

# The translation and cultural adaptation of the Management of Aggression and Violence Attitude Scale – MAVAS – for nurses in Brazil

TRADUÇÃO E ADAPTAÇÃO CULTURAL *MANAGEMENT OF AGGRESSION AND VIOLENCE ATTITUDE SCALE – MAVAS – EM ENFERMEIROS BRASILEIROS*

TRADUCCIÓN Y ADAPTACIÓN CULTURAL DEL *MANAGEMENT OF AGGRESSION AND VIOLENCE ATTITUDE SCALE – MAVAS – EN ENFERMEROS BRASILEÑOS*

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## ABSTRACT

This study translated and culturally adapted the *Management of Aggression and Violence Attitude Scale – MAVAS –* for use in Brazil (BR). The methodology followed the international guidelines for the cultural adaptation of psychometric scales: conceptual equivalence, semantic equivalence, items equivalence, and operational equivalence. A group of judges performed a content validity analysis that resulted in a 23-item scale divided into four factors with satisfactory content validity coefficients (CVCs) for the following parameters: clarity of language (CL; 0.88), practical relevance (PR; 0.91), and theoretical relevance (TR; 0.92). The data were collected in Londrina, state of Paraná, BR in 2011. The MAVAS was translated and culturally adapted for use in BR, and the MAVAS-BR exhibited satisfactory content validity. Future studies concerning the MAVAS-BR are suggested, including the evaluation of psychometric qualities, such as its construct validity and reliability.

## DESCRIPTORS

Psychiatric nursing  
Scales  
Aggression  
Validation studies

## RESUMO

Este estudo objetivou traduzir e adaptar culturalmente a *Management of Aggression and Violence Attitude Scale – MAVAS –* para uso no Brasil. As etapas metodológicas seguiram as diretrizes internacionais para adaptação cultural de escalas psicométricas: equivalência conceitual, equivalência semântica, equivalência de itens e equivalência operacional. A validade de conteúdo realizada por um grupo de juízes resultou numa escala composta por 23 itens divididos em quatro fatores com Coeficientes de Validade de Conteúdo (CVC) satisfatórios nos parâmetros avaliados: (0,88) para clareza de linguagem, 0,91 pertinência prática e 0,92 para relevância teórica. Os dados foram coletados no ano de 2011, em Londrina, PR, Brasil. Concluiu-se que a MAVAS-BR está traduzida e adaptada culturalmente para uso no Brasil e que o instrumento traduzido e adaptado apresenta validade de conteúdo satisfatória. Estudos futuros relacionados à MAVAS-BR são sugeridos, dentre eles a avaliação de suas qualidades psicométricas, como a validade de construto e a confiabilidade do instrumento.

## DESCRIPTORIOS

Enfermagem psiquiátrica  
Escalas  
Agressão  
Estudos de validação

## RESUMEN

Este estudio tuvo como objetivo traducir y adaptar culturalmente el *Management of Aggression and Violence Attitude Scale – MAVAS –* para su uso en Brasil. Las etapas metodológicas siguieron las directrices internacionales para la adaptación cultural de las escalas psicométricas: equivalencia conceptual, equivalencia semántica, equivalencia de los elementos y la equivalencia operacional. La validez de contenido realizado por un grupo de jueces resultó en una escala con 23 ítems divididos en cuatro factores, con Coeficientes de Validez de Contenido (CVC) satisfactorios en los parámetros evaluados: claridad del lenguaje (0,88), pertinencia práctica (0,91) y relevancia teórica (0,92). Los datos fueron recolectados en Londrina, PR, Brasil en el año de 2011. Se concluyó que el MAVAS-BR está traducido y adaptado culturalmente para su uso en Brasil y la traducción y adaptación tiene validez de contenido satisfactorio. Se sugieren estudios futuros con MAVAS-BR para evaluar cualidades psicométricas, como la validez de constructo y la confiabilidad del instrumento.

## DESCRIPTORIOS

Enfermería psiquiátrica  
Escalas  
Agresión  
Estudios de validación

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## INTRODUCTION

Psychiatric emergencies are estimated to constitute approximately 10% of all emergency room (ER) visits in general and a greater proportion in psychiatric ERs specifically. The aggressiveness of the individuals who seek this emergency service is a serious problem faced by general healthcare workers, and this concern is considerably elevated in psychiatric contexts, especially among short-stay psychiatric units. These situations have required the staff who work in these areas to increase their technical and scientific training/knowledge by providing appropriate assistance when facing violent situations to avoid catastrophic outcomes<sup>(1)</sup>.

A search of the studies archived by PubMed<sup>(2)</sup> revealed that 267 articles were published with regard to violence and aggression among healthcare service users between 2000 and 2007, which demonstrates that this problem has worldwide attention. Although the interest concerning studies on violent behavior among healthcare service users has increased, few studies have been conducted in Brazil (BR), especially with regard to the perspective of nurses.

A study conducted in the UK<sup>(3)</sup> demonstrated that 16% of nurses had experienced physical violence over the last year and that one in five professionals who experienced an aggression episode had serious health repercussions leading to work absenteeism. Another study conducted in Switzerland showed that 72% of nurses who worked in psychiatric wards felt seriously threatened and that 70% reported having been attacked at least once during their professional career<sup>(4)</sup>.

Of the few studies on this topic in BR, the majority<sup>(5-6)</sup> have described the profiles of assistance concerning psychiatric emergency care services. The lack of Brazilian nursing publications on this matter is even greater, given that nurses are most often the front line of healthcare services (psychiatric or otherwise) and are most likely to be vulnerable to aggression and violence.

A study conducted with ER nurses<sup>(7)</sup> revealed that these caregivers perceived psychiatric patients as aggressive individuals and placed themselves in a defensive position in relationship to them. Another study conducted with mental health service nurses<sup>(8)</sup> showed that these participants felt unprepared to work in mental healthcare and that 75% of them would prefer to be better prepared to respond to psychiatric emergencies. Furthermore, over a third of these participants reported difficulties in managing patients with aggressive and violent behaviors.

A real difficulty exists in caring for patients during a psychiatric emergency, as is widely known among nurses. A study in Germany<sup>(9)</sup> suggested that these difficulties are due to the lack

of professional training in psychiatric nursing<sup>(8)</sup>. Starting at the undergraduate level, nursing students report difficulties when managing aggressive patients. Thus, these authors noted the need to develop skills through specific training and education.

Unpreparedness and the preconceived notion that the mentally ill are potentially aggressive tend to lead to the idea that patients must be cared for in a specific location (i.e., the asylum model of segregation and exclusion). Thus, effective preventive strategies<sup>(10)</sup> are essential to better prepare mental health nursing teams to provide improved nursing care for people with violent and aggressive behaviors, thereby avoiding outcomes that might physically or mentally affect the nursing staff during an aggression episode.

One strategy for coping with these situations is to recognize the attitudes of these workers with regard to patient aggression and violence. This strategy requires adequate tools to cope with these situations because once the professional understands how to predict and manage violent behavior (including recognizing their attitudes when facing the problem), they also tend to realize that patient violence

and aggression can be minimized via a professional approach. When nurses recognize their attitudes toward aggressive and violent patients, they can more adequately handle their own behavior in the presence of these patients, thereby resulting in the humane and appropriate care of individuals exhibiting aggressive or violent behaviors<sup>(11-12)</sup>.

Given the lack of tools that are capable of measuring nursing professional attitudes toward violent and aggressive patients, the Management of Aggression and Violence Attitude Scale (MAVAS) was created in the UK<sup>(13)</sup>. The current study translated and culturally adapted the MAVAS for use in BR.

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### *The Management of Aggression and Violence Attitude Scale*

The theoretical framework used to construct the MAVAS was based on an understanding of the dynamics of aggressive behavior from three explanatory models: the internal, external, and situational models<sup>(12)</sup>. The internal model suggests a direct relationship between mental disorders/personality and aggressive behavior; i.e., the presence of a mental disorder is a risk factor for violence. Conversely, the external model suggests that environmental or external factors influence the manifestation of patient aggression. Importantly, a therapeutic environment is needed to aid patient rehabilitation. Factors such as gender, length of experience, and staff training likely have a substantial effect on aggressive patient behavior. Despite being commonly reported as external factors, patients contribute to and are influenced by the whole context. The interaction between the staff and the patients can increase aggression, which is correlated with the length of experience and the training of the staff<sup>(11-13)</sup>.

The situational model argues that examining the interaction among the different variable categories, which includes external and internal factors, is necessary when exploring patient aggression and violence. The situational model explores the effect of these combined factors and considers them to be more valid predictors of violence compared with occupational, group, or individual contexts alone.

Managing an aggressive patient requires a greater emphasis on preventing aggression, which involves interventions or controlling the environmental factors that elicit aggressive behaviors. Predicting aggression using the risk factors of violent behavior is also necessary. Finally, an appropriate intervention must be performed by administering medication and physical restraints<sup>(12-13)</sup>.

In most cases, nurses are pressured to coerce and control patients, although they understand the ineffectiveness of these methods<sup>(13)</sup>. The MAVAS<sup>(13)</sup> assists in the improvement and training of staffs who frequently work with aggressive patients.

The original version of the MAVAS was created under this theoretical assumption and is composed of four factors that represent interactional and situational perspectives (Items 2, 3, 6, 20, and 23), external perspective of patient violence and aggression (Items 1, 16, and 27), biological perspectives of violence and aggression (Items 4, 5, 7, 9, and 14), and management perspectives of patient aggression and violence (Items 8, 10-13, 15, 17-19, 21, 22, and 24-26)<sup>(12-13)</sup>.

The MAVAS is a Likert-type scale with response options ranging between 1 and 5, in which 1 represents *strongly agree* and 5 denotes *strongly disagree*. Lower scores indicate stronger agreements between the subject and the explanatory model of violent behavior with which each item is related. An alternative version of the MAVAS is arranged in a 100-mm straight line with two anchor points (*strongly agree or disagree*). Using this format, a caregiver marks the line at the point closest to their rating. The Likert format is used in the current study.

The MAVAS relates the attitudes of nursing professionals with one or more explanatory models, identifies and compares their perceptions of the attitudes and management of patients with aggressive behavior, and assists in continuing education programs. Previous studies have shown that this scale has psychometric properties that are satisfactory, showing a reliability index (Pearson's *r*) of 0.89<sup>(13-14)</sup>.

## METHOD

Adapting a survey for use in another language and culture requires a unique methodology that seeks equivalence between the original source/language and the new language and culture. Therefore, this study is methodological because it assesses the methods for obtaining, organizing, and analyzing data and addresses its development,

validation, and evaluation in a cross-cultural setting. This type of study seeks to adapt an accurate tool for use in the desired language by other researchers.

To translate and culturally adapt the MAVAS for use in BR, the following equivalences were evaluated<sup>(15)</sup>: (1) conceptual, (2) semantic, (3) item, (4) operational, (5) measurement, and (6) functional. This study describes the procedures followed for translation and cultural adaptation (i.e., Steps 1 through 4); however, the remaining steps are ongoing.

### Step 1: Conceptual equivalence

In this step, a literature review of the publications of the MAVAS's cultural aspects and the target population (nurses who work in ERs and urgent care) with regard to the technical and scientific characteristics of British and North American psychiatric care was performed. Authorization to adapt and validate the MAVAS for BR was obtained from its author, Joy Duxbury, via e-mail.

### Step 2: Semantic equivalence

In this step, two professionals with extensive experience and knowledge of English translated the original version of the MAVAS into Portuguese in two separate translations. These professionals had no contact prior to the translation. This process resulted in two translations: T1 and T2. Subsequently, a meeting was organized with the translators and researchers to compare possible discrepancies between the original version and T1 and T2. The result of this meeting was Translation 1-2 (T1-2), the initial version of the Portuguese-language MAVAS.

Following the semantic analysis, a back translation of T1-2 was conducted. Two native-English-speaking bilingual translators who resided in BR (without previous experience with the original tool) performed a back translation of the scale that result in back translations RT1 and RT2.

RT1 and RT2 were provided to a third translator who combined the back translations. After the researchers and translators evaluated this summary, the author of the scale evaluated it. The author accepted this version, only asking that the original title be maintained and suggesting that a few words be changed in the translations and back translations.

### Step 3: Item equivalence

In the third step, a panel of judges composed of a linguist, a psychologist, two psychiatric nursing doctors with experience in scale validation, and two nurses with experience in emergency psychiatric services assessed the scale. To evaluate the scale, the judges first received the original version of the MAVAS, T1, T2, T1-2, RT1, and RT2 as well as instructions for the scale parameters and scoring to evaluate the items, use and sum the scale, and interpretations of the scores and conceptual definitions of the causal factors of aggression based on the original version of the scale<sup>(16-17)</sup>.

At this stage, the judges evaluated the MAVAS with regard to semantic, idiomatic, conceptual, and cultural equivalences. For this purpose, the judges assigned an adequacy score for each item with regard to clarity of language (CL), practical relevance (PR), and theoretical relevance (TR) dimensions<sup>(16)</sup>. Each judge evaluated each parameter using an adequacy scale that varied from 1 to 5 in which 1=*very poor*, 2=*poor*, 3=*average*, 4=*good* and 5=*very good*<sup>(16)</sup>. The judges were able to express their opinions concerning the MAVAS on a form that was part of the validation tool.

After completing this step, a second preliminary version of the MAVAS was created. The content validity coefficient (CVC)<sup>(16)</sup>, which evaluates the agreement between the judges and whose results denote content equivalence, was calculated to examine the content validity or whether the items that composed the scale adequately represented the correct construct. Based on the judges' scores, the mean ( $M_x$ ) score for each item was calculated:

where  $\sum_{i=1}^j 1^{x_i}$  represents the sum of all scores, and denotes the number of judges that evaluated the six items. The CVC

$$M_x = \frac{\sum_{i=1}^j 1^{x_i}}{j}$$

for each item (CVC) was calculated based on  $M_x$ , where  $V_{\max}$  represents the maximum score of an item (5 in this case):

The error term ( $Pe_i$ ) was also calculated for each item. This statistic reduces the bias caused by the analysis of the

$$CVC_i = \frac{M_x}{V_{\max}}$$

six judges represented by

$$Pe_i = \left(\frac{1}{j}\right)^j$$

The final CVC ( $CVC_f$ ) for each item was then calculated:  $CVC_f = CVC_i - Pe_i$ . The overall CVC was calculated by averaging  $CVC_i$  and  $Pe_i$  ( $CVC_t = Mcvc_i - Mpe_i$ ), where  $MCVC_i$  represents the average of  $CVC_i$  in the questionnaire, and denotes the average of the errors of the items in the questionnaire.

The permanence of the MAVAS items must exhibit  $CVC_f \geq 0.8$ <sup>(16)</sup> for the three parameters evaluated. At the end of this step, the previous version of the MAVAS-BR was sent to an independent translator who performed a new back translation. This back translation to English indicated that the Portuguese version strongly resembled the original version, and only simple observations were made.

#### Step 4: Operational equivalence

The fourth step verified the relevance, appropriateness, and clarity of the MAVAS using the target population (pre-test). The pre-test of the MAVAS-BR was conducted with a sample of 20 nurses from mental health services (psychiatric hospitals, psychiatric ERs, and Psychosocial

Attention Centers [Centro de Atenção Psicossocial; CAPS]) in a municipality of the state of Paraná.

For inclusion in the pre-test, nurses were required to work in mental health services, have experience with emergency psychiatric care, and agree to participate in the study. The data were collected in the first semester of 2011 at participants' workplaces. These nurses were informed of the study objectives and received instructions regarding the evaluation.

An open question was added to the end of the scale regarding the nurses' opinions of the MAVAS and the clarity of the questions. Their answers were discussed with each volunteer at the data collection, and this discussion enabled a qualitative assessment of the MAVAS-BR.

In this stage, the wording of the questions of the second preliminary version of the MAVAS-BR was adjusted based on the responses of the target population to whom it would be applied. Unlike the original MAVAS, in which the scale was applied to psychiatric patients, only the nurses received the scale due to the social and cultural differences present among the majority of Brazilian patients and the cultural setting in which the MAVAS was developed.

#### Ethical aspects

The Human Research Ethics Committee (Comitê de Ética em Pesquisa; CEP) of the State University of Londrina (Universidade Estadual de Londrina; UEL) approved this study (CAAE [Certificado de Apresentação para Apreciação Ética, or Certificate of Ethical Appreciation]: 3060.0.000.268-09), and all participants freely signed an informed consent form (ICF).

#### Sample characteristics

The sample for the adaptation and cultural validation pilot study of the MAVAS-BR was predominantly composed of females (85%), and more than 60% were over 40 years old. Half were specialists in psychiatric nursing and mental health with more than 10 years of experience in the field, and the majority (60%) worked in psychiatric hospitals.

## RESULTS

Discrepancies were not found in the translation and back translation of the MAVAS; thus, these versions were immediately sent to the judges for analysis. The initials MAVAS were maintained, and the initials BR (for Brazil) were added to the end to denote its adaptation for use in this country. This naming procedure upheld the wishes of the original author because the tool is internationally recognized and facilitates database searches. The original author also suggested that the term *aggression* (*agressividade*), which was back translated as *aggressive* in Items 20 and 21, be translated as *aggression*, per the original version.

In the semantic evaluation of the MAVAS-BR, Item 26 (*The use of de-escalation successfully prevents violence*)



was excluded from the Brazilian adaptation because it did not reach the cutoff point of  $CVC \geq 0.8$ .

In the translation of Items 6 and 20, the word *staff* was translated as *team*. The judges suggested that *professionals* was a better translation.

The original author and the judges agreed that the word *ward* should not be changed to *health facility*; thus, the word *ward* was maintained. According to the original author and the judges, the word *ward* was translated in Items 6, 20, and 21 as *health unit*. With regard to the allocation of each item in the original factors, all judges agreed that the proposed dimensions were correct, and no changes were applied to the adapted version.

Four items that did not reach  $CVC \geq 0.8$  were excluded by the judges' scoring analysis of the semantic, idiomatic, conceptual, and cultural equivalences after assigning an adequacy score for each item for clarity of language (CL), practical relevance (PR), and theoretical relevance (TR).

Specifically, Items 8 (*Different approaches are used in the ward to manage patient aggression and violence*), 9 (*Patients who are aggressive toward professionals should try to control their feelings*), 22 (*Prescribed medications can sometimes lead to patient aggression and violence*), and 26 (*The use of de-escalation successfully prevents violence*) were excluded from the MAVAS-BR. With the exception of Item 8, all items addressed *views concerning the management of aggression and violence*.

When the four steps to translate and culturally adapt the MAVAS-BR were finished, the scale was composed of 23 items (85.2%) from original version. All of the items that remained in the Brazilian version had satisfactory CVC. The CVC of the MAVAS-BR for each parameter evaluated by the judges were 0.88, 0.91, and 0.92 for CL, PR, and TR, respectively (Table 1). Table 1 displays the four factors and the respective items that represent and constitute the MAVAS-BR, as well as the parameters used for content validation<sup>(16)</sup>.

**Table 1** – The final version of the MAVAS-BR, resulting from the translation and cultural adaptation for use in Brazil; Londrina, state of Paraná, Brazil, 2011

Item	Sentence	CL*	PP**	RT***
<b>Factor 1: Interactional and situational perspective (Perspectiva interacional/situacional):</b>				
02	Other people make patients aggressive or violent.(outras pessoas fazem os pacientes ficarem agressivos ou violentos);	0.95	0.87	0.96
03	Patients commonly become aggressive because staff do not listen to them.(os pacientes, normalmente, se tornam agressivos porque os funcionários não lhes dão atenção);	0.93	0.85	0.96
06	Poor communication between staff and patients leads to patient aggression (a má comunicação com os profissionais pode tornar o paciente agressivo);	0.88	0.88	0.88
20	Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence (a melhora na relação entre os profissionais e pacientes pode reduzir a incidência de agressividade no paciente);	0.87	0.93	0.84
23	It is largely situations that contribute towards the expression of aggression by patients (de uma maneira geral são as situações que levam os pacientes a serem agressivos);	0.93	0.99	0.98
<b>Factor 2: External perspective (Perspectiva externa ou ambiental):</b>				
01	Patients are aggressive because of the environment they are in (os pacientes são agressivos por causa do ambiente em que eles se encontram);	0.94	0.95	0.99
16	Restrictive care environments can contribute towards patient aggression and violence (os ambientes de cuidado muito rígidos podem contribuir para a agressão e violência);	0.87	0.87	0.85
27	If the physical environment were different, patients would be less aggressive (se o espaço físico fosse diferente, os pacientes seriam menos agressivos);	0.99	0.99	0.99
<b>Factor 3: Biological perspective (Perspectiva biológica):</b>				
04	It is difficult to prevent patients from becoming violent or aggressive (é difícil evitar que os pacientes se tornem agressivos);	0.85	0.87	0.84
05	Patients are aggressive because they are ill (os pacientes são agressivos porque estão doentes);	0.99	0.99	0.99
07	There appear to be types of patients who frequently become aggressive towards staff (há tipos de pacientes que frequentemente se tornam agressivos com os profissionais);	0.87	0.85	0.82
14	Aggressive patients will calm down automatically if left alone (os pacientes agressivos automaticamente se acalmam se deixados sozinhos).	0.86	0.81	0.86
<b>Factor 4: Management perspectives of patient aggression and violence(Manejo da agressão e violência):</b>				
10	When a patient is violent, seclusion is one of the most effective approaches to use (quando um paciente está violento, o isolamento é uma das abordagens mais eficientes a ser usada);	0.80	0.83	0.87
11	Patients who are violent are often restrained for their own safety (os pacientes violentos frequentemente são contidos para a sua própria segurança);	0.84	0.89	0.89
12	The practice of secluding violent patients should be discontinued (a prática de isolar pacientes violentos deve ser evitada);	0.83	0.99	0.99

Continue...

...Continuation

Item	Sentence	CL*	PP**	RT***
12	The practice of secluding violent patients should be discontinued (a prática de isolar pacientes violentos deve ser evitada);	0.83	0.99	0.99
13	Medication is a valuable approach for treating aggressive and violent behaviour (a medicação é uma abordagem valiosa no tratamento de comportamentos agressivos e violentos);	0.99	0.99	0.99
15	The use of negotiation could be used more effectively when managing aggression and violence (a negociação poderia ser usada com mais eficiência quando se lida com agressão e violência);	0.82	0.86	0.89
17	Expressions of aggression do not always require staff intervention (as manifestações de agressividade nem sempre exigem intervenção dos profissionais);	0.89	0.99	0.99
18	Physical restraint is sometimes used more than necessary (algumas vezes a contenção física é utilizada mais que o necessário);	0.99	0.99	0.99
19	Alternatives to the use of containment and sedation to manage patient violence could be used more frequently (as alternativas ao uso de contenção e sedação para lidar com a violência de pacientes poderiam ser utilizadas com mais frequência);	0.95	0.93	0.93
21	Patient aggression could be handled more effectively on this ward (a agressividade do paciente poderia ser lidada com mais eficiência nesta unidade de saúde);	0.82	0.99	0.93
24	Seclusion is sometimes used more than necessary (algumas vezes o isolamento é usado mais do que o necessário);	0.80	0.92	0.93
25	Prescribed medication should be used more frequently to help patients who are aggressive and violent (os medicamentos prescritos deveriam ser usados com mais frequência para ajudar pacientes que estão agressivos e violentos)	0.80	0.82	0.93
<b>Total (CVC)</b>		<b>0.88</b>	<b>0.91</b>	<b>0.92</b>

CL\*=Clareza de Linguagem, PP\*\*=Pertinência Prática, RT\*\*\*=Relevância Teórica

Factor 1 was composed of five items; Factor 2 was composed of three items; Factor 3 was composed of four items, and Factor 4 was composed of 11 items. Table 1 shows that Items 5, 13, 18, and 27 had the highest parameter score possible (i.e., 0.99).

An open-ended question at the end of the MAVAS-BR solicited comments and suggestions from the professionals who participated in the pre-test. The analysis of this question revealed that one participant expressed doubts regarding Items 10, 12, and 24. Specifically, this participant argued that the term *seclusion* might be understood as physical and chemical containment, the attitudes of the professionals, or even hospitalization as a means of social isolation. During the clarifications that were made to each of the participants in this step, the meaning of this term was explained to this participant as *seclusion from others and physical restraint in a private room for this purpose*.

## DISCUSSION

The translation and cultural adaptation of the MAVAS for use in BR was conducted systematically and followed all the steps recommended by the guidelines for the cultural adaptation of psychometric scales<sup>(17)</sup>.

In the judge-performed semantic evaluation, Item 26 (*The use of de-escalation successfully prevents violence*) was excluded because it did not reach the CVC required for the permanence. The item was excluded due to a disagreement among the judges regarding its clarity. This confusion might have been due to the word *de-escalation*; although this term refers to a widely used nursing technique, it is unknown to most professionals.

De-escalation is the gradual resolution of a potentially violent or aggressive person via verbal and physical

expressions of empathy, alliance, and non-confrontational limit setting based on the respect between the professional and the patient<sup>(18)</sup>.

The judges suggested excluding Item 26 because it was not a part of the scientific context regarding mental healthcare in Brazil. The specialized literature<sup>(16)</sup> discusses the occurrence of this type of problem with regard to the equivalence of advanced technical terms from other countries and cultures, but the committee was able to make a final decision.

Items 10, 12, and 24 contained the word *seclusion* but remained in the MAVAS-BR. Although ample legal considerations exist regarding the limitations of using seclusion techniques and physical restraints, they are still practiced in varying degrees; however, these practices have been misaligned with the principles of Brazilian psychiatric reform<sup>(5-8)</sup>. These items showed satisfactory CVC, with the caveat that their psychometric properties (and those of the other items) should be evaluated in future studies. The fact that the use of seclusion and physical restraints is considered inhumane and controversial from legal and technical standpoints in Brazilian psychiatric practices was considered when judging these items<sup>(5-8)</sup>. In addition, efforts exist outside of BR to reduce or use these practices as a last resort<sup>(19-22)</sup>.

The items eliminated by the judges were 8 (*Different approaches are used in the ward to manage patient aggression and violence*), 9 (*Patients who are aggressive toward professionals should try to control their feelings*), 22 (*Prescribed medications can sometimes lead to patient aggression and violence*), and 26 (*The use of de-escalation successfully prevents violence*). These items were deficient with regard to all three aspects analyzed by the judges (CL, PR, and TR), which led to their exclusion.

Because approximately all terms (except for Item 8) belonged to the factor *views concerning the management of aggression and violence*, differences in the management of patients with aggressive behavior might exist between the UK (i.e., the country of original MAVAS) and Brazil. This supposition might be confirmed in the next steps of this study, which evaluate the psychometric properties of this tool.

Importantly, one participant noted that the word *seclusion* might be perceived in different ways during the operational step. Similar to the way in which admission to Brazilian psychiatric hospitals is criticized, a concern also exists regarding seclusion and physical restraints, which should be used only as a last resort<sup>(1,20-22)</sup>.

Despite the advances provided by this study, its results should be interpreted with caution given its limitations. Among these limitations are the differences in the validation process compared with that of the original scale, in which this tool was used with patients and nurses<sup>(12-13)</sup>, and the fact that the participants in the pre-test were recruited from a single municipality in one region of the country.

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## CONCLUSION

The MAVAS-BR was translated and culturally adapted for use in Brazil. The methodological process was guided by international guidelines to conduct this type of study; thus, this translated and adapted tool has satisfactory content validity.

This study creates opportunities for future studies regarding the use of the MAVAS-BR in Brazil, including the evaluation of its psychometric qualities (e.g., construct validity and reliability) and the identification of the attitudes of Brazilian nurses toward violent and aggressive patients.

This study significantly advances psychiatric nursing, specifically with regard to emergencies and urgent care, given the relevance and importance of providing a tool that has been validated in Portuguese to measure the attitudes and perceptions of Brazilian nurses concerning violent patients. Ultimately, this study contributes to improving the care and training of nursing professionals.

Finally and importantly, the translated scale has great potential for application in academia and medical care, thereby enabling a greater interest in psychiatric nursing given that this topic has been seldom explored in BR.

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