty-five percent (25%) of the patients population and many of them were involved in verbal abuse and seventy five percent (75%) of the violent incidents at home where they were coming from. The factors behind the high rate of female patient's verbal abuse, particularly in secure setting, may be defense mechanism (Maden, 2015). In summary relatives nursing mentally ill patients in the community are expected to develop thick skin towards verbal abuse from their sick relatives as responding to them often leads violent actions.

2.3.3 Sexual abuse

Dobash (2016) reported that the rate of offences of violence among women clients was mostly very high toward their caregivers, friends (inmates), and health workers (prison warders). However the factors behind the higher rate of sexual abuse among Caregivers women remain uncertain. In fact, the argument that patient's at home, specifically women are more violent, was argued by Gudfonsson (2015), when he commented that this could be as a result of stressors at home and the care-taker in particular guardians underestimating the risk of violence from female-patients. Secker etal (2017) on understanding the social context in which violence take place, looked at gender as contributing factor to sexual abuse and reported that men were more violent than women towards their caregivers and abused them sexually. Needham, etal (2014); Jansen and Jebbink (2015) in their different studies looked into gender and aggression, in their findings they demonstrated that male patients were more physically aggressive and sexually abusive towards others (including caregivers) while females directed aggression and violence against themselves. National study done by Bell (2016) found that eight percent (8%) of women were victims of sexual abuse, another study done family and Intimate Violence Prevention

Team (2014) in the New-York State, nearly six percent (6%) of female caregivers were sexually abusedand seven percent (7%) of male patients were reported to be involved in violence/destruction and sexual abuse in the community. Noble and Roger (2017) using a matched control approach, found a greater proportion of African-Caribbean patients were sexually abusive, not only to health providers, even to their caregivers These clients were also found to be younger, more psychotic, more seriously violent, more likely to be detained and more likely to be treated in locked rooms. McNiel and Binder (2015) agreed that it is generally accepted that there is an over prediction of violence and sexual abuse in Afro-Caribbean patients.

In all the art of prediction the principle of historical evidence has been the best, in particularly the past history of violence is the predictor of future violence which caregivers should be aware (Klasson& O'Connor 2008). Reid (2012) reported that it would be useful to look at risk future assessment. On understanding aggression Secker, etal (2017) looked at age of the patient; findings demonstrated that the youths were more aggressive than other ages regardless of the diagnosis, towards their caregivers. Noble and Roger (2011) confirmed the aggression in young ones. The developmental approach believes that early life experiences, particularly relationship with parents or lack of them, fosters development of personal behavioral control mediate properties for violence toward any one (Rosenberg & Mercy, 2011) quoted by Clark (2015).According to interpersonal violence or intra -individual dynamics model, violence has been the result of some psychopathology: mental illness or drug abuse. Because of being paranoid towards others and their caregivers, the risk of violence is influenced by their age, and their sickness. Harris and Voimey(2009) argued that patients under the age of forty (40), present the high risk of violence and sexual abuse than older people toward others. Other studies do give respect to the cross age range that generally it does decrease with the age (Hodkinson, 2009).

2.4 conclusions

The literature review shows that the violence experienced by Caregivers is wordwide. The studies reviewed show that one of the reasons of violence is the illness itself, the lack of the knowledge from the Caregivers, ignoring the patients demands, discreminationa and stigma and lack essential commodities at home, this has made the situation to become worse and made the patient to become violent. The literature review also show that few studies have been done especially on caregivers who nurse the patients at home. The purpose of this study was to come up with reasons for violence towards caregivers by getting their views.

CHAPTER THREE

Research Methodology

3.1. Introduction:

Research methodology refers to the manner of collecting research data (Bun & Grove, 2005). This chapter contains information on how study was conducted. Among other things included in this chapter are: issues on the design that was used for the study, the sampling technique and sample size, sample selection, and explanation on how data was collected and analyzed, data collection tool, pilot study and the ethical considerations that was observed.

3.2 Research Design

A research design is a programme to guide the research in collecting, analyzing and interpreting observed object(Polit and Hungler, 2008). It is a specificification of the most adequate operations to be performed in order to test a specific hypothesis under a given condition. This ia a qualitative research design. Qualitative research is more concerned with individual situations with incidents and phenomena, which either occurs infrequently or which are explored as isolated incidents or phenomena(Cormack, 2017). Qualitative research employs non-numeric data and is aim is to describe in details with a view to explaining the objective of the study (Wilson, 2013).

In a qualitative study the research is guided by certain ideas, perspectives or hunches in the overall approach to be investigated, but the aim is to allow partipants to provide information in a more spontaneous way (Cormack, 2017). The researcher had chosen this research design because it provides detailed information especially for topic that has not been widely researched. The study used qualitative method because it was dealing with a sentive topic that has not been widely researched on. Since it was a sensitive topic, the researcher planned to allow the respondents discuss their personal experiences in private set up.

3.3 Research Setting

The study was conducted at Chainama Psychiatric Hospital which isa referral Hospital in Zambia, specifically at the filter clinic, where patients were accompanied for review by caregivers. The researcher appliedfrom Chainama Hospital management for permission to carry out the study on the caregivers experience on violence from mentally ill patients discharged from the hospital.

3.4 Target Population

The target population was Caregivers who had nursed clients with violence and had experienced more than two episodes of violence and whose clients are still attending Chainama filter clinic. An accessible population is a portion of target population, might be elements within a state, city, hospital or nursing units (Burn & Grove, 2015). The accessible population was available caregivers who had experience of violence from patients suffering from mental illness at the filter Clinic at Chainama during the study.

3.4 Sample Selection

3.4.1 Selection of study Respondents

The researcher considered the recommendation of Morse and Field (2015) of maintaining small sample size as they increase efficiency and effectiveness in data collection. In this approach, subjects were selected because of some similar characteristics. Patton (2010) showed that this method is widely used in qualitative research. This study used purposive sampling because it targeted caregivers who had nursed and had an experience of violence.

3.4. 2 Selection Process

The researcher worked with nurses available that day, the nurses selected the respondents who met the selection criteria and introduced them to the researcher. The researcher met the study respondents and they were explained about the procedure and later signed the conent form.

In this study the relevant information made each group homogeneous, nursing a patient with episodes of violence. Since units in each group were similar to each other, following the order on the list to select respondents did not bring bias. These respondents were engaged in a one on one

interview with the interviewer and later on, they were involved in a focus group discussion. (FGD) The selected respondents, who signed to consent, formed a focus group.

3.4.3 Hospital

The researcher purposively decided to select the hospital because that is the only referral hospital in the country, where caregivers bring relatives for reviews. Respondents from Chainama filter clinic were selected using purposive sampling; the researcher needed patience due to the low numbers of caregivers accompanying patients (Burn & Grove, 2015).

3.4.4 Sample Size

Sample size for this study was 40 Caregivers' with experience of violence. To do this, the researcher engaged the Nurses as key informants who helped to select caregivers who were eligible to participate in this study. This approach was to help ensure that members who participated were drawn from those members with characteristics of the problem under study. Other members were selected using snow bow method through the other caregivers who had information.

Inclusion criteria

The inclusion criteria for this study was:

Caregivers above 18 years with experience of nursing a patient with more than two episodes of violence

Available at the research time

Caregivers who were still living with the patients who experienced violent episodes

Exclusion Criteria

Caregivers were not eligible for the study if they:

Care-givers were critically ill, mentally ill at the time of the study.

All caregivers who had experience of violence less than once were excluded from the study and replaced.

3.5 Data Collection Tool/ Instrument

Data was collected from the caregivers at filter clinic within the hospital areas through in-depth interviews on a one to one basis with the interviewer. Structured interview guides (for FGDs and IDIs) were used to guide the interview process meaning that a qualitative approach was used in this case. An interview guide was used to conduct in-depth interviews and focus group discussions with the respondents. During the interviews, an audio electronic recorder was used to capture the discussion before transforming the messages into a transcript. Michael (2012) shows that this method is suitable for this study because it allows exploration. The interviewee's responses were collected here and then without having to come back again. In interrogating the views of selected residents, the method facilitated the exploration of beneficiaries' experiences in much detail. The approach further gave an opportunity to investigate even non quantifiable things such as individual experiences on sexual violence, physical violence which were the integral part of this study. It also allowed respondents to provide data in their own words and in their own way. An interview was conducted for each interviewee and lasted for 15-20 minutes.
According to Polit (2011) four (4) groups of ten (10) care givers were selected to participate in a FGD.Finishing the interviews, the participants were given an opportunity to talk to the interviewer and ask questions. The interview was conducted in a conversational manner to promote relaxation and honest responses. A tape replayed, to verify the irregularities after the interview. All issues were discussed. The interview guide line was developed in English. However, the researcher was aware that the target group spoke Nyanja and Bemba…. Therefore, the interview schedule was translated into these languages. Difficulties in terms of losing some information during translation were anticipated. The researcher looked into this limitation and used two people to translate.

3.6 Data Collection Techniques

The interviews took place in a quiet place. Data collection included completion of a demographic form followed by an interview. Each interview was conducted by the moderator (researcher). The interview was audiotaped. One tape recorder was used at each interview session to provide backup recordings to the written scripts. The moderator led the interview and ensured that all the necessary information was covered with the aid of an interview guide. Among the two research assistants, one was the note taker and the other one maintaining the audio equipment and assisting with facilitation of the interview session. The moderator also took general notes on the content of the interview. The notes were used to provide more immediate access to the interview

data for the purpose of determining emerging themes. In order to overcome interview problems, the researcher tactfully guided the interview for participants who tended to wonder off the topic, phones were switched off during the interview.

Permission from the participants was obtained prior to data collection. The purpose, nature, beliefs and risks of the study was explained to the participants including on how the findings could be utilized. All the participants participated in the selection to help reduce uncertainties and questions such as "why have they selected me and not the other person?" Permission to use the tape recorder was sought from the participants. The respondents were informed that if they had some discomfort or any anxiety they did not wish to participate in the study, they had the right to withdraw . All participants were given information regarding direct and indirect benefits from the study. Participants were given time to go through the information sheet (appendix I). Assurances were given that all the information that would be provided by the participants would be treated with utmost confidentiality. In this way, participants were assured of anonymity. Participants were availed with the consent form, on which they appended their signatures as endorsement to participate in the study. The researcher had15 to 20 minutes for one to one recording and verbatim transcriptions were made. Interviews were carried out once with each participant. The researcher used communication skills such as; reflection, nodding, questioning, clarification, and maintaining eye contact, to facilitate and encourage participant to talk, until there was no new themes or issues emerging from the participants. The researcher also took field notes during the interview which contributed to the data collection process. Field notes are those that are taken by the researcher to record unstructured observations or occurrences in the setting that seem of vital interest (Polit and Beck, 2008). The researcher also documented the observations and expressions that were noted.

3.7 Ethical Consideration

Ethical consideration involves an understanding of ethical codes and guidelines for protecting the rights of the research subjects (Dampsey&Dampsey, 2010). The proposal was submitted to university of Zambia Research Ethics and Publication committee for approval. Before the data collection process, permission was sought from Chainama Hospital administration to seek permission to use the facility, this is important because the management is accountable to the daily happenings in the hospital and areas. Informed consent was sought from the participants to ensure that they were well informed and do understand what the study was all about, before

conducting the interviews. Each participant agreed to participate in the study signed a consent form. Ethical clearance was sought from UNZABREC.

Measures were taken to respect participants autonomy in the sense that potential participants were full informed and given a choice about participating in the research or not (Burns and Grove, 2009).The purpose of the study was clearly explained to the respondents as a one meant to determine the assessment of risk of violence in prevention of aggression from patients with mental illness Based on the right to privacy, the researcher participant had the right to assume that data collected been kept under strictly confidential (Creswell, 2016). Confidentiality was upheld, the names of participants were not documented. Participants were assured of anonymity and confidentiality, for example transcription of the tapes was under codes. Information about the tape recorder, note taking and duration of each session was given as code number.

The participants were informed that their participation in the study was strictly on voluntary basis and that they were not under any obligation to participate. In addition, they were informed that they were free to withdraw at any time they wished to do so and no penalty or punishment could be given. They were also explained that no payment was to be given to all participating in the study. Risks and benefits were explained to them. Concerning benefits, all participants were informed that the findings would guide and help caregivers and health workers to improve their care and prevent violence and aggression from mental ill patients. Additionally, all participants were also informed about indirect benefits of the study such as advocacy for proper care and support programs on the wider community level that help reduce and prevent violence in the community.

The researcher also asked the participants to report to him whenever they felt traumatized. Some observations were made from the researcher during the interview for any signs of discomfort or prompt action; counseling services were readily available for those identified to be traumatized. Each participant who agreed to participate in the study signed a consent form. Audiotape recording process as well as physical privacy were ensured throughout the interviews by using a quiet place specifically for the interview purpose.

3.7.1 Informed Consent

Permission was sought from each participating interviewee before proceeding with the interview. All relevant information was availed to them about the study and they were given a consent form which they signed before the interview. After they had read and agreed, then they were allowed to sign. The participants were told that they have the right to withdraw in the course of the interview if they wished to.

3.7.2 Anonymity

Assurance was given to the interviewees that information collected from each one of them will be treated with anonymity. Reference to each piece of information will be done through allocated code numbers for each participant. Follow up on this information will be done using these code numbers and not individual names per say.

Confidentiality

The Participants were assured that all information collected from them was not to be shared to any third party without their consent. A private room was used to ensure that no one would get breeze of any piece of information under discussion between the researcher and the participant. They were assured that all information will be kept under key and lock.

Right to withdraw

The participants were told that they have the right to withdraw at any time since the exercise is voluntary and that they can be replaced if it so happens.

Data protection

Participants were assured that the information obtained from recording using recorders, will be kept in confidence under lock and key and will only be shared to the researcher's supervisors and later be destroyed.

Benefits to society

The participants were informed that the study will be so helpful in formulating of policies and preventive measures to reducing deaths, injuries, sexual abuse and physical abuse from the violence after being discharged patients from psychiatric hospitals.

Principle of beneficence

Based on the ethical principle of beneficence, people must take an active role in promoting good and preventing harm in the world around them, as well as in research studies (Wood & Haber, 2016: 300). The participants in this study were assured that the information they are going to provide would not be used against them and could not be shared with the hospital or the staff within the hospital. The participants were informed that no payment was to be given for participating in this study.

Principle of justice

The principle of justice requires that people should be treated fairly and should receive what they are due or owed (Wood & Haber, 2016:300). Fair treatment is equitable selection of subjects and their treatment during the research study. Therefore, to ensure justice in this study, participants were given equal opportunity to take part in the study as indicated by the inclusion and exclusion criteria.

3.8 Pilot Study

Pilot study was done at the university Teaching Hospital: Clinic 6. Purposive sampling was used to select the respondents and they were interviewed using in-depth interview schedule. The hospital was selected because is the only tertiary hospital in the country and patients come for review.

3.9 Data Analysis

Data analysis is the process of categorizing, scrutinizing and cross checking the research data (Basavanthappa, 2017).Data collection and data analysis was done simultaneously. Data was analyzed using thematic analysis. Audiotapes of the interview were transcribed verbatim and Nvivo software was used to manage the data analysis process. The researcherread and re-read the transcribed interview before identifying tentative themes. During the repetition, key words and theme titles were noted on a separate sheet of paper to look for connections and to identify or isolate master themes that were captured participants' experiences accounts on the knowledge of assessing violence. List of categories was again repeatedly read through then combining similar categories into broader categories. As themes were emerging, the original transcript was

recorded and the same process was repeated for each participant until all the entire transcripts was analyzed. The researcher then while in the field made an effort to confirm that findings wereaccurately reflecting the experiences and the knowledge, and views of participants by going back to participants and share preliminary interpretations with them. This helped prevent reflecting on researcher's perceptions hence maintaining participants' experiences consistent in the analysis (Polit et al 2008).

3.10 Limitations Of The Study

Limitations are weaknesses of a study identified by the researcher as potentially affecting the results. The study focused only on caregivers who had experience violence by patients suffering from mental illness attending Chainama hospital reviews

The researcher had difficulties in getting the caregivers on time because they live in different communities in Lusaka. Even those within may be busy trying to settle down. And some still faced challenges of movements. Others did not want to participate in exercise for fear of stigmatisation. Transcribing also proved to be a challenge for the researcher, as taking notes and modulating the interview process was done by the researcher hence some emotional responses could have been missed.

3.11 Dissemination of Findings

The findings of this research study will be disseminated to relevant authorities and institutions to contribute to the socio economic development of the country. Some of the key institutions which will receive this document include the Ministry of health; Chainama Hospital, University Teaching hospital Lusaka others will include relevant government policy making bodies. This will be done by availing them with a copy of the report. The participants will also access this information through the hospital managements.

3.12 Conclusion

This chapter discussed the research methodology which included the research design, research setting, Sampling inclusion and exclusion criteria, data collection, data analysis, ethical consideration and limitations of the study.

CHAPTER FOUR:

Presentation of Research Finding

4.1 Introduction

This chapter presents the analysis of research findings based on the participants' experience of assessing risk of violence in clients suffering from mental illness. Interviews were conducted with the caregivers in 4 FGDS and 12 IDIs. Thefindings are presented in themes selected during the data analysis process to attain the study objectiveson caregivers' experience of abuse by mentally ill patients in trying toassess the care-givers' experiences of violence by mentally ill patients discharged from Chainama Hills Hospital. The report also covers caregivers knowledge of mentally ill patients handling at chainama hospital, the extent to which violence contribute to injuries among care-givers, the support given to care givers in managing mentally ill patients. Most of the caregivers interviewed are also actively participating in the care ofdischarged patients in the community. Where necessary, unique and significant individuals were presented as verbatim and in italics.The findings are presented in a narrative form.

4.2 Findings

4.2.1 Coding process

Preparation of data for analysis

Data recorded during the interview (transcription) was transcribed into text and configured the document so that the margin could be used for identifying individual bits of data. This was done by assigning marked numbers as identifiers for cross referencing.

Reading the text and noting items of interest:

initial reading of the text

I. INITIAL READING OF THE TEXT

An inductive approach to thematic analysis was used to allow themes to emerge from the data. During the first reading, the author took note of major issues as they came to mind in order to acquire a sense of the various topics rooted in the data.

Re-reading the text to interpret any thoughts in the margin

After, the text was examined closely, line by line, to facilitate a micro analysis of the data to heighten open coding which identifies any new information by de-contextualizing bits of data embedded within the primary material.

Sort items of interest into proto-themes

At this stage, themes emerged by organizing items relating to similar topics into categories. A computer was used to paste the line references together through a fluid process so that categories could be improved, developed and new ones allowed to emerge freely. At this stage, the themes were saved as simple as possible to assist flexibility in the categorization process so that any re-ordering of the clusters of categories helped to generate and re-define the initial themes.

Examine the proto-themes and attempt initial definitions

This phase of back going through the data helped to examine how information was assigned to each proto-theme in order to evaluate its existing meaning. A provisional name and flexible definition was by then created for each emerging theme.

Careful re-examination of the text for relevant incidents of data for each proto-theme

The second process of searching back through the data referred to as "axial coding" was done. This involved re-contextualization whereby any data was now considered in terms of the categories developed through the analysis. Each theme was taken separately and re-examining the original data for information relating to that theme was done. This is a vital stage in the analytic process to avoid overlooking the relevance of data by the selective human perception. Furthermore, pieces of data previously assigned to a theme may in fact be contradictory.

Construct the final form of each theme

The name, definition and supporting data wasre-examined for the final construction of each theme, using all the material relating to it. This stage of re-contextualization focused more closely upon the underlying meaning of each theme.

Report each theme

The tag of each theme was finalized; its description was written and illustrated with a few quotations from the original text to help communicate its meaning to the reader.

Themes' reliability and validity

Miles &Huberman (1994) points out that in thematic analysis "themes" need to be evaluated to ensure they represent the whole of the text. They further suggest that validating the themes in the early and late stages of data analysis is essential. In this case, the principal researcher involved an outside reviewer during the early stage to evaluate the identified themes to test if they were well-matched with the whole text or not. The principal researcher was afterward involved as independent reviewer for his feedback. Miles &Huberman (1994) emphasizes that this enables the researcher to link the two sets of feedback. Hosmer (2008) points out that this procedure will help increase reliability in the "themes analysis coding. This process, eventually informed the principal researcher improved any conflicting results (if there are any) with respect to any themes that were added or removed by the outside and independent reviewers (Miles &Huberman 1994; Hosmer 2008). Consequently, the researcher referred to the list of themes agreed with the outside reviewer and identify those extracts from respondents that support each theme. Later, Late checking and verification involving the independent reviewer was done to evaluate the overall

themes, demonstrate and confirm the details of documented extracts which were "similar to validity in positivistic terms" (Hosmer 2008, p.52). Miles &Huberman (1994) say that by including two outside/independent reviewers at two separate phases builds a strong process for analytical credibility.

4.3 Measures For Trustworthiness

Assessing of trustworthiness was done according to Licoln and Guba (2000). All participants were taken through the same ground breaking question, debriefing with informants, and any additional information was taken into consideration during analysis. The participants were interviewed to the point at which there was data saturation (prolonged engagement) and the interviews was tape-recorded and transcriptions made of each interview (referral adequacy). The researcher prolonged time in the field to develop an in-depth understanding of the phenomenon under study and had more experience with the participants. An independent coder who was given the research objectives and some of the raw text from which the categories were developed to provide accuracy of findings. Stakeholder instructions was also done to enhance the credibility of findings by allowing research participants and other people who may had specific interest in research to comment on or assess the research findings. The researcher checked transcripts to make sure that they did not contain obvious mistakes made during transcription. The researcher also made sure that there was not a drift in the definition of codes, shift in the meaning of the codes during the process of coding. This was achieved through comparing data with the codes and by writing notes about the codes and their definitions. Member checking were done by taking the final report or specific descriptions or themes back to the participants so as to determine whether the findings were according to the information given during the interview. The researcher also used an external examiner to review the entire project to validate the findings. All interview materials, transcriptions, documents, findings, interpretations, and recommendations, were kept, to be available and accessible to the supervisor and any other researcher, for the purpose of conducting an audit trail.

4.2 Thematic Coding

Thematic coding is the strategy by which data are segmented and categorized for thematic analysis. It is a strategy of data reduction, in contrast to the axial and open coding strategies characteristic of grounded theory research which enriches and complicates data through the

inclusion of analytic insights and inquiries used. In this process, the author begun with a list of themes known (or at least anticipated) to be found in the data.

4.2.1 Table 2: Participant's Profile

Profile	Gender	Number or respondents	Age range
FGD 01	Males	10	25 – 30
FGD 02	Females	10	25 -30
FGD 03	Males	10	31 and above
FGD 04	Females	10	31 and above
IDIs	Males	8	25 -65 yrs.
IDIs	Females	4	25 -65 yrs.

The participants in the in-depth interviews comprised of a widowtwo pastors, a chief, another one was a carpenter, and the rest were small farmers, marketers etc. Their ages ranged from 25 years to 65 years.

These are the findings : caregivers' experience of abuse by mentally ill patients, assessing the care-givers' knowledge and experiences of physical abuse, sexual abuse, verbal abuse by mentally ill patients discharged from Chainama Hills Hospital, caregivers knowledge on mental illness and how to handle them, the extent to which violence contribute to injuries among care-givers, the support given to care givers in managing mentally ill patients, Stigma/ handling of the client.

4.4 Violence

In this section, the focus will be on how the caregivers are able to identify and describe physical violence, the knowledge and experience the caregivers have on the prediction of violence, that they are able to do to prevent violence (precautions and measure).

4.4.1 Knowledge On Violence

Regarding violencemost respondents believed that violence is a feeling of pain inside the heart, and it is shown by destroying things, pricking children, beating friends, changing of the behavior,reacting to all situations, turning the head in all direction showing aggression, trembling of the whole body, others did not know how to describe violence. One respondent explained from interview number 05 that:

> "I *determine violence by the way the person looks at me with red eyes, a very direct eye contact without fear, then the client changes the behavior, the speech, you can also observe by the way he is turning his head with grandiosity in all directions, trembling of the body, overreaction to all situations, the way of walking changes, becoming angry or aggressive anytime." Chainama Hill hospital caregiver 05*

4.4.2 Physical Abuse

On physical abuse most respondentscommented thatit was a way of beating or destroying and throwing things, also as changing of behavior, becoming angry, shouting on top of voice, pricking children Opposing/arguing, opposing and arguing to instructions given, disorganized behavior, changing of the speech, showing wrinkles when talking and not getting along with friends, feeling of pain inside.

4.4.2 Prediction of Violence

Regarding identification and prediction of violence most mentioned that the client searches for dangerous objects for example getting a knife or an axe and throwing it directly to the person, the client does not want answer questions when asked, does not want to be talked to, not even wanting to be sent, insulting people. The client becomes too demanding, wanting big shares of food, the client does not want to be told to move where is sited, he does not want things that belong to him to be taken away or shared, he can throw food while he is angry, wandering about in the village or compound, refusing to eat, wanting to beat people, climbing trees and cutting trees without reasons, were throwing things, when the patient defaults drugs, they become very aggressive because they relapse.

One husband among the participants mentioned that: *"if you want to insist on giving food the client tells you that why are you emphasizing, have you put poison? At one time the case went up to the police that I have put poison, until when at the hospital it was confirmed about her being mentally sick". Chainama Hill hospital caregiver 02*

Another participant reported that*: when he wants to go to town, and you discourage him, he becomes violent, throwing things or destroying properties, threatening to beat people the mood is high, pacing around, change of speech and behavior, not wanting to be discouraged, displacement, of things, using abusive language, not want to respond to greetings, talkativeness, direct eye contact, red eyes, throwing food, becoming suspicious, shouting looking at the food without saying anything, grabbing people's properties mentioning that food is not hygienic, if he defaults drugs, he relapses and becomes so violent that he cannot listen to anyone, he can beat , can insult and break things, he can threaten to kill using sharp things, we just need to hide, you can observe the rolling of the eyes, red eyes, and then he shouts, after that fits. After the fit, he can do anything, he can beat he can be unruly, he insults."Chainama Hill hospital caregiver 03*

One of the participants had specific observation, when he reported that: "*I have observed specific days in a month where the client is observed of changing of the behavior, banging of the doors and windows, opening of the eyes and closing, unfolding of the chitenje, displacement of thing in the house, and becomes aggressive from nowhere" Chainama Hill hospital caregiver 06*

4.4.4 Verbal and Sexual Abuse

When asked concerning verbal and sexual abuse, most responded explained that they determine verbal abuse by the way the person looks at a person with red eyes, and then the client changes the speech and the behavior, then start insulting people, raping children and women, especially at home. Others could not properly identify the signs and symptoms, because some of them realized when the client was already abusive.

One of the respondents reported that: "*my son refused to eat and when I invited him, for food he became suspicious, started shouting at me and insulting me that I wanted to kill him and almost*

raped me, imagine I cry my son, my own son, one day he almost raped a niece who came to visit us; while she was bathing, he entered the bathroom until shouted at him." *FGD 01 respondent*

4.4.5 Injuries and Destruction of Properties

Regarding injuries and destruction of properties most respondents reported that you just observe the clientsbanging of the doors and windows climbing trees and the client can slaughter chickens, goats and cutting trees without reasons. Opening doors and closing, displacement of things in the house, throwing things or destroying properties, threatening and beating people and axing people, sudden changing of mood, not want to respond to greetings.

One of the respondents reported that: *"my son just woke up one morning and started chasing chickens, he slaughtered chickens, goats and when I stopped him he axed me in the head and I bled until I was taken to the hospital, I was almost dead". Chainama Hill hospital caregiver 07*

Another One of the respondents narrated that: "*my son left me naked, he pulled my chitenge in public, I was embarrassed that day and end up cutting me with a knife in my leg"FGD 03 respondent 05*

4.4.6 Handling of Violence

Concerning handling the patient who is violent many responses came up , respondents reported that to avoid aggression you needed to keep quiet when the client is shouting, leaving him alone, not provoking him, removing dangerous objects, avoiding him by not being near, observing strange behavior as to take precautions and measures, visitors should be aware about the situation for prevention of being hurt, Visitors should keep quiet when he is talking; no need to compromise with him when he is doing things deliberately, calming him down, telling friends to avoid him or leave him alone, and avoid laughing at him/her, or opposing, avoiding provoking him, we leave him alone then he thinks that he has worn the battle, we also avoid quarrelling with him, so that he does not become aggressive, when he goes into the bush we leave him, if we follow him he thinks you are provoking him, and he becomes aggressive, calling neighbor to help taking him to the hospital.

One husband among the participant reported that: "*I have stayed for so long with my wife, I have identified someone whom they are in good terms, so I call for that person to negotiate with her,*

handling her well and calling for the volunteers for help, providing her with food, she likes most". FGD 04 respondent 07

Another participant mentioned that: "*I call for help so that he is tied and put him at a nice place while waiting to be taken to the hospital, and when he becomes talkative we become alert that anytime he can become aggressive, then we find ways of protecting ourselves, sometimes we try to reason with him as a way of calming him and protect our properties, we ask him what he wants. If we fell to convince him to take drug, we call someone they are in good terms such a friend, a daughter, a wife or husband, if we do not manage, we take him to the hospital for further management".FGD 01 respondent 01*

4.5 Referral System

Regarding referral system most respondents mentioned that we call the volunteers, the community police or calling neighbors for help, and using other means.

One participant said:" *the neighbors come in with bicycles to escort us to the hospital"*

4.6 Stigma

When respondents were asked to report on stigma and how it contributed to violence, most from both the FGDs and IDS said that most of the time it was due to provocation by friends, relatives and children, parents, time for medication or lack of it, sometimes when food is not enough, stopping them what they want to do or grabbing something from them, drinking beer, smoking ganja, lack of concern or love to the client, lack of food was the big contributing factor to aggressive behavior, when people are calling the client by names or mad person, or reminding him of old situation for example that she undressed during her sickness, side effects of the medication given, when people are chatting, he thinks they are talking about him, most of the time when you give him a job to do, or sending him to do something he does not want and he says this is not my house why are you sending me. When the client is lacking clothes provide.

Its due to provocations due to luck of food, smocking, and calling the client names not necessarily stigma FGD 03

4.7 Inadequate Support

The researcher wanted to know how inadequate food and lack of medication contributed to violence. The respondents mentioned time for medication, and others lack of food. Most participants reported thatwhen food (relish) is there but not of his choice, he becomes violent.

The pastor mentioned that: "*sometimes when he is sleeping and the house is leaking and the food is socked, when he sits far from the dining table, he thinks friends are eating nice relish, and when there are only vegetables without proteins he becomes aggressive".*

4.8 Participants' opinion on the care of a client who is violent

On caring of the client, the researcher wanted to find out participants' opinion on how to take care of a violent client. Some the participants reported that when he is washing make sure that you give enough soap because you may find that the whole soap is finished. If you try to advise him you provoke aggression,

Another respondent pointed to say: "*if the client is provoked by friends, and is told that he is mad, we tell him that they are the ones who are sick not you. Even when children acting in that way, and forget about them."*

4.9 Participants' knowledge on how to predict violence in a mentally ill patient

The participants were requested to talk about their knowledge on how to predict violence in a client, they gave the following answers that when most of the times the reports about people chasing him, vehicles wanting to hit me, sometimes mentioning, dreaming about a new world and him being at the top of the world or on the top of the mountain, beating children for no apparent reasons, slaughtering chickens, goat chasing them, displacement of items in the house. When he reaches that extent we become alert that something will happen now, just observing the month and dates, when she complains about headache, cough, and very high mood, and when asked to cook she refuses on top of her voice, and tells me to cook, refuses to sweep and to go to the garden, becomes isolative, quiet, when cooking nsima, it is full of mealie meal. Another one reported that: "sleeps a lot, does not want to be asked why he is having a prolonged sleep, when people are discussing he thinks they are discussing about him, wandering about in the village, looking at harmful objects, and then refusing to eat. Most of the time you discover later when the client was already violent and had destroyed properties, or beating people.

One participant pointed out that her patient became isolative and hallucinating. This is her experience on to predict violence:

> "*my client becomes isolative, and he talks about been sick, sometimes he looks at himself and mentions that I want to go to the hospital, palpitating himself the whole body. Saying, I have HIV/AIDS, when sleeping I see people coming to bewitching me. The eyes become very red and with direct eye contact without fear.Does not want to be corrected on mistakes or talked to". Chainama Hill hospital caregiver 02*

Another participant reported that her patient will also exhibiting some hallucinations and stupor:

> "*he avoids eye contact by looking in the sky, and talking self, does not want to answer when asked, mentions about destroying things, looking at harmful objects, becomes talkative, showing anger, throwing things, not wanting people to be near him, if you try to be near him he becomes aggressive and mentions about killing someone. He does not want to stay at home; he picks dirty things shouting on top of his voice threatening to burn houses, there is a big change in the behavior, sometimes refusing to take food, from all this I know that he is becoming aggressive". FGD 03 respondent 08*

4.10 Participant's violent situation encountered in the process of caring for the client

The participants were asked to talk about the violent situation and sad moment they encountered in the process of caring for the client, many answers derived from there more participants reported that they were beaten during the care of the clients because of some restrictions imposed upon the clients broking of items in the house, undressing himself or herself, beating children, running in the mountains, wanting to kill himself or herself, crying the all night and day, removing maize in the field, throwing food away, being very aggressive preaching the whole night in the hospital, not sleeping , stoning people, undressed in public, becoming sexually active. Below are extracts from different respondents.

This respondent talked about how she encountered violence from her son, who exhibited violent behaviors even to neighbors and relatives. Here is how she put her experience:

> "*my son was studying inMatero Secondary School, I gave him money to go and pay for his school fees, and he spent all the money. The Head-master sent to me a report about my son misusing the money, being violent towards his friends. My child was chased from*

school, he had to finish at a private school, and he struggled to finish his schoolHe went to a teacher's Training College. When he finished his training, rather than coming back home, heleftfor Tanzania. When the client was given a job at a certain school, he couldn't continue teaching, rather he came back to the village; he stayed for some weeks, and then left for town to look for employment; up to now he doesn't maintain his job. As at now he is just wandering in town. At one time I took him to Chainama Hospital for treatment. After that he took beer then he relapsed. At one time the client was arrested for two (2) years at Kamwala Prison; there he was given a job of teaching friends, but could not persevere. These days, he does not keep his clothes, he sells, even friends complain of selling their clothes. Another time when he was discharged from the prison I left him at home and I went to attend a meeting, he closed all the windows, his siblings were not there; he went drinking. When he came back, he broke all the window and entered into the house, without fear that thieves can use the same window and go away with the entire household." Chainama Hill hospital caregiver 01

A respondent from interview number three put it this way;

I was in the bedroom preparing for work, then my neighbor shouted and I came out found him holding the mother and beating her badly. We have no peace at home, young brother lives in fear they cannot study well, and the mother cannot do business to supplement at home. He has lot of demands he can ask for break- fast and lunch together if he did not eat. I was beaten by my son, he axed me in the head, he could not even respect his mother, he also broke my arm, and I felt very bad. When food was given to him, he threw; I asked him oh my son do you want to die from anger. He destroyed lot of things in the house, could not sleep, he liked the night than the day, he was wandering about in the village, the all day and night, throwing food". Chainama Hill hospital caregiver 03

This respondent wanted to kill her own baby just after delivery that the bay was smelling. She became violent and suspicious. This what the respond said:

"*the client just after delivery she started avoiding her baby that she was smelling, and wanting to kill her several time, she has done that before. Many times she is so abusing verbally and physically beating children, the waste moment is where she gets feces rubbing on the walls and does even in the toilet. Today she rubbed the feces the whole*

wall of the bedroom, and became so violent wanting to kill the baby, my sister after delivery became so paranoid or too suspicious and refusing the baby, she became so violent, does not use the toilet wherever she sits she helps herself, if you say something about she becomes very violent breaking things in the house, insulting neighbors, one day she got a knife wanting to kill her grade nine child, sometimes wakes in the night wanting to suffocate her using a pillow. Yesterday she got a container of cooking oil poling in the mealie meal." Chainama Hill hospital caregiver 05

4.10.1 Assistance from the Community

Participants were asked to talk about assistance which they received from the community. The high number of participant reported that the community does help them to manhandle the client when he has become very violent to take him to nearest Bus Station; sometimes neighbors use their bicycles, vehicles. The community police are so helpful when they are called and accompany up to the hospital, the people in the community sometime they do give us even food, help us to take the client to the hospital, traditional healers are not common in many village so we cannot mention about them, they receive help from the chief, and the clinics in the villages, and also from volunteers, the church does help, because believers come and pray for us, give us encouragement on how we can persevere in our tribulation, receiving material help such as clothes and food, The participants were expected to give details on the support they expected from the community, many participants reported that the community and the caregivers should come together to form clubs to discuss matters on how to prevent violence from patients suffering from mental illness.

One mother said: "*The community police are so helpful when they are called and accompany up to the hospital, the people in the community sometime they do give us even food."*

4.10.2 Support from the health providers (Nurses, health surveillance….)

The participants were asked to talk about the support received from health workers the highest number of the participants mentioned transport because lack of it makes guardians to go to traditional healers, to seek for help, the building of health centershas minimized incidences, they provide emergency medication with the volunteers, so that when drugs are finished we able to collect others, information given on how to handle violence, they also had a concern

thatgovernment should provide them with small loans such as fertilizer and seeds, providing them with an ambulance, sometimes inviting them for workshops, training them on how to handle violence, building of more health centres.

One husband said: *when my son become sick and was violent the nurses at the hospital really helped us medicines and food.*

4.10.3 Type of Support Expected from Relatives

In this area participants needed to mention the support they expected from relatives participants had many needs which the family was supposed to render to them, Relatives who are living in town should to give us money to help cultivate the fields, having family counseling, being near during the period of trouble as to help one another, helping money to buy medication and for transport as to alleviate burden on one person, bring food to the client, and prayer being very important in people's life. Relatives who are living in town should help with fertilizer, seeds, money to give to people to help cultivate, sending them nice clothes and relish, alleviating burden on one person, being near during the period of trouble, bringing food to the client, because caregivers do not have time to be in the field while nursing the client, the should be helped with fertilizer, seeds, money, sending nice clothes and relish.

One participant mentioned that: "I *want relatives to come together and explain the background of the family, the roots and how mental illness started, and what they did to others who had mental illness". Chainama Hill hospital caregiver 02*

4.10.4 Type of Support Expected from The Church

The participants were asked to talk about they expected from church, they gave different answers according to their experiences, they emphasized on the church to show a good example in the community by giving what belongs to poor people, donations such as food, second hand clothes, money to transfer the client to the hospital, helping with soap, prayer and pastoral counseling, helping with money to transfer the client to the hospital, the church members should visit the family, as to encourage them.

One husband said:"*when my son was very sick we called on the pastor to pray for and he came and we prayed the all night."*

4.10.5 Type of Support Expected from Non – Government Organization

The researcher asked the participants which types of support they expected from non – governmental organizations most of participants mentioned that on- governmental organizations should provide with loans to guardians (fertilizer, seeds, money, cow, iron – sheets, solar panels, cement) and building of health centers, they should give clothes, food, provide water wells, also provide medication.

One wife mentioned that: "*we don't know them here because they don't come to help us".*

4.10.6 Type of Support Expected from Volunteers

The searcher wanted to know the support participants expected from the volunteers most participants complained about volunteers not having transport facilities as to come to help quickly, volunteers should have emergency stock of drugs; this will make people avoid going traditional healers.

One husband said: "*when my wife was sick, the volunteers came to help us and to take him to the hospital."*

4.10.7 Issues of violence in the community

The researcher wanted to hear from the participants about the issues of violence community many participants concluded by reporting that violence in the community is due to the client's feelings, lack of at home, the violence in the community is due to provocation by friends, children insulting the client, not understanding the client's feeling (stigma) and the lack of food at home.

4.11 Conclusion

In conclusion this chapter has presented findings as narrated by participants. In this chapter, the researcher has also included in italics and direct quotes on statements made by the participants, their responses in a table form (interview questions). Most reactions to violence were that of disappointment, and injuries, participants also felt they had lost their properties. One (1) of the participants whose son is mental ill was almost depressed to the extent of having suicidal thoughts. Guardians and clients lacked the social and psychological support. The psychosocial needs for the participants were financial support, emotional and support, need for love and attachment from other relatives, the people in the community, and health providers.

CHAPTER: FIVE

Discussion of findings

5.1 Introductions

This chapter presents data analysis and discussions of the findings based on the participants experience of assessing the risk of violence from mentally ill patients discharged from Chainama hills hosp. Data analysis and discussion were done simultaneously. Discussion was mainly on significantly observed in focus group discussion. These were also based on coded concepts and themes. The data analysis and discussion are presented based on questions given to focus group discussion and presented as in the presentation of the findings.

5.2 Discussions On Demographic Data

Out of forty (40) participants sixteen (16) were females which is the expected number because of the random sampling, the gender of the mentally ill patients and the aggression of the same patients. This study is about violence and in our cultural and traditions set up the women tend to stay away from violent scenes. Secker etal(2017) agrees with the trend because women on top of physical violence are prone to sexual abuse therefore in caring for violent mentally ill patients men would rather be in forefront. The marital status of the care givers was as expected because in Zambian situation patients who need special care are normally being looked after by families who are normally older than the patient.

Where the widow was a caregiver means that she had no choice but to care for the patient and could be the only one available, in addition there could have been some family support because of the nature of the illness. This is in agreement with Adler(2008) and Martin (2008) who mentioned that guardians should have helper s at home otherwise there will be serious assaults occurring. The ages of the participants were within acceptable limits ethically according to Zambian government an adult is anyone above twenty one (21) (Sililoetal ,2009).The persons above 65 are regarded as senior citizen and according to the community policy (2015).

Occupations of the participants were varied and well spread, this insured that the information given was good and from different sources and experiences which made the study valid and rich. The pastors and the chief were knowledgeable about the study and this rendered correct and trustworthy data. The discussion was very open because of their knowledge of the subject they

brought out issues of violence beyond the scope of the study such: eating of fecal matter, rubbing and beating an innocent mother, wanting to kill the daughter, wanting to rape.

5.3 Social assessment(Violence)

5.3.1 Participants' knowledge and experience of violence from mentally ill patients(physical, verbal and sexual harassment)

Although the participants could not define violence academically the responses stressed the practical side. Some participants believed that violence is a heavy feeling of pain. Crichton(2015) also believes that there many definitions of violence but dwells mostly on practical outcomes.

5.3.2 Participants' general knowledge and involvement in preventing violence

Participants had the practical knowledge of violence were the mentally ill patients showed anger, annoyance, aggression and being destructive most of the patients were uncooperative. Participants were also able to explain signs of violence in the patient. Most of the patients had signs before being violent. Participants talked about the patient being unreasonable, demanding or getting dangerous items such as knives and axes or exhibiting strange behaviour without reasons.

"I have observed specific days in a month where the client is observed of changing of the behavior, banging of the doors and windows, opening of the eyes and closing, unfolding of the chitenje, displacement of thing in the house, and becomes aggressive from nowhere"

Stanko(2012) states that parents have received verbal abuse which have produced negative effect on psychological, and physical well- being. Bell (2016) found that minority but significant number of women was victims of sexual abuse. People such as Clark(2015), Noble and Rogger (2017) and MacNiel and Binder (2015) agree to sexual abuse of female care givers mostly but also gave a hint that statistics could be higher as it is very difficult for the victims to be open because of the nature of the illness , the relationship the caregiver have with the patients and the heeded nature of the subject and the embarrassments it brings.

5.4 Epidemiological

5.4.1 Involvement of the participants

On this section most participants who responded to identification of signs and symptomsmentioned the signs and symptoms of violence although the experience was slightly different from one another. The signs and symptoms of violence included aggressiveness, very direct eye contact and changes in behavior and speech. The majority of participants had similar experience on signs and symptoms of violence and thebehavior leading to violence.

"participants reported on the client turning the head in all direction showing aggression, trembling of the whole body, Banging of the doors and windows, not wanting to be told to move where is sited, climbing trees and cutting trees without reasons.

Another responded reported on the client opening doors, closingand slaughtering chickens and goats".

These findings are supported by WHO (2015) and Single (2015) who categorized violence as biological, psychological, sociological and anthropological and multifactorial. The various types of violence signs and symptoms most are destructive and cause injury to care givers. Therefore, it is important for the care givers to know the signs and symptoms leading to violence.

5.4.2 The experience when thepatient is becoming Violent

The experience is almost similar to all respondents although, there some which are different from each individual. Some participants narrated that there are particular experiences with mentally ill patients, two participants talk about food eating.

"when he wants to go to town, and you discourage him, he becomes violent, throwing things or destroying properties, threatening to beat people High mood, pacing around, change of speech and behavior, not wanting to be discouraged, displacement, of things, using abusive language, not want to respond to greetings, talkativeness, direct eye contact, red eyes, throwing food, becoming suspicious, shouting looking at the food without saying anything, grabbing people's properties mentioning that food is not hygienicif you want to insist on giving food the client tells

you that why are you emphasizing have you put poison? At one time the case went up to the police that I have put poison, until when at the hospital it was confirmed about her sickness".

Jansen (2005) identified that inadequate knowledge, lack privacy, lack freedom and irritating factors contributed to violence and aggressive behaviour. He also stated that violence experienced by caregivers is very common in home where symptoms can be detected without reaction or proper reaction.

5.5 Behavioural and Environmental assessment

5.5.1 Areas to check for Violence

The respondents gave different answers depending on their experience and the patient. The common areas were irritating behaviour, shouting, and sudden hyperactivity. The respondents stated that irritable behaviour was the sure sign that the patient is becoming aggressive and violent. Clark (2009) believed that early life experiences, particularly relationships with parents or lack of them, developed the person's behaviour, and the control for violence. Naturally it is difficult to predict whether someone is going to harm in a given situation, although in the short term certain warning signs, changes in mood or behaviour, may indicate that a particular person is more likely to do something destructive or violent towards guardians, friends, and health workers. There some important responses which very few respondents mentioned such as the changing of the weather, some dates in the month and even seasonal patterns when these factors were mentioned most respondents were agreeable to situations.

5.5.2 Handling the patient when is violent

The participants were unanimously agreeable that they take action, to avoid aggression against them or to mitigate the violence so that it is cut short. Various actions are reported, like, they needed to keep quiet when the client is shouting, leaving him alone, not provoking him, removing dangerous objects, avoiding him by not being near, observing strange behavior as to take precautions and measures, visitors should be aware about the situation for prevention of being hurt being sexually abused, Visitors should keep quiet when he is talking; no need to compromise with him when he is doing things deliberately. Others mentioned calming him down, telling his friends to avoid him or leave him alone, and avoid laughing at him/her, or opposing, provoking the patient.

" Since *we have stayed for so long with my wife, I have identified someone whom they are in good terms, so I call for that person to negotiate with her, handling her well and calling for the volunteers for help, providing her with food, she likes most"*

"We leave him alone then he thinks that he has worn the battle, we also avoid quarrelling with him, so that he does not become aggressive, when he goes into the bush we leave him, if we follow him he thinks you are provoking him, and he becomes aggressive.

Some participants said that some patients are too aggressive and the only way is to seek protection for themselves and their properties from injuries, sexual harassment and destruction, in such cases they lock him up until he comes down. One participant mentioned of chaining the patient up, some participants lock themselves up or go to safe places where he cannot reach them. There is a mention of confronting the patient with violence until he is over powered. One participant talked about prayers when he becomes violent, some family members lock themselves to pray. Handling patients vary from patient to patients, depends on the patients aggression and severity of violence.

"we call for help so that he is tied and put him at a nice place while waiting to be taken to the hospital, and when he becomes talkative we become alert that anytime he can become aggressive, then we find ways of protecting ourselves, sometimes we try to reason with him as a way of calming him and protect our properties, we ask him what he wants. If we fell to convince him to take drug, we call someone they are in good terms such a friend, a daughter, a wife or husband, if we do not manage, we take him to the hospital for further management".

Depp (2017) said that frequents assaults on care givers could be reduced if the care givers knew what to do during violence situation. Jebbink(2015) in his studies included restraint and seclusion as ways of closing aggression and mishandling mentally ill patients.

5.5.3 Networking

Respondents regularly call on other people for assistance in handling aggressive and violent mentally ill patients. The people called on are readily available and leave whatever they are doing to come and assist. Such networks are very helpful because many people can easily handle a violent patient, the first group of networking is family members who include distant relatives mostly in the village set up, these are called on at any time and some are even willing to take on patients into their homes. The second are immediate neighbors but these may not be available at

all times because they have got their own jobs and duties to care off. The other group is the volunteers, these are called on and they help whenever they are available. The last group is the community police, they are in three categories: The first category is the regular officers these are very unhelpful, the second category is the police reservists, and they are slightly helpful mainly when they know the family very well. The third category are the concerned citizens who take upon themselves to maintain law and holder within their community, these are most helpful group and they assist when called upon. Depp (2017) talks about relatives being victims of assault, also Adler 2008 also mentions the need to have helpers at home.

"*When he becomes violent, we call the community police to help us"*

5.5.4 Stigmatization

The stigmatization of the patients leads to escalation of violent behaviour, the calling of names by friends, relatives and the other close people.

Stigmatizing a mentally ill patient come in many and various ways such as calling the utensils he uses and the medication as items for mad person, also discussing his abnormal behaviour such as talking about larger amount of food he takes. "When children or friends are calling by names such as a mad person, he becomes so aggressive" According to Clark (2015) mentions interpersonal violence or intra- individual dynamics as a result of some psychopathology, mishandling mental illness and stigmatization.

5.6 educational and Organization assessment

5.6.1 Care of the Patients/ Inadequacy of Support

In spite of the all efforts from families, networking individuals and hospital services medication and food have been lacking. Sometime it may that the patient ask for the type of food which is beyond families reach such as meat and bread with butter, if such are not provided the patient becomes violent in such circumstances the care givers have to use initiative to protect themselves and mitigate the violence.

"When he sits far from the dining table, he thinks friends are eating nice relish, and when there are only vegetables without proteins he becomes aggressive. If the client is provoked by friends, and he is told that he is mad, we tell him that they are the ones who is sick not you, even when children acting in that way, and forget about them"

Whenever the patient is violent most participants remove dangerous objects such as machetes. The other thing they do is to try to come him down and prepare medication mainly tranquilizers, then ask the patient to take the medication. The tranquilizers make the patient drowsy and most of the time the patient falls asleep. The other participants call the community or the networking people to assist; when the patient tried to go on his own they follow him. Violence of a mentally ill patient requires proper studying of the patient behaviour and measure are taken accordingly.

Jebbink (2015) talks about restraint and medication as some of the ways in which treatment is obtained.

5.6.2 Prediction of violent behaviour

Participants talked about their knowledge on prediction of violence and almost each one had a different response.

"he avoids eye contact by looking in the sky, and talking to self, does not want to answer when asked, mentions about destroying things, looking at harmful objects, becomes talkative, showing anger, throwing things, not wanting people to be near him, if you try to be near him he becomes aggressive and mentions about killing someone. He does not want to stay at home; he picks dirty things shouting on top of his voice threatening to burn houses, there is a big change in the behavior, sometimes refusing to take food, from all this I know that he is becoming aggressive".

"I observe the month and dates, when she complains about headache, cough, and very high mood, and when asked to cook she refuses on top of her voice, and tells me to cook, refuses to sweep and to go to the garden, becomes isolative, quiet, when cooking nshima, it is full of mealie meal".

Most participants talked about the client wandering about in the village, looking at harmful objects, and then refusing to eat. The care givers discovered later when the client was already violent and had destroyed properties, or beating people. Ellen, Fagan-Pryor, Harber, Dunlap, Nall Stanley and Wolpert (2009) focused on patients' views on causes of aggression and effective intervention; findings demonstrated that the causes were reflecting interpersonal relationships, conflicts of patient- to-patient and patients to staff.

5.7 Administrativeand Policy Assessment

5.7.1 Restriction and inadequate capacity

The respondents all talked about the violent situations and sad moment, they encountered when the patient was violent. All the respondents talked about being beaten when restrictive measures were imposed on the patient.

"I was beaten by my son, he axed me in the head, he could not even respect his mother, he also broke my arm, and I felt very bad. When food was given to him, he threw; I asked him oh my son do you want to die from anger. He destroyed lot of things in the house, could not sleep, he liked the night than the day, he was wandering about in the village, the all day and night, throwing food The other sad moment was today, the mother was washing plates, he grabbed her by the neck, hit her badly, I was in the bedroom preparing for work, then my neighbor shouted and I came out found him holding the mother and beating her badly. We have no peace at home, young brother lives in fear they cannot study well, and the mother cannot do business to supplement at home. He has lot of demands he can ask for break- fast and lunch together if he did not eat. He opened the door to the bathroom wanting to rape a niece who visited us"

"*My wife who is the client stoned me, she undressed in public, I had to cover her so that her nakedness is not seen by men and being raped, because when she is sick, she becomes sexually active, and one she was almost raped".*

Torpy and Hall (2009) found that patients who had been placed on a restriction order, following a conviction for a grave offence, were no more likely to be assaultive than non-restricted patients. A restriction order was not in itself found to be a good predictor of aggressive behaviour within hospital, even at community level, there is no consensus about whether staff, patients, and caregivers are more commonly assaulted, and both groups are common victims. Hodgkinson (2011) found that a strange-person to the client was assaulted more frequently, and another study showed that inexperienced strange person in the house was more likely to be injured by assault or raped (Carmel & Hunter 2011). Walker and Seifert (200 9) found that trained guardians were assaulted more frequently. Hodgkinson (2001:985) also found

that a small group of guardians were repeatedly assaulted and pointed to the fact that this was either due to particular guardian not using predictive measures at risk at that moment, or because of individual guardian's styles.

5.7.2 Support expected and support received

Support from the relative was an area which the entire respondents were positive about, the relative of the patients rendered some kind of support, though most of the time, it will be inadequate. Those who had relatives in town expected a high financial support compared to those in the village. In one situation the caregiver calledfor a meeting to tress origin of mental illness and its history in the families, so that each member in the family should assist in supporting the patient.

"Relatives who are living in town should to give us money to help cultivate the fields. *He wanted relatives to come together and explain the background of the family, the roots and how mental illness started, and what they did to others who had mental illness".*

The respondents talked about the neighbors and the community around them to be supportive. Some participants said the community police was also helpful when called upon. Very few participants talked negatively about them.

"The people in the community sometime they do give us even food; help us to take the client to the hospital".

Health providers, community, community development workers were talked about positively, the health providers rendered emergency to the patients and trained the caregivers on managing violent situations, community health workers trained the participants on social and community situations such as networking and stigmatization. The community development workers trained the care givers on how to gain extra income so as to be able to meet the cost of looking after the patients.

"Government should provide us with small loans such as fertilizer and seeds".

All the participants reported receiving some kind of support from some churches and spiritual organization. They received most of the support from the churches were the caregivers belonged.

"The church does help, because believers come and pray for us, give us encouragement on how we can persevere in our tribulation".

"The pastor came, and prayed for him and we noticed change in the behavior for a long period of time".

Participants reported on donations such as food, second hand clothes, soap to be given to care givers, helping with money to transfer the client to the hospital, the church members visit the family, as to encourage them.

Support from volunteers was very good, they were always available and most volunteers took it as personal contribution to the welfare of the patient, some participants complained that some volunteers do not have transport facilities for movements. Some respondents also asked to allow volunteers to stock some drugs for emergency.

Participants said there are very few non organizations which came to assist them in any form, despite having a large number in their vicinity.

"N*on- governmental organizations should provide with loans to guardians (fertilizer, seeds, money, cow, iron – sheets, solar panels, cement) and building health centre. There is a need to provide medication, building up health centre in the community".*

James and Fineberg (2011) reported that increases in violence are strongly associated with the eexperiences, also shows that caregivers are the target of violence, because of the direct contact, and the first care they give to the client in the community.

5.8 Summary of the chapter

The chapter has analyzed the data and discussed the findings presented by respondents and participants. The discussion has been done the following the pattern of data presentation and has been analyzed using the situations that arose, the objectives, the research question and in agreements with the literature review. The analysis centered on the violence that the caregivers are subjected to by the mentally ill patients. The findings and discussions show the reality of violence and the need to mitigate it due to the number of destruction, lot of injuries that the care givers suffer. Finally, the discussion centered on the support that the caregivers need.

5.9 Nursing Implcation

Physical and verbal assault from patients is not only difficult to deal with at the time but can have long and lasting negative impact on Caregivers' lives or wellbeing and mental health. There is need for a safe environment and adequate health care at home. Caregivers' violence in the community has effects on Caregivers's health for decreasing general health, mental health, as observed in Caregivers who felt threatened, and in the increased levels of psychological distress related to bullying and verbal sexual harassment suffered by Caregivers. Violence results in Pain, sprain, hearing damage, palpitations, sleep disorders, stress, depression, fear of patients, fatigue, headaches, sleeping problems, fear, anxiety, which are predominant expressions of Mentally ill violence psychological and physical wounds, consultation or treatment is needed. There is a high rate of aggression in female caregiverse causing mental and physical disorders, loneliness, irritability, anger, sadness, low self-esteem, and crying and mostly depression.

What are the best interventions?

There are many interventions for Caregivers, including counseling, home visits, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, non–clinician mentors, or community workers. Counseling generally includes information on safety behaviors and community resources. In addition to counseling, home visits may include emotional support, education on problem solving strategies, and parenting support.These interventions will improve physical and emotional health, safety promoting behaviors, use community based resources. It also to focuse on self–efficacy and empowerment, focusing on access to community resources, and brief non–physician interventions (collaborative multidisciplinary care teams)**.**

5.9.1 Nursing Practice

Providers can play a significant role*:* creating and maintaining trust relationships with patients and being supportive is key to Caregivers disclosing sensitive information. Providers can inform a patient that violence has prevalent and has serious health consequences, which is better than just providing information on resources, but may not be better than doing nothing.

Many Caregivers do not feel comfortable disclosing violence; by providing education and resources, they can still receive the information and use it when it is most appropriate for them. Also, discussing safe and healthy relationships is important and can prevent serious abuse from occurring later on.

5.9 .2 Nursing Education

The study showed that many providers are not competent to identify the causes of violence on dischanged patients in the community, hence ther is need to intergrate the subject in the curriculum for non-psychiatric trained providers. There is need to include them in the management of patients suffering from mental illness in the detecting the main causes of violence by organizing workshops. This includes coordinating with departments such as the police and collaborating with other categories of health workers. In nursing education, ethics and the code of conduct should be emphasized to enables nurses to handle sensitive legal issues on violence.

5.9.2 Nursing Research

The further research should be done in the community where these patients and caregivers live.

CHAPTER SIX:

Conclusions and Recommendations

6.1 Introduction

This chapter looks at the conclusion of the study and the recommendations made by the researcher.

6.2 Conclusions

The purpose of the study was explore the Caregivers' experience of violence by Mentally Ill patients dischanged form Chainama Hospital but attending reviews at the filter clinic. The study relied on Caregivers who accompanied patients for review. Twenty four (24) were males and 16 females .They were all aged between 21 to 65 years. They all concented and participated in this study.

The study used the PRECEDE-PRECEDE model to analyse the problem in order to identify areas which need intervention and achieve the study objectivesw. The study identified that violence escalated because of the illness itself, ignoring patients demands, stigma, discrination and lack of being involved in social activities, lack of support from relatives, government, the NGOS.

The study also discovered that female caregivers were more abused verbally, sexually, physically and psychologically because of their make up.

The study also discovered that caregivers needed to have knowledge on the signs and symptoms of violence. They were bitter because of injuries , destruction of properties and no help from the police is rendered to them when they call for help only well wishers or neighbors come sometimes to their rescue.

The administrative and policy assessment of the study identied the policies, resources and circumstances that could facilitate a reduction in violence towards Caregivers. The study

revealed that there were adequate laws to protect caregivers, so violence was attributed to the laxity of the law to be reinforced.

In this study has been observed that the violence by mentally ill patients to the caregivers is wide sprayed; all the respondents have experienced violence which sometime has brought injuries and destruction to them and to their properties. The care givers have found it difficult to predict the onset of this violence because not a single mentally ill patient is like the other one; they are different from each other**.** All the care givers have no system of protecting themselves. Prevention and protection are dependent on the prevailing conditions and situations

There is need for caregivers to be knowledge of mental illness, where they should be trained on what to do with the aggressive and violence from mentally ill patients. They should also know about restrictive behaviour, command situations, medication and treatment procedures and these will go a long way in mitigating the violence behaviour of the patient.

The support for the caregivers is not systematic and this sometime is no available, members within their community render random and up hazards type of support, networking has helped but all this has failed to eliminate aggression and violence. It requires more to be done and more to support the care givers.

6.3 Recommendations

The study makes the following recommendations:

1. The community health workers in mental health departments should make constant regular and constant follow ups to the patients who have been discharged from the hospital and who are now under the care of the family
2. The caregivers must be constantly trained on the mental illness, medication and treatment procedures, prevention and protection of themselves from aggression and violence by the mentally ill patients so as to avoid injuries and destruction of properties in the community.
3. Maximum support should be availed to all caregivers and this support must be networked where community health workers must also be included. All the stakeholders should be

actively involved and no wait for that alarm raised but to a system were the support must be available all the time.

4. The government through the community workers and the discharging health center should provide financial and material resources periodically to alleviate the problem of material demands by mentally ill patients, the gorvenment should establish rehabilitation centers in the community such as carpentry workshops, gardening, tailoring to train patients and caregivers, recreation facilities where patients should go and relax.
5. The study also recoomends that caregivers should be taught the dangers of not hiding issues patterning to violence
6. There is need to teach the people in the community about violence and how to rescue the caregivers when violence occurs.
7. There is need to intensify Information, Education and Communication(IEC) to the general public especially in the community where the caregivers and patients live.
8. The existing policy on violence should be put to effect by the government. If this policy is effected it will protect the caregivers to experience violence by Mentally ill patients.
9. There is need for all relevant authorities and stakeholders to address the issue.
10. The study recommends that the Government, Non Government Organizations, churches, chiefs, traditional healers,and stakeholders should recognize the existence Mentally ill patient violence towards Caregivers and discouge the practice. All these entities should come together and find a solution in fianancing some of the activities.
11. More research is needed in areas that were not understood. Especially on the psychological trauma.
12. There is need to replicate this study on a larger scale(nation wide) in order to yield more information and enable generalization of the findings.

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APPENDICES

APPENDIX I

Information sheet

Care-givers experiences of violence by patients suffering from mental illness at Chainama Hospital

INTRODUCTION

I, Erick Musala Kunda, a student in the Masters of Nursing Sciences degree program at the University of Zambia is kindly requesting for your participation in the research study mentioned above, because it is important to explore the **caregivers experiences of violence by patients suffering from mental illness at Chainama Hospital.** Before you decide whether or not to participate in this study, I would like to explain to you the purpose of the study, any risks or benefits and what is expected of you. Your participation in this study is entirely voluntary. You are under no obligation to participate; you may choose to participate or not to participate. If you decline to participate, no privileges will be taken away from you. If we get to a question that you are not comfortable or willing to answer, you can tell me so that we proceed to the next question. If you agree to participate, you will be asked to sign the consent form in front of someone. Agreement to participate will not result in any immediate benefits.

PURPOSE OF THE STUDY

The study obtained information on the caregiver's experiences of violence by patients suffering from mental illness. This is important as the data obtained from this study helped the MOH and Chainama hospital in practical setting and also assist policy makers and stakeholders to improve

on the gaps that identified. The findings has also informed curriculum development education and clinical area support.

PROCEDURE

After you have signed the consent form, and have had a chance to ask questions, you will be asked questions concerning the caregivers' experiences of violence by patients suffering from mental illness. You will also be given a chance to make suggestions on what you think would assist on the care and prevention of violence.

RISK AND DISCOMFORTS

Risks and discomforts are involved since you will have to spend time in answering questions which is stressful and the presence of the research assistants will cause some discomfort. Answering questions will take approximately 60 minutes and this will be tape recorded for easy capturing of data.

BENEFITS

By taking part in this study, you will be able to provide us with information that will help the, hospitals, Ministry of Health and MAZ relevant authorities and policy makers to come up with effective strategies and policies to promote mentorship and supervision during internship. There will be no money provided in exchange for information obtained.

CONFIDENTIALITY

Information obtained from this research will be locked or a password confidential to the extent permitted by law. You will be identified by a number, and personal information will not be released to other persons. The Ministry of Health, Chainama Hospital and University of Zambia as well as Research Ethics committee may review your records again this will be done in confidence.

APPENDIX 11

Informed consent form

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that:

If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary. I am also free not to answer questions that I may feel to be too personal.

I…….. (Names)

Agree to take part in the interview schedule

Signed/ thumb……..… **Date……**

Signed/thumb……. **Date……**

Personal contact:

Erick Musala Kunda

University of Zambia, School of Medicine, Department of Nursing Sciences, P.O. Box 50110, Lusaka, Zambia. Mobile Phone: +26**0977722075/0955722075. Email address:** musalakunda@yahoo.com

APPENDIX III

INTERVIEW SCHEDULE

TITLE: **caregiversexperiences of violence by patients suffering from mental illness at Chainama Hospital.**

Place of interview…….

Date of interview……..

Time started…….

Time ended……

Name of interviewer…….

Identity of interviewee…….

Hospital……

Ward…….

Index number……

Instructions

1. Introduce self to interviewee
2. Remind interviewee that the interview will be tape-recorded
3. Reassure confidentiality
4. Obtain consent
5. **Demographic data**

How old were you on your last birthday? .....

What is your marital status? .....

What is your religion? .....

How many children do you have? .....

What is your highest level of education? .....

SECTION B

Opening question

1. Describe your experiences on violence from patients suffering from mental illness
2. Explain any violent situation that you encountered in the process of caring for the client
3. Describe the way you predict violence in a client.
4. Explain how you know that this person is becoming aggressive or violent.

Section c

1. Explain how the community assists you when a client becomes violent.
2. Describe precautions and measures you take to prevent violence.
3. Describe any support you would like mental health care providers, to render to you in order to manage violence appropriately.
4. Explain the areas you look for when assessing violence in clients.

CONCLUSION:

Explain to me any issues which you think are related to violence and aggression?

APPENDIX IV

FGD GUIDE

TITLE: **caregivers'experiences of violence by patients suffering from mental illness at Chainama Hospital.**

Place of interview…….

Date of interview……..

Number of Respondents ……..

Gender of Respondents ……..

Time started…….

Time ended……

Name of interviewer…….

Identity of interviewee…….

Hospital……

Ward…….

Index number……

Instructions

6. Introduce self to interviewee
7. Remind interviewee that the interview will be tape-recorded
8. Reassure confidentiality
9. Obtain consent

Demographic data

How old were you on your last birthday? .....

What is your marital status? .....

What is your religion? .....

How many children do you have? .....

What is your highest level of education? .....

SECTION B

Opening question

5. Describe your experiences on violence from patients suffering from mental illness
6. Explain any violent situation that you encountered in the process of caring for the client
7. Describe the way you predict violence in a client.
8. Explain how you know that this person is becoming aggressive or violent.

Section c

5. Explain how the community assists you when a client becomes violent.
6. Describe precautions and measures you take to prevent violence.
7. Describe any support you would like mental health care providers, to render to you in order to manage violence appropriately.

8. Explain the areas you look for when assessing violence in clients.

CONCLUSION:

Explain to me any issues which you think are related to violence and aggression?

APPENDIX V

Budget justification

1. **Stationary / Binding**

   The researcher will require a total of 1**,500** for stationary and binding of the report.

2. **Personnel**

   The researcher will require **K1, 000** for transport during literature review. The two research assistants will be trained for a day at a cost of **K300**. A pre-test will be conducted for a day at a cost of **K300**. The researcher will require **K300** for 2 days as allowances during training and pre-test. The researcher and the two assistants who will require transport and lunch allowance during the period of collecting data which will amount to **K6000.** A statistician will be consulted for statistical calculations and data analysis, at a cost of **K2, 000** giving a total of **k 13, 500**

3. **Contingency**

   10% of the total budget (**K1, 000**) will be set aside as contingency to cover up for any unforeseen expenses.

4. **Total budget**

The total budget for the study is **K 13, 500**

APPENDIX VII

APPLICATION LETTER FOR AUTHORITY

The University of Zambia

School of medicine

Department of nursing Sciences

P.O Box 50110

Telegrams: UNZA, Lusaka

Telephone: 2526412

Fax: +260 257706

The Senior Medical Superintendent
Chainama college hospital
p.o box 3004
Lusaka

UFS. The Head of Department
Department of Nursing Sciences
University of Zambia
School of Medicine
P.O. Box 50110
Lusaka

Dear Sir/Madam

Ref: Permission to conduct a pilot study on caregivers experiences of violence by patients suffering from mental illness at Chainama Hospital.

With regards to the reference above, I am here by requesting for permission to undertake a study at Chainama Hospital. I am a student pursuing a Master of Science in Nursing, majoring in Mental Health at the University of Zambia.

The purpose of the study is to explore the experiences of violence experienced by Guardians by Mentally ill patients discharged from the hospital but attending reviews at Chainama filter clinic The information to be generated from the study will form a basis of conducting large scale studies, influence the Ministry of Health on improving measures to protect guardians against violence from mentally ill patients.

Prior to the main study, I would like to conduct a pilot study at the University Teaching Hospital in order to test the trustworthiness of my data collection tools and make necessary adjustments.

Thank you for your support.

Yours Faithfully,

Erick Musala Kunda
Master of Science in Nursing Student

APPENDIX VIII

APPLICATION LETTER FOR AUTHORITY

The University of Zambia
School of medicine
Department of nursing Sciences
P.O Box 50110
Telegrams: UNZA, Lusaka
Telephone: 2526412
Fax: +260 257706

The Medical Superintendent
Chainama Hospital,

P.O Box3004

Lusaka

UFS. The Head of Department

Department of Nursing Sciences

University of Zambia

School of Medicine

P.O. Box 50110

Lusaka

Dear Sir/Madam

Ref: Permission to conduct a pilot study on caregivers experiences of violence by patients suffering from mental illness at Chainama Hospital.

With regards to the reference above, I am here by requesting for permission to conduct a pilot study at Chainama Hospital. I am a student pursuing a Master of Science in Nursing, majoring in Mental Health Nursing at the University of Zambia.

The purpose of the study is to explore the experiences ofcaregiversexperiences of violence by patients suffering from mental illness at Chainama Hospital. The information to be generated from the study will form a basis of conducting large scale studies, influence government on improving the care and measure on preventing violence in the community.

Prior to the main study, I would like to conduct a pilot study at university Teaching Hospital Clinic 6 in order to test the trustworthiness of my data collection tools and make necessary adjustments.

Thank you for your support.

Yours Faithfully,

Erick Musala Kunda

Master of Science in Nursing Student