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In this issue the authors dealt with themes varying from prevention to violence against nursing to professional commitment in the Middle East.

In a paper on professional commitment among nurses as a moderator of job stress and job performance, the author looked at the Middle East in an empirical way. This study examined the relationship of overall job stress, challenge stress and hindrance stress with job performance, absenteeism and turnover intention among hospital nurses (N=255) in Gulf States of the Middle East. Multiple sources of data collection were employed. A structured questionnaire was used to collect data on measures of job stress and turnover intention. No differential effects of challenge and hindrance stress were found for the study's three dependent variables. Professional commitment among nurses moderated more than 50 percent relationship between the measures of stress and dependent variables. Overall, the results of the present study supported the convergence instead of divergence perspective in international management. Implications of the findings are discussed for future researchers in international and cross-cultural management.

Another paper looked at the prevention of colorectal cancer using aspiring. The author stressed in his review that colorectal cancer is a major public health concern, globally and nationally. Thus, every effort should be done to improve prevention strategies, which may decrease colorectal cancer incidence, and thus, decrease the number of people who suffer from this disease and its complications. Promising results have described aspirin and other non-steroidal anti-inflammatory drugs as possible candidate for pharmacological prevention of colorectal cancer. The purpose of this evidence based practice is to evaluate the association between aspirin consumption and the incidence of CRC among average risk adult population. Electronic literature search of six databases was conducted for English language articles published between 2003 and 2013, which are available as a free full text articles, using MeSH terms "aspirin", "colorectal cancer", and "incidence". Studies conducted in specific high risk populations were excluded, as well as studies that measured mortality rate, or the incidence of adenomas as an outcome, rather than measuring the incidence rate of colorectal cancer. In one study that was randomized controlled trial, the results emphasized the effectiveness of aspirin in reducing colorectal cancer; however, the duration, dose and frequency of aspirin consumption may affect this relationship. The authors concluded that long term consumption of five years or more is essential to observe the relationship between aspirin and colorectal cancer risk. Additionally, for aspirin to be preventive, daily consumption is crucial. Finally, the optimal dose of aspirin for CRC prevention was not established

A paper from Jordan looked at the issue of violence against nurses. Health care workers don't have the immunity to violent encounters, nurses reported they experienced workplace violence at least one in their professional period. In recent years, many studies showed that violence against nurses increased dramatically, and consider as a major health problem. There is a growing awareness in the public opinions regarding violence against nurses . All health care providers are facing more violence than ever before , all over the world .Nurses are the most exposed people from all health care providers to verbal, physical, emotional ,and sexual abuse.

A paper from Queen Alia looked at the Phases of Therapeutic relationship. The author stressed that achieving a relationship of mutual trust and respect between the nurse and the patient requires the ability to communicate a sincere interest in the patient. The therapeutic relationship is purposeful and goal oriented, which creates a beneficial outcome for the patient, unlike the social relationship, where there may not be a specific purpose or direction. In fact, for interventions to be successful with clients in all nursing specialties, it is crucial to build a therapeutic relationship. So, crucial phases are involved in establishing a therapeutic nurse-patient relationship and the communication within it which serves as the underpinning for treatment and success. The purpose of this study is to assess the current practices and problems that are encountered regarding the implementation of therapeutic relationship phases among registered nurses at Queen Alia Heart Center.

PROFESSIONAL COMMITMENT AMONG NURSES AS A MODERATOR OF JOB STRESS AND JOB PERFORMANCE : AN EMPIRICAL EXAMINATION IN THE MIDDLE EAST

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Abstract

This study examined the relationship of overall job stress, challenge stress and hindrance stress with job performance, absenteeism and turnover intention among hospital nurses (N=255) in the Gulf States of the Middle East. Multiple sources of data collection were employed. A structured questionnaire was used to collect data on measures of job stress and turnover intention. Job performance and absenteeism data were obtained from hospital records. Multiple regressions and moderated multiple regressions were used to analyze data. Overall job stress, hindrance stress and challenge stress were significantly related to job performance, absenteeism and turnover intention. No differential effects of challenge and hindrance stress were found for the study's three dependent variables. Professional commitment among nurses moderated more than 50 percent relationship between the measures of stress and dependent variables. Overall, the results of the present study supported the convergence instead of divergence perspective in international management. Implications of the findings are discussed for future researchers in international and cross-cultural management.

Key words: **Nurses, stress, job performance, Middle East**

Introduction

The nursing profession has long been considered a stressful one globally (Jamal & Baba, 2000). It is one in which rates of absenteeism, staff turnover and burnout are consistently high (Hassan, Hassan & King, 2012; Yoon & Kim, 2013). Two factors are peculiar to the hospital work environment: the prevalence of shiftwork and the situation of facing patients in distress, as well as death and dying, on a regular basis (Al-Hammad et al. 2 012; Jamal & Baba, 1992). These two factors have been suggested as possible contributors to high stress and strain among nurses. The present study examined employees' job stress and job performance relationship among hospital nurses in the Gulf States, Middle East. Two comprehensive meta-analyses of stress and performance have highlighted the importance of this type of empirical study in non-western countries (Gilboa, Shirom, Fried & Cooper, 2008; Muse, Harris & Field, 2003). In a recent thought-provoking article, Zahra (2011) has also alluded to the importance of conducting rigorous empirical research similar to the Western tradition in the (new) Middle East. In addition, the present study also examined the role of professional (occupational) commitment in the relationship of job stress and job performance (Lee, Carswell & Allen, 2000).

Job stress refers to an individual's reactions to characteristics of the work environment that tend to be emotionally and physically threatening (Jamal, 2007). It points to a poor fit between the individual's capabilities and the work environment, in which excessive demands are made of the individual or the individual is not fully prepared to handle a particular situation (Jamal, 1984). In general, the higher the imbalance between the demands and the individual's abilities, the

higher will be the perceived stress (Jamal, 1993). Job performance can be viewed as an activity in which an individual is able to accomplish successfully the task assigned to them, subject to the reasonable utilization of available resources (Jamal, 2007).

Conventionally and historically, job stress has been primarily viewed as a unidimensional construct affecting individuals' work attitudes and behavior (Jamal, 2013). In recent years, it has been suggested that some inconsistent findings between measures of job stress and employees' attitudes and behavior might be due to the convention of treating job stress as unidimensional. These scholars have suggested two distinct dimensions of job stress: challenge stress and hindrance stress (Cavanaugh, Bosewell, Roehling & Boudreau, 2000). Challenge stressors are perceived to be stimuli such as high workload, time pressure and high level of responsibility. They were labeled as such because they include potentially stressful demands perceived effectively under the control of the individual and, if overcome, they might allow for opportunity for personal growth (Wallace, Edwards, Arnold, Frazier & Finch, 2009). Hindrance stressors are stimuli such as organizational policies, red tape, work role ambiguity and resource inadequacy. They were labeled as such because they create potentially stressful demands generally perceived as beyond the control of the employees, so that they might restrict opportunity for personal growth (Wallace et al., 2009).

To date, there are only a few empirical studies reported in the literature employing the two-dimensional conceptualization of job stress (Clark, 2012; Jamal, 2012; Rodell & Judge, 2009; Wallace et al., 2009). The present study examined the relationship between challenge stress and hindrance stress with job performance, absenteeism and turnover intentions among nurses working in hospitals in the Gulf States, Middle East. Constructs like job stress, burnout, job satisfaction and professional commitment are developed and empirically tested primarily in developed industrialized countries (Baba, Jamal & Tourigny, 1998; Maslach, 2003). Their portability and usefulness in developing and non-Western countries have rarely been examined despite repeated suggestions to do so (Jamal, 2010; Pudelka, Carr, Fink & Wentage, 2006; Zahra, 2011). In this respect, the present study contributes to international stress management literature by examining the newly proposed two dimensions of stress (challenge and hindrance) along with an independent overall job stress scale (Parker & DeCotiis, 1983) with job performance, absenteeism and turnover intention. A conceptual framework was developed which guided the present study. The conceptual framework is presented in Figure 1 - opposite page.

As shown in Figure 1, it is suggested that nurses' professional commitment may moderate the relationship between measures of job stress and outcome variables. In the literature, professional commitment and occupational commitment have been used interchangeably (Blau, 1985; Lee, Carswell & Allen, 2000). We prefer to use the term of professional commitment in the present study as nursing has long been recognized as a "profession" with a long period of training, exhaustive guidelines and intense ethical standards (Gould & Fontenla, 2006; Fornes, Rocco & Wollard, 2008; Yoon & Kim, 2013). When an individual shows commitment to his profession, the phenomenon of self-selection plays an important role (Jamal, 1984). In many cases, individuals who consciously look for certain types of jobs and professions tend to exhibit stronger commitment when they are in such jobs. Therefore, it may be the case that such individuals, through anticipatory socialization, become more knowledgeable about these jobs, in terms of demands and excesses, and may appear to be more receptive to job stresses and general work environment. Whenever these individuals face adverse things at the job, it does not necessarily lead to reality shock for them because of their prior learning about the daily intricacies of their chosen profession / job (Jamal & Baba, 1992). It is thus predicted that the job performance of individuals with high professional commitment will be less affected by high job stress than the performance of individuals with low professional commitment.

In light of the proposed conceptual model as well as the previous empirical evidence on job stress, challenge-hindrance stress, and outcome variables, a number of hypotheses were developed and tested in the present study. Both overall job stress and challenge-hindrance stress were employed as independent variables. Job performance, absenteeism and turnover intention were employed as dependent variables. Professional commitment was used as a moderator variable. These hypotheses are listed below:

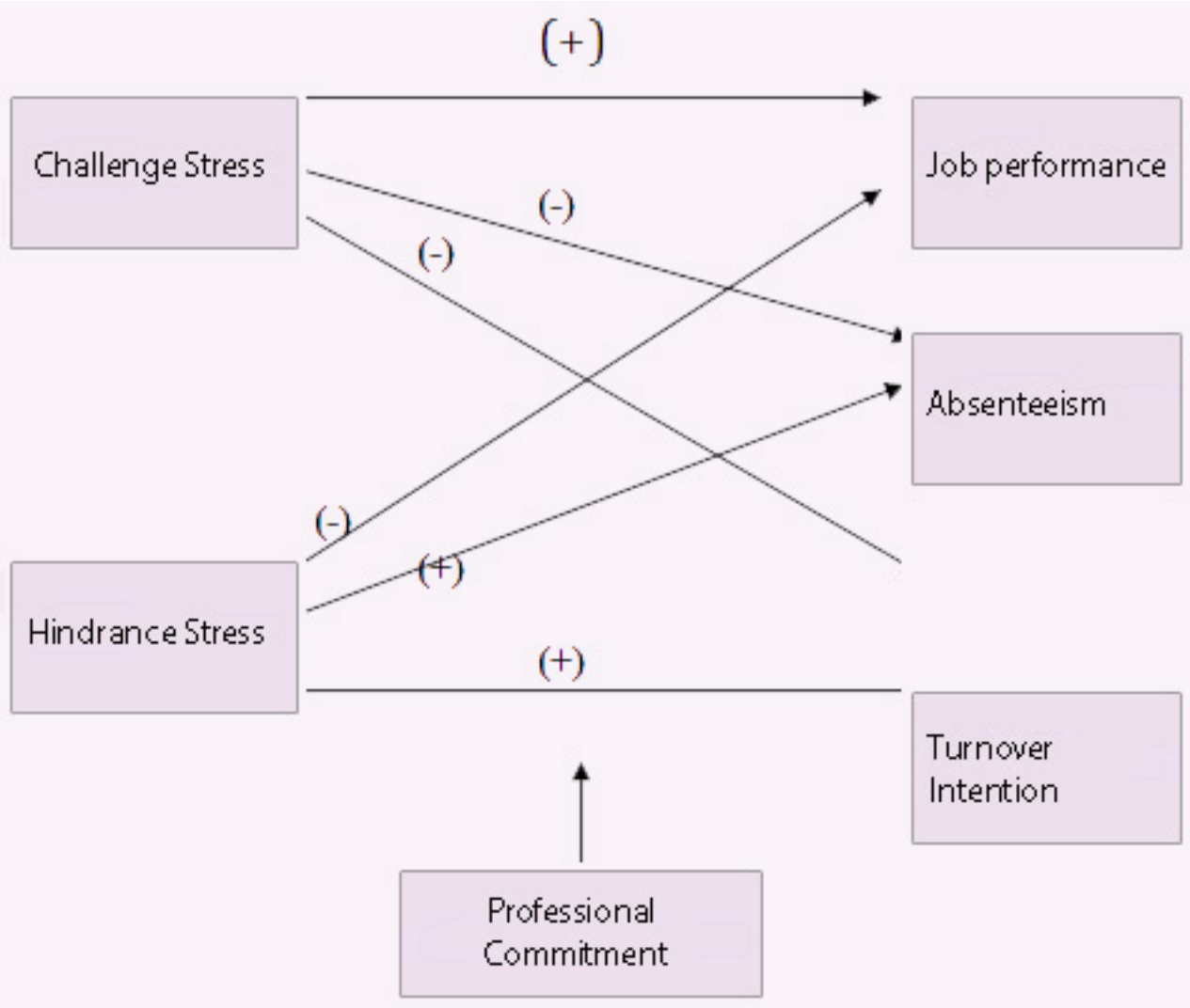
Hypothesis 1: Overall job stress will be negatively related to job performance and will be positively related to absenteeism and turnover intention.

Hypothesis 2: Challenge stress will be positively related to job performance and will be negatively related to absenteeism and turnover intention.

Hypothesis 3: Hindrance stress will be negatively related to job performance and will be positively related to absenteeism and turnover intention.

Hypothesis 4: Professional commitment will moderate the relationship between the measures of job stress and three dependent variables. It is hypothesized that nurses with higher professional commitment will be better off than nurses with lower professional commitment.

Figure 1: Conceptual framework of stress and outcome relationship



Method

Research Setting

The present study was conducted among hospital employees in the Gulf States, Middle East. A number of hospitals were contacted and invited to participate in the study, explaining the scope and purpose of the study. All hospitals were publicly funded and had state-of-the-art medical facilities. Data were collected primarily from three hospitals which showed the willingness to support the study.

Procedures

For this study, data were collected by means of a structured questionnaire. All nursing staff in three hospitals were the potential respondents. With the help of the hospital administration, copies of the questionnaire were given to randomly selected potential respondents along with their paychecks. They were given instructions to return the completed questionnaire directly to the researcher at the university address. Approximately 450 questionnaires were given out and with one follow-up reminder, 257 completed questionnaires were returned, yielding a response rate of 59 percent. It should be acknowledged that this type of research is rather rare in the Gulf States, and that might be partially responsible for the modest response rate.

Sample Characteristics

The majority of the respondents were female (88%) and were married (78%). The average respondent was 34 years of age, had 14 years of education, 9 years of seniority in the hospital and had 6 dependents to support. Respondents were quite similar to non-respondents with regard to a number of background and socio-demographic variables.

Measures

In line with the recommendation of international management researchers, standardized scales with known reliabilities and validities were used to assess the study's independent, dependent, and moderator variables (Schaffer & Riordan, 2003; Zahra, 2011). It is a requisite for the meaningful comparison of results with studies done in western industrialized countries.

Overall Job Stress: Overall job stress was assessed with the 13-item Likert-type scale developed by Parker & DeCotiis (1983). The scale had one to five response options, on indicating a strong agreement with the item and five indicating a strong disagreement. This scale is regularly used to assess overall job stress and has good psychometric properties (Baba, Jamal & Tourigny, 1998).

Challenge Stress: Challenge stress was assessed by the 6-item scale developed by Cavanaugh, Bosewell, Roehling and Boudreau (2000). This is a Likert-type scale with one to five response options, one indicating a strong agreement and five indicating a strong disagreement with the item. Only limited empirical studies have been conducted using this scale. However, available empirical evidence indicated good internal consistency reliability (Jamal, 2012).

Hindrance Stress: Hindrance stress was assessed by the 5-item scale developed by Cavanaugh, Bosewell, Roehling and Boudreau (2000). This is also a Likert-type scale with one to five response options. Because of its short history, only limited psychometric data are available about this scale, which has indicated its reasonable internal consistency and stability (Jamal, 2012).

Job Performance: Job performance data were obtained from hospital records. All hospitals used a 10-item graphic rating scale for annual performance appraisal completed by immediate supervisors. Each item has one to five response options, five indicating an excellent performance and one indicating a poor performance. In all three hospitals, the same performance scale and ratings were used. In the present study, ratings on ten items were combined to create the index of overall job performance.

Absenteeism: Absenteeism was assessed by the actual incidents of absence reported in hospital files for each employee, for 4 months from the day the questionnaires were distributed. Frequency of absenteeism was measured instead of the duration of absence.

Anticipated Turnover: Anticipated turnover was assessed by asking each respondent to state the probability of his/her staying with the same hospital for two years, from the day the questionnaire was completed. This measure has been reported to be highly correlated with actual turnover (Jamal & Baba, 2000).

Professional Commitment: Professional commitment was assessed with the 18-item occupational commitment scale for nurses developed by Meyer, Allen and Smith (1993). Similar to the organizational commitment scale, occupational commitment scale tends to assess affective, continuance, and normative commitment to the occupation. The scale has one to five response options, five indicating a strong professional commitment and one indicating a low professional commitment. This scale is regularly used in social sciences and has good psychometric properties (Lee, Carswell & Allen, 2000).

Results

The means (M values), standard deviations (SD values) and reliability coefficients of all variables with multiple items are presented in Table 1. Reliabilities (Cronbach's alpha) varied from .81 (hindrance stress) to .91 (professional commitment). Overall, reliabilities were considered to be good for survey-type research design.

Inter-correlations among the study's variables were computed and are presented in Table 2.

The average correlation among three scales of job stress was .37. The average correlation among three dependent variables (performance, absenteeism, turnover intention) was .25. Professional commitment was weakly correlated with three job stress scales as well as with two dependent variables. However, professional commitment showed a moderate negative correlation with turnover intention which indicated their shared nomological network. To test hypotheses 1 to 3, bivariate multiple regressions were computed after controlling for age, gender, marital status, and seniority. Results are presented in Table 3 - page 8.

Overall job stress was significantly related to job performance, absenteeism and turnover intention in the predicted direction, thus supporting hypothesis 1. Challenge stress was significantly related to job performance and absenteeism, but was not related to turnover motivation. However, in both significant relationships, the direction of the relationship was contrary to the hypothesized relationship. Thus, hypothesis 2 was not supported by data in the present study. Hindrance stress was significantly related in the predicted direction to job performance, absenteeism and turnover motivation, thus supporting hypothesis 3. In sum, overall job stress, hindrance stress and challenge stress were found to be related to job performance, absenteeism and turnover motivation in the same manner. No differential effects of challenge and hindrance stress on three dependent variables were found in this study. However, it is noted that the strength of correlation was stronger for hindrance stress than for challenge stress (-.54 vs -.23 for job performance; .31 vs .19 for absenteeism).

Moderated multiple regressions were used to test hypothesis 4 which concerned the interactive effects of professional commitment on three dependent variables. Hierarchical regression analysis was performed in which overall job stress was entered first, followed by professional commitment, and then overall job stress and professional commitment. A summary of results are presented in Table 4. Professional commitment appeared to be an important moderator in this sample of nurses, moderating five of the nine relationships between three measures of job stress and three dependent variables. Job performance and absenteeism were the dependent variables in which the moderating effect of professional commitment was more prominent.

The unique variance explained by the interaction effects of overall job stress and professional commitment was 5 percent for job performance and 4 percent for turnover intention. The unique variance explained by the interaction effects of challenge stress and professional

Variable	Number of Items	Mean	Standard Deviation	Reliability[a]
(1) Overall Job Stress	13	2.36	1.23	.88
(2) Challenge Stress	6	3.44	0.69	.83
(3) Hindrance Stress	5	3.16	0.89	.81
(4) Job Performance	10	3.45	0.62	.84
(5) Absenteeism	1	2.65	1.89	--
(6) Turnover Intention	1	2.63	1.02	--
(7) Professional Commitment	18	3.75	1.12	.91

Table 1: Means, Standard deviations and reliability coefficients of study variables

N = 255; a. Reliability coefficients are Cronbach's alpha.

Variables	(1)	(2)	(3)	(4)	(5)	(6)	(7)
(1) Overall Job Stress[a]	--						
(2) Challenge Stress	.29	--					
(3) Hindrance Stress	.43	.39	--				
(4) Job Performance	-.42	-.23	-.54	--			
(5) Absenteeism	.38	.19	.31	-.29	--		
(6) Turnover Intention	.20	.13	.19	-.16	.31	--	
(6) Professional Commitment	-.12	.09	-.17	.09	.07	-.44	--

Table 2: Intercorrelations among study's variables

a. N = 255, r = .15, p < .05

Table 3: Multiple regression of overall job stress, challenge stress and hindrance stress with three dependent variables

Variable	Job Performance		Absenteeism		Turnover Intention	
	R	R^2	R	R^2	R	R^2
(1) Overall Job Stress	.40	.16	.35	.12	.18	.03
(2) Challenge Stress	.20	.04	.17	.03	.09	.01
(3) Hindrance Stress	.49	.24	.29	.08	.17	.03

N = 255, R = .14, p < .05

Table 4: Results from hierarchical moderated multiple regression analysis showing the relationship between overall job stress, challenge stress, hindrance stress, and professional commitment with three dependent variables.

Regression Results	Dependent Variable					
	Job Performance		Absenteeism		Turnover Intention	
	R^2	$\blacktriangle R^2$	R^2	$\blacktriangle R^2$	R^2	$\blacktriangle R^2$
(1) Overall Job Stress (OJS)	.16*	.16*	.12*	.12*	.03*	.03*
Professional Commitment (PC)	.18*	.02	.12*	.00	.04*	.01
OJS x PC	.23*	.05*	.14*	.02	.08*	.04*
(2) Challenge Stress (CS)	.04*	.04*	.03*	.03	.01	.01
Professional Commitment (PC)	.05*	.01	.04*	.01	.00	.00
CS x PC	.08*	.03*	.05*	.00	.02	.01
(3) Hindrance Stress (HS)	.24*	.24*	.08*	.08*	.03*	.03*
Professional Commitment (PC)	.25*	.01	.08*	.00	.03*	.00
HS x PC	.29*	.04*	.09*	.01	.08*	.05*

* p < .05

commitment was 3 percent for job performance. The unique variance explained by the interaction effects of hindrance stress and professional commitment was 4 percent for job performance and 5 percent for turnover intention. A close examination of the data through subgroup analysis indicated that nurses with high professional commitment appeared to be better off than nurses with low professional commitment in terms of the negative consequences of job stress. No significant interaction effects were found with the dependent variable, absenteeism. Thus, hypothesis 4 was only partially supported by the data in this study.

Discussion

The results of the present study derived from hospital nurses in the Gulf States, Middle East supported the relationship between the measures of job stress and outcome variables of job performance, absenteeism and turnover intention. Overall job stress was negatively related to job performance and was positively related to nurses' absenteeism and turnover intention. Contrary to our prediction, challenge stress was also negatively related to job performance and positively related to absenteeism. Hindrance stress was negatively related to job performance and was positively related to nurses' absenteeism and turnover intention. Before the findings are discussed any further, a note of caution is warranted about the limitations of the study which might include perceptual measures of three job stress scales, turnover intention, nurses' professional commitment, a modest response rate, and cross-sectional research design. For future research, it will be desirable to use objective measures of job stress along with perceptual measures and to use longitudinal research design for greater confidence in results.

The absence of differential effects of challenge stress and hindrance stress on nurses' job performance, absenteeism is not only contrary to the two-dimensional framework of job stress (Cavanaugh et al., 2000) but also to a few empirical studies on the topic. For example, in a recent study of 215 employees across 61 offices of a state agency in the U.S., the authors noted a modest positive relationship between challenge stress and role-based performance and a negative relationship between hindrance stress and role-based performance (Wallace et al., 2009). However, the average correlation between challenge stress and four measures of performance was a meager +.12, while the average correlation between hindrance stress and the four measures of performance was -.35. In a recent study of employees in a multinational organization in Malaysia (N = 305) and Pakistan (N = 325), job stressors similar to challenge stress (i.e. work overload) and stressors similar to hindrance stress (i.e. work conflict, ambiguity, resource inadequacy) were found to be negatively related to job performance (Jamal, 2011). The results of the present study along with two recent studies on the topic (Jamal, 2011; Wallace et al., 2009) lend support to the pervasive effects of stress on employee and organization well-being and in general tend to be consistent with the bulk of existing literature on job stress (Eatongh, Change, Miloslavic & Johnson, 2011; Jamal, 2010). Empirical evidence, perhaps, suggests clearly that chronic job stress, lasting a relatively long time or even permanently, affects employees' and organizations' health and well-being inversely. Any notion of calling some stress as challenge and good for the individual is not well supported by the empirical studies on job stress outcome relationships. Since the data for the present study was collected in the Gulf States of the Middle East with a strong collectivistic cultural orientation (Hofstede, 2001), the results of the present study tend to be more supportive of the convergence as opposed to divergence perspective in international and cross-cultural management (Pudelko et al., 2006)

Professional commitment among nurses moderated five of the nine relationships between three measures of job stress and three dependent variables - performance, absenteeism and turnover intention. According to the test suggested by Brozek & Tiede (1952), the probability of this number of differences occurring by chance is less than .01. Though professional commitment moderated more than 50 percent of the relationship between job stress and outcome variables, yet the dominant patterns of results in both significant and non-significant comparison was that nurses who showed higher professional commitment appeared to be better off against the negative consequences of job stress than nurses who showed low professional commitment. Thus, in the present study, professional commitment acts as a buffer against the aversive effects of job stress on nurses' job performance and work behavior. Since nurses are the essential part of the healthcare system globally, it is highly recommended that management should pay serious attention to factors which might enhance professional commitment and reduce or even remove factors which hinder professional commitment. A recent British study has provided insights into factors which might lead to increased professional commitment and they included team work, feedback from patients, the variety of work, good support from management, family friendly work environment, support from doctors, and the multidisciplinary team work (Gould & Fontenla, 2006). Similarly, nursing literature has also provided insights into factors which might lead to decrease in professional commitment among hospital nurses and they included factors such as shift work (especially quick rotating shifts), verbal and physical abuse, poor pay, heavy work load, work-life imbalance, too much paper work and poor image of nursing held by the public (AbuAlRub, 2004; Gould & Fontenla, 2006; Harrison, Newman & Roth, 2006; Lu, Change & Wu, 2007).

In sum, the present study found the negative relationship between the measures of job stress and job performance and the positive relationship between the measures of job stress and absenteeism and turnover intention among hospital nurses. Professional commitment was found to be an important moderator

of job stress and outcome relationship. Measures of job stress assessed in the present study were of the nature which will be affected primarily through management actions. Therefore, it is recommended that management invest time and resources toward discovering how job stress among nurses might be managed for better performance, well-being and retention of hospital nurses (Jamal, 2007; Schmidt, 2007). In addition, it is felt that despite management's concerted efforts and serious actions to combat job stress, it is probably going to remain an important concern for many in the world of work for years to come, primarily because of our incomplete knowledge of what causes stress in many job situations. Among hospital nurses, building and enhancing professional commitment may be an important mechanism in combating some of the aversive effects of job stress (Fornes, Rocco & Wollard, 2004). As the process of globalization becomes more pervasive in coming years, it seems more important that these strategies should reflect a cross cultural perspective (Al-Roubaie, 2002; Alvi & Al-Roubaie. 2011).

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USING ASPIRIN TO PREVENT COLORECTAL CANCER: AN EVIDENCE BASED PRACTICE

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Abstract

Colorectal cancer is a major public health concern, globally and nationally. Thus, every effort should be done to improve prevention strategies, which may decrease colorectal cancer incidence, and thus, decrease the number of people who suffer from this disease and its complications. Promising results have described aspirin and other non-steroidal anti-inflammatory drugs as possible candidates for pharmacological prevention of colorectal cancer.

The purpose of this evidence based practice is to evaluate the association between aspirin consumption and the incidence of CRC among an average risk adult population. Electronic literature search of six databases was conducted for English language articles published between 2003 and 2013, which are available as free full text articles, using MeSH terms "aspirin", "colorectal cancer", and "incidence". Studies conducted in specific high risk populations were excluded, as well as studies that measured mortality rate, or the incidence of adenomas as an outcome, rather than measuring the incidence rate of colorectal cancer. The final sample size is seven, five studies were systematic reviews, one study was a randomized controlled trial, and the last one was a large cohort study.

The results of this paper emphasized the effectiveness of aspirin in reducing colorectal cancer; however, the duration, dose and frequency of aspirin consumption may affect this relationship. From the available evidence we can conclude that long term consumption of five years or more is essential to observe the relationship between aspirin and colorectal cancer risk. Additionally, for aspirin to be preventive, daily consumption is crucial. Finally, the optimal dose of aspirin for CRC prevention was not established.

Key words: **aspirin, incidence, colorectal cancer, evidence based practice.**

Introduction

Colorectal cancer (CRC) is the third most common cancer in the United States, and it is the third leading cause of cancer-related deaths when men and women are considered discretely, while it is the second leading cause when both sexes are combined. Unfortunately, CRC was expected to cause about 50,830 deaths during 2013 in U.S.[1].

Similarly, CRC is the second most common cancer type in Jordan, specifically, it is the first among Jordanian males and the second among Jordanian females; furthermore, it is the leading cause of cancer death among both genders [2]. Obviously, CRC is a major public health concern, globally and nationally. Thus, every effort should be done to improve prevention strategies, which may decrease colorectal cancer incidence, and thus, decrease the number of people who suffer from this disease and its complications.

Promising results have described aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs) as possible candidates for pharmacological prevention of CRC. NSAIDs produce their clinical benefits against cancer by disturbing some mechanisms that potentially manipulate carcinogenesis, such as angiogenesis, inflammation, cell-turnover kinetics, and cell differentiation [3]. Currently, aspirin emerged to be the most promising drug because of its known cardiovascular benefit, and also because of its parallel antiplatelet effects, which are not shared with non-aspirin NSAIDs [4]. However, no authoritative recommendations have been made regarding its use for CRC prevention.

Thus, the purpose of this review is to evaluate the association between aspirin consumption and the incidence of CRC among an average incidence of CRC among an average risk adult population.

PICO Question

Population	Intervention	Comparison	Outcome
Adult people with average risk for developing CRC.	Regular aspirin consumption.	Not receiving aspirin.	Reduction in CRC incidence.

The PICO question is: What is the effect of aspirin consumption on the incidence of CRC among an average risk adult population?

Methodology

Electronic literature search of six databases: MEDLINE, CINAHL, Academic Search Complete, Education Research Complete, SocINDEX, and Science Direct was conducted for English language articles published between 2009 and 2013, which are available as free full text articles, using MeSH terms “aspirin”, “colorectal cancer”, and “incidence”. Studies conducted in specific high risk populations; such as history of CRC, familial adenomatous polyposis, or inflammatory bowel disease, were excluded, as well as studies that measured mortality rate, or the incidence of adenomas as an outcome, rather than measuring the incidence rate of CRC. The retrieved sample consisted of three studies only. So, another literature search for articles published between 2003 and 2008 was done with the same criteria mentioned above, which revealed another four studies.

The final sample size is seven; five studies were systematic reviews, one study was a randomized controlled trial, and the last one was a large cohort study. (Please refer to Table 1, appendix).

Findings

Level IV of Evidence

Three studies found that aspirin had a chemo-preventive benefit for colorectal cancer ([5]; [6]; [7]). These studies are systematic reviews of cohort studies and case control studies.

One study emphasized that the optimal dose of aspirin is not fully established, [7]. While, Dube et al (2007) found that the chemoprevention benefit was more evident when aspirin was used at a high dose and for longer than ten years [6]. This result is consistent with the findings of another study that showed that long term daily use of high dose aspirin was associated with lower incidence of colorectal cancer [8]. Then, Flossmann, & Rothwell (2007) specified that 300 mg or more a day of Aspirin for about five years reduced the incidence of colorectal cancer, with a latency of 10 years, [9].

Level II of Evidence

A randomized controlled trial with a large sample of women found that alternate day use of low-dose aspirin (100 mg) for an average of ten years did not lower risk of colorectal cancer, [10]. This may be explained by the short half life of aspirin, which makes the more frequent doses more effective to produce its effect.

Level I of Evidence:

A systematic review of five randomized controlled trials found that the consumption of 75-1200 mg of aspirin per day reduced the risk for colon cancer; this reduction was more pronounced when aspirin is taken for five years. Also, this study found a positive relationship between duration of aspirin consumption and its benefit in reducing CRC, [11].

Additionally, another study observed that the consumption of 300mg or more of aspirin per day for about 5 years reduced the incidence of colorectal cancer, with a latency of 10 years ,[9]. However, another study observed that the low dose aspirin (325 mg and 100 mg) which was taken every other day failed to show a protective effect from CRC, [6]. Again, this result can be explained by the short half life of aspirin, especially with small doses, which makes the “every other day” frequency not appropriate to produce its effect.

Appraisal of the Evidence

Strengths of the Evidence

Among the strong points of this evidence is the large sample sizes of the included studies, which may enhance the generalizability of the results, and may compensate for the small sample size of the articles included in this paper. Additionally, all of the studies used in the evidence were retrieved from credible international journals.

Limitations of the Evidence

Not all the studies evaluated the effect of dose, duration, and frequency of aspirin consumption on the risk of CRC. Additionally, only seven studies were included in this paper; however it may be justified by the extensive literature search from multiple data bases.

Summary and Conclusions

The purpose of this paper was to evaluate the association between aspirin consumption and the incidence of CRC among an average risk adult population. Extensive literature search revealed seven articles met the inclusion criteria.

The results of this paper emphasized the effectiveness of aspirin in reducing CRC, however, the duration, dose and frequency of aspirin consumption may affect this relationship. From the available evidence we can

conclude that long term consumption of five years or more is essential to observe the relationship between aspirin and CRC risk. Additionally, it was obvious that for aspirin to be effective in CRC prevention daily consumption is crucial, no chemo-preventive benefit was observed when aspirin was taken every other day, which can be explained by its short half life, especially when taken in small doses. Finally, the optimal dose of aspirin for CRC prevention was not established.

Recommendations

Clinicians should take into consideration the ability of aspirin in reducing CRC when it is taken daily for a long period of time. However, they are recommended to assess the benefit risk ratio for each patient before prescribing it.

Researchers are recommended to conduct more studies to establish the optimal dose, duration, and frequency for CRC prevention.

Educators are recommended to include the chemopreventive benefit of aspirin in their lectures, and to stimulate their students to conduct related studies.

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Author	Design	Sample	Main Findings	Level of evidence
Algra and Rothwell (2012).	Systematic review	32 case-control studies. 11 cohort studies.	Regular use of aspirin was associated with reduced risk of colorectal cancer.	IV
Garcia-Albeniz and Chan (2011).	Systematic review	5 cohort studies. 3 case-control studies. 12 RCTs.	Aspirin had a chemopreventive benefit for colorectal cancer. The optimal dose not fully established. Aspirin's adverse effects on gastrointestinal and intracranial bleeding limit its use.	IV
Rothwell et al. (2010).	Systematic review	5 RCTs	Aspirin 75-1200 mg/day reduce risk for colon cancer (proximal). Effect more pronounced when aspirin is taken for 5 years Benefit increased with duration. When duration increased, risk for rectal cancer decreased	I
		2 RCTs	Low dose aspirin (325 mg and 100 mg every other day) failed to show a protective effect	I
Dube et al. (2007).	Systematic review	8 case control studies. 7 cohort studies	Regular use of aspirin was associated with reduction of 22% for colorectal cancer incidence. Benefit more evident when aspirin was used at a high dose and for longer than 10 years.	IV
Flossmann and Rothwell (2007).	Systematic review	2 RCTs	Aspirin (300 mg or more a day for about 5 years) reduced the incidence of colorectal cancer, with a latency of 10 years.	I
		19 case control studies. 11 cohort studies.	Same as the RCT results.	IV
Cook et al. (2005)	RCT	39,876 women	Alternate day use of low-dose aspirin (100 mg) for an average 10 years of treatment does not lower risk of colorectal cancer.	II
Jacobs et al. (2007).	Cohort study	69,810 men and 76,303 women	Long term daily use of adult-strength aspirin was associated with lower incidence of colorectal cancer.	IV

Appendix

Table 1: This table summarizes the results obtained from the seven research articles

PHASES OF THERAPEUTIC RELATIONSHIP IMPLEMENTATION AMONG THE QUEEN ALIA HEART CENTER NURSES

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Characteristics	Number	Percentage
• Gender:		
a. Male	73	42.9%
b. Female	97	57.1%
• Experience years:		
a. 1-10 years	94	55.2%
b. 11-20 years	76	44.8%
• Work Area:		
a. Critical units	69	40.4%
b. Floors/Wards	101	59.6%

Table 1: The characteristics of the sample

Introduction

Achieving a relationship of mutual trust and respect between the nurse and the patient requires the ability to communicate a sincere interest in the patient (1). The therapeutic relationship is purposeful and goal oriented, which creates a beneficial outcome for the patient (2+3), unlike the social relationship, where there may not be a specific purpose or direction (11+12). In fact, for interventions to be successful with clients in all nursing specialties, it is crucial to build a therapeutic relationship. So, crucial phases are involved in establishing a therapeutic nurse-patient relationship and the communication within it which serves as the underpinning for treatment and success (2+4+10).

The concept of therapeutic relationship is used in many disciplines and is recognized as one of the important concepts in nursing (2+3+4+6+9). In the practice, the therapeutic relationship can be described in terms of four sequential phases, each characterized by identifiable tasks and skills, and theses phases are: preinteraction phase, introduction phase, working phase, and termination phase (2+4+5). So, the therapeutic relationship must progress through the stages in succession because each builds on the one before. In fact, even though most healthcare professionals, including nurses, know the phases and its skills very well, they have trouble applying them to their behaviors, particularly in hospitals where there are a huge number of patients in comparison with small number of nurses assigned to the patients (3+5+6+7+8).

This gap between the therapeutic relationship perception and the therapeutic relationship practice directs us toward this study (5+11+12). So, the purpose of this study is to assess the current practices and problems that are encountered regarding the implementation of therapeutic relationship phases among registered nurses at Queen Alia Heart Center.

Methodology

The descriptive design was used for this study. A convenience sample of 200 registered nurses was selected from both genders with different experiences, who were working in the wards and units of the Queen Alia Heart Center (Table 1 - above).

A questionnaire was developed by the researchers and consists of 25 statements that assessed the implementation of the therapeutic relationship phases by nurses, in addition to the barriers for providing the

phases according to the nurses. The four point's Likert scale questionnaire was reviewed by an expert panel consisting of nurse educator, nurse administrator and senior nurse colleague to establish its content validity. The stability reliability was checked by administering the questionnaire to a group of 40 registered nurses selected conveniently from both genders with different experiences. Then after 3 weeks, the same instrument was administered to the same group. The correlation coefficients were calculated, and it was equal to (+0.83).

The data collection was carried out on 21 st of July 2013. The response rate was 85% (n=170).

Results

The therapeutic relationship in our study was divided into four sequential phases: preinteraction phase, introduction phase, working phase, and termination phase. The preinteraction phase involves preparation for the first encounter with the client, which includes obtaining available information about the client from the available sources; like their file, family, and other health team members(2+4+5). The preinteraction phase also includes examining the client's feeling, fears, and anxieties before the interaction with the client(10). In our study, the majority of the nurses either always (46%) or usually (40.1%) practice the preinteraction phase during their encounter with their clients, while (10.3%) rarely do it, and (3.6%) not at all. (Table 2)

Characteristics	Always	Usually	Rarely	Not at all
• Gender:				
a. Male	45.2%	40.3%	11.3%	3.2%
b. Female	47.1%	39.5%	9.5%	3.9%
• Experience years:				
c. 1-10 years	55.3%	38.3%	4.09%	2.31%
d. 11-20 years	35.2%	28.2%	23.5%	13.1%
• Work Area:				
c. Critical units	40.7%	25.5%	20.6%	13.2%
d. Floors/Wards	52.8%	30.6%	10.1%	6.5%

Table 2: The results of preinteraction phase

The second phase of the therapeutic relationship is the introduction phase. During this phase, the nurse and client become acquainted (2). This phase includes creating an environment for establishment of trust and rapport, identifying the client's strength and limitations, and exploring feelings of both client and nurse (2+4+5). The introduction phase also includes formulating nursing diagnosis, setting mutually agreeable goals, in addition to developing a realistic plan of action to meet the established goals (4+5+9). In our study, almost three quarters of the nurses stated that they were either always (32.4%) or usually (38.5%) practicing the introduction phase of the therapeutic relationship, while (20.1%) rarely did it, and (9%) not at all. (Table 3)

Characteristics	Always	Usually	Rarely	Not at all
• Gender:				
a. Male	46.3%	42.1%	10.1%	1.5%
b. Female	49.2%	36.1%	10.5%	4.2%
• Experience years:				
e. 1-10 years	59.7%	35.8%	2.9%	1.6%
f. 11-20 years	31.8%	26.9%	25.7%	15.6%
• Work Area:				
e. Critical units	37.5%	24.7%	21.6%	16.2%
f. Floors/Wards	48.1%	33.1%	11.2%	7.6%

Table 3: The results of introduction phase

The third phase of the therapeutic relationship is the working phase, in which the therapeutic work of the relationship is accomplished (4+7+9). This phase includes problem solving and overcoming client's resistance, in addition to maintaining the trust and rapport that was established during the introduction phase (2+5). The working phase also includes continuously evaluating progress toward goal attainment by using direct and purposeful questions during the interaction with the client, while keeping eye contact with them (4). In our study, the majority of the sample either

always (32.8%) or usually (41.8%) practice the working phase of therapeutic relationship, while (19.7%) of the nurses stated that they did it rarely and (5.6%) not practicing it at all. (Table 4).

Characteristics	Always	Usually	Rarely	Not at all
• Gender:				
a. Male	47.4%	40.1%	10.3%	2.2%
b. Female	48.2%	38.9%	7.5%	5.4%
• Experience years:				
g. 1-10 years	50.2%	42 %	6.3%	1.5%
h. 11-20 years	36.6%	26.3%	22.7%	14.4%
• Work Area:				
g. Critical units	41.9%	28.7%	18.2%	11.2%
h. Floors/Wards	56.8%	30.5%	8.2%	4.5%

Table 4: The results of working phase

The fourth and last stage is the termination phase, in which therapeutic conclusions were brought to the communication and relationship with the client (2+4). This phase includes attaining of mutually agreed-on goals and setting a plan for continuing care, in addition to providing health education according to the client's needs(5). In our study, just one third of the nurses were either always (13.8%) or usually (21.2%) practicing the termination phase, while (35.8%) rarely did and (29.2%) were not practicing the termination phase at all. (Table 5).

Characteristics	Always	Usually	Rarely	Not at all
• Gender:				
a. Male	20.7%	25.5%	30.2%	23.6%
b. Female	16.5%	18.2%	34.9%	30.4%
• Experience years:				
i. 1-10 years	13.1%	20.2%	31.2%	35.5%
j. 11-20 years	18.6%	25.1%	30.1%	26.2%
• Work Area:				
i. Critical units	12.2%	16.8%	39.6%	31.4%
j. Floors/Wards	15.5%	21.3%	36.3%	26.9%

Table 5: The results of termination phase

On the other hand, in response to a question about the biggest perceived barrier to practicing therapeutic relationship phases with their clients; 40% of the nurses think that the most common barrier is gender differences, while 35.4% of the nurses think that the nursing shortage and educational background differences are considered as barriers for the practicing of the therapeutic relationship phases.

Discussion

Although each phase of the therapeutic relationship is presented as specific and distinct from each other, there may be some overlapping of tasks, particularly when the interaction is limited (4). Even then, there are major tasks and goals during each phase and the client-nurse relationship must progress through these phases in succession. So, nurses must identify and practice these phases to build a healthy therapeutic relationship with their clients.

In our study, the preinteraction phase, introduction phase, and working phase were practiced always and usually by the majority (more than 65%) of the participants, while, the termination phase was practiced always and usually by just about one third (35%) of the participants. The small percentage of practicing the termination phase by the participants in comparison with the other phases reflects the high need to train nurses about how to practice the phases of therapeutic relationship, because the therapeutic relationship must progress through the phases in succession to build a healthy relationship with the clients. The termination phase is often expected to be difficult and filled with ambivalence (2+4), which could be caused by the feeling of sadness and loss that may be experienced by both the nurse and the client. However, if the previous phases have evolved effectively, the client generally has a positive outlook and feels able to handle problems independently (5).

The results of our study also show that both male and female participants practice the first three phases of

therapeutic relationship in almost the same percentage, but on the other hand, the male participants practice the termination phase more than female participants. This could be caused by the nature of warm emotions that females have more than males.

In related to years of experience, the results show that the less experienced nurses (1-10 years) practice the first three phases of therapeutic communication more than the highly experienced nurses (11-20 years), which may be because the less experienced nurses are more restricted by the rules of the hospital, and their knowledge is fresher than the highly experienced nurses. In contrast, the results show that termination phases are practiced by highly experienced nurses more than the less experienced nurses, because the termination phase is more difficult to practice than the other phases and needs more experience in dealing with and building relationships with clients.

In addition, the results show that the phases of therapeutic relationship are more practiced in the general floors/wards than the critical units, which may be caused mostly by the fact that the consciousness and orientation status of clients in the critical units are lower than in general floors/wards. Indeed, consciousness and orientation status of the clients is considered as an integral element of nurse-client interactions to build the therapeutic relationship (3).

Furthermore, the barriers of practicing the therapeutic relationship by nurses in our study were mainly the gender differences between the nurse and the client, then by the huge workload that is caused by nursing shortage. In the previous studies, the barriers were mainly the nursing shortage (4+6+7).

Conclusion and Recommendations

The therapeutic relationship is the foundation on which nursing care is delivered. So, nurses who practice therapeutic relationships effectively are better able to initiate change that promote the health, establish trust relationship with the patient, and prevent legal problems associated with the nursing practice. Healthcare institutions must provide effective training to enhance the therapeutic relationship. Indeed, we hope that the hospitals will heed the call to improve discretion for the patients who entrust us with their care.

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VIOLENCE AGAINST NURSES IN THE WORKPLACE

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Introduction

Violence against nurses is making headlines all over the world. It is considered an alarming phenomenon for nurses worldwide. Health care workers don't have immunity from violent encounters, nurses have reported they experienced workplace violence at least one in their professional period (Adib, Al-Shatti, Kamal, El-Gerges, & Al-Raqem, 2002; Beech & Leather, 2005).

In recent years, many studies show that violence against nurses has increased dramatically, and is considered a major health problem (Ayranci, 2005). There is a growing awareness in public opinion regarding violence against nurses. Violence has continued to be a major theme in television, music, advertising, and movies (Whelan, 2008). Violence was included in the 22 priority areas in the healthy people 2000 report (Presley & Robinson, 2002) .

All health care providers are facing more violence than ever before, all over the world. Nurses are the most exposed people of all health care providers to verbal, physical, emotional ,and sexual abuse (Jones & Lyneham, 2001). Nurses are the first and the most available health care provider at hospitals, they are always present in many stressful situations such as deaths, accidents, waiting to visit a doctor , dealing with critical situation in front of families, dealing with lovely persons for others , sending patients to the general floors, and providing the primary care for the patients . All of this may increase the time that they are being exposed to more abuse or violence from the patients or from their companions, than other health care providers(Gates, Ross, & McQueen, 2006; Glasson, 1995).

Many factors make nurses highly exposed to violence from patients and their companions more than other health care providers such as working long hours, hospitals overcrowded , continuous controlling of conditions all the time, nagging patients and families, lack of personnel, many stressful situations, shortage of nurses, and dealing with special and sensitive topics with patients and their families (Crilly, Chaboyer, & Creedy, 2004).

Definition of violence

There is no universal definition of violence in general .There are many different models, theories, philosophical beliefs regarding the definition of violence, causes, consequences, and strategies to solve the problem. Many words are used interchangeably when talking about violence like assault, threats, or workplace violence. Violence against nurses has many definitions, there is no consensus between the researchers about specific definitions of violence against nurses, but all the definitions are consistent with a range of behaviors from verbal abuse to physical assault (Behnam, Tillotson, Davis, & Hobbs, 2009).

The World Health Organization defines violence in general as "the intentional use of physical force or power , threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death , psychological harm, maldevelopment or deprivation" (WHO, 2005).

Nachreiner et al (2007) define violence against nurses as any activity associated with the job, or any events that may happen in the work environment involving any intentional use of physical or emotional abuse against nurses, resulting in emotional and physical consequences. Jones & Lyneham (2001) defined violence as any behavior that intended to cause harm whether it results in it or not, it can be verbal, physical, active, passive, or forced on the victims. It may be direct or indirect, with or without weapon, with or without manifestations of anger to self or for others, with or without clinical signs and symptoms.

Other definitions for violence against nurses is anything that make nurses feel unsafe, afraid, or anything that alters their job through repression, intimidation, or anything that making them not as respectful a person as themselves in job as a nurse. It may be caused by patients, families, doctors ,colleagues, management, or anyone that makes them not comfortable, or creates feelings of inadequacy (Chapman & Styles, 2006).

Every violent situation contains mainly four parts; a perpetrator, causative factors, environment, and the target population. The perpetrator may be the person who commits the criminal act; the person who receives the services from nurses; employees or the relatives of the patients. The causative factors are related mainly to economical, social, emotional, spiritual, and psychological factors. Environmental factors may include population density, family instability, and racial disharmony. The target people, who are the fourth element , is anyone in the health care providers that may subject them to violence , but nurses are the most targeted people for violence (Ayranci, 2005).

Types of Violence

Nachreiner et al. (2007) reported the types of violence against nurses that may occur like physical, verbal, sexual, or a threat. The physical assault may occur when one is hit, slapped, chocked, pushed, grabbed, kicked, or subjected to any physical objects that are intended to cause harm or injury for the nurse. Some actions by relatives may occur such as, lack of trust of nurses, lack of compliance, not waiting for their turn to arrive. The threat may occur when someone uses words, actions, and gestures that are aimed at intimidating, frightening, or causing harm physically or otherwise.

Sexual harassment may occurred when the person experiences any type of unwelcomed sexual behavior, it may be caused by words or actions that may result in hostile and conflicts and stressful work environment (Deeb, 2003).

Verbal abuse may result when the person uses any words that intended to cause harm, or emotional problems for the nurse ,many types of verbal violence have been reported by researchers, such as degradation insults, slamming the table with the fist, hitting, abuse of power, mistreatment, eye contact with disdain, lack of appreciation and appraisal hostile unjustified behavior (Deeb,2003).

Deeb. (2003) conducted a study about the workplace violence in the health sector in Lebanon. The study was qualitative and quantitative. The participants reported that violence is defined as verbal and nonverbal communication, or any behavior that intended to make harm physically or emotionally for the nurses.

Literature Review

The incidence of violence against nurses in the developing countries is not well documented. On the other hand violence in the developed countries has increasingly been brought into public attention since the mid-80 s. In 1987 the UK health and safety commission reported that 1 in 20 health care providers had been threatened with a weapon, and 87% of the staff was worried about being a victim of violence. In the USA , 100 staff of health care providers died from violence between 1980 and 1990 (Glasson, 1995).

Nurses in general are worried about violence, and constantly express fear of being subjected to violence. However, the reasons for their concerns differ between nurses working in hospitals, clinics, home care, public sector, or the private sector (Adib, et al., 2002; Çelebioglu, Akpinar, Küçükoglu, & Engin, 2010).

Deeb. (2003) reported some reasons that make nurses worried about being subjected to violence such as poor salaries, lack of security, poor management of the directors of the nursing, nurses being involved in problems while providing caring for their patients, patients tendency to interfere with nurses work, constant presence of the family members while providing the care for the patients, and the relatives may compare their job with other staff, many nurses enter the room alone while providing care for the patients, many nurses touch the patients, and expose some parts of the patients so the nurses become offended by the way that patients look at them so nurses become afraid of sexual harassment.

Adib et al. (2002) conducted a cross sectional study about violence against nurses in health care facilities in Kuwait. The study involved all nurses working in the health related facilities in all the country in 1999.The majority of nurses were female 85% and 88% of the nurses were non -Kuwaiti. 48% of the sample reported they had experienced verbal abuse in the previous 6 months ago, and physical violence was reported by 7% of the sample. There were no reported cases of physical harm in 63% of patients that reported physical violence. Nurses who reported they had never experienced physical violence, were more likely to be male, had less experience in nursing, non-Kuwaiti, working in hospitals rather than in primary health care centers. The results showed that the verbal abusers were relatives of patients or friends; while the physical abusers were the patients themselves (51 %.) .Only 56% of verbal incidents and 72% of physical violence were reported.

Workplace violence in British and Columbia hospitals was studied by Hesketh et al. (2003). All registered nurses in Alberta and British Columbia were surveyed on their experiences regarding violence in the last 5 shifts. The results showed nurses were experiencing many reported cases of violence, especially in emergency, medical surgical units, and psychiatric units. Most violent people were the patients. The majority of workplace violence cases were not reported.

Workplace violence and abuse against nurses was studied in Iran. Violence against nurses has increased dramatically in Iran in recent years (Shoghi, et al., 2008). Verbal abuse was experienced by the majority of Iranian nurses during the last 6 months period. Physical violence was reported by 27% of the sample during the same period. No physical harm was reported in the 66% of the total cases that reported physical violence. One third of verbal abuse cases were reported, while 50% of physical cases were reported. The majority of nurses

who reported abuse reported it was followed by inaction or actions which failed to satisfy the nurses. And the majority of nurses who were exposed to violence were men, not like other studies, and there was a higher positive relationship between the incidence of violence and years of job experience and the numbers of working hours. Nurses in the emergency department reported a higher incidence of violence than other nurses in other positions.

Workplace violence among Iraqi nurses was studied by AbuALRub et al (2007). The purpose of the study was to investigate the occurrence and the frequency of physical workplace violence among Iraqi nurses, and to investigate the contributing factors that may lead to violence, and to identify the strategies used to protect nurses from violence, and to identify the policies that were used to deal with the violence in Iraq.

A descriptive exploratory survey was used; the sample was 116 Iraqi nurses. The results showed that the majority of nurses reported that they have experienced physical abuse. Few nurses reported there were specific policies regarding workplace violence. At the end of that study nurses were asked an open ended question about the contributing factors for the violence against them, and the policies and measures that were used to solve the problem. Most nurses reported the main causes of violence against nurses in Iraq were related to the nature of the Iraqi environment, because nowadays there is no clear system after the war, insufficient beds for a huge numbers of victims, high mortality rate, bad image for nurses in Iraq, and there was no clear policy regarding violence. There was poor support from higher administrators for nurses, lack of assertive legislations, lack of programs and training courses regarding workplace violence.

Violence against Emergency Nurses

Conflicts and problems with health care providers in emergency departments have increased recently worldwide. Patients and their families are highly dependent on medical staff especially nurses concerning patient's needs, and proper medical management (Lin & Liu, 2005).

Many doctors don't empower the patients by providing support for patients, nor provide good information about them, or at least listen to them in emergency rooms. Nurses consider the public face for the patients and other medical staff. Nurses are usually the first person that patients and their families meet, so nurses are often blamed. Patients don't blame physicians, because they are afraid that a physician may not treat them properly, or refuse to care for them. In effect nurses become a scapegoat for the patients (Lin & Liu, 2005; Presley & Robinson, 2002; Whelan, 2008).

Nurses in emergency department reported higher incident of physical abuse more than other nurses (Behnam, et al., 2009; Crilly, et al., 2004; Hesketh, et al., 2003; Presley & Robinson, 2002). Emergency nurses reportedly experienced violence weekly; the increased level of violence is due to many causes such as increased numbers of patients and families using drugs, or they are alcoholic, or have many psychiatric disorders, stressful environment in the emergency department, presence of weapon, open access for the emergency department for 24 hours, quarrels victims arrive at hospitals angry and aggressive, and the high flow of violence from the community in to the emergency department. In addition, many emergency rooms were crowded, and hand a prolonged waiting times to see the doctors, and shortage of nurses; all of those factors add stress to that people who are already having difficulties in adapting and coping with the highly stressful situations (Adib, et al., 2002; Çelebioglu, et al., 2010; Chapman & Styles, 2006; Lin & Liu, 2005; Nachreiner, et al., 2007).

Gates and colleagues. (2006), conducted a study to describe the violence experienced by workers in the emergency departments, during the 6 months before surgery. The sample was 242 workers from 5 hospitals who were included in the study. The results showed that all workers in the emergency department had verbal assault from patients or families at least once; the paramedics reported 100% of them experienced verbal abuse, while nurses reported 98% had experienced verbal abuse. Nurses and physicians were the highest group that experienced violence in comparison with other workers in the emergency department.42% of workers reported sexual harassment from patients while nurses reported levels of 21% of sexual harassment compared with doctors 13%.

There were 319 reported cases of violence from patients, and 10 cases were reported from families. 65% of workers in the emergency department didn't report the violence to hospital authorities. The majority of nurses didn't report they attended training programs in the previous year. The results found a strong relationship between violence, job satisfaction, and feeling of safety.

Another study that described violence towards emergency nurses by patients was conducted by Crilly et al. (2004), and was done in Australia. The study identified the incidence of violence in 2 emergency departments. The contributing factors and the circumstances were identified in the study. 70 nurses were included in the study; the majority of nurses reported 110 episodes of violence in the last 5 months period, which means 5 violent incidents happened per week. Violence was reported mainly on evening shift. Nurses in that study were pushed, sworn at, or kicked. Nurses reported the majority of violent people were under the influence of alcohol or drugs, or had mental illnesses, which is accompanied by other research that found that the majority of violent people were alcoholic or drug abuser, or with mental diseases (Chapman & Styles, 2006; Merecz, Rymaszewska, Moscicka,

Kiejna, & Jarosz-Nowak, 2006; Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001).

The type of nurse's license may affect the chances of being subject to violence. While the registered nurses are considered the largest health occupation in USA , and licensed practical nurses are considered the second largest group of health care providers (Merecz, et al., 2006). Nachreiner et al. (2007) conducted a study to compare the experiences of violence between registered (RN) nurses and licensed practical nurses (LPN), to investigate the contributing factors and to gain insight to solve the problem. A random sampling of 6,300 licensed nurses was surveyed over the last one year. Self reported violence and demographic data was obtained. The results showed that LPNs had higher rates of physical and nonphysical violence. Nurses who experienced violence were mainly dealing with mental illness patients and nurses who were providing primary care for the patient while working in clinics resulted in decreased risk for exposure to violent conditions.

Violence Against Mental Health Nurses

Recent studies suggests that violence against mental health nurses has increased (Nolan, et al., 2001). The association between mentally ill patients and violence against nurses has undoubtedly been emphasized in the media. The general impression of mental health patients are that they victims of violence not the perpetrators of violence. The general public believe that mentally ill patients are not dangerous and unpredictable; many attempts were done to change this view point (Adib, et al., 2002).

Continuous exposure to violence among mental health nurses led them to accept it as a normal part of their job; nurses failed to demand better strategies to protect them from abusive patients. The environment of nurses in psychiatric hospitals make the patients more aggressive and anxious; inadequate staffing levels, inappropriate training program, uncoordinated treatment interventions worsen the problem, and make the patients more aggressive and abusive (Jones & Lyneham, 2001).

Nolan et al. (2001) conducted a cross cultural study to compare the experiences of violence between Swedish and English mental health nurses. Many studies had been done in each country in this field, but it was the first study in comparing the levels of violence between 2 cultures. The researchers adopted and agreed on the definition of violence against nurses to be used in 2 countries. 296 nurses were included in the study from England, and 720 nurses were included from Sweden. The questionnaire was 20 items, designed to investigate the number, type, severity of violence, effects on self-esteem and satisfaction, and extent to which support provided following the incident happened. The results showed that 71% of English nurses had experienced violence; compared with 59% of Swedish nurses, in the last year. 60% of nurses reported the experience of being subject to violence from mentally ill patients several times. The majority of incidents of violence reported by English nurses were with family members. 2 thirds of Swedish nurses and half of English nurses had never been injured as a result of violence at work .English nurses reported lower levels of self-esteem than Swedish nurses.

The researchers found a positive correlation between perceived influence over work and self-esteem. The results showed that younger nurses , or nurses working in the community, or nurses who receive little support after the incident of violence, are at greater risk for experiencing more violence from mentally ill patients (Chapman & Styles, 2006; Hesketh, et al., 2003; Merecz, et al., 2006; Nolan, et al., 2001).

Consequences of Workplace Violence Against Nurses

Although violence against nurses increased in the workplace recently, it is considered a significant problem in health care providers. The effect of violence exceeds the number of incidents reported, but it has a significantly profound traumatic effect on the primary, secondary, and tertiary victims. Many nurses are suffering from post traumatic stress disorder. All the violent incidents didn't not affects the victim alone, but also harm the aggressor and the people around them. The consequences may occur at different levels, and the severity of the incident varies according to the conditions that are found in that situation. The levels of consequences may occur at many levels,; it may occur at individual level, or at workplace atmosphere, or at the level of services that are provided in health care settings (Adib, et al., 2002; Çelebioglu, et al., 2010; Chapman & Styles, 2006; Lin & Liu, 2005).

The consequences that may occur at the individual level are, resignation of nurses from their jobs, injury, pain, stigma, crying, post traumatic symptoms, and many physical symptoms, firing of employees, suicidal ideation, many psychological problems, less job satisfaction, negative effect on team work, frustration, depression, feeling of being threatened, anger, isolation, distraction, increased medical errors, increased workload on the peers (Whelan, 2008).

While the consequences on the level of work, tension, absence of trust, chaos of work, uncomfortable media for work, aggressive behaviors among peers, delegation, increased workload , absence of team work, and stressful environment (Gates, et al., 2006).

On the level of the services that are provided in the health care settings, bad quality of services, bad image about the health care providers, shortage of nurses, many nurses start to work in many different areas to

avoid being subject to violence, physical damage for the health care settings, bad image from other healthcare providers about the health services that provided in that hospital are noted (Beech & Leather, 2005).

Reporting of Violence

The frequency and severity of violence against nurses is not well documented. Many methodological problems were found in reporting and identification of the actual cases of the violence against nurses worldwide. Some studies reported physical violence alone, while others reported the verbal violence, and other studies reported the threats of being subjected to violence (Jones & Lyneham, 2001).

Little cases have been reported from nurses about their experience of violence, because there is no standard instrument measurement for reporting violence. Nurses found that being involved in violence give them feeling of stigma of being abused, because reporting incidents often conflict with other data that found in the systems, because different instruments, measurements, and definitions have been used. The stigma of being involved in the violence from the patients cause reactions such as fear, shame, threat, isolation, feeling of inferiority in front of peers and limits reporting of the actual cases (Ayranci, 2005).

Nurses found reporting the incident was followed by nothing or improper actions, that didn't satisfy the nurses (Adib, et al., 2002). Nurses reported the actions that were taken were not satisfactory, nurses consider reporting as just time consuming, it lacks formalization, and there were no clear policies regarding the incident. Most nurses consider being victim of violence is the part of their job, and there is no need to report (Chapman & Styles, 2006; Shoghi, et al., 2008)

Policies and Violence Against Nurses

There are no specific measures taken in case of violent incidents reported in many health care centers. Many problems were solved by social workers in the hospital. There is lack of policies that deal with incidents especially violence against nurses. The supervisor or the general manager acts as a mediator between the nurse and the abuser and tries to solve the problems, and to interfere with the conflict. Whenever, the patient, is responsible violent behavior, the general impression that nurses have to be more patients , and to they have is to tolerate patients behaviors as they can stand it (Presley & Robinson, 2002). Most nurses indicated that there are no specific policies regarding violence and workplace violence (Merecz, et al., 2006; Shoghi, et al., 2008).

Strategies to prevent Violence Against Nurses

The Registered Nurses' Association of Ontario (RNAO) takes a 'Zero Tolerance' approach to violence in the workplace. RNAO believes that all nurses have to work in a safe environment, and to use many strategies to keep them safe and protected from violence (Hesketh, et al., 2003). Hospitals have a responsibility to provide policies, strategies, procedures, and interventions to keep their staff safe and protected from violence especially nurses. Governments have to support any interventions or strategies that make nurses safe in their job, which will enhanced safety, and promote job satisfaction (Chapman & Styles, 2006; Wand & Coulson, 2006).

RNAO suggested many interventions to limit the violence against nurses in the workplace. The strategies need an association between nurses, hospitals, administrators, society, organizations, and the individual perspective. Each sector have to do some actions that lead to a decrease in the violence against nurses(Wand & Coulson, 2006) .

Societal organizations have to increase their funding on health care systems, to ensure highest quality of care, and the safest environment for the health care providers. Mental illnesses patients and alcoholic patients have to be supported in their recovery like providing homes, or educational or facilitating opportunities for jobs for those people. Using multi sectorial strategies to address the root of the causes like dealing with poverty and social exclusion will decrease the incidence of violence and will strengthen communities(Stubbs, Winstanley, Alderman, & Birkett-Swan, 2009).

While using strategies at the workplace level, which are the main strategies that can be used by nurses directly, the results will be seen by nurses, like using a zero tolerance policy which will decrease the violence against nurses significantly, and this policy has to be disseminated to all staff, family members, clients, and visitors. Adequate staffing will ensure delivering the care for the patients in a faster way. Continuous educational programs for all nurses, about violence, conflict management, resolving problems, dealing with critical situations, time management, team work, and communication, will be very helpful in decreasing the incidence of violence against nurses. Providing an immediate action plan from the managers and supervisors at the shift especially should be incorporated, especially during night shift, because the majority of violence cases were reported at night. Law agencies have to be included in the management of actual or potential threat, and increasing the security men in the hospital, and with provision of a special program for them about dealing with specific situations like violence against nurses. Support for nurses increase their awareness about reporting the cases (Kling, Yassi, Smailes, Lovato, & Koehoorn, 2010).

While the individual level, many strategies have to be taken ,each individual has the responsibility to respect each other, and to deal with nurses in a more respectful way, without any discrimination based on race, religion, sex, color , ethnicity , or profession (Kling, et al., 2010).

Conclusion

Violence against nurses increased recently; nurses consider violence as one part of their job, so the actual number of cases worldwide is not well documented. There are insufficient policies regarding violence worldwide. Many strategies have been used to prevent violence, but all nurses have to invent more strategies to have them feel them safe in their work, and to feel satisfied.

Nurses have to do more research studies to identify the causes and prevalence of the actual causes, and they have to make difference in the policies, regarding reporting, and follow up the incidents, and use legislation to support being in a safe environment.

Arabic countries have a high prevalence of poverty, low socioeconomic status, unemployment, low level of education, high morbidity of comorbid illnesses, and all of that put nurses high risk of being a victim of violence, so Arabic nurses have to invent strategies to keep them safe in their environment, and to change the policies to support safety, prevent injury, prevent harm, and prevent being at risk for all nurses.

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