INVESTIGATING THE CAUSES OF AGGRESSIVE BEHAVIOUR OF PATIENTS' RELATIVES TOWARDS NURSES AT KWARA STATE UNIVERSITY TEACHING HOSPITAL ILORIN, KWARA STATE.

BY

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DECLARATION PAGE

This is to declare that this research project titled **INVESTIGATING THE CAUSES OF AGGRESSIVE BEHAVIOUR OF PATIENTS' RELATIVES TOWARDS NURSES AT KWARA STATE UNIVERSITY TEACHING HOSPITAL ILORIN, KWARA STATE** carried out by **DADA VICTORIA TOLUWALASE** is solely the result of my work except where acknowledged as being derived from other person or resources.

Matric Number: 21/05NSS044

In the department of Nursing Science, Thomas Adewumi University Oko-Irese, Kwara State

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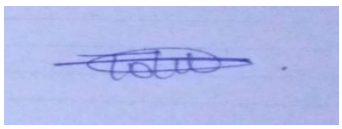
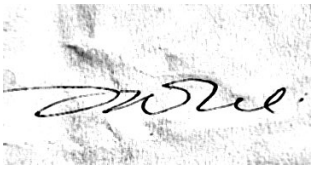


CERTIFICATION

This is to certify that this research project carried out by DADA VICTORIA TOLUWALASE with matric number 21/05NSS044 has been examined and approved for the award of Bachelor in Nursing Science Degree

Signature 

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ABSTRACT

This study investigated the causes of aggressive behaviour exhibited by patients' relatives towards nurses at Kwara State University Teaching Hospital (KWASUTH), Ilorin, using a descriptive cross-sectional survey of 138 patient relatives. Age distribution showed that 53.6% were between 31–40 years. Females accounted for 64.5% of respondents, while 35.5% were male. Educationally, 44.2% had tertiary education, 37.7% had secondary, 12.3% had primary, and 5.8% had no formal education. Regarding relationship to the patient, 42.1% were spouses. Religious affiliation included 49.3% Muslims, 47.8% Christians, and 2.9% other religions. Marital status indicated 59.4% married, 24.6% single, 10.1% divorced, and 5.8% widowed. Aggressive behaviours were common, with 60.9% reporting verbal confrontation, alongside threats, shouting, intimidating body language, and physical aggression. Perceived causes included delays in care, poor communication, misunderstanding of medical procedures, emotional stress, and financial burden. Chi-square analysis showed no significant association between educational level and perceived cause ($\chi^2 = 5.89$, $df = 9$, $p = 0.75$) or between age and perceived cause ($\chi^2 = 10.78$, $df = 12$, $p = 0.63$).Based on the findings, the study recommends regular conflict resolution and de-escalation training for nurses, improved communication protocols, cultural sensitivity training, enhanced hospital security, provision of psychological support services, and implementation of policies promoting respectful interactions between nurses and patient relatives. Addressing these factors is essential for improving nurse safety, fostering therapeutic nurse-relative relationships, and enhancing overall healthcare delivery.

Word Count: 227 words

Keywords: Aggressive behaviour, Nurses, Patient relatives, Communication, Healthcare settings

DEDICATION

This research project is dedicated to God Almighty for granting me strength, grace, wisdom and favour throughout the period of conducting this research and to my beloved parents and siblings who selflessly sacrificed everything and stood by me physically, spiritually, emotionally and financially, supporting me in all aspects that led to the success of this project.

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Special appreciation goes to my HOD Dr Elizabeth Fashiku, and all academic staff members in the faculty of nursing sciences in person of Mrs. Aina Olusayo, Mrs. Arosanyin, Mrs. Omotosho, and Mr. Aransiola.

I extend my sincere appreciation to the management and staff of Kwara State University Teaching Hospital, Ilorin, for granting me access to conduct this research.

I'm grateful to all the participants of this study, who provided valuable information that made this research a success.

My profound gratitude goes to my parents, Pastor and Mrs. Dada and my siblings Oluwatimilehin, Precious and Oluwadamilare for their support and encouragement, I love you guys with the whole of my being.

OUTLINE

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Understanding the intricate relationship between nurses and patients is essential. However, the sobering reality of patients' families acting forcefully against nurses is not lost on us, even in the midst of tender care and diligent efforts to promote health. This issue challenges the fundamental tenets of patient-centered care and jeopardizes the health and safety of nurses.

Recently, there has been a lot of attention focused on aggressive behavior aimed against nurses. Numerous studies have shown how widespread this behavior is and how detrimental it is to both individual nurses and healthcare institutions. These incidents not only make nurses feel uncomfortable psychologically, but they also dramatically increase turnover rates and work discontent.

According to Xu et al. (2021), the rising prevalence of violent behavior from patient relatives poses a growing threat to the safety and wellbeing of nurses in modern healthcare settings. In addition to endangering the physical and mental well-being of nurses, aggressive behaviours including verbal abuse, threats, and even physical violence significantly lower the standard of patient care and the atmosphere in the hospital.

Aggressive behavior by patients' relatives toward nurses is still a major issue in healthcare set tings worldwide. On a global scale, the World Health Organization (WHO) estimates that 8–38% of nurses will experience some form of violence at work during their careers (WHO, 2022). According to recent reports by smith et al (2020), aggressive behaviour against healthcare workers especially nurses, is on the rise. While specific data on aggression from patient relatives towards nurses may vary, the World Health Organization (2021) acknowledges workplace violence as a significant issue affecting healthcare professionals worldwide. Stress, poor communication and insufficient personnel levels are some of the things

causing this phenomenon (Johnson & Brown, 2021). Across a broader sample in Africa, a survey found that 59.2% of nurses experienced work place violence in the prior year, with 49.5% of the perpetrators being patients' relatives or companions (Ogunlaja et al., 2021).

In Nigeria, aggressive behaviour towards nurses by patient relatives is a significant challenge within the healthcare system. Despite the global discourse on aggression towards nurses, the Nigerian healthcare context presents unique challenges and dynamics that warrant specific attention. Existing studies have highlighted the widespread occurrence of aggressive behaviour towards nurses in Nigeria, with verbal abuse, threats, and physical assaults being common manifestations (Olatubi et al., 2020). A 2020 study in Katsina, Nigeria, reported that 100% of nurses had endured some form of workplace violence (WPV), with 87.2% of the incidents perpetrated by patient relatives (Isah et al., 2020). Supporting this, a narrative review on violence against nurses reports that up to 38% of nurses are exposed to physical violence over the course of their careers (Wang et al., 2023). However, these studies often lack comprehensive exploration of the contextual factors contributing to such aggression, including socio-cultural, organizational, and systemic dynamics.

Limited resources and overcrowded facilities contribute to tensions between healthcare providers and patients' families (Ogunsemi et al., 2021). Cultural factors, such as traditional beliefs about illness, further complicate interactions between nurses and patient relatives (Adebayo et al., 2020). Despite efforts to mitigate workplace violence, incidents of aggression against nurses persist in Nigerian healthcare facilities (Adeloye et al., 2022).

In Kwara State, there are similar challenges regarding aggression towards nurses in healthcare settings. While specific data on the incidence of such incidents in Kwara State may be limited, anecdotal evidence suggests that aggressive behaviour from patient relatives is a prevalent issue (Omotayo et al., 2023). Efforts to address this issue in Kwara State include training

programs for healthcare workers and community engagement initiatives aimed at promoting respectful behaviour in healthcare settings (Oyedunni et al., 2022).

The abuse of nurses by patients and their relatives represents a distressing phenomenon that has gained prominence within the broader discourse of healthcare challenges. Nurses, as frontline caregivers, play a pivotal role in delivering patient-centered care, yet they often find themselves vulnerable to various forms of abuse, ranging from verbal and emotional mistreatment to physical assaults.

Lamichhane & Bae, (2020) said that verbal abuse is a common form of patient aggression towards nurses that affects their psychological well-being and job satisfaction, including a decreased level of dedication to work and a weaker intention to stay in the field. Verbal abuse towards nurses may have detrimental effects on their psychological health, as well as their productivity and results at work.

The abuse of nurses by patients' relatives is a complex issue with far-reaching implications for both healthcare professionals and the quality of patient care. By identifying the root causes and dynamics of aggression towards nurses, healthcare institutions can develop targeted interventions and policies aimed at prevention and mitigation. Ultimately, it is my fervent hope that this endeavor will serve as a catalyst for fostering positive change within the realm of healthcare, nurturing environments where both patients and healthcare professionals can thrive harmoniously.

1.2 Statement of the problem

As a student nurse who has undergone several clinical postings, the researcher has observed and personally experienced aggressive behaviour from patients' relatives on multiple occasions. These incidents often occurred in high-pressure environments such as emergency units and wards, where nurses are the most visible healthcare professionals and are frequently

blamed for systemic delays or perceived inadequacies. These repeated exposures to aggression formed the basis for the researcher's interest in investigating the root causes and contributing factors of such behaviours.

Research has shown that multiple factors contribute to aggressive behaviour toward nurses. These include the high expectations of patients' relatives regarding care delivery, emotional distress resulting from the critical condition of loved ones, long waiting times, and limited communication between healthcare workers and patients' families (Arfaoui et al., 2023; Ugwu et al., 2024). Additional factors such as cultural and language differences, overcrowded hospitals, and inadequate staffing have been identified as significant stressors that may trigger violence from patients' relatives (Olaore & Olanrewaju, 2022).

Workplace violence not only affects the physical and psychological wellbeing of nurses but also negatively impacts the quality of care delivered to patients. By identifying the underlying causes of aggressive behaviour from patients' relatives, this research aims to contribute to strategies that promote a safer and more supportive healthcare environment for nurses, ultimately improving patient outcomes and job satisfaction among healthcare providers.

1.3 Objectives of the study

Broad Objective

This study seeks to investigate the causes of aggressive behaviour of patients' relatives towards nurses at Kwara State University Teaching Hospital (KWASUTH) Ilorin.

The specific objectives of this study are to;

1. Assess the prevalence of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH Ilorin;

2. Identify the most common type of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH Ilorin;
3. Identify the perceived causes of aggressive behaviour by patient relatives towards nurses at KWASUTH Ilorin; and
4. Identify various ways by which aggressive behaviour towards nurses can be reduced at KWASUTH Ilorin.

1.4 Research questions

The following research questions will be answered in this study:

1. What is the prevalence of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH, Ilorin?
2. What are the most common types of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH, Ilorin?
3. What are the perceived causes of aggressive behaviour by patient relatives towards nurses at KWASUTH, Ilorin?
4. What are the various ways by which aggressive behaviour towards nurses can be reduced at KWASUTH, Ilorin?

1.5 Research hypotheses

H_{01}: There is no significant relationship between the perceived cause of aggressive behaviours of patient relative and their level of education

H_{02}: There is no significant relationship between the perceived cause of aggressive behaviours of patient relative and their age

1.6 Significance of the study

- The study will contribute to the implementation of new rules and regulations that will promote a stress-free workplace environment for nurses, with zero tolerance for aggressive behaviour.
- The study will help in modifying and monitoring the system of communication between nurses and patients' relatives to foster reduction in aggressive behaviour.
- This study will enhance the knowledge of nurses on the causes and management of aggressive behaviour and also demonstrate the necessity for nurses to use preventative measures in stressful circumstances and environments where aggressive behaviour is possible
- This study will emphasize why Kwara state university teaching hospital should establish a training program for newly hired Registered Nurses in order to inform them of the factors that cause aggressive behaviour, how to respond to the situation, and how to minimize the negative consequences on the personal and professional levels.
- This study will help the federal, state and local government create an environment where nurses are safe, secure and productive by employing more nurses and reducing instances of nurses being overworked or under pressure.

1.7 Scope of the study

This study was carried out at Kwara State University Teaching Hospital Ilorin, Kwara State to investigate the causes of aggressive behaviour of patients' relatives towards nurses at Kwara State University Teaching Hospital Ilorin. The study population include Patients' relatives at Accident and Emergency unit, Male surgical ward and Maternity.

1.8 Operational definition of terms

Investigate: To inquire about the aggressive behaviour of patients' relatives towards nurses

Cause: The reason for patients' relatives action towards nurses

Aggression: The anger and attack directed towards nurses by patients' relatives

Behaviour: The way in which patients' relatives act or conducts themselves towards nurses

Patient Relative: A member of a person's family related through blood or by marriage.

Nurse: A person who cares for individuals and assists them in regaining their health

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

This chapter provides a comprehensive review of the existing literature related to the causes of aggressive behaviour of patients' relatives towards nurses in health care setting. The purpose of this literature review is to synthesize existing research on the causes of aggressive behaviour by patient relatives towards nurses, with the goal of identifying key factors that contribute to this behaviour. By examining the current state of knowledge on this topic, this review aims to provide a comprehensive understanding of the underlying reasons for aggressive behaviour, inform the development of effective interventions, and ultimately promote a safer and more supportive healthcare environment for nurses and patients' relatives.

It is organized into various sections, each addressing a specific aspect of aggressive behaviour which include the following headings; definition of aggressive behaviour, types of aggressive behaviour, factors contributing to aggressive behaviour, causes of aggressive behaviour toward nurses, prevention of aggressive behaviour, Theoretical framework and Empirical review.

2.1 Conceptual Review

2.1.1 Introduction

Aggressive behaviour towards nurses by patient relatives is a pervasive issue in healthcare settings, posing a significant threat to the well-being and safety of nursing professionals. This phenomenon has been increasingly recognized as a major concern, with far-reaching implications for healthcare quality, patient safety, and nurse job satisfaction. Despite its significance, the causes of aggressive behaviour by patient relatives towards nurses remain poorly understood.

2.2 Definition of Aggressive Behaviour

APA Dictionary of Psychology (2021) defines aggression as behaviour aimed at harming others physically or psychologically. A multidimensional phenomenon that can be parsed by cognition, affect and behaviour. A tendency toward social dominance, threatening behaviour and hostility. It can occur sporadically or be a characteristic trait of an individual. This definition highlights that aggression can manifest in different forms including verbal, physical, direct and indirect with the primary goal of causing injury or destruction, or it can be instrumental, where harm is inflicted to achieve a specific goal.

Albert Bandura (1973) known for his Social Learning Theory, defines aggression as behaviour intended to harm another individual who is motivated to avoid that harm. This definition highlights the intent and the harmful outcome as key components of aggression.

Strassnig et al. (2020) define aggression as intentional behaviour, either physical or verbal, meant to inflict harm on an individual or group. This definition also distinguishes violence as a subtype of aggression involving the use of physical force to cause injury, psychological harm, or death.

Haller (2020) describes aggression from a neurobiological perspective as any behaviour, physical or verbal, intended to cause harm or injury to another person or animal. The author emphasizes the role of biological and environmental factors, such as genetics, mental health disorders, alcohol consumption, and trauma, in precipitating aggressive behaviour.

According to the World Health Organization (2021), aggression is "the behaviour of attacking without being provoked, often resulting in physical or verbal injury".

In the Annual Review of Psychology (2023), aggression is defined as "behaviour intended to harm another individual who is motivated to avoid that harm, and it can be physical or verbal".

Conner (2004) said aggression may be defined as harmful behaviour which violates social conventions and which may include deliberate intent, harm or injury to another person or object. In many cases it escalates into violence. Aggression has also been viewed as a heterogenous concept encompassing a wide variety of behaviours. Research have attempted to create more homogenous categories in this behavioural domain by identifying subtypes of aggression based on statistical techniques such as factor analysis.

The European commission defined aggression as an incident in which a person is attacked, bullied and insulted in the workplace.

2.3 Types of Aggressive Behaviour

According to Sean and Mitus (2022), aggression can be classified into the following types:

Impulsive aggression: This type of aggression is also known as emotional or affective aggression and stems directly from emotions you experience in the moment. Examples include physical aggression, verbal aggression, relational aggression and passive aggression.

Instrumental aggression: This type of aggression is also known as cognitive aggression and involves planning and intent, typically to achieve a specific desire or goal. Examples include using coercion and manipulation to maintain social status and control and threatening to harm others or themselves.

Physical Aggression: This involves physical acts intended to harm or injure someone physically, such as hitting, pushing, or physical intimidation.

Verbal Aggression: Verbal aggression includes behaviours such as yelling, name-calling, threats, or using harsh language with the intent to harm or intimidate.

Relational Aggression: Also known as social aggression, this type involves behaviours aimed at damaging someone's social relationships or reputation, such as spreading rumors, social exclusion, or manipulation.

Hostile Aggression: This type is driven by anger or hostility and is aimed at causing harm or pain to the target without any clear reward or objective.

Cyber Aggression: Involves using electronic communication to threaten, harass, or intimidate others, such as through social media, texting, or online forums.

Passive-Aggressive behaviour: Indirectly expressing negative feelings through actions such as sulking, procrastination or subtle sabotage

Environmental Aggression: Aggression directed towards the environment such as pollution or destruction of natural resources

Economic Aggression: Aggression related to economic or financial gain such as exploitation or fraud

Cultural Aggression: Aggression directed towards someone's cultural background, values or beliefs

Rippon (2000) also grouped aggression into eight types which is shown in the table below:

Type of Aggression	Example
Physical-active Aggression	Stabbing, Punching, Shooting
Physical-active direct Aggression	Physically preventing another person from obtaining desired goal
Physical-active indirect Aggression	Setting a mine or hiring an assassin
Physical-passive indirect aggression	Refusing to perform necessary tasks
Verbal-active direct Aggression	Insulting or causing a person to lose face in public
Verbal-active indirect Aggression	Spreading malicious rumours or gossip about another individual
Verbal-passive direct Aggression	Refusing to speak to another person or to answer a question
Verbal-passive indirect Aggression	Failing to respond to a specific verbal comment e.g. failing to speak in defense of another person when he/she is unfairly accused or criticized

Table 2.3.1

2.4 Factors Contributing to Aggressive Behaviour Toward Nurses

2.4.1 Family Stress and Anxiety: Relatives experiencing high levels of stress and anxiety due to the patient's condition or hospitalization may exhibit aggressive behaviour towards nurses. This can stem from feelings of helplessness or frustration Gonzalez et al., (2021).

2.4.2 Perceived Threat to Patient's Well-being: Relatives who perceive inadequate care or treatment for their loved ones may express aggression towards nurses as a protective or advocacy response Smith et al., (2023).

2.4.3 Lack of Communication and Information: Insufficient communication or unclear information about the patient's condition or treatment plan can lead to misunderstandings and heightened emotions, potentially resulting in aggression Turner et al., (2022).

2.4.4 Cultural and Linguistic Barriers: Differences in cultural beliefs, language proficiency, or communication styles between nurses and patient relatives may contribute to misunderstandings and conflict, increasing the likelihood of aggression Choi et al., (2020).

2.4.5 Emotional Distress and Coping Mechanisms: Relatives experiencing grief, guilt, or fear related to the patient's illness may have maladaptive coping mechanisms that manifest as aggression towards healthcare providers Hoffman et al., (2024).

2.4.6 Role Stress and Caregiver Burden: Relatives who perceive themselves as primary caregivers may experience high levels of stress and burden, which can escalate into aggression when they feel overwhelmed or unsupported O'Connell et al., (2021).

2.4.7 Unmet Expectations: Unrealistic expectations regarding the patient's care outcomes or treatment progress can lead to frustration and anger, prompting aggressive behaviour towards nurses perceived as responsible Brown et al., (2023).

2.4.8 Ethical Dilemmas and Decision-Making: Situations involving complex medical decisions or ethical dilemmas can create tension between healthcare providers and patient relatives, potentially resulting in aggressive responses Jones et al., (2022).

2.4.9 Past Experiences with Healthcare: Negative past experiences with healthcare systems or providers can predispose relatives to mistrust and hostility, influencing their interactions with nurses in current settings Petersen et al., (2020).

2.4.10 Socioeconomic Factors: Economic hardship or social disadvantage may exacerbate stress and frustration, contributing to aggressive behaviour towards healthcare staff perceived as representing authority or privilege Nguyen et al., (2024).

2.5 Causes of Aggressive Behaviour Toward Nurses

2.5.1 Emotional Stress and Anxiety: This is widely documented in healthcare literature. For example, a study highlighted in the BMC Nursing journal emphasizes the stress experienced by patient families and its impact on behaviour towards nurses. Alshahrani & Baig, (2022)

2.5.2 Lack of Communication: Communication issues are a known cause of aggressive behaviour. A systematic review published in Critical Care explores how inadequate communication can lead to frustration and aggression from patient relatives. El-Gilany et al., (2020)

2.5.3 Perceived Neglect or Inadequate Care: Studies have shown that perceptions of neglect can lead to aggressive behaviour. For example, a meta-analysis in Critical Care discusses this issue in depth. Afaneh et al., (2021)

2.5.4 Cultural and Societal Factors: Cultural influences on behaviour towards healthcare workers have been documented. The same systematic review in Critical Care provides insights into how cultural differences can contribute to aggressive behaviour. El-Gilany et al., (2020)

2.5.5 Mental Health Issues: The connection between mental health and aggressive behaviour in healthcare settings is well-documented. A study from BMC Nursing discusses how underlying mental health issues can lead to aggression Alshahrani & Baig, (2022)

2.7 Prevention of aggressive behaviour

2.7.1 Training and Education

Occupational Safety and Health Act (OSHA) emphasizes the critical role of training in preventing workplace violence. This involves:

Recognizing Early Signs: Educating staff on identifying early warning signs of potential violence, such as verbal threats or aggressive body language.

De-escalation Techniques: Training healthcare workers in verbal de-escalation techniques, helping them to defuse tense situations before they escalate into violence.

Simulation Drills: Conducting regular drills and simulations to practice responses to aggressive incidents.

2.7.2 Improving Communication

Effective communication is crucial in managing patient and relative expectations:

Clear Information: Providing clear, concise, and regular updates to families about patient status and care plans to reduce anxiety and frustration.

Active Listening: Training staff to actively listen and empathetically respond to patient relatives' concerns.

Transparency: Maintaining transparency in communication to build trust and prevent misunderstandings that could lead to aggressive behaviour

2.7.3 Supportive Work Environment

A supportive organizational culture helps mitigate workplace violence:

Support Systems: Implementing support systems such as counseling and peer support groups for staff who experience violence.

Leadership Involvement: Encouraging leadership to actively promote a culture of safety and respect.

Reporting Mechanisms: Establishing clear and anonymous reporting mechanisms for incidents of violence, ensuring that staff feel safe to report without fear of retaliation.

2.7.4 Environmental Design

The physical environment can influence the likelihood of violence.

Safe Spaces: Designing healthcare facilities with safe spaces where staff can retreat if threatened.

Visibility and Surveillance: Improving visibility and surveillance in high-risk areas to deter violent behaviour.

Comfortable Environment: Creating a comfortable and calming environment for patients and their relatives, reducing stress and potential triggers for aggression.

2.7.5 Policy Implementation

Effective policies essential in preventing workplace violence include:

Clear Protocols: Developing clear protocols for managing and reporting incidents of workplace violence.

Consistent Enforcement: Ensuring that policies are consistently enforced and that there are consequences for aggressive behaviour.

Preventive Measures: Implementing preventive measures such as screening for high-risk individuals and providing adequate staffing to reduce stress and burnout among nurses.

2.7.6 Family Involvement

Involving families in patient care can help reduce aggression in the following ways:

Inclusive Care Plans: Developing care plans that include input from patient relatives to make them feel involved and informed.

Educational Resources: Providing educational resources to help families understand the patient's condition and treatment, reducing anxiety and misunderstandings.

Support Services: Offering support services such as family liaisons or counselors to assist families in coping with stress and emotional challenge

2.8 Theoretical Framework

2.8.1 Social Learning Theory

Social Learning Theory (SLT) was developed by Canadian-American psychologist Albert Bandura in the 1960s. It emerged as a response to the limitations of behaviorism, which focused primarily on learning through direct experience, reinforcement, and punishment.

Bandura proposed that much of human learning occurs in a social environment, and that people can learn new behaviors simply by observing others, without direct reinforcement.

2.8.2 Core Assumptions of Social Learning Theory

1. Learning is a cognitive process that takes place in a social context.
2. Learning can occur purely through observation or direct instruction, even without motor reproduction or direct reinforcement.
3. Mental states (like attention, retention, motivation, and expectations) are critical to learning.
4. People are not passive learners; they actively interpret and make decisions about what behaviours to imitate.

5. Reinforcement is not always necessary for learning to occur, but it can strengthen or discourage behaviour.

2.8.3 Key Concepts and Processes of Social Learning Theory

Social learning theory includes several essential components and mechanisms:

1. Observational Learning (Modeling)

This is the central concept. It means learning by watching others.

For example, a child watches their parent politely greet others and begins doing the same.

Bandura identified four subprocesses necessary for observational learning:

a. Attention

- The individual must notice the behaviour.
- Influenced by:
    - Characteristics of the model (attractiveness, status, similarity)
    - Characteristics of the observer (interest, cognitive ability)
    - Situation (novelty, importance)

b. Retention

- The observer must remember the behaviour.
- Involves encoding into memory through mental imagery, verbal rehearsal, or symbolic representation.

c. Reproduction

- The observer must have the ability (physical and mental) to replicate the behaviour.

- Also involves feedback and practice.

d. Motivation

- The observer must want to perform the behaviour.
- Influenced by:
    - Anticipated rewards or punishments
    - Observing others being rewarded (vicarious reinforcement)
    - Personal values and expectations

2. Vicarious Reinforcement and Punishment

- People do not have to be directly rewarded or punished to learn.
- They can learn by seeing others rewarded (or punished).
- This explains how children or adults may imitate behaviours they've never performed themselves.

Example: A student sees a peer praised for turning in homework early and becomes motivated to do the same.

3. Self-Efficacy

- A key later addition by Bandura.
- Defined as a person's belief in their ability to succeed in specific situations.
- Affects how people think, feel, and act:
    - High self-efficacy → persistence, resilience, willingness to take on challenges
    - Low self-efficacy → avoidance, fear of failure, giving up easily

Sources of self-efficacy:

- Mastery experiences (past success)
- Vicarious experiences (seeing others succeed)
- Verbal persuasion (encouragement)
- Emotional states (managing stress, anxiety)

4. Reciprocal Determinism

This refers to the dynamic and reciprocal interaction between:

- Behaviour (what the person does)
- Personal factors (thoughts, beliefs, emotions)
- Environmental factors (social influences, context)

Rather than behaviour being determined solely by the environment (as in behaviourism), Bandura emphasized mutual influence.

Example: A student who is confident (personal factor) participates more in class (behaviour), and receives praise from the teacher (environment), which further boosts confidence.

5. Identification with the Model

- People are more likely to imitate behaviour from models they identify with.
- Identification increases when the model is:
    - Similar in age, gender, or background
    - Respected or admired
    - Competent or successful

2.8.4 Major Contributions and Strengths of Social Learning Theory

- Bridges the gap between behaviourism and cognitive psychology.
- Explains complex behaviours that cannot be understood by trial and error (e.g., language, aggression, moral development).
- Introduced the idea of indirect learning (through media, peers, etc.).
- Emphasized the active role of the learner in choosing what to observe and imitate.
- Influenced educational strategies, media studies, health promotion, criminal behaviour studies, and therapy (e.g., CBT).

2.8.5 Criticisms and Limitations

- Underestimates biological and genetic influences on behaviour.
- Less emphasis on unconscious processes (unlike psychoanalysis).
- Some critics argue it's more descriptive than predictive.
- Moral or emotional factors may interfere with imitation (e.g., someone may observe theft but not replicate it due to conscience).

2.8.6 Application to Aggressive Behaviour of Patients' Relatives

According to Bandura's Social Learning Theory, aggressive behaviour is not only learned through personal experiences but also by observing others, especially in emotionally charged or stressful environments like hospitals.

Patient relatives who engage in aggression may have learned and reinforced these behaviours by watching others, experiencing similar stress in the past, or believing aggression is an effective way to get attention or results.

2.8.7 Key Constructs of Social Learning Theory Applied to Aggressive Behaviour

1. Observational Learning (Modelling)

Aggressive behaviour by patients' relatives often stems from observing similar behaviour in the healthcare setting. Relatives may observe other patients' families expressing aggression, shouting, threatening, or physically confronting staff and see that they get faster attention. These observations teach and reinforce the idea that aggression is an acceptable and effective behaviour in that environment.

Bandura's four subprocesses of observational learning apply as follows:

a. Attention

Aggression is often dramatic and emotionally charged, drawing attention from onlookers. In a healthcare setting, relatives focus on aggressive individuals when:

- The situation is tense (e.g., emergency care, delays in service),
- The model (other relatives or patients) is loud, dramatic, or emotionally expressive,
- The aggression leads to visible results (like the nurse responding quickly or management intervening).

b. Retention

The observed aggression is encoded into memory i.e. observers remember how others confronted healthcare workers and the outcomes that followed:

- "When that man shouted, the nurse came immediately."

- “When they threatened the doctor, they got answers.”

This memory forms a mental script for future response in similar situations.

c. Reproduction

Once similar stressors occur, like perceived neglect, waiting time, or poor communication, relatives may imitate the behavior they previously observed. If they believe they are capable and justified i.e., if they think “the hospital is ignoring us” or “this is the only way to be heard” they are more likely to act aggressively by:

- Yelling at nurses,
- Threatening to escalate to media or hospital management,
- Physically intimidating healthcare workers.

d. Motivation

Motivation to act aggressively is influenced by:

- Direct reinforcement: when the aggressive relative receives immediate attention or service.
- Vicarious reinforcement: Seeing others succeed through aggression.
- Past personal experiences: “I had to shout last time to get help.”
- Social and cultural norms: If aggression is normalized in society or in the family.
- Frustration and emotional stress: High-stress environments reduce self-control and increase impulsive behaviour.

2. **Vicarious Reinforcement and Punishment**

Relatives don't need to experience rewards or punishments themselves. They learn from others' outcomes through:

Vicarious Reinforcement**:** A relative observes another being aggressive and receiving immediate attention or better service. This perceived "reward" increases the likelihood that the observer will copy the behaviour when agitated.

Vicarious Punishment (or lack thereof): If aggressive individuals face no consequences, observers infer that the behaviour is permissible or effective. The absence of visible sanctions contributes to normative acceptance of aggression in that setting.

3. **Self-Efficacy**

Self-efficacy determines whether a person feels capable of carrying out aggressive behaviour. When individuals believe they are capable of confronting nurses and managing the outcomes, they are more confident in executing aggressive behaviour.

- **High Self-Efficacy:** The relative may think, "I know how to pressure them, I've done this before." These individuals are more likely to act out under stress.
- **Low Self-Efficacy:** A relative may **desire** to be aggressive but feels too nervous, powerless, or inhibited to do so. This may build up frustration or eventually explode in a delayed outburst.

Sources of Self-Efficacy include:

- Mastery experiences: Having used aggression in a past hospital setting and seeing results.
- Vicarious experiences: Seeing others succeed through aggression.
- Verbal persuasion: Other relatives encouraging, "You have to be tough with them."

- Emotional states: Heightened emotions (stress, grief) may distort self-perception and increase perceived justification for aggression.

4**. Reciprocal Determinism**

The hospital environment itself may contribute to aggressive behaviour:

- Understaffed or overworked nurses may delay care unintentionally.
- This delay leads to frustration in relatives.
- A frustrated relative behaves aggressively.
- Nurses become fearful or withdrawn, creating more delays or poor communication.
- This reinforces the belief that aggression is necessary.

Thus, there is a continuous feedback loop among:

- The relative's behaviour
- Their personal emotions and beliefs
- The hospital's response and setting

5. Identification with the Model

People are more likely to imitate those they identify with. A relative may copy aggression modelled by someone of:

- Similar age, gender, or social background
- Someone they admire for being assertive or "not taking nonsense"
- Someone who successfully navigated the healthcare system using aggression

Identification increases the perceived legitimacy and effectiveness of the aggressive response.

2.9 Empirical Review

2.9.1 The Prevalence of Aggressive Behaviour Exhibited by Patient Relatives Towards Nurses

Zhang et al. (2021), in their study titled "Workplace Violence in Nursing: A Global Meta-Analysis," conducted a comprehensive meta-analysis of 42 international studies to determine the prevalence of aggressive behaviour toward nurses. The study revealed that verbal abuse from patient relatives was the most frequently reported form of aggression, with an overall global prevalence exceeding 60%. Similarly, Omotayo et al. (2023) carried out a cross-sectional descriptive study titled "Incidence and Impact of Violence on Nurses in Southwest Nigeria," using questionnaires distributed to 210 nurses across three tertiary hospitals. They found that 62% of the nurses had experienced aggression from patient relatives, particularly in emergency and obstetric units. In another Nigerian-based review, Adeloye et al. (2022), in their systematic study "Healthcare Workplace Violence in Nigeria," reviewed literature published between 2010 and 2020 and found that over 70% of violent incidents reported involved patient relatives as the primary aggressors. Ahmed et al. (2020), in a qualitative study titled "Aggressive Encounters in Tertiary Hospitals: Nurses' Experiences and Management," interviewed 30 nurses in a tertiary facility in Cairo and discovered that many nurses perceived aggression from relatives as a normal routine part of their work and often did not report such incidents.

2.9.2 Common Types of Aggressive Behaviour Exhibited by Patient Relatives Towards Nurses

Ahmed et al. (2020) also documented in their observational study that verbal abuse including threats and shouting, accounted for 73% of aggressive encounters. This is corroborated by Smith and Taylor (2024), whose research titled "Nurses' Encounters with Verbal and Physical

Abuse in Emergency Departments" used a cross-sectional survey of 185 emergency nurses in the UK and found that 85% had experienced verbal assaults. Alshehri et al. (2023), in their study "Patterns of Aggression from Patient Relatives in Saudi Public Hospitals," used surveys across five hospitals and reported that verbal threats (76%) and threatening body language (55%) were the most frequent forms of aggression. Similarly, Alquwez (2020), in his correlational study "Workplace Violence Against Nurses and Patient Care Outcomes," noted a strong association between verbal abuse by patient relatives and reduced nurse performance and safety outcomes.

2.9.3 Perceived Causes of Aggressive Behaviour by Patient Relatives Towards Nurses

Alfuqaha and Alsharah (2021), in their mixed-method study titled "Understanding the Root Causes of Violence in Healthcare," gathered data from 120 healthcare workers and found that delays in care, communication breakdowns, and procedural misunderstandings were major triggers. Johnson and Brown (2021), in their study "Socioeconomic Predictors of Hospital Aggression in Nigeria," utilized regression analysis from surveys of 250 patients and relatives, discovering that emotional distress and financial difficulties significantly predicted hostile behaviour. Wang et al. (2022), through observational research in three Chinese ICU units titled "Emotional Triggers of Aggressive Behaviour in Critical Care Units," found that emotional overload and grief contributed to confrontational conduct by patient relatives. Furthermore, Betacourt (2021), in a qualitative ethnographic study titled "The Role of Culture and Communication in Hospital Violence," identified that cultural misunderstanding and language differences often escalated tensions between nurses and relatives.

2.9.4 Ways to Reduce Aggressive Behaviour Towards Nurses

Hashim et al. (2023), in their intervention study "Mitigating Healthcare Violence Through Staff Training," evaluated the impact of conflict resolution training on 100 nurses and found

that aggressive incidents dropped by 34% post-training. Andersson et al. (2020), in their policy evaluation study "Organizational Strategies to Prevent Nurse Abuse," examined Scandinavian hospitals and found that those with structured communication policies and adequate staffing levels recorded fewer incidents of aggression. Pilgrim et al. (2020), in a correlational study titled "Communication Quality and Its Impact on Nurse-Relative Conflicts," demonstrated that regular and clear updates to patient families significantly reduced the frequency of aggressive outbursts. Lastly, Jones et al. (2022), in a comparative study titled "Culturally Competent Care: A Tool for Conflict Reduction," showed that culturally sensitive training led to a 40% decrease in conflicts with patient relatives in multicultural healthcare environments.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter outlines the research methodology used in data collection for the investigation of aggressive behaviour of patients' relatives towards nurses at Kwara State University Teaching Hospital Ilorin, Kwara State under the following subheadings: research design, setting, target population, sampling, sampling technique, instruments for data collection, validity of instrument, reliability of instrument, method of data collection, method of data analysis and ethical considerations.

3.1 Research design

This research is a descriptive type and the approach for this study is a quantitative method using primary data. It is structured to obtain information from patient relatives in Accident and Emergency unit, Male surgical ward and Maternity ward at KWASUTH Ilorin, to investigate the causes of aggressive behaviour of patient relatives toward nurses in these wards.

3.2 Setting

The study was conducted at Kwara State University Teaching Hospital Ilorin, Kwara state. The hospital is a tertiary healthcare facility located at Taiwo Oke, opposite Queens College, Ilorin West Local Government Area, kwara state. It was established in 1957, during the colonial era in Nigeria. At that time, it was known as Ilorin Provincial Hospital. After Nigeria gained independence in 1960, the hospital was leased to the federal government. It was used temporarily by the University of Ilorin for their medical students and other health care professional courses up until 2010 where it served as a tertiary facility. When the permanent site of the University of Ilorin Teaching Hospital was completed, the hospital was returned to the state government. Extensive renovation took place between the year 2011 and 2012, after

the renovation, the hospital was renamed General Hospital Ilorin and was used as a secondary healthcare facility.

In June 2024, it was upgraded to a tertiary health care facility and renamed as Kwara State University Teaching Hospital. This upgrade has made it a major referral centre in Kwara State, providing services to patients across and outside the state.

It has various departments and units including General Outpatient Department, Accident and Emergency units, Medical and Surgical wards for both adult and children, Maternity, Laboratory, Pharmacy, Theatre, Clinics etc. With all cadres of health practitioners including Nurses, Doctors and other health care professionals.

3.3 Target population

The target population for this study include a total number of 180 patients' relatives from accident and emergency unit, male surgical ward and maternity at KWASUTH Ilorin, Kwara State.

3.4 Sampling

The sample size is determined using a statistical formular. Considering the total number of patients' relatives in the departments used at KWASUTH Ilorin and the desired confidence level, the sample size is calculated to ensure sufficient statistical power for the study.

Using a target population of 180 patients' relatives, the sample size will be calculated using Taro Yamane statistical formular:

$n= N/1+N(E^2)$

where n= sample size

N= Target population

E= margin of error required (e.g. 0.05 or 5%)

Calculating the sample size:

$n = 180/1+180(0.05)^2$

n= 124.13

Rounding up to the nearest whole number:

n = 124

Attrition Rate

Attrition rate = N/1 - 10% Attrition rate

124/ 1-0.10 = 124/ 0.9 = 137.8 approximately 138

3.5 Sampling technique

A Convenience sampling technique was used to select a sample of patients' relatives from the target population. The sample size consists of 138 patients' relatives from three wards at Kwara State University Teaching Hospital Ilorin, Kwara State.

3.6 Instrument for data collection

The tool used for data collection consists of a self-structured questionnaire which is composed of five sections:

- Section A: Demographic information
- Section B: prevalence of aggressive behaviour exhibited by patient relatives towards nurses
- Section C: most common types of aggressive behaviour exhibited by patient relatives towards nurses
- Section D: perceived causes of aggressive behaviour by patient relatives towards nurses

- Section E: the various ways by which aggressive behaviour can be reduced towards nurses

The questionnaire was constructed in the formal language (English Language) for easy administration to the respondents.

Inclusion Criteria:

- Relatives from 18 years and above
- Relatives who were available at the time of the study
- Relatives who were willing to participate

Exclusion Criteria:

- Relatives below 18 years of age
- Relatives who declined consent

3.7 Validity of instrument

To ensure the validity of the research instrument, a structured questionnaire was developed based on the study objectives and existing literature related to aggressive behaviour towards nurses. The questionnaire was subjected to expert review to establish its face and content validity.

For face validity, the initial draft of the questionnaire was reviewed by the project supervisor who reviewed the instrument for clarity, relevance, and appropriateness of the items. Content validity was assessed using the Item-Level Content Validity Index (I-CVI). To determine the I-CVI, the questionnaire items were evaluated for relevance by three experts: two specialists in the field and the project supervisor. Each item was rated as relevant, resulting in an I-CVI score of 1.00. This score indicates perfect agreement among the validators and confirms that the instrument possesses a high level of content validity.

3.8 Reliability of instrument

To ascertain the reliability of the instrument, the test-retest method was employed prior to its final administration to the study population. A pilot study was conducted by administering 10% (n = 14) of the total questionnaires to nurses at the University of Ilorin Teaching Hospital. The responses were analyzed using Cronbach's Alpha reliability coefficient and the values obtained were:

Sections	**Cronbach's Alpha**
Prevalence of Aggressive Behaviour (Section B)	0.82
Most common types of Aggressive Behaviour (Section C)	0.85
Perceived causes of Aggressive Behaviour (Section D)	0.80
Ways in which aggressive behaviour can be reduced (Section E)	0.81

The analysis indicated a high level of internal consistency, confirming that the instrument is reliable for the intended study.

3.9 Method of data collection

An introductory letter was collected from Thomas Adewumi University, Faculty of Nursing Sciences which was given to the Chief Medical Director of the hospital who subsequently directed the letter to the Research committee. After then, the letter was directed to the HOD Nursing who then directed the researcher to the CNO in charge of each unit. Copies of the questionnaire were administered to the respondents after introducing the researcher to the selected subjects. Information on the questionnaire and the importance of their consent was sought for before the administration of the questionnaire, they were told not to write their names and they were assured that all given information shall be kept confidential.

The questionnaires were administered to the subjects on individual basis and retrieved by the researcher immediately after they were filled.

3.10 Method of data analysis

The data collected was analyzed using descriptive statistics for research questions in form of simple frequency distribution tables. Inferential statistics such as chi-square test was also used for research hypotheses.

3.11 Ethical consideration

Ethical approval was sought from the hospital's ethical review committee, Institutional access was obtained via an introductory letter from Thomas Adewumi University to the Chief Medical Director of Kwara State University Teaching Hospital, Ilorin.

Informed consent was obtained from all participants after explaining the study's purpose and confidentiality was maintained as the participants used for the research were instructed not to write their names to prevent identification. They were also assured that whatever information given will be treated private, hence, they were advised to answer the questions sincerely after an informed consent had been obtained.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter reports the results from the analysis of the data obtained from the respondents. These data were used to answer the research questions and also the hypotheses of the research.

4.2 Socio-demographic Data

This section addresses the demographics of the respondents. Moderating variables for the demographics are age, gender, level of education, relationship to patient, religion and marital status.

Table 4.1: Socio-demographic Data of Respondents

Variable	Category	Frequency (F)	Percentage (%)
Age	18–30	3	2.2%
	31–40	74	53.6%
	41–50	48	34.8%
	Above 50	13	9.4%
	Total	**138**	**100.0%**
Gender	Male	49	35.5%
	Female	89	64.5%
	Total	**138**	**100.0%**
Level of Education	No formal education	8	5.8%
	Primary education	17	12.3%
	Secondary education	52	37.7%
	Tertiary education	61	44.2%
	Total	**138**	**100.0%**
Relationship to Patient	Parent	29	21.0%
	Sibling	34	24.6%
	Child	17	12.3%
	Spouse	58	42.1%
	Total	**138**	**100.0%**
Religion	Christianity	66	47.8%
	Islam	68	49.3%
	Others	4	2.9%
	Total	**138**	**100.0%**
Marital Status	Single	34	24.6%
	Married	82	59.4%
	Divorced	14	10.1%
	Widowed	8	5.8%
	Total	**138**	**100.0%**

Table 4.1 reports the demographic characteristics of patient relatives in KWASUTH. Among the 138 respondents, the majority (53.6%) were between 31 to 40, followed by 34.8% who were between 41–50years, while those aged 18–30 and above 50 years constituted 2.2%, and 9.4% respectively. In terms of gender distribution, 64.5% were female and 35.5% were male. Regarding their educational background, 44.2% had attained tertiary education, 37.7% had secondary education, 12.3% had only primary education, while 5.8% had no formal education. The participants' relationship to the patient revealed that 42.1% were spouses, 24.6% were siblings, 21.0% were parents, and 12.3% were children. Concerning religion, 49.3% identified as Muslims, 47.8% as Christians, and 2.9% adhered to other religions. Marital status analysis showed that 59.4% of the respondents were married, 24.6% were single, 10.1% were divorced, and 5.8% were widowed.

4.3 Research Questions

Four research questions were formulated for this research and answered in this section.

Research Question One: *What is the prevalence of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH, Ilorin, Kwara State?*

Table 4.2: Frequency and Percentage report on the Prevalence of Aggressive Behaviours towards Nurses

Statements	SA	A	D	SD
I have been aggressive towards a nurse while on duty.	35 (25.4%)	41 (29.7%)	36 (26.1%)	26 (18.8%)
I have witnessed other patient relatives act aggressively in the hospital.	42 (30.4%)	38 (27.5%)	34 (24.6%)	24 (17.4%)
I have verbally confronted a nurse over patient care.	40 (29.0%)	44 (31.9%)	30 (21.7%)	24 (17.4%)
I have seen physical confrontation between relatives and nurses.	28 (20.3%)	33 (23.9%)	45 (32.6%)	32 (23.2%)
I have shown frustration to nurses more than once per week.	38 (27.5%)	35 (25.4%)	37 (26.8%)	28 (20.3%)
Aggressive behaviour from patient relatives is more common now than before.	41 (29.7%)	36 (26.1%)	31 (22.5%)	30 (21.7%)
I have raised my voice at nurses due to stress or delays.	34 (24.6%)	39 (28.3%)	40 (29.0%)	25 (18.1%)
Hospital staff rarely resolve complaints raised through aggression.	33 (23.9%)	30 (21.7%)	39 (28.3%)	36 (26.1%)

Table 4.2 reports the prevalence of aggressive behaviour among patient relatives towards nurses. The findings reveal that a significant number of respondents reported exhibiting aggressive behavior towards nurses. Approximately 25.4% of respondents strongly agreed and 29.7% agreed that they had been aggressive to a nurse while on duty. Similarly, 30.4% strongly agreed and 27.5% agreed to have witnessed other patient relatives acting aggressively in the hospital. Regarding verbal confrontation, 29.0% strongly agreed and 31.9% agreed to having verbally confronted a nurse over patient care. Physical confrontations were also observed, with 20.3% strongly agreeing and 23.9% agreeing that they had witnessed such incidents. About 27.5% strongly agreed and 25.4% agreed that they showed frustration to nurses more than once weekly. When asked about the frequency of aggression, 29.7% strongly agreed and 26.1%

agreed that such behaviours are more common now than in the past. Additionally, 24.6% strongly agreed and 28.3% agreed that they had raised their voice at nurses due to stress or delays. Lastly, 23.9% strongly agreed and 21.7% agreed that hospital staff rarely resolve complaints raised through aggression. This indicates that the prevalence of aggressive behaviours of patient's relative towards nurses at KWASUTH in high.

Research Question Two: *What are the most common types of aggressive behaviour exhibited by patient relatives towards nurses at KWASUTH, Ilorin, Kwara State?*

Table 4.3: Reports Common Types of Aggressive Behaviours towards Nurses

Statements	**SA**	**A**	**D**	**SD**
Verbal abuse is the most common way I express dissatisfaction.	47 (34.1%)	42 (30.4%)	28 (20.3%)	21 (15.2%)
I have threatened nurses due to disagreements.	44 (31.9%)	39 (28.3%)	29 (21.0%)	26 (18.8%)
I have shouted at nurses when I felt ignored.	38 (27.5%)	46 (33.3%)	31 (22.5%)	23 (16.7%)
Physical aggression is sometimes necessary to get attention.	24 (17.4%)	33 (23.9%)	41 (29.7%)	40 (29.0%)
I have used body language to intimidate nurses.	36 (26.1%)	38 (27.5%)	35 (25.4%)	29 (21.0%)
I have seen relatives damage hospital property during disputes.	31 (22.5%)	30 (21.7%)	43 (31.2%)	34 (24.6%)
I know someone who made false accusations against a nurse.	29 (21.0%)	34 (24.6%)	38 (27.5%)	37 (26.8%)
I have seen relatives use threats to influence treatment decisions.	40 (29.0%)	36 (26.1%)	32 (23.2%)	30 (21.7%)

Figure 4.3: Reports Common Types of Aggressive Behaviours towards Nurses

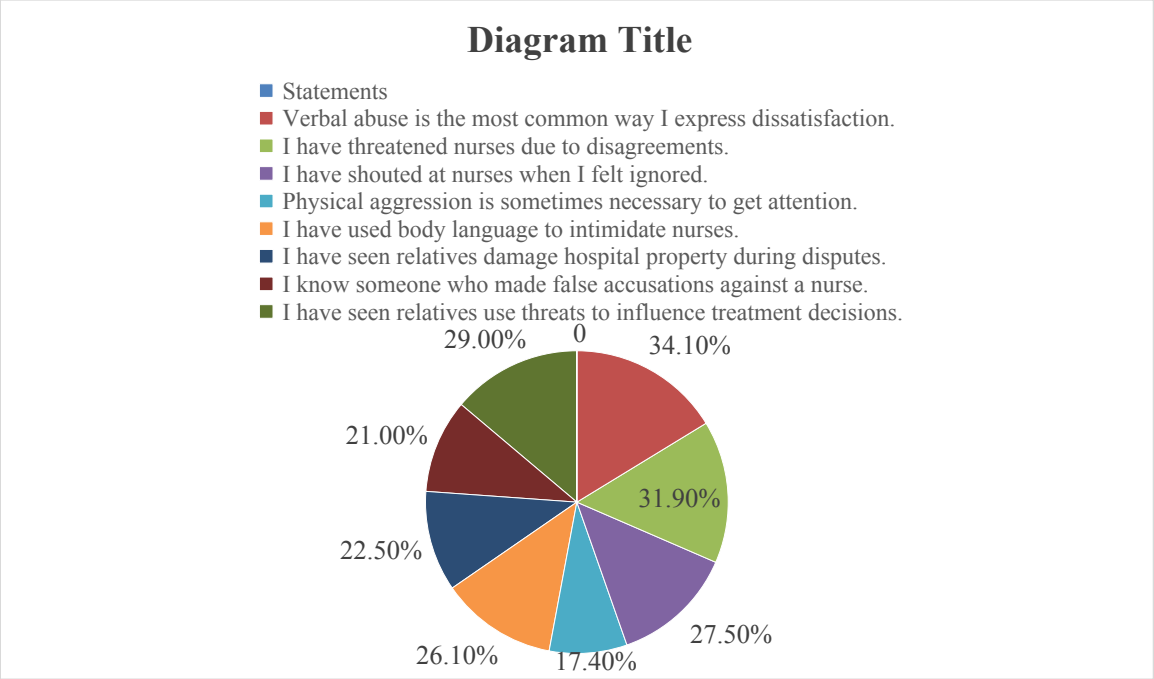

Table 4.3 reports the common types of aggression patient relatives have shown towards nurses. Concerning common types of aggressive behaviour, verbal abuse emerged as the most prevalent, with 34.1% of respondents strongly agreeing and 30.4% agreeing that it was their primary means of expressing dissatisfaction. Threats to nurses were admitted by 31.9% (strongly agree) and 28.3% (agree), while 27.5% strongly agreed and 33.3% agreed to shouting at nurses when feeling ignored. A smaller proportion (17.4% strongly agreed and 23.9% agreed) considered physical aggression sometimes necessary to get attention. Using intimidating body language was affirmed by 26.1% (strongly agree) and 27.5% (agree). Damage to hospital property was observed by 22.5% (strongly agree) and 21.7% (agree). Regarding false accusations against nurses, 21.0% strongly agreed and 24.6% agreed that they knew someone who had done this. Lastly, 29.0% strongly agreed and 26.1% agreed that they had seen relatives use threats to influence treatment decisions.

Research Question Three: *What are the perceived causes of aggressive behaviour by patient relatives towards nurses at KWASUTH, Ilorin, Kwara State?*

Table 4.4: Perceived Causes of Aggression towards Nurses

Statements	SA	A	D	SD
Delay in care makes me feel compelled to act aggressively.	49 (35.5%)	44 (31.9%)	27 (19.6%)	18 (13.0%)
Poor communication from nurses can provoke my anger.	41 (29.7%)	38 (27.5%)	30 (21.7%)	29 (21.0%)
I get frustrated when I don't understand medical procedures.	36 (26.1%)	45 (32.6%)	31 (22.5%)	26 (18.8%)
Overcrowding and long wait times increase my agitation.	34 (24.6%)	40 (29.0%)	39 (28.3%)	25 (18.1%)
The shortage of nurses makes me more impatient.	28 (20.3%)	37 (26.8%)	42 (30.4%)	31 (22.5%)
Cultural expectations shape how I react to health delays.	33 (23.9%)	35 (25.4%)	38 (27.5%)	32 (23.2%)
Emotional stress from my relative's illness fuels my reactions.	39 (28.3%)	43 (31.2%)	27 (19.6%)	29 (21.0%)
Financial burdens increase my tendency to lash out.	32 (23.2%)	30 (21.7%)	44 (31.9%)	32 (23.2%)

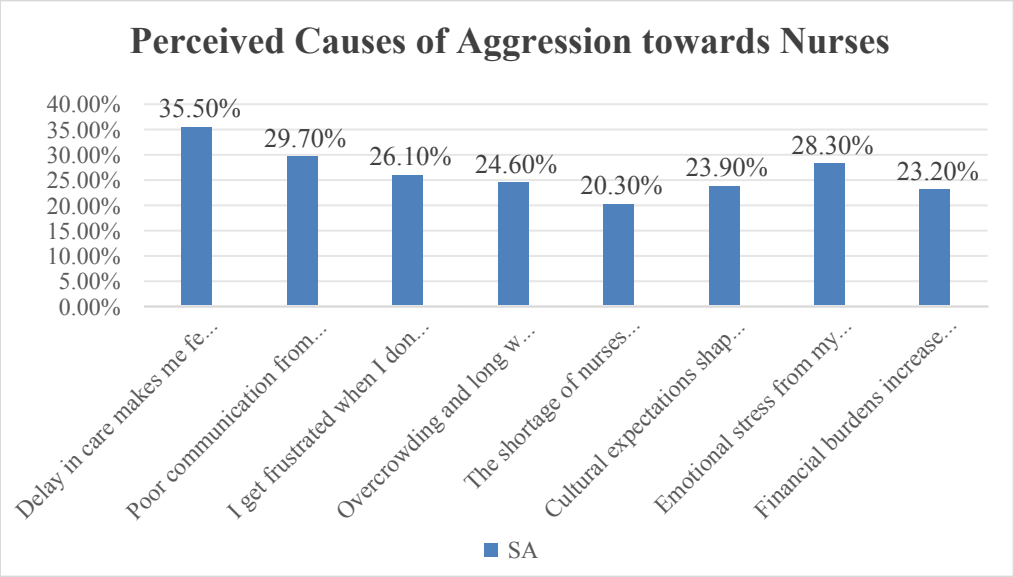

Table 4.4 reports the perceived caused of aggression by patient relatives towards nurses at KWASUTH. The data shows that delays in care were identified as a major cause of aggression, with 35.5% strongly agreeing and 31.9% agreeing. Poor communication by nurses was another major factor, as 29.7% strongly agreed and 27.5% agreed it could provoke anger. Additionally, 26.1% strongly agreed and 32.6% agreed that lack of understanding of medical procedures led to frustration. Overcrowding and long wait times also contributed, as stated by 24.6% (strongly

agree) and 29.0% (agree). The shortage of nurses made 20.3% strongly agree and 26.8% agree that it increased their impatience. Cultural expectations were also influential, with 23.9% strongly agreeing and 25.4% agreeing. Emotional stress from a loved one's illness was acknowledged by 28.3% strongly agreeing and 31.2% agreeing, while financial burdens were a contributing factor for 23.2% (strongly agree) and 21.7% (agree).

Research Question Four: *What are the various ways by which aggressive behaviour towards nurses can be reduced at KWASUTH, Ilorin, Kwara State?*

Table 4.5: Various Ways to Reduce Aggressive Behaviour

Statements	SA	A	D	SD
If nurses explained things better, I would be less aggressive.	52 (37.7%)	41 (29.7%)	27(19.6 %)	18 (13.0%)
Nurses should be trained in handling conflicts with us.	44 (31.9%)	39 (28.3%)	30 (21.7%)	25 (18.1%)
More nurses would mean fewer frustrations for us.	40 (29.0%)	36 (26.1%)	34 (24.6%)	28 (20.3%)
I support strict rules against aggression in hospitals.	36 (26.1%)	33 (23.9%)	39 (28.3%)	30 (21.7%)
Presence of security in wards can reduce aggressive outbursts.	30 (21.7%)	34 (24.6%)	41 (29.7%)	33 (23.9%)
Teaching us hospital procedures can reduce misunderstandings.	29 (21.0%)	38 (27.5%)	40 (29.0%)	31 (22.5%)
Attending to complaints quickly can stop situations from escalating.	35 (25.4%)	37 (26.8%)	36 (26.1%)	30 (21.7%)
Nurses should have emotional support after experiencing aggression.	42 (30.4%)	40 (29.0%)	28 (20.3%)	28 (20.3%)

Table 4.5 reports the various ways to reduce aggressive behaviours among patient relatives towards nurses. Participants highlighted several strategies to reduce aggression towards nurses. The majority (37.7% strongly agree and 29.7% agree) believed that better explanations from nurses would reduce aggression. Training nurses on conflict resolution was supported by 31.9% (strongly agree) and 28.3% (agree). Increasing the number of nurses was seen as helpful by 29.0% (strongly agree) and 26.1% (agree). A large portion (26.1% strongly agree and 23.9% agree) endorsed stricter rules against aggression. The presence of security personnel in wards

was favored by 21.7% (strongly agree) and 24.6% (agree). Teaching relatives about hospital procedures was supported by 21.0% (strongly agree) and 27.5% (agree). Timely responses to complaints were viewed as effective by 25.4% (strongly agree) and 26.8% (agree). Lastly, 30.4% strongly agreed and 29.0% agreed that nurses should receive emotional support after aggressive incidents.

4.4 Research Hypotheses

Two hypotheses were formulated for this research and this section addresses the result.

Hypothesis One: *There is no significant relationship between the perceived cause of aggressive behaviours of patient relative and their level of education*

Table 4.6: Chi-square Report on the relationship between Perceived Caused of Aggression and Level of Education

Variables	**Number**	**Df**	**X^2 calc.**	**X^2 tabulated**	**P-value**	**Decision**
Level of Educcation						
	138	9	5.89	16.92	0.75	**Not Rejected**
Perceived Cause						

Table 4.6 reports the calculated chi-square value for the perceived causes of aggressive behaviour and the respondents' level of education to be 5.89, with 9 degrees of freedom. The p-value is 0.75. Given that the p-value (0.75) is greater than the standard significance level of 0.05, we do not reject the null hypothesis. This indicates that there is no statistically significant relationship between the perceived causes of aggressive behaviour and the level of education of respondents. This suggests that respondents across different educational levels perceive the causes of aggressive behaviour in a similar way.

Hypothesis Two: There is no significant relationship between the perceived cause of aggressive behaviour of patient relative and their age

Table 4.7: Chi-square Report on the relationship between Perceived Caused of Aggression and Age

Variables	Number	Df	X^2 calc.	X^2 tabulated	P-value	Decision
Age	138	12	10.78	21.03	0.63	**Not Rejected**
Perceived Cause						

Table 4.7 reports the calculated chi-square value for the perceived causes of aggressive behaviour and the age of respondents to be 10.78, with 12 degrees of freedom. The p-value is 0.63. Given that the p-value (0.63) is greater than the standard significance level of 0.05, we do not reject the null hypothesis. This indicates that there is no statistically significant relationship between the perceived causes of aggressive behaviour and the age of respondents. This suggests that respondents across different age groups perceive the causes of aggressive behaviour in a similar manner.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

The investigation into the causes of aggressive behaviour of patients' relatives towards nurses at Kwara State University Teaching Hospital (KWASUTH) provided insightful revelations about the nature of such behaviours, their underlying causes, and potential mitigation strategies.

5.1 Discussion of Findings

Demographic Characteristics

The demographic characteristics of patient relatives at KWASUTH, as presented in Table 4.1, reveal a middle-age respondent base, with (53.6%) respondents between the ages of 31–40, and (34.8%) between the ages of 41-50 suggesting that middle-aged individuals are often present as patient caregivers. A higher proportion of female relatives (64.5%) participated, which may reflect societal roles where women often take on caregiving responsibilities. The educational profile indicates a relatively literate group, with the majority having tertiary (44.2%) or secondary (37.7%) education. The close proportions of parents (28.3%), spouses (27.5%), and siblings (24.6%) as primary patient supporters indicate a family-centric care culture. Religiously, the population was evenly split between Muslims (49.3%) and Christians (47.8%), reflecting the general religious composition in Kwara State. Most respondents (59.4%) were married, aligning with the age demographics and likely indicating the presence of mature, responsible family members at the hospital.

Prevalence of Aggressive Behaviour

Table 4.2 details the prevalence of aggressive behaviours, indicating a high level of aggression towards nurses. Many respondents admitted to direct or witnessed aggressive behaviour, with over 55% reporting they had acted aggressively towards nurses or observed such acts from others. Verbal confrontations and raised voices were particularly common, often linked to stress or dissatisfaction with care delivery. These findings underscore a growing tension in

nurse-relative relationships, with rising incidents of confrontation over time. This trend reflects not only patient relatives' frustration but also potentially systemic inefficiencies within the hospital setting that contribute to a hostile care environment.

Types of Aggression

The types of aggression reported in Table 4.3 suggest that verbal abuse and threats are the most frequent forms of hostility directed at nurses. These non-physical yet damaging behaviors such as shouting, using intimidating body language, and even making false accusations, create a psychologically unsafe workplace. While physical aggression was less frequently acknowledged, its presence highlights the potential risk nurses face. The use of threats to influence care decisions further complicates the nurse's role and may compromise patient care standards. This pattern of behaviour signals a deeper cultural or systemic issue that needs urgent addressing through institutional and policy interventions.

Perceived Causes of Aggression

As indicated in Table 4.4, perceived causes of aggression largely stem from operational inefficiencies such as delays in care, overcrowding, and poor communication. The emotional toll of having a loved one in distress, combined with cultural expectations and financial burdens, further heightens tensions. This multi-faceted set of triggers reveals that aggression is often a manifestation of unmet needs and poor hospital-patient-relative interaction. Such findings call for a review of care delivery systems, staff communication protocols, and waiting time management to alleviate the stressors that fuel aggressive incidents.

Strategies to Reduce Aggression

The strategies suggested to reduce aggression in Table 4.5 focus primarily on improving communication and hospital responsiveness. A significant number of respondents believe that clear explanations from nurses and timely complaint handling would reduce frustration. Other solutions include nurse training in conflict resolution, increasing staff numbers, enforcing rules

against aggression, and providing psychological support for affected staff. These proposed interventions highlight the importance of both systemic reforms and interpersonal communication improvements to restore trust and civility in the care environment.

Hypothesis One

Table 4.6 shows no statistically significant relationship between perceived causes of aggression and the educational levels of respondents ($\chi^2 = 5.89$, df = 9, p = 0.75). This suggests that the tendency to attribute aggression to systemic or communication failures is consistent across all educational backgrounds. Whether a respondent had no formal education or tertiary-level qualifications, their perception of the causes of aggression remained largely similar, indicating that education level does not influence how hospital-related frustrations are interpreted or expressed.

Hypothesis Two

Similarly, Table 4.7 reveals no statistically significant relationship between age and the perceived causes of aggression ($\chi^2 = 10.78$, df = 12, p = 0.63). This suggests a shared perception of causative factors of aggression across different age groups. Whether the respondent was young or elderly, the understanding of what provokes aggressive responses toward nurses remained consistent. This finding may imply that hospital experiences are universally frustrating, transcending generational differences, and further supports the need for comprehensive institutional reforms in patient-relative management strategies.

5.2 Key Findings

The following are the major findings of the study above:

1. Age Distribution:

- The majority of respondents (53.6%) were between 31 - 40 years.

2. Gender:

- A higher proportion of respondents were female (64.5%) compared to male (35.5%).

3. Educational Background:

- 44.2% had tertiary education, 37.7% had secondary education, 12.3% had primary education, and 5.8% had no formal education.

4. Relationship to Patient:

- Majority (42.1%) of respondents of spouses of the patient

5. Religious Affiliation:

- Respondents were predominantly Muslims (49.3%) and Christians (47.8%), with a small portion adhering to other religions (2.9%).

6. Marital Status:

- The majority were married (59.4%), with others being single (24.6%), divorced (10.1%), and widowed (5.8%).

7. Prevalence of Aggressive Behaviour:

- A significant number admitted to aggressive acts towards nurses, including verbal confrontation (60.9%), physical incidents, and frequent expressions of frustration.

8. Common Types of Aggression:

- Verbal abuse was the most prevalent, followed by threats, shouting, intimidating body language, and physical aggression.

9. Perceived Causes of Aggression:

- Major causes included delays in care, poor communication, misunderstanding of medical procedures, emotional stress, and financial burden.

10. Strategies to Reduce Aggression:

- Suggested interventions included better communication from nurses, training on conflict resolution, increasing staffing, strict policies, and emotional support for nurses.

11. Chi-Square Analysis – Level of Education vs. Perceived Cause:

- No statistically significant relationship was found ($\chi^2 = 5.89$, $df = 9$, $p = 0.75$).

12. Chi-Square Analysis – Age vs. Perceived Cause:

- No statistically significant relationship was found ($\chi^2 = 10.78$, df = 12, p = 0.63).5.2

Aligning findings with findings of previous studies cited

The findings of the study indicate that aggressive behaviour from patient relatives towards nurses is a prevalent issue in hospital settings. Many respondents acknowledged involvement in verbal abuse, threats, yelling, and even physical aggression, corroborating studies such as that by Zhang et al. (2021), which revealed high exposure of nurses to workplace violence, particularly in tertiary healthcare settings. Verbal aggression emerged as the most common form, with a majority of respondents admitting to raising voices or issuing threats during disagreements with nursing staff. This supports the findings of Alquwez (2020), who reported that verbal abuse is the most frequently experienced form of aggression among nurses in public hospitals.

Physical violence and non-verbal forms of aggression, such as hostile gestures or intimidating posture, were also reported, though less commonly. These findings align with those of Liu et al. (2020), who emphasized that while physical assaults occur less frequently, they are still a significant concern in nurse-patient relative interactions. The reasons cited for these aggressive behaviours included delays in care, poor communication, lack of understanding of medical procedures, hospital overcrowding, and a shortage of healthcare staff. This aligns with the findings of Alfuqaha and Alsharah (2021), who identified similar triggers in their study on the causes of violence against healthcare workers in Middle Eastern hospitals.

Emotional stress and financial burdens were also recognized as major contributors to aggressive behaviour. As supported by Wang et al. (2022), high emotional involvement and financial strain among patient relatives significantly increase the risk of aggression towards hospital staff. Cultural expectations and beliefs were found to influence how relatives perceive delays or treatment plans, confirming the research of Alshehri et al. (2023), who highlighted

that sociocultural norms can shape how patient relatives engage with hospital staff, particularly in terms of entitlement and perceived fairness.

Demographic data revealed that a larger proportion of respondents were female and aged between 18–30 years. While gender and age were not found to be statistically significant in influencing perceptions of aggression, this demographic trend is in line with recent studies by Ayhan et al. (2020), which found that younger relatives, particularly female caregivers, are more likely to express dissatisfaction openly due to emotional proximity and concern for the patient.

Another key finding is that respondents perceived an increase in aggressive incidents over recent years. This perception is substantiated by Khoshknab et al. (2021), who reported a steady rise in healthcare-related violence due to increased stressors on health systems and reduced tolerance for delays or poor communication. Furthermore, participants expressed dissatisfaction with hospital management's response to aggression, stating that incidents were rarely addressed properly. This aligns with the findings of Ahmed et al. (2020), who noted that the failure of administrative structures to act on reports of aggression leads to decreased staff morale and trust in institutional systems.

In terms of mitigation strategies, respondents strongly agreed that improved communication between staff and patient relatives, conflict management training for nurses, increased staffing, enforcement of anti-violence policies, and enhanced security presence could help reduce aggressive behaviours. These suggestions align with recommendations from the World Health Organization and findings by Hashim et al. (2023), who concluded that a multi-level approach involving staff training, policy enforcement, and public education is essential for violence prevention in healthcare settings.

Statistical analysis using chi-square tests found no significant relationship between the respondents' level of education or age and their perceived causes of aggression. This contrasts

with earlier studies such as Huang et al. (2020), which suggested educational background might influence behavioural responses in clinical contexts. However, it reflects the increasingly universal nature of aggressive responses across demographic groups under stress in hospital settings.

5.3 Implications of findings to Nursing

1. Need for Workplace Violence Prevention: The high rate of aggression toward nurses necessitates the implementation of comprehensive violence-prevention programs in hospitals.
2. Training in Communication and De-escalation: Nurses should receive regular training in conflict resolution, de-escalation techniques, and effective communication to manage aggressive behavior.
3. Universal Application of Interventions: Since aggression was not significantly influenced by age or education, interventions must be designed to address all demographics, not just specific groups.
4. Strengthening Institutional Support: Hospitals must provide stronger support systems for nurses by enforcing zero-tolerance policies on aggression and ensuring timely resolution of reported incidents.
5. Psychological Support for Nurses: Emotional and psychological support services should be made readily available to nurses affected by aggression to reduce burnout and maintain job satisfaction.
6. Public Education and Awareness: Campaigns should be launched to educate the public on the roles, limitations, and challenges faced by nurses, which may reduce unrealistic expectations and hostility.

7. Policy and Leadership Action: Nurse leaders and administrators must advocate for and implement clear policies to protect staff from violence and promote safe working environments.
8. Integration into Nursing Curriculum: Nursing education should incorporate modules on managing aggressive behavior, emotional intelligence, and interpersonal skills to better prepare nurses for real-world challenges.
9. Cultural and Systemic Relevance: The findings reinforce that workplace aggression toward nurses is a global issue, highlighting the need for systemic changes across healthcare institutions.
10. Enhanced Nurse-Relative Relationship: Promoting respectful and informed interactions between nurses and patient relatives can lead to improved cooperation and patient outcomes.

5.4 Limitation of the Study

The limitations of this study include a relatively small sample size, which may not fully capture the wide range of aggressive behaviors or all contributing factors that exist in larger or different healthcare settings. Additionally, the reliance on self-reported data from patient relatives introduces potential bias, as respondents may not fully disclose aggressive incidents due to fear of reprisal or may exaggerate certain behaviors due to emotional distress.

Lastly, the time frame used in formulating, distributing and retrieving the questionnaire was relatively short. Despite the limitations, the researcher was able to make use of the available resources in completing the study.

5.5 Summary of the Study

This study examined the causes of aggressive behaviour exhibited by patients' relatives towards nurses at Kwara State University Teaching Hospital (KWASUTH), Ilorin. Data from 138 respondents revealed a high prevalence of aggression, with verbal abuse, threats, and

shouting being the most common forms. Key causes included delays in care, poor communication, emotional stress, financial burdens, and overcrowding. Statistical analysis showed no significant association between perceived causes of aggression and demographic variables such as age or education level, indicating that these behaviours cut across different groups. Respondents recommended improved nurse-patient communication, conflict resolution training, increased staffing, and stronger enforcement of hospital rules as effective strategies for reducing aggression. The findings highlight the need for systemic interventions and institutional support to ensure nurses' safety and enhance the overall quality of patient care.

5.6 Conclusion

this study has revealed that aggressive behaviour by patients' relatives towards nurses at Kwara State University Teaching Hospital, Ilorin, is a prevalent and concerning issue. Verbal aggression, threats, and emotional outbursts are frequently encountered, largely driven by factors such as delays in care, poor communication, emotional distress, and systemic hospital challenges like overcrowding and understaffing. Despite varying age and educational backgrounds, respondents shared similar perceptions regarding the causes of aggression, suggesting these behaviours stem more from situational stressors than personal demographics. While participants proposed actionable strategies such as improved communication, conflict resolution training, and institutional policy enforcement, the findings underscore a critical need for healthcare administrators to create safer work environments for nurses. Addressing these challenges holistically will not only protect nursing professionals but also promote better therapeutic relationships and improve overall patient care outcomes.

5.7 Recommendations

Based on findings, the following recommendations were made:

i. Healthcare institutions should implement regular training programs for nurses on conflict resolution and de-escalation techniques.

ii. Hospitals should establish clear communication protocols to keep patient relatives informed and reduce anxiety.

iii. Cultural sensitivity training should be provided to healthcare staff to bridge potential cultural and linguistic gaps.

iv. Security measures, including surveillance and on-site personnel, should be enhanced to ensure the safety of nurses.

v. Psychological support services should be offered to both patient relatives and healthcare workers to manage emotional distress.

vi. Hospital management should introduce policies that address nurse-patient relative interactions, ensuring mutual respect and understanding.

5.8 Suggestions for further studies

i. Future studies should explore the impact of healthcare infrastructure and staffing levels on the aggressive behavior of patient relatives.

ii. Researchers should investigate the role of communication technologies in reducing misunderstandings and aggression in healthcare settings.

iii. Further studies should assess the effectiveness of psychological support interventions for both healthcare workers and patient relatives in minimizing aggressive behavior.

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APPENDIX I
QUESTIONNAIRE

FACULTY OF NURSING SCIENCES, DEPARTMENT OF NURSING SCIENCE, THOMAS ADEWUMI UNIVERSITY, OKO IRESE, KWARA STATE.

Dear Respondent,

I am a 500-level student of the above-named Institution and I'm conducting research titled "INVESTIGATING THE CAUSES OF AGGRESSIVE BEHAVIOUR OF PATIENTS' RELATIVES TOWARDS NURSES AT KWARA STATE UNIVERSITY TEACHING HOSPITAL". The aim of this study is to collect data for academic purpose. Your responses are confidential and will be used solely for research purposes. Please answer the questions honestly.

Thank You

Dada Victoria

SECTION A: DEMOGRAPHIC INFORMATION

1. Age: 18–30( ) 31–40( ) 41–50( ) Above 50( )

2. Gender: Male( ) Female( )

3. Level of Education: No formal education ( ) Primary education( )

Secondary education( ) Tertiary education( )

4. Relationship to Patient: Parent( ) Sibling( ) Child( ) Spouse( )

5. Religion: Christianity( ) Islam( ) Others( )

6. Marital Status: Single( ) Married( ) Divorced( ) Widowed( )

SECTION B: PREVALENCE OF AGGRESSIVE BEHAVIOUR EXHIBITED BY PATIENT RELATIVES TOWARDS NURSES

Statements	**SA**	**A**	**D**	**SD**
I have been aggressive towards a nurse while on duty.				
I have witnessed other patient relatives act aggressively in the hospital.				
I have verbally confronted a nurse over patient care.				
I have seen physical confrontation between relatives and nurses.				
I have shown frustration to nurses more than once per week.				
Aggressive behaviour from patient relatives is more common now				

than before.				
I have raised my voice at nurses due to stress or delays.				
Hospital staff rarely resolve complaints raised through aggression.				

SECTION C: COMMON TYPES OF AGGRESSIVE BEHAVIOUR EXHIBITED BY PATIENT RELATIVES

Statements	**SA**	**A**	**D**	**SD**
Verbal abuse is the most common way I express dissatisfaction.				
I have threatened nurses due to disagreements.				
I have shouted at nurses when I felt ignored.				
Physical aggression is sometimes necessary to get attention.				
I have used body language to intimidate nurses.				
I have seen relatives damage hospital property during disputes.				
I know someone who made false accusations against a nurse.				
I have seen relatives use threats to influence treatment decisions.				

SECTION D: PERCEIVED CAUSES OF AGGRESSIVE BEHAVIOUR BY PATIENT RELATIVES

Statements	**SA**	**A**	**D**	**SD**
Delay in care makes me feel compelled to act aggressively.				
Poor communication from nurses can provoke my anger.				
I get frustrated when I don’t understand medical procedures.				
Overcrowding and long wait times increase my agitation.				
The shortage of nurses makes me more impatient.				
Cultural expectations shape how I react to health delays.				
Emotional stress from my relative's illness fuels my reactions.				
Financial burdens increase my tendency to lash out.				

SECTION E: WAYS TO REDUCE AGGRESSIVE BEHAVIOUR TOWARDS NURSES

Statements	**SA**	**A**	**D**	**SD**
If nurses explained things better, I would be less aggressive.				
Nurses should be trained in handling conflicts with us.				

More nurses would mean fewer frustrations for us.				
I support strict rules against aggression in hospitals.				
Presence of security in wards can reduce aggressive outbursts.				
Teaching us hospital procedures can reduce misunderstandings.				
Attending to complaints quickly can stop situations from escalating.				
Nurses should have emotional support after experiencing aggression.				