Making sense of incidents of violence and aggression: A constructivist grounded theory analysis of inpatient mental health nursing staff's experiences

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ABSTRACT

Introduction: While previous research explored nursing staff's perceptions of violence and aggression thematically, there was a gap identified for in-depth analysis of the social processes and narratives which inform such perceptions.

Aims: To explore the social processes underpinning narratives used to conceptualise violence and aggression. To identify which narratives support or threaten staff in constructing a positive professional identity.

Method: Eight semi-structured interviews were completed with nursing and support staff who had worked, or currently worked in adult mental health inpatient contexts in the national health service of the United Kingdom. Analysis was conducted applying principles of constructivist grounded theory.

Results: A model, 'the impact of narratives of violence and aggression on professional identity construction' was generated. This integrated four key theoretical codes: 1) constructing a positive nursing identity; 2) constructing the (un)deserving patient; 3) professional identity threats related to violence and aggression; and 4) mediating factors and support following violence and aggression. The theory explored the social processes which mediated the use of different narratives; and which narratives operated as protective or threating to the construction of a positive nursing identity. The theory further identified processes of support which could mitigate detrimental emotional and behavioural responses staff may experience following incidents. Narratives that contextualised violence and aggression in relation to restrictive ward environments, threat-responses, and patients' previous experiences of trauma seemed to support empathy and understanding.

Conclusion: Contextualising violence and aggression in terms of environment and distress in nursing teaching; staff training; and reflective practice may prove beneficial. Debriefs, supervisor support, and informal support from peers and senior team members seemed important following incidents. Mental health support may benefit staff whose emotional and behavioural responses to violence and aggression

are acute, or long-lasting. Further research could support transferability and amplify underrepresented voices such as racialised staff.

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1. INTRODUCTION

The introductory chapter will start with a working definition of the terms violence and aggression (VA). A narrative review will contextualise the issue, covering the prevalence of VA from patients in nursing contexts; VA within inpatient mental health (MH) contexts; approaches to prevention, management, and response to VA; and psychological consequences for nursing staff. A systematic-style review will then be presented which will further explore research conducted on staff experiences of VA in inpatient nursing contexts, and identify gaps in the understanding of the social processes involved in construction of narratives around VA. This will set the rationale for this study – exploring underlying social processes behind how nursing staff construct meaning from experiences of VA; and which processes and narratives help, or hinder them with creating a positive professional identity.

1.1 Definition of Violence

When using the terms violence or aggression or the abbreviated form – VA, I will be using the following definition of interpersonal violence

> "Violence is 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." (World Health Organization (WHO), 2020, p. 82)

As well as being comprehensive, it is a good fit for this as it is used in the National Health Service (NHS) violence prevention and reduction standard (National Health Service (NHS) England & NHS Improvement, 2020). I will additionally include verbal abuse of a threatening or discriminatory nature.

1.2 Narrative Review

1.2.1 Prevalence of Violence and Aggression in Nursing

Questions in the 2021 NHS staff survey (NHS, 2022) aligned with the People's Promise to make the NHS a good place to work including: 'we are safe and healthy' (NHS, 2021, p. 6), covering: staffing levels, experiences of physical violence, harassment, bullying and abuse, work-related stress, and burnout (2022). Only 27% of staff who responded agreed staff levels were adequate; 14.3% had experienced physical violence and 27.5% had experienced harassment, bullying or abuse from patients, relatives of patients or members of the public in the past year (NHS, 2022). Issues of pay and working conditions have resulted in unprecedented strike action from nurses in the United Kingdom (UK) (Royal College of Nursing (RCN), 2022). The Royal College of Nursing (RCN), the professional registering body and largest union for nursing staff in the UK, published workforce standards which specify prevention of, and response to violence and aggression (VA) as a health and safety requirement; and have campaigned for standards of safe nursing staffing to be ratified by law (RCN, 2022). Their annual staff surveys provided a snapshot of the context in which nurses are working; and notably contained an entire section on physical and verbal abuse. Almost two thirds (64.3%) of nurses surveyed had received verbal or physical abuse from a patient or relative in the last year (McIlroy & Maynard, 2022). Power within the hierarchy is also an important factor, respondents to the RCN survey reported a lack of respect for nurses, that patients were more likely to abuse them than doctors (McIlroy & Maynard, 2022); and previous research has found that staff who are less experienced, and a younger age are more likely to experience abuse (Edward et al., 2014). The government response to striking staff, as well as a pay offer to nursing and other allied health professional staff, also outlined their commitment to continued work on reducing deliberate VA (Department of Health and Social Care (DHSC), 2023). VA may disproportionately impact racialised nursing and support staff; a recent NHS England policy focused on challenging racism included responding to VA (NHS England, 2022).

1.2.2 VA in Mental Health and Inpatient Nursing

The vacancy rate across England for MH Nurses was higher than the general nursing vacancy gap in all seven regions measured: data from 2021/22 showed a vacancy rate of 16:5% in MH nursing, compared 10% nationally, and in most regions, the vacancy rate increased from the previous year (NHS Digital, 2022b). Such gaps in the workforce have resulted in services running with less staff than required, and/or increased use of agency or 'bank' staff, often unfamiliar with the service and patients. Staff shortages have been linked with increases in incidents of violence from patients against staff (Bellman et al., 2022; Gilliver, 2020; HSJ & Unison, 2018; RCN, 2018). Staff in MH settings were found to be over seven times more likely to be assaulted than other staff (HSJ & Unison, 2018). There were higher rates of physical and verbal abuse against inpatient than community nurses; and MH inpatient settings had the highest rates of physical and verbal abuse (McIlroy & Maynard, 2022).

1.2.3 VA in the Workplace: Legal Context

Staff in NHS workplaces remain protected by standard UK health and safety legislation. NHS staff in England and Wales who were victims of assault have been awarded additional protections in the form of the Assaults on Emergency Workers Act; which increased sentencing for those guilty of such assaults to a potentially unlimited fine, and a maximum of 12 months imprisonment (compared with a maximum of six months for common assault) (UK Parliament, 2018). For inpatient MH staff, however, the legal context has tended to be more complicated.

A memorandum of understanding (MOU) between the police and the RCN detailed incidents that would require police response to inpatient MH contexts which included: immediate risk to life and limb, immediate risk of serious harm, serious damage to property, offensive weapons, and the taking of hostages (College of Policing, 2017, pp. 8–9). In 2016 the Guardian reported statistics from London trusts showing the Metropolitan Police (Met) often did not respond to staff's requests for help at inpatient MH units, and linked this to reported guidance by the Met since 2013 not to respond unless there is "significant threat to life or limb", something the

Met denied (Quinn, 2016). While acknowledging that two thirds of violence against NHS staff is within a MH context, one police body asserted that if NHS services increased their compliance with health and safety and human rights, police would not need to attend to help manage safety on wards as frequently, if at all (National Police Chiefs' Council (NPCC), 2020). This is a complex area: while VA in the workplace has been considered to violate employees human rights (WHO & International Labour Organization (ILO), 2022); this MOU (College of Policing, 2017) rightly highlighted the need for an approach that balanced this with the human rights of vulnerable patients at risk of (re)traumatization, who may be frightened by police presence.

1.2.4 Service Context: Inpatient Mental Health Settings

For the purposes of this research the term 'inpatient MH settings' included different contexts such as, acute MH inpatient wards, psychiatric intensive care units (PICUs), and forensic secure inpatient MH services. Many patients in MH inpatient wards have been compulsorily detained under the Mental Health Act (MHA) (1983).

1.2.4.1 Mental health act

The rate of involuntary admission using the MHA has continued to rise since the late-80s, and by 2016 had almost doubled compared to 1988 (Sheridan Rains et al., 2020). While rates of admissions for treatment have not increased significantly, there have been large increases in detention for assessment; though it has not been possible to establish the proportion of detentions representing first-time admissions, versus individuals detained more than once (Sheridan Rains et al., 2020). Reasons for increased detentions are complex, some possible associated factors have been posited as increasing rates of MH issues, demographic changes – increases in population of people from groups disproportionately detained, a reduction in beds driving early discharge and subsequent readmission, perceived need to section patients due to less informal admission resource (Sheridan Rains et al., 2020) and; economic recession, austerity and the impact on health and social care provision, and legislative changes in the MHA which have led to its increased use for admissions that would have previously been informal (Smith et al., 2020). There has

been evidenced disparity in detentions and restrictive practices according to ethnicity and gender. Black and Black British people were detained at over four times the rate of White British people (NHS Digital, 2022a) and were more likely be subjected to restrictive practices, including seclusion and prone physical restraint, compared to other ethnicities (Payne-Gill et al., 2021). Non-binary identifying people were repeatedly detained more often than those identifying as female or male (around 46% non-binary people, 20% of female, 18% of male) (NHS Digital, 2022a). The Care Quality Commission's (CQC) annual health and social care report highlighted MH services as high risk for developing 'closed cultures' – characterized by six common features: abusive and restrictive practices; inadequate training and staff competence; a culture of covering up when things go wrong; poor management and leadership; generally poor care; and unacceptable quality of reporting (Care Quality Commission (CQC), 2021, p. 53). In line with relevant law (Mental Capacity Act (MCA), 2005; MHA, 1983), guidance has mandated avoidance and minimisation of the use of restrictive interventions (National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU), 2016; National Institute for Health and Care Excellence (NICE), 2015; Royal College of Psychiatrists (RCP), 2019b, 2019a, 2020) such as chemical restraint (for example, rapid tranquilisation), physical restraint, and seclusion; though the Care Quality Commission (CQC) reported no reduction despite clear recommendations in 2020 (CQC, 2022). Restrictive practices such as enforced medication and seclusion have resulted in patients being treated in undignified ways, and potentially breached their right to freedom from torture and inhuman and degrading treatment (Human Rights Act (HRA), 1998; Universal Declaration of Human Rights (UDHR), 1948). The right to freedom from torture and inhuman and degrading treatment has been designated an absolute right: meaning there are *no acceptable circumstances* in which this right can be interfered with, unlike rights to liberty, or life which may be conditional depending on danger to others. There have been many recent exposés of human rights abuses perpetrated against patients by staff on inpatient MH wards – particularly of people with learning disabilities, all of which are in keeping with the description of closed cultures: Winterbourne View (Cafe, 2012), Whorlton Hall (Triggle, 2019), Edenfield Centre

(Panorama, 2022), and wards at Essex Partnership University NHS Foundation Trust (Dispatches, 2022). Psychologists and other state-registered and state-employed professionals have agreed to the duty to work toward upholding human rights principles in their places of work, and to protect and respect the rights of staff and patients as bearers of these fundamental rights (Patel, 2019, p. 2). While staff deserve a place of work free from abuse, attempts to understand the impact of VA towards staff must be considerate of this context.

1.2.4.2 Mental capacity act

Another relevant piece of legislation is the Mental Capacity Act (MCA) (2005) which has outlined when best interest decisions may be made on behalf of someone who is unable to make these decisions for themselves due to disturbed or impaired brain function. This may be applied to any decision, whereas the MHA covers detention and treatment for MH only. Guidance has outlined that it is necessary to assume capacity, help people make the decision with support, and not prevent someone from making a decision purely because it is not wise (MCA, 2005). Capacity has been defined as a dynamic construct: a person can only be assessed as lacking capacity for each specific decision, at that particular time if they are unable to understand, weigh, and retain relevant information sufficiently to make the decision, or to communicate their choice (MCA, 2005).

1.2.4.3 NHS standards and guidelines on VA

The NHS violence prevention and reduction standard (VPRS); outlined a risk-assessment framework putting the onus on trusts to commit adequate resources for preventing and reducing violence against staff (NHS England & NHS Improvement, 2020). Though it mandated biannual review, elements of the VPRS remained open to interpretation, for example it advised designating ‘appropriate and sufficient resources’, yet offered no tangible definition of what may be considered appropriate or sufficient (NHS England & NHS Improvement, 2020, p. 9).

Improvements to NHS inpatient ward environments have been stated as a key priority within the NHS Long Term Plan (NHS, 2019, p. 71). There was specific guidance on the buildings that house adult acute MH units which highlight issues of

relational, procedural and physical security (Department of Health (DoH), 2013). It included considerations such as: natural light, colour, space, ventilation and temperature control, artwork, noise levels, external areas, and smoking (DoH, 2013). Smoking has been outlined as potentially problematic on wards: the NHS have stated an aim for all inpatients being offered NHS-funded cessation support by the end of the 2023/24 (NHS, 2019); though prohibiting smoking has been argued to lead to secret smoking, increasing risks of fire, and VA (DoH, 2013). The use of physical measures such as locked wards has continued to be part of ward security arrangements (Allen, 2015). Relational security has outlined prevention of VA through the ward environment: privacy, quiet and relaxed areas to socialise, good lines of sight, places staff can intervene therapeutically, agreed 'rules' for living together, and regular access to fresh air (Allen, 2015, p. 35). These considerations were broadly in line with the Safewards model, which resulted in in a 15% reduction in conflict events, and a reduction of restrictive practices of over a quarter in a randomized controlled trial of over 30 NHS inpatient MH wards (Bowers et al., 2015). Ward environment has been a crucial consideration for VA in inpatient MH contexts, though as this is something that often cannot be controlled directly by nursing or support staff, it will not be a main focus of this review.

According to service standards staff should be trained in conflict management and verbal de-escalation techniques to prevent VA (NAPICU, 2016a; RCP, 2019b, 2019a, 2020). Guidance on the short-term management of VA in MH settings has offered a nuanced understanding of multiple factors and covered risk assessment, prevention, and response (NICE, 2015). The National Institute for Health and Care Excellence (NICE) advocated for: staff training in understanding relationships between aggression and MH, de-escalation skills and response including restrictive practices; risk assessment of "constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors"; offering psychological therapy; and post-incident debriefing (NICE, 2015, p. 69). Recent and regular training in management of VA has been associated with lower levels of hyperarousal in psychiatric inpatient nurses (Hilton et al., 2022). A common approach to VA prevention in training for NHS inpatient MH staff has been relational security

(NAPICU, 2016; RCP, 2019b, 2019a, 2020); a framework which has denoted four key safety elements on wards: team factors, including how staff communicate boundaries and provide therapeutic input; other patients, interpersonal dynamics; the inside world, comprising the ward environment and personal world of patients – such as their mood; and the outside world, relationships with visitors and contacts maintained in the community (Allen, 2015).

A systematic review included studies in which up to 80% of VA incidents remained unreported to managers (Edward et al., 2014). Barriers to reporting included: unclear procedures, lack of management support, previous inaction (Edward et al., 2014); time constraints, not knowing what would improve, fearing blame, perceived police inaction, high thresholds for verbal aggression in 'unwell' patients, not knowing what to write if 'personality' was perceived as a factor, and a high tolerance for assaults against nurses compared to other staff groups, such as doctors (Archer et al., 2019).

There has been an assumption in the guidance above that staff have understood potential causal, mediating factors, and triggers for VA well enough to prevent and manage VA, and support patients to identify early signs; it will be important to explore in depth if this is the case.

1.2.5 Causes and Contributory Factors to VA in Inpatient MH Contexts

Some state-based patient-related factors – related to transient and dynamic states of emotion, that have been associated with VA included alcohol use (Bowers et al., 2009), substance use (Dack et al., 2013; Salzmann-Erikson & Yifter, 2020), and boredom (Foye et al., 2020). Some demographic risk factors included younger age and male gender (Dack et al., 2013). Reviews associated some diagnoses for example, psychosis (Asikainen et al., 2020; Dack et al., 2013; Salzmann-Erikson & Yifter, 2020) and affective diagnoses (Salzmann-Erikson & Yifter, 2020). Personality disorder (PD) diagnoses have been associated with VA (Asikainen et al., 2020; Harford et al., 2019, 2019; Howard, 2015; Salzmann-Erikson & Yifter, 2020): with mediating factors suggested as: impulsivity (Harford et al., 2019; Howard, 2015), emotional dysregulation, delusional ideation (Howard, 2015), severe anger, and disturbance in identity (Harford et al., 2019).It has remained unclear how such

proposed mediating factors have discriminant validity for PD in particular. PD diagnoses have attracted criticism, for pathologizing natural responses to experiences of abuse, in a context of relative lack of power (Shaw & Proctor, 2005, p. 485). Nonetheless, discourses around diagnoses seemingly prevail in the NHS, so will doubtless be relevant to considering how nursing staff make meaning of VA in these contexts. A systematic review will explore this further.

1.2.6 Psychological Consequences of VA

Nursing staff have been found to be impacted by VA in multiple ways which could be experienced as traumatic, potentially experiencing distress associated with being subject to VA, witnessing VA against colleagues, and enacting and witnessing the VA of restrictive practices against patients. The emotional consequences of traumatic experiences such as VA for MH and nursing staff have been researched by applying multiple psychological constructs in previous literature. These have included occupational consequences which can impact professionals' ability to maintain empathy and energy such as, burnout and compassion fatigue (for a more comprehensive timeline of associated constructs and analysis of their unique historical and epistemological origins see: Newell et al., 2016); moral distress, and moral injury; as well as diagnostic constructs related to trauma, such as post-traumatic stress disorder (PTSD). Alternatives to diagnostic understandings of distress following potentially traumatic events have been proposed, such as the trauma informed approach (TIA) and the power threat meaning framework (PTMF).

1.2.6.1 Occupational consequences

Burnout, first hypothesised by Freudenberger (1974) featured in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon resulting from exposure to long-term work stress, resulting in: reduced efficacy; negativity or cynicism; and exhaustion (WHO, 2019) – the three aspects measured in the Maslach Burnout Inventory (MBI) (Maslach & Leiter, 2021). The NHS have recognised burnout as a serious threat to staff's wellbeing, a financial risk in lost employment hours, and a compromise to good patient care (NHS Employers, 2022). A systematic review of studies with inpatient MH nursing staff found burnout

to be a potential risk factor for PTSD following an experience of VA (Hilton et al., 2022).

Compassion fatigue was identified as an aspect of burnout; which particularly impacted caring professionals; described as an inevitable detachment from feelings, and indifference to patients, caused by persistent stressors (Joinson, 1992); and a process by which professionals have absorbed clients' suffering, eventually resulting in a loss of compassion (Figley, 2015). Professionals working with clients who have experienced trauma have been highlighted as vulnerable to compassion fatigue due to: frequent exposure to trauma; high levels of empathy; and many having their own (possibly unresolved) experiences of trauma (Figley, 2015). A recent systematic review of international quantitative literature on compassion fatigue in MH nursing found substantial variance in prevalence (Marshman et al., 2022). There was no clear relationship found in this study between levels of workplace violence and compassion fatigue, though only four studies were from contexts with high reported levels of violence (Marshman et al., 2022). The authors identified some potential protective and mitigating factors against compassion fatigue, including culture and leadership, reflection and clinical supervision (Marshman et al., 2022); all of which could be influenced by clinical psychology work into teams.

Moral distress was first described in the 1980s, as the distress felt by being in a situation where you cannot act in the way that you know to be right (Jameton, 2017). Given the impact of understaffing, it is understandable that this has been a concept often referred to in relation to NHS nursing, as it helpfully recognised the context as vital (Jones, 2021). Shay defined moral injury as 'a betrayal of what's right, by someone [in] authority, in a high stakes situation' (Shay, 2014, p. 183). This seemed pertinent for inpatient MH settings, as recorded use of restrictive practices may be considered as fitting the concept of betrayal by authority; indeed a recently published literature review which explored possible sources of moral injury for inpatient MH staff found that some felt that it stood against their values and moral standards to limit people's daily freedoms to the extent seen in services (Webb et al., 2023). This systematic review included 20 international studies on moral distress, eight on

ethical challenges, and one on moral injury. Authors constructed 19 main concepts that were mediating factors for moral injury in healthcare staff which included: the context of restrictive practices and coercion in care; medicalisation with a main focus on risk and medication; depersonalisation – emphasis on task completion; a culture of dehumanisation of staff and patients; poor physical environments; staff hierarchy preventing challenges from nurses, and resulting in their role being minimised by senior colleagues; the challenge of balancing risk and care; and questioning their abilities to do the job well (Webb et al., 2023). The study did not explore patient VA specifically as a potential mediating factor impacting on moral injury or moral distress for healthcare staff.

A problem common to the concepts of, burnout, moral injury, moral distress, and compassion-fatigue has been their individualistic framing which can be said to pathologize individuals as having failed to correctly process traumatic events. This has potentially resulted in a danger that such constructs, not intended as diagnoses, have started to be used in this way. Maslach wrote that the MBI has been misused as a diagnostic tool which she described as unethical – as burnout is not an illness, and the measure was not designed for the purpose of individual diagnosis (Maslach & Leiter, 2021). The potential danger is for such terms to become medicalised, individualised narratives, placing the onus for change in the person rather than focusing on changing the systems and power hierarchies that cause and mediate such distress.

1.2.6.2 Trauma and post-traumatic stress disorder

PTSD, a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), has been defined as direct or indirect exposure to "(…) death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (…)", followed by a collections of symptoms grouped into criteria of intrusion, avoidance, negative evaluation, and hyperarousal; persisting for over one month after the incident, and impacting on functioning or causing distress (NICE, 2013). Two key models of PTSD have remained most utilised in diagnosis and support in the UK. Firstly, the cognitive model, in which the individuals are

understood to have misinterpreted the memory and associated feelings of the trauma as a current threat, reinforced by behaviours such as avoidance of triggers (Ehlers & Clark, 2000), with PTSD posited a result of how individuals process the memory. Secondly, dual representation theory: that traumatic experiences resulted in two types of memories, verbally accessible memories – possible to recall and put into words and situationally accessible memories – automatically activated by triggers that evoke the environment or meaning of the original traumatic event (Brewin et al., 1996). Chronic processing, and premature inhibition of processing have been contextualised as errors that can lead to PTSD.

Guidance for treatment of PTSD in adults has recommended individual psychological therapies such as trauma-focused cognitive behavioural therapy to aid processing of trauma memories (NICE, 2018). According to a recent systematic review, some risk factors for PTSD in inpatient MH nursing staff who have been exposed to violence or aggression were found to be: assault severity; repeated exposure to violence or aggression; burnout, poor MH , low compassion satisfaction (pleasure from helping others), neuroticism; and with lesser evidence: female gender identity, poor training, any exposure to violence or aggression, and compassion-fatigue (Hilton et al., 2022). The authors concluded that the best targets for intervention in reducing the risk of PTSD would be mental health support for nursing staff exposed to VA, and the prevention of VA (Hilton et al., 2022).

Such diagnostic manuals and guidance have medicalised enduring experiences following a traumatic experience as abnormal symptoms of illness. Critics have argued this approach decontextualises the experience from the adverse event and pathologizes people (Rapley et al., 2011); and recommended alternatively conceptualising distress as ‘cultural communications’ with which people make meaning from events (Watters, 2010, p. 77). Decontextualization of distress has been argued to have reassured MH professionals they can be useful in treating an illness, provided a simplified narrative of complex moral issues such as policing patients in coercive environments, and maintained focus on individuals rather than harmful environments in systems of support (Rapley et al., 2011, pp. 4–5). Despite

these criticisms, it was of use to explore the existing literature around PTSD in MH professionals, as data may help with understanding the scale of distress experienced, and the factors associated with poorer or better outcomes for professionals working within this context.

1.2.6.3 Alternatives to diagnostic understandings: Trauma informed approach and power threat meaning framework

The TIA was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). SAMHSA defined trauma by the 'three E's': event(s), experience, and effects: a result of one or more event(s), which the individual experiences as harmful (physically or emotionally) or life-threatening, from which that there are lasting negative effects impacting people's ability to live their lives (SAMHSA, 2014, p. 7). The SAMHSA view of trauma could be criticised similarly to constructs in sections 1.2.6.1 and 1.2.6.2, as individualised and pathologized. However, SAMHSA advised responses to trauma which targeted changes to *systems*. They have stated that a trauma-informed system: 'realizes' the impact trauma can have, 'recognizes' trauma, 'responds' by ensuring this knowledge is embedded throughout system processes, and aims to 'resist re-traumatisation' (SAMHSA, 2014, p. 9). By advocating for staff training at all levels and functions of the organisation – TIAs have not been delegated only to parts of systems with a specific remit to support with trauma, such as therapy teams (SAMHSA, 2014, p. 10).

The PTMF concept of distress has been constructed in narrative rather than medicalised language, and presented people's responses as understandable reactions to life events (Johnstone & Boyle, 2018). The PTMF has focused on: how power has operated in people's lives; the impact of distressing life events (threats); how people responded in order to survive or cope (threat responses); and how people made meaning from their experiences (Johnstone & Boyle, 2018).

The authors accumulated literature on factors associated with distress from various epistemologies: epidemiological prevalence and incidence related to social factors,

and dose-response relationships; psychodynamic ideas of attachment; developmental theory; physiological mechanisms of the sympathetic and parasympathetic nervous systems; cognitive ideas around emotions; and behavioural theory (Boyle & Johnstone, 2020, p. 103). They integrated these into a 'foundational pattern' to illustrate how elements of power, threat, meaning, and threat responses might interact (Boyle & Johnstone, 2020, pp. 102–104). This foundational PTMF pattern presented elements relevant to understandings of VA in inpatient MH wards for example,:

- negative operations of power – patients detained under section, use of restrictive interventions in the management of VA;
- experiences of violence;
- feelings of being trapped or unable to escape;
- being unable to predict or control threats;
- threats of an interpersonal nature;
- whether the threat was intended;
- threats present in emotional or attachment-based relationships
- that the threats trigger automatic physiological threat responses in the body; and
- the potential for iatrogenic harm, or retraumatization by services [bullets added] (Boyle & Johnstone, 2020).

The PTMF presented an alternative to medicalised narratives of distress on the basis that they have erroneously equated emotional responses with diagnosable and treatable physical diseases, ascribed biological causes with insufficient evidence, and arranged diagnoses which lacked ecological validity or interrater reliability into taxonomies such as the ICD and DSM (Johnstone & Boyle, 2018, p. 21).

TIA and PTMF have been applied to understanding and preventing VA, and reducing restrictive practices in inpatient MH services. NHS TIAs have been frequently modelled on the SAMHSA key principles (Office for Health Improvement and Disparities (OHID), 2022; SAMHSA, 2014). The NHS Long Term Plan stated that community MH and primary care services will provide 'trauma-informed care'

(NHS, 2019, p. 69); though offers no definition, targets, or deadlines. There has been no consistent UK-, or England-wide NHS strategy for implementation of TIA, nor dedicated funding (Emsley et al., 2022). TIA was not instructed for MH inpatient contexts, instead 'therapeutic', 'patient-oriented', and 'recovery focused' care was detailed (NHS, 2019, p. 21), though many trusts have trained staff in this model across the board. A literature review of the application of TIAs in inpatient MH settings found a key focus on reducing restrictive practices (Muskett, 2013). Effective strategies for improving wards' TIA comprised routine screening of past trauma, staff training, and improved environments (Muskett, 2013). A recent review detailed that though research is in early stages there were promising indications of reduced restrictive practices, and improved relations between staff and patients as a result of TIAs in acute and crisis care (Saunders et al., 2023: unpublished). One NHS trust which used PTMF team formulation and weekly TIA staff training combined with other approaches reported reductions in restraints by over a third, and seclusion by 40% (Nikopaschos et al., 2020). Another study with acute ward staff in London found that team formulation (linked to PTMF and TIA by the authors) was a safe space to discuss challenges, which improved relationships between staff, and between staff and patients (Kramarz et al., 2022). Given the increased dissemination of TIA in services, it will be of use to explore nursing staffs' knowledge and perceptions of these in relation to VA.

1.2.6.4 Psychology-informed staff support

Psychology has been prioritised in standards as an important part of the inpatient MH multidisciplinary team (MDT) (NAPICU, 2016; RCP, 2019b, 2019a, 2020). Recent guidance to inform service provision and policy outlined key roles that inpatient MH psychological services can provide: psychological assessment, formulation and intervention; influencing team culture, supporting reflective practice and trauma-informed care; providing post-incident support to teams and leading team supervision; helping staff retention through supporting wellbeing; and providing specialist training to increase psychological knowledge (Association of Clinical Psychologists (APC UK) & British Psychological Society (BPS), 2021, p. 3).

Reflective practice (RP) groups have aimed to bring staff together to reflect on clinical theory, experiences, and practice so they can learn, and improve. Though recommended RP groups have not been mandated in inpatient MH service standards (RCP, 2019b, 2019a, 2020). RP has been valued by staff and both nursing bodies and unions have called for protected RP time (Nursing and Midwifery Council, 2019; Unison, 2022). Though RP could be run by any professional group, psychologists have traditionally been considered well placed to facilitate (APC UK & BPS, 2021; Onyett, 2007). According to one study, psychologist-led MH ward groups typically lasted forty-five minutes to an hour, and resulted in increased psychologically-informed care; reduced staff reactivity; increased empathy and compassion; reduced judgment toward patients; decrease in VA; and improvements in felt security (Heneghan et al., 2014, p. 21). Barriers included staff being unwilling or unable to attend; interruptions; hostility; and lack of team cohesiveness, management support, staff, and time (Heneghan et al., 2014, p. 21). Protected 'huddles' of 15 minutes for group reflection after nursing shifts resulted in a reduction in staff burnout scores and secondary traumatic stress, and a slight improvement in compassion satisfaction (counterpart to compassion fatigue) (Ragoobar et al., 2021), therefore even brief RP sessions may prove of benefit.

Guidance and evidence for debriefs has been mixed. The HSE recommended offering optional debriefing to staff as soon as possible following an incident (HSE, 2023). Post-incident debriefs involving a doctor and a nurse which assess identification and response to physical and harm to staff or patients and any continued risks have been recommended (NICE, 2015). In an evaluation conducted across five MH wards, staff valued incident-specific debriefs, and highlighted an inconsistency of whether they were offered based in subjective impressions of whether an incident was serious (Burman, 2018). Facilitating factors were a trusted, possibly senior, facilitator who conducted them in a quiet place away from the site of the incident (Burman, 2018). Barriers included stigma for needing support, narratives of VA as 'part of the job', and time and staff pressures (Burman, 2018). Debriefs have been found to offer an opportunity for staff and patients to reflect together and prevent further occurrences (Asikainen et al., 2020). An in-depth review into the role

of psychological debriefing for healthcare staff described them as one to three-and-a-half hour, structured interventions, for groups of healthcare staff to reflect, usually three days to a fortnight following a traumatic incident (Regel, 2007). Guidance for patients at risk of PTSD suggested *not* to provide psychologically-focused individual or group post-incident debriefing, citing no clear benefit for prevention of PTSD, and a suggestion things may have worsened for some people following debriefing (NICE, 2018). Though psychological debriefing was not intended as a preventative measure for PTSD, rather a way to educate people about what is usual to experience following a traumatic incident, and to encourage help-seeking if needed (Regel, 2007). The HSE recommended offering counselling to staff impacted directly and indirectly following incidents of VA (HSE, 2023). Suggested support interventions have included: psychoeducation on stress and coping, group psychological support, and mindfulness (Bekelepi & Martin, 2022b).

Psychologists in inpatient MH contexts have also been key providers of specialised training; as well as team formulation which supported MDT staff in contextualised understandings of patient's distress such as trauma and TIA; and cognitive-behavioural models, emotional regulation, communication of needs via challenging behaviour, and the PTMF (Kramarz et al., 2022), all of which may have contributed to understandings of VA in these contexts.

In order to support inpatient MH nursing staff effectively with the complexities of prevention and management of, and response to VA from patients, as well as with the emotional and behavioural responses to experiencing and witnessing VA, it will be necessary to interrogate rich data on the experiences and understandings of nursing staff. To explore current research and consider any potential gaps in the evidence, a systematic-style review was conducted.

1.3 Systematic Review

1.3.1 Methods Selection and Analysis

A systemic review question was constructed to explore the question:

> How do adult MH inpatient nursing staff, perceive, experience, and make sense of VA from patients toward staff?

Key search terms (Table I) were identified from previous literature and pilot searches. An inclusive approach was taken to mitigate against missing relevant articles. Search streams were constructed for the areas of topic – violence or aggression; context – inpatient MH ward; and population – nursing and support staff.

Table I

Key search terms

Area	**Key Search Terms**
Topic: Violence or aggression	Aggression or Aggressive behavior or Aggressiveness or Attack or Attack behaviour or Homophobia or Homosexuality (Attitudes Toward) or Hostility or Microaggression or Patient Violence or Physical violence or Racism or Sexual violence or Threat or Transgender (Attitudes Toward) or Transphobia or Verbal abuse or Violence or Violent or Workplace violence
	AND
Context: Inpatient MH ward	Psychiatric hospital or Psychiatric hospitalization or Psychiatric Unit or inpatient psychiatric unit or inpatient psychiatric ward or inpatient psychiatric hospital or acute MH ward or psychiatric intensive care unit or MH hospital or Forensic psychiatry
	AND
Population: Nursing and support staff	Nurses or Nursing or Nursing staff or Nursing students or Trainee nurses or Health care assistants or Social Therapists or Patient care technician or Medical assistant or Trainee nurse or Student nurse or Psychiatric nurse or Forensic nurse or

> Psychiatric hospital staff or trainee nursing associate or nursing associate or nursing apprenticeship or student nurses or nursing students or student nurse or nursing student or undergraduate nurse or healthcare assistants or health care assistants or HCAs or nursing assistants or support workers

Once key words were identified the following electronic databases were searched:

- CINAHL 2012 to 22nd August 2022
- PsychInfo 2012 to 22nd August 2022
- Medline 2012 to 22nd August 2022

Inclusion criteria questions were as follows:

- Is study context inpatient MH care (e.g. PICU, acute, forensic inpatient setting)?
- Is study context adult =>18 years?
- Is VA the key focus?
- Is the study about VA from patients towards staff?
- Are staff experiences a key focus?
- Is the study focused on nursing and support staff?
- Current: 2012 onwards?

An initial search generated 5722 articles. Items were de-duplicated and non-English language papers were removed. A search for grey literature was conducted on Google and Google Scholar and returned no relevant results unpublished in academic journals; no additional items were included at this stage.

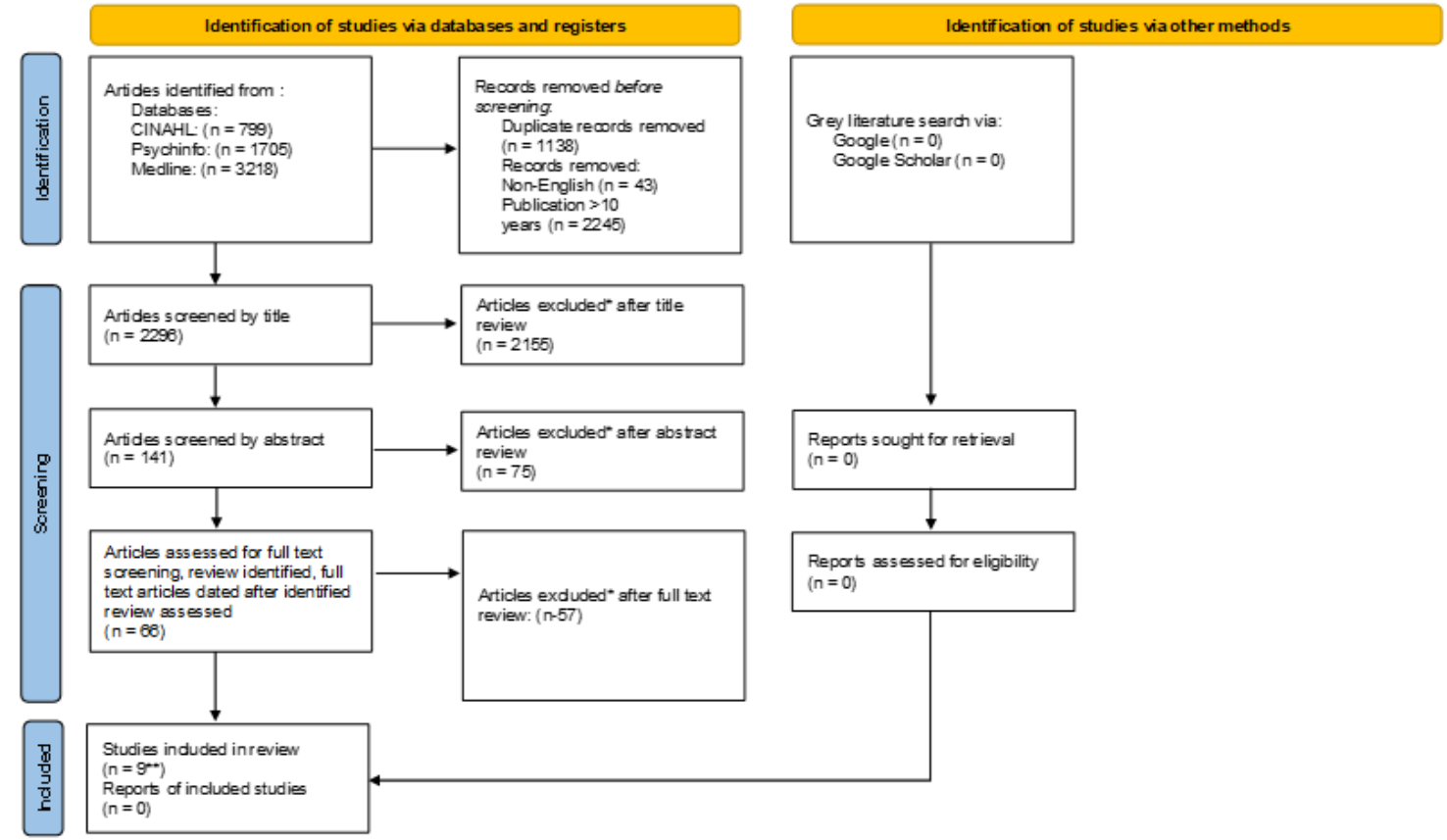
Studies were excluded that focused exclusively or predominantly on people under the age of 18; focused on a population other than MH; were not conducted in inpatient MH settings; did not address VA toward staff from patients; or did not focus on perception, experience, or attitude of staff.

For a summary overview of the search process see the systematic review process chart (Table II). As there were a large number of results following the initial searches the research and their director of studies decided it wise to prioritise screening reviews of the literature – assuming there was a recent review that fit the systematic review question, it was decided to narrow the systematic review to that paper, and any relevant subsequent research that met the criteria of the question. A recent integrative review of staff and patient perspectives on the causes of VA on inpatient wards was identified as providing a good overview of the area to date (Fletcher et al., 2021). Relevant studies conducted after the searches in this review underwent abstract and full-text reviews using inclusion criteria above. Finally, 9 items, subsequent to the Fletcher review were identified for analysis.

Included papers were appraised for quality and scores were assigned out of a possible high of twelve for cross-sectional (Center for Evidence Based Management (CEBM), 2014) and 8 for qualitative studies (Centre for Evidence-Based Medicine (CEBM) et al., 1997): see Table III. Papers were critically examined. The eight qualitative papers were compared narratively, and overlapping and divergent themes described.

Table II

Systematic Review Process, Adapted from (Page et al., 2021)



Adapted from (Page et al., 2021)

*Exclusion criteria: client population not =>18 years; not exclusively inpatient mental health (MH) (exclude: older adult/dementia; learning disability; brain-injury wards, general health settings (e.g., A&E, physical health inpatient, community MH); not addressing violence/aggression toward staff by patients; not focused on nursing or ward support staff attitude/perception as a key part; de-duplications previously not screened out; non-English articles previously not screened out.
**Number excludes Fletcher et al. review

1.3.2 Overview of the Integrative Review

The review (Fletcher et al., 2021) comprised 30 articles: five quantitative, 21 qualitative, and four mixed methods on staff perspectives of VA in inpatient MH. The included studies were international; most (one third) were UK-based, so applicable to the population for this study. The studies were appraised for quality using appropriate tools for the included study type (CEBM, 2014; CEBM et al., 1997), while quality varied, most studies included were judged as good quality. There were areas of divergence between staff and patient views on causes for violence: staff perspectives centred on systemic issues such as policy, staffing levels and resourcing, as well as on individual patient factors such as personality or particular diagnoses; whereas patients attributed coercion, boredom, lack of privacy and personal space, and a lack of respect toward patients by staff as key factors (Fletcher et al., 2021, p. 935). The model of interactions suggested by the authors between the differing views of patients and staff, and the ward environment (Fletcher et al., 2021), focused on environment change and need for staff training. The scope of the review did not include interrogating social processes underpinning the common narratives of VA constructed by staff in depth. More detail on the origin and perpetuation of common narratives would be of use for creating effective interventions.

1.3.3 Systematic Review Results

As outlined in the process above, nine papers were identified from literature published after the Fletcher and colleagues review: one cross-sectional and eight qualitative studies.

1.3.3.1 Quantitative study

One quantitative study met criteria for inclusion in the review, having a key focus on staff perceptions and experiences of violence by Lenk-Adusoo et al. (2022). They used the validated Management of Aggression and Violence Attitude Scale (MAVAS): a 27-item questionnaire, designed to elicit respondents perceptions around the causes and management of aggression (Duxbury et al., 2008). MAVAS items encompass statements based around three core theoretical models of the causes of VA: internal factors; external factors, and situational or interactional factors (Duxbury et al., 2008). Lenk-Adusoo and colleagues compared mean ratings between nursing staff's, psychiatrist', and patients' perspectives of violence across MAVAS items. While the MAVAS is a well-respected and useful measure of attitudes, it is not possible to obtain rich data to give a more nuanced understanding of phenomena from quantitative means alone. For example, while all three groups agreed strongly that there are certain types of patients who become aggressive, there is no way to know if respondents had the same 'type' in mind. The MAVAS presented a medicalised view of distress and implied aggressive and violent behaviour can be treated with medication (Duxbury et al., 2008). NICE guidance outlined unscheduled, or pro re nata (prn) 'medication' as part of de-escalation and prevention strategy, and rapid tranquillisation as a restrictive intervention (NICE, 2015). The validity of medicalisation of distress has been contested (Johnstone & Boyle, 2018; Rapley et al., 2011), the categorisation of VA as illness in need of treatment may be considered as representing a further conceptual leap.

1.3.3.2 Qualitative studies

The eight qualitative studies varied in their epistemological and methodological approaches. They represented studies from seven countries, and at least 40 MH wards and 357 staff members. The studies were assigned a score out of a possible eight for highest quality (CEBM et al., 1997); these ranged from a lowest score of '3' to a high of '7' (Table III). Most papers (six) presented mainly descriptive thematic analyses of data in their findings, rather than proposed models or theories for understanding staff experiences. Authors of a qualitative study of 13 inpatient nursing staff from two forensic wards in Demark used data from a thematic analysis

to develop a proposed a dynamic model of how factors may interrelate as a mechanism for ‘tipping points’ in situations of conflict (Gildberg et al., 2021). As the participants were staff from one hospital, it is hard to know to what extent the context and culture of that particular institution may have influenced staff perceptions. Research with participants from a range of services would be of use to increase applicability of findings.

Table III

Overview of studies and quality appraisal

Lead author(s) and country	Aim	Design, context and methods	Main Findings	Quality Appraisal Score
Lenk-Adusoo et al. (2022) Estonia.	Explored and compared nurses', psychiatrists' and patients' attitudes of cause and response to patient aggression.	Quantitative. Psychiatric clinics in Estonia (n=4) Staff (n=260 of which: psychiatrists n=63, nurses n=197) and inpatients (n=199). Management of Aggression and Violence Attitude Scale (MAVAS) (translated to Estonian) and Likert-style questions for staff on frequency of, and anxiety related to three aggression subtypes (verbal/destructive	There were similarities and differences in views of the causes and management of aggression, between psychiatrists, nurses, and patients. Patients agreed more than nurses that patients will calm down if left, and that improving relationships between staff and patients can reduce aggression. Nurses agreed more than patients that aggression could be handled better on the ward(s) in question. Nurses experienced verbal aggression and destructive behaviours significantly more frequently than psychiatrists, physical aggression was infrequent for both groups. Moderately positive correlations were identified between frequency of	7/12

		behaviour/ physical aggression). Median scores MAVAS scores were compared between groups.	experiencing aggression and anxiety about aggression, and frequency of involvement in coercive practices.	
Ayhan et al. (2022), Turkey.	Explored perceptions of staff who had experienced physical violence from patients	Qualitative semi-structured interview design, with healthcare workers. A clinic in Ankara, Turkey. Criterion sampling to recruit those who experienced violence from patients in the past year at the psychiatric clinic, collected until data saturation (n=21; 76% nurses or assistive care personnel, 23.8% doctors) Inductive qualitative content analysis method.	Three themes and subcategories were identified. (1) Effects of warning signs of violence: uncertainty, fear, wanting to take control. (2) Clinical management of violence: helplessness, protecting self, restraint, persuading the patient. (3) Effects of violence: sadness, anger, and fear; location change; injuries and pain; normalization; stigma; restructuring of the therapeutic environment.	5/8

Bekelepi & Martin (2022), South Africa.	Explored and described experiences and coping strategies of, and support received by nurses who had encountered violence.	Qualitative, exploratory, descriptive design, using semi-structured interviews. Nurses (n=14) from psychiatric acute wards (n=6) across hospitals (n=3) in Cape Town, South Africa. Purposive sample of staff from all nursing categories who had experienced physical violence. Thematic analysis of data.	Five themes: (1) violence perceived to be 'part of the job'; (2) contributing factors to patient violence, (3) physical and psychological effects on nurses, (4) adaptive and maladaptive coping strategies, and (5) perceived support from stakeholders.	5/8
Gildberg et al. (2021), Denmark.	Explored nursing staff perceptions of staff-patient conflicts and links to restrictive practice.	Semi-structured interviews with nursing staff (n=24). Purposive sample of forensic MH nurses (n=11) and nursing assistants (n=13) across forensic wards (n=2). Data collected to saturation. Qualitative thematic analysis.	The authors proposed a dynamic model determining when/if staff moved to using restrictive practices, comprising six themes which were interrelated and interdependent: (1) Personal and collegial tolerance to conflict; (2) conflict-tolerant strategies and competencies; (3) safe/unsafe; (4) patient-related factors; (5) relationship, observation and assessment; and (6) colleague-related factors.	6/8

Ham et al. (2022), Canada.	Explored psychiatric staff's understanding of exposure to trauma.	Qualitative analysis of two open-ended qualitative questions which formed part of a wider survey of staff at psychiatric services (n=6) around workplace violence and PTSD symptoms. 30 staff responded to both questions, data from this subsection of the survey participants were analysed. Inductive thematic analysis informed by constructivist-grounded theory.	Five main themes: (1) direct experience of violence; (2) vicarious traumatization; (3) lack of organizational support; (4) effect on self: patient and personal relationships; and (5) effect on self: growth and recovery.	3/8
Hiebert et al. (2022), Canada.	Aimed to raise awareness of violence at work; share nurses' experiences; potentially	Qualitative, descriptive phenomenological design. Semi-structured interviews with registered psychiatric nurses (n=10) on acute care psychiatric units in Western	Three main themes of nurses' lived experiences: 1) nurses' perception of workplace violence; 2) factors contributing to workplace violence; and 3) the impacts of workplace violence.	7/8

	persuade organisations to make commitments to reduce violence; and develop understanding and meaning of violence.	Canada. Iterative analysis, data collected to saturation, Colaizzi's (1978) seven-step process applied to thematic analysis.		
Jenkin et al. (2022), New Zealand.	Aimed to understand staff and service user perspectives of violence.	Qualitative interviews with 42 staff members and 43 patients at adult acute MH inpatient units (n=4) in New Zealand. Covered the topic of violence once it emerged as a central concern during interviews aimed at eliciting views on architectural design and social milieu. Thematic analysis.	Four identified themes about causes of violence: (1) Individual service user factors; (2) The built environment; (3) Organisational factors; and (4) Social milieu. Each theme contains subthemes from staff and service user accounts, some convergent, others divergent. There were two overarching 'meta-themes' of: (1) Interpretations of behaviour, and (2) 'Othering'.	7/8

Pelto-Piri et al. (2020), Sweden.	Explore staff perspectives of the contributing factors, and actions and experiences before, during, and after violent incidents from psychiatric inpatients.	Qualitative: questionnaire comprised of open-ended questions. Critical Incident Technique analysis of 283 incidents of violence reported by staff members (n=181) from psychiatric inpatient wards (n=10, in four regions of Sweden).	Staff were more inclined to attribute violence to internal patient factors (traits and states), rather than situational, relational, or organisational factors. Active measures used to deal with incidents, included removal of the patient from the ward and other coercive measures; de-escalation and passive management were less reported. Staff experienced emotional and psychological effects following incidents. Support from colleagues was mentioned, but from managers more rarely. Staff reported having to keep working with patients following violence.	7/8
Välimäki et al. (2022), Hong Kong.	Explored views of nurses, patients and informal caregivers on the possible causes and outcomes of patient aggression, and aimed to	Qualitative focus group study based in an interpretivist paradigm. The participants (12 nurses, 36 patients, 30 carers) were recruited from adult inpatient psychiatric wards (n=15) in Hong Kong hospitals (n=2). Purposive sampling, data collected until saturation.	Found common perceptions of causes of patient aggression, and that aggression provided a psychological burden. Patients and nurses described how aggression could occur spontaneously, without warning, and discussed restrictive practices following incidents. Types of aggression described: physical, verbal, and threats. Targets of aggression: others, objects, or self. Reasons for aggression themes: Unstable	6/8

	strategize prevention and management.	Inductive thematic analysis of focus groups. Findings triangulated with larger study from the same research group.	mental status, unmet needs, social conflicts, and no clear reason. Consequences themes: Action – seeking help, controlling, calming down; and Burden – physical and psychological. Themes of development ideas: Helping attitude, communication, structural changes, restrictive interventions, self-management, assessment, creative activities, and safety measures.	

Staff perceptions of the causes or precipitating factors for VA from the qualitative studies could be categorised in terms of individual patient factors, individual staff factors, relationship factors; and external factors such as environment or system pressures. In studies that explored staff's perceptions of the causes of VA individual patient factors were commonly cited. Mental illness was the most prominent factor (Bekelepi & Martin, 2022a; Gildberg et al., 2021; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020; Välimäki et al., 2022). Specific diagnoses and symptoms were seen as contributing factors, in particular: psychosis (Bekelepi & Martin, 2022a; Jenkin et al., 2022); bipolar disorder (Bekelepi & Martin, 2022a); and disinhibition and impulsivity (Jenkin et al., 2022; Pelto-Piri et al., 2020). Interestingly, none of the included studies mentioned PD diagnoses. Substance use was seen as an important causal factor (Bekelepi & Martin, 2022a; Gildberg et al., 2021; Hiebert et al., 2022; Pelto-Piri et al., 2020). Staff also attributed VA to intentional behaviour (Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020) described as disruptive (Pelto-Piri et al., 2020), or instrumental (Hiebert et al., 2022; Jenkin et al., 2022).

Only one study cited individual staff factors, such as attitude, as a potential foundation for patient VA. It highlighted staff abusing power, disrespecting patients, not responding to patients, and communicating in ways construed as 'arrogant, controlling, and patronizing' by patients (Gildberg et al., 2021, p. 410).

Gildberg et al.'s (2021) dynamic model outlined relationship factors such as knowledge about patients and a good relationship as important prevention measures. Unmet needs (Jenkin et al., 2022; Välimäki et al., 2022), and social conflicts (Välimäki et al., 2022) were cited as possible factors that explained incidents. Some staff felt that incidents occur without warning (Pelto-Piri et al., 2020; Välimäki et al., 2022). Inconsistent rule enforcement between different staff members was seen as a contributory factor to VA (Gildberg et al., 2021; Pelto-Piri et al., 2020). Involuntary admission (Bekelepi & Martin, 2022a) was seen a factor that could lead to VA. Power differentials were rarely mentioned by staff in the included

studies; though patients alluded to the complexity of power dynamics in one study (Jenkin et al., 2022).

External factors such as staffing issues were seen as possible reasons for incidents of VA: for example staff being busy and shift changes (Pelto-Piri et al., 2020); level of staff cover, experience-level, and the proportion of available staff of different genders (Jenkin et al., 2022, p. 8). Staff in two studies mentioned enforcement of smoking policies causing VA (Bekelepi & Martin, 2022a; Jenkin et al., 2022). Staff named components of the physical environment that contribute to including: ward design – potential for staff to be cornered (Hiebert et al., 2022; Jenkin et al., 2022), overcrowding (Hiebert et al., 2022), and inadequate means of temperature control and ventilation (Jenkin et al., 2022). Failures of safety mechanisms such as alarms (Hiebert et al., 2022; Välimäki et al., 2022), metal detectors, and camera blind spots (Hiebert et al., 2022) were considered important.

Fear was commonly experienced by staff following VA (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Hiebert et al., 2022; Pelto-Piri et al., 2020; Välimäki et al., 2022) as were anger (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Hiebert et al., 2022) and anxiety, worry and panic (Bekelepi & Martin, 2022a; Hiebert et al., 2022; Jenkin et al., 2022; Välimäki et al., 2022). One study suggested that anger resulted in some staff having thoughts of retaliating with violence, though feeling able to control this (Ayhan et al., 2022). Other emotional impacts included: sadness, uncertainty (Ayhan et al., 2022); hopelessness (Bekelepi & Martin, 2022a); and guilt, self-blame, and self-doubt (Hiebert et al., 2022). Stress was mentioned in several of the studies (Ham et al., 2022; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020), as was trauma, or experiences commonly associated with trauma (for example, hypervigilance, flashbacks, and nightmares) (Bekelepi & Martin, 2022a; Ham et al., 2022; Hiebert et al., 2022; Pelto-Piri et al., 2020). One study focused specifically on the concepts of ‘trauma’ and ‘vicarious trauma’ in staff as part of their analysis (Ham et al., 2022). It referred to PTSD symptoms, though the supporting quotation referred to experiences of distress associated with PTSD which diminished over a time of three months (Ham et al., 2022, p. 1486) – so the key criterion of longevity of

symptoms needed for a diagnosis of PTSD was not met. Physical injury, pain, or physical health concerns were another cited impact of VA (Ayhan et al., 2022; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020; Välimäki et al., 2022). Normalisation of aggression from patients as 'part of the job' was a common narrative (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Gildberg et al., 2021; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020); in some cases this was accepted by staff for verbal, but not physical aggression (Gildberg et al., 2021; Pelto-Piri et al., 2020). It would be helpful to explore in more detail how nursing staff respond to this normalisation of VA, which social processes promote it, and what impact it has on nursing staff, as this was not specified in the reviewed literature. In one study staff spoke of minimising what had happened, and withdrawing from patients as ways to cope (Bekelepi & Martin, 2022a). Some considered leaving the ward, or the role altogether (Ayhan et al., 2022; Bekelepi & Martin, 2022a). Though there was some mention of how staff coped with the impacts for example, talking with colleagues (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020), and using substances such as alcohol and nicotine (Hiebert et al., 2022; Jenkin et al., 2022), this was not a central focus of the studies included here and would be of benefit to explore in more depth.

'High conflict tolerant strategies' where patients were permitted to display feelings of frustration, and staff attempted to make sense of what they might need were outlined by Gildberg et al. (2021). In one study some staff identified that prn medication could be used to help de-escalate, by helping someone to calm before they reach the point of VA (Hiebert et al., 2022). While various de-escalation techniques were summarised, there was little exploration of staff perceptions. Restrictive interventions included enforcing the rules, 'crowding' the patient (outnumbering with staff), 'shielding' (following, watching and correcting the patient) and restricting movement and freedoms (Gildberg et al., 2021, p. 411). These interventions included restraint, seclusion, and coercive administration of medication; again with little exploration of how staff perceived the practices, though one paper mentioned staff feelings of uncertainty, a need to protect themselves and others; and helplessness (Ayhan et

al., 2022). It would be beneficial to understand more about staff's perspectives on such interventions, and their intersection with VA.

Staff perspectives on post-incident support were again, mainly descriptive, with little information on the social processes and narratives that were helpful or unhelpful. Staff found support from various places helpful including: staff peers (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020; Välimäki et al., 2022); managers (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020); personal networks such as friends and family (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020); professional support (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020); and training (Bekelepi & Martin, 2022a).

1.4 Current Study

The literature on nursing staff's experiences VA would benefit from richer qualitative exploration into how staff make meaning of incidents. To expand on current literature, an examination of the social processes and narratives which construct how nursing staff make sense of VA, cope with incidents, and retain their sense of purpose – or professional identity would be of benefit. In order to represent views from a range of perspectives that represent the wider population of nursing staff, data collection should not be restricted to only one ward, hospital, or trust. An analysis that could generate a theory or model of the findings would be of benefit. The study should answer the following research questions:

- Which social processes support which kind of narratives about VA for nursing staff?
- Which of the available narratives support the construction of a positive professional identity for nursing staff?
- Which processes threaten professional identity?

2. METHODS

2.1 Epistemology

David Pilgrim wrote about the three core facets of critical realism: ontological realism, a ‘real’ world exists and endures irrespective of our knowledge or perspective of it; epistemological relativism, that people interpret the world in ways that can differ – some understandings become societal and cultural discourses; and judgemental rationalism, that by considering the above, we can judge what may be true, with the caveat that no knowledge is flawless (Pilgrim, 2020). Given the multiple narratives around VA in the literature to date, a relativist epistemology, which recognises that people construct and perceive multiple realities was needed for this research. The act of VA, and physiological responses to threats are objective realities, so a realist ontology was equally necessary. Therefore a critical realist epistemology was chosen for this research; an approach which Carla Willig eloquently argued most constructivist qualitative research already employs (Willig, 2016).

2.2 Methodological Approach

The methodological approach was chosen to align with the epistemology, and to provide a depth of analysis suitable for theory formation of social processes. As the research question concerns exploration of how people make meaning from their experiences, a qualitative approach providing rich data was needed. There are many useful qualitative approaches. Interpretative phenomenological analysis would have provided deep insight into the embodied experiences of individual participants, but for the purposes of the research question, would have been less well suited to constructing a theory of social processes. Reflective thematic analysis would have been well suited to constructing relevant themes, and how they relate to current

evidence, but again, would not have lent itself as naturally to theory generation of social processes. The interpersonal nature of VA, and restrictive context of inpatient mental health, made it vital to choose an approach that recognised the importance of power. An approach to data analysis informed by constructivist grounded theory (Charmaz, 2014) was chosen as it was well suited to analysis of rich data, involved the examination of social processes, considered power, and provided potential for theory development.

2.3 Ethics

The research was conducted in line with the British Psychological Society (BPS) Code of Human Ethics:

- "Respect for the autonomy, privacy and dignity of individuals, groups, and communities.
- Scientific integrity.
- Social responsibility.
- Maximising benefit and minimising harm." [bullet points added] (British Psychological Society, 2021, p. 6);

and the University of East London Code of Practice for Research Ethics (University of East London, 2013).

2.3.1 Ethical Approval

Ethical approval was granted by the University of East London School of Psychology Ethics Committee (Appendix A).

2.3.2 Informed Consent

A detailed participant information sheet (Appendix B) was provided to all potential participants with details of the study including: the research topic; what taking part entailed; eligibility and exclusion criteria; the interview schedule; information on potential disadvantages – such as potential emotional distress; data management; plans for dissemination; and key contacts for further information. Signed consent

was obtained prior to interview for all participants (Appendix C). Consent was reaffirmed verbally before the start of each interview.

2.3.3 Safeguarding Participants

Participants had experienced or witnessed VA, a potential 'physical or psychological trauma' (BPS, 2021, p. 15). Exclusion criteria were formulated to safeguard potential participants who might be at greater risk of harm (section 2.5). In case of risk or safeguarding concerns during interviews, the telephone number, and the address of the current location of participants was noted - saved directly to the secure One Drive system, and deleted immediately after the completion of the interview.

2.4 Setting

The context of the study was inpatient MH contexts – acute, PICU, and low- and medium-secure forensic wards, within the NHS in the UK.

2.5 Participants

Participants were adults (18 years or over) who work or previously worked as nurses, or nursing support staff in NHS inpatient mental health contexts (such as health care assistants, social therapists, ward support workers, student nurses).

To mitigate some of the possibility for emotional harm, potential participants for whom incidents occurred recently (two months ago or less) were excluded from the research, as were those who were experiencing high levels of distress following the incident, or were diagnosed or being investigated for PTSD. Ethnicity and current job role were described at group level to minimize the risk of identifying people. Although recruitment was aimed to attract a wide range of nursing and support staff, the demographics of the participants mainly identified as White British (6) or White European (1), with one participant who identified as Black African; and all

participants identified as female. People's current roles varied from Agenda for Pay Scale Bands 5 to 8 and included the roles: care coordinator, psychological wellbeing practitioner, trainee clinical psychologist, specialist MH nurse, senior MH practitioner, charge nurse, senior staff nurse, nursing lecturer, clinical lead, and modern matron. Other demographic data collected relevant to the study included: the ages of participants, banding at the time of the first incident(s) of VA discussed, years of experience in MH Nursing now and at the time of the first incident(s) of VA discussed (Table IV).

Table IV

Demographics

Gender	Current age (y)	Experience (n years)	Role at time of incident(s)	Band at time of incident(s)	Experience (n years) at time of incident(s)
Female	<25	3	Staff Nurse	5	0-1
Female	25-29	3	Staff Nurse	5	0-1.5
Female	25-29	4-5	MH Care Assistant	3	1
Female	25-29	7	Student / Staff Nurse	Unbanded/ 5	6m
Female	30-35	8-9	Staff Nurse	3/ 5	0-1.5
Female	30-35	8	Clinical nurse lead	6	7
Female	30-35	10	Staff Nurse	5	6y
Female	40-45	8	Deputy Ward Manager	6	5-6y

2.6 Data Collection and Management

2.6.1 Theoretical Sampling and Recruitment

Sampling was theoretical – focusing on recruitment of staff who were likely to have had most experience of violence and aggression: nurses and nursing support staff. The definition of 'nurses and nursing support staff' included staff at a variety of levels of qualification: from health care assistants and ward support workers who may have no formal training, to nurses who hold an undergraduate or master's degree-level qualification. NHS salaries are organised by 'Band' according to the agenda for change pay scales (NHS Employers, 2023), and the aim was to recruit staff who were working at a range of levels, from Band 2 (health care assistant) through to nursing Bands 5 and up, and those working permanently on wards as well as 'bank' staff – employed on a temporary basis to cover absences on wards and who may not always be familiar with the wards they attend. To improve the validity of findings and potentially applicability to inpatient MH more broadly, recruitment was via social media to reach participants UK-wide. This allowed for inclusion of staff from different regions, including urban and rural settings. This was purposive, so as to avoid any bias in the results that might arise, such as results being heavily reflective of organisational culture, were participants drawn from the same unit or trust. The researcher also shared the research with people within her existing networks, so some convenience sampling was part of the process. One participant was known to the researcher through the mental health field, this was discussed with the director of studies and deemed to be appropriate ethically, as the relationship was in the context of work, and not a personal one. Recruitment took place via Twitter, Instagram, Linked In, the researcher's Facebook Page, a nursing specific Facebook group (MH Nursing), and sharing study information directly within professional networks. A poster (Appendix D) and website: https://lauramctraineeclinpsy.weebly.com/ were created to promote the study. A debriefing sheet with signposting information to sources of support was shared with participants on expression of interest in the study and again after the interview (Appendix E). So people who expressed an interest but did not fit these criteria had access to the support information. The participant information sheet detailed the interview schedule, to ensure that people knew what to expect in advance, so they

could gauge how they might feel talking about their experiences. This was effective as an additional safeguard; one potential participant withdrew from their interview citing feeling ‘sad’ when thinking back to their experiences.

How many participants are sufficient for qualitative studies has proved a contentious topic. Charmaz outlined considerations for how many interviews to conduct for constructivist grounded theory, for example the purpose of research, including meeting academic requirements; and recommends increasing the number of interviews in cases of heterogeneity of participants (Charmaz, 2014); something which timescales unfortunately prevented in this case. In their applied exploration of the number of participants needed to achieve data saturation for a qualitative study using semi-structured interviews, Guest et al. (2006) identified 73% of their codes from 30 participant interviews during the analysis of the first six transcripts, and 92% from the first 12. Given this, a sample of six participants or more should give a reasonable representation of most frequent codes, and crude codes required for beginning tentative theory generation. There was sufficient saturation from the eight interviews conducted to move from thematic categorisation toward a theoretical understanding; with important codes represented across the data set, and enough participants represented to show some nuance in understanding of these codes. Thus data collection and analysis remained informed by concepts underpinning constructivist grounded theory.

2.6.2 Method

There are different methods of data collection in line with a constructivist grounded theory approach. The research question is focused on the experiences and perceptions of nursing staff, and how they construct meanings about VA in terms of social processes and possible mechanisms for change. It was important to ground this in the first-hand experience of nursing staff who had experienced VA, and collect sufficiently rich primary data to reveal constructed processes. The researcher considered various methods that would meet such aims. Observational and field data triangulated with personal accounts of staff collected within NHS MH inpatient

sites was considered. Due to the nature of the research programme, this would have been restricted to a single trust given the procedures that would have been necessary for ethical approval. This was not desirable, as it would have resulted in data confined to a single working culture (of a ward, or collection of wards in one trust), limited possible inferences, thus made theory-generation less feasible. Another qualitative method considered was focus groups; useful for exploring social and relational processes in a way that is considered ecologically valid, with group process part of the experience. The researcher was concerned that focus groups would have resulted in dominant narratives taking over, with those who disagreed reluctant to speak. Focus groups conducted in teams would have comprised mixing staff from different levels of the hierarchy: for example senior nurses, junior nurses, trainees, and support staff, this could have resulted in junior staff's narratives being lost. As previous research has suggested the place in the hierarchy is important in terms of prevalence of VA experienced, with lower banded and less experienced staff at greater risk this was not desirable as an approach. Additionally, a focus group comprised of strangers, could have increased potential for harm from the research by further exposing participants to witnessing each other's previously unheard narratives of VA, and was considered unsuited to discussion of such a sensitive topic. In light of these considerations, individual interviews were chosen as the most appropriate method to meet the scope of the research project, and the aims of the research questions. Interviews would allow the collection of rich data, from participants from different NHS inpatient MH trusts, and would afford the highest amount of psychological safety in terms of confidentiality from employers, and not having to share potentially distressing experiences in front of a group of peers. A semi-structured interview schedule formed of open-ended questions and possible prompts was constructed (Appendix F). This ensured sufficient focus on the research questions, facilitation of rich answers, and allowed the interviews to progress as a discussion. It was recommended that the focus of interviews be developed in line with ongoing analysis of the data during the collection stage, focusing subsequent interviews to explore emerging categories of constructed meanings (Charmaz, 2014); though due to the time constraints of completing this

research as part of an accredited programme, this was not possible. Interviews were conducted in line with guidance on intensive interviewing including:

- allowing sufficient time and not interrupting or cutting short interviews;
- listening for the majority of the interview;
- taking time for participants to delve into a question before using prompts;
- paying attention to non-verbal communications including possible distress;
- reiterating throughout that they may stop, not answer, or take a break at any time;
- ensure they feel positive at the end of the interview about the experience and themselves;
- supporting them and showing empathy for their experiences; and
- thoughtfully seeking further clarification where needed, without asking 'why…?' to avoid seeming judgemental, for example, 'could you talk more about…?' [bullets added] (Charmaz, 2014, pp. 70–71).

2.6.3 Data Management

A detailed and extensive data management plan was constructed by the researcher and approved by a UEL Research Data Management Officer. This covered processing special category data in line with UEL guidance (UEL, 2019, 2020).

2.7 Data Analysis

2.7.1 Approach

The approach to analysis was informed by constructivist grounded theory (Charmaz, 2014), as this was a good fit with the epistemological approach of critical realism, and is designed to work toward generation of a theory of meaning-making. Charmaz's approach advocated for the integration of rich data, and moving between both inductive, and deductive approaches to the data analysis (Charmaz, 2014, p. 243); being informed by this approach allowed for the integration of inductive analysis of the transcripts with deductive knowledge from the existing literature

around VA in inpatient MH contexts, which also acknowledging that the observations made by the researcher will be informed by their own view of the phenomenon. A core facet of the approach was a focus on processes, rather than merely themes during analysis.

2.7.2 Transcription

Transcripts were generated in MS Teams using the recording and transcription function. They were then corrected by hand soon after the interviews took place using the recordings. For the first two participants, there was an error in the recording function, and only transcripts were available so these were corrected immediately after collection while the memory of the conversation was fresh. There were a couple of parts where the data was not clear, though this can be the case with a recording when there are fluctuations in sound quality, and the impact on the quality of the transcripts was minimal. The transcription aided familiarisation with the data, and as it was completed with a few days after each interview, some early reflections could be made and similarities and differences in the narratives within and between participants considered iteratively. The transcription conventions used are detailed in Appendix G. An example of a page of transcript from one of the interviews can be seen in Appendix H.

2.7.3 Coding Process

Data analysis was completed by hand on hard copies of the transcripts. It followed stages of analysis outlined in constructivist grounded theory:

- Initial coding
- Memo writing
- Focused coding
- Theoretical coding

2.7.3.1 Initial coding

Initial coding was quick, line-by-line coding of segments aimed to be mainly inductive, though of course with the choice of categories and languages influenced by the researcher's perspective informed by available knowledge. At this stage of

coding there is a focus on verbs and ‘gerunds’ – nouns transformed to verbs by a suffix, in English -ing for example, constructing (from construction); as these offer information on the social processes that are being employed to make-meaning in the data (Charmaz, 2014, pp. 120–121). The researcher aimed to construct initial codes which similarly evoke ‘action’ where possible; an example of annotations using gerunds can be seen in Appendix I.

2.7.3.2 Memos

If analytic ideas occurred during initial coding they were recorded in memos to be checked and developed throughout analysis. Memos consisted of reflective notes about the emotional impact of the data, as well as initial ideas at a more analytical level, and links to any existing concepts and theories. The researcher kept a journal of memos throughout the data collection, transcription, and analysis stages. Some example excerpts from a memo at the initial coding stage can be seen in Appendix J. The memos allowed a record of analysis to build, and a way to put initial ideas aside to avoid making conceptual connections too quickly to existing knowledge and theory, without having completed a deeper analysis (Charmaz, 2014, p. 117). Additionally, they offered a place for researcher reflexivity to develop (see sections 2.7.4 and 4.2.3 below). They were continued into the focused coding stage of analysis, which begins tentatively alongside initial coding and develops as the analysis progresses (Charmaz, 2014, p. 141). During the initial coding stage the researcher practiced constant comparison, coding the data in the order it was collected, but going back and forth between the transcripts regularly, and when new gerunds were constructed, to ensure things were not missed.

2.7.3.3 Focused coding

The research moved to focused coding once data started to repeat and need grouping, alongside initial coding. Focused coding is comprised of deciding which of the initial codes are most important analytically and identifying those which appear frequently, for example by categorizing and coding the initial codes (Charmaz, 2014, p. 138). The process of focused coding is not purely categorization of what is there, it involves continued reflection on your position in constructing the codes; comparing

the focused codes with the data to see which have more power in explaining the processes; comparing codes with codes; considering what is unsaid but implied, and any gaps or questions that arise (Charmaz, 2014, pp. 140–141). I collected tentative focused codes alongside initial codes in a spreadsheet, making note of the participant codes and lines of data, so I could continually refer back to the data; ensuring codes were grounded in the text, to balance out influences from my own experience and prior reading.

The focused codes were grouped into initial conceptual categories and subcategories. These conceptual categories were re-examined to explore whether they represented what seemed to be happening in the data (Appendix K) (Charmaz, 2014, p. 189). Where some initial coding was represented only by one reference to the text, I checked to see if it was less of a central concept, or if the data fit with another focused code and had been superseded. For example, one of the initial codes, ‘othering or de-normalising VA as threat response’, had only one reference for one participant, when this was explored further it referred to comparing patients with certain diagnoses to others, but specifically those with eating disorder diagnoses. As this was different to other diagnosis comparisons in the data set it was considered less relevant and not integrated into the categories (Appendix K).

Through this process of returning to the focused coding, and initial codes; organising these together where they fit; and considering any which did not, categories were constructed summarising the social processes and narratives identified in the data.

2.7.3.4 Categories

Conceptual categories of codes that were constructed from the data via the iterative process outlined above. Consideration was then given to how these categories integrate and influence one another. Categories were grouped, and regrouped to assess how processes might mediate identity construction. Conceptual maps were created to help envisage potential links between categories (Appendix L).

2.7.3.5 Theoretical coding

The categories were organised into theoretical codes by the researcher, these codes are intended to present how codes relate to one another, and tell a coherent story of the researcher's theoretical analysis of the data (Charmaz, 2014, pp. 150–151).

2.7.3.6 Theory development

The categories and theoretical codes were then integrated to construct a tentative theory of how social processes and narratives of VA facilitate or threaten nursing staff's construction of a positive professional identity.

2.7.4 Reflexivity

The researcher is a White, British, middle-class, cisgendered woman, in her late-30s who is training to be a clinical psychologist. As a clinical psychologist training at the University of East London her professional training has been grounded in social constructionist theories of distress, which fit with her previous undergraduate training at the Open University. By contrast many services in which she has gained clinical experience involve working with medicalised and diagnostic models of mental illness, which aligns with much research into this area. The researcher holds the view that medical and diagnostic narratives are one of numerous understandings of distress, which, like others such as trauma-informed approaches and the power threat meaning framework, can be useful or harmful depending on how they are used, and crucially how the person who is experiencing the distress makes sense of what they are going through. The background of the researcher is relevant in how she has constructed meaning from the data, as she will have held certain preconceptions and assumptions; so it was an important part of the process to notice when ideas in the data seemed surprising – this likely indicated an assumption being challenged (Charmaz, 2014, p. 156). The researcher's interest in the topic came from a number of places: working pre-training in an acute medium-secure forensic environment with a large focus on physical and relational safety, teaching during training on human rights and the disproportionate use of restrictive interventions for certain patients – for example those racialised as Black, and the experience of joining reflective practice discussions on acute general MH wards and

a PICU as a trainee – hearing the accounts of ward staff who had been victims of VA from patients and how this impacted them. The topic interested her, as it is a complex ethical issue, a wicked problem where the solution to one part may lead to unintended negative consequences in another area (Rittel & Webber, 1973). For example, allowing the use of enforced medication to manage an incident of VA, may lead to iatrogenic harm and heightened fear for the patient, which in turn may increase their potential for future VA as a threat-survival response. Understanding more about how nurses construct meaning around VA from patients seemed a necessary step in considering how to support staff and patients and reduce incidents of VA. Although she has been in positions of feeling threatened at work and in her personal life at times – as a subject of verbal aggression, threats, and physical intimidation including in the workplace, these have been in contexts outside of MH. The researcher has been involved in incidents which some might class as incidents of VA in MH, including being shouted at by patients, though has not understood these as VA personally. She has not observed incidents of physical aggression, nor seen or been involved in the administration of restrictive practices in inpatient MH wards. This puts her in a position of privilege compared with nursing and support staff. While this may mean she lacks personal insight into the issue of VA; it could also offer an advantage in terms of not having experienced negative impacts from witnessing or experiencing VA in these contexts which could influence the construction of codes.

2.8 Quality Appraisal

As the research has been heavily informed by constructivist grounded theory the quality of the research was assessed according to the principles of this approach including: ‘credibility, originality, resonance, and usefulness’ (Charmaz, 2014, pp. 337–338) (section 4.2.2).

3. RESULTS

3.1 Model of the Impact of Narratives of VA on Professional Identity Construction

A tentative model of how nurses make sense of VA was formulated from the results. The model (Figure 1 and Appendix M) depicted how aspects of VA, and the social processes and narratives involved in understanding them, threatened the construction of a positive professional identity. It examined which narratives contributed to the maintenance of a positive professional identity despite VA, and which mediating factors exacerbated or counteracted identity-threats. The model integrated the theoretical codes and categories constructed from the results. First, I will expand on the theoretical codes and categories that comprised the model, then I will explain how these were integrated to explore social processes behind how participants understood VA and built their professional identities.

Figure 1

Model: Impact of Narratives of VA on Professional Identity Construction

3.2 Theoretical Codes and Categories

Four main theoretical codes were constructed to bring together identified categories, and their associated narratives and social processes:

- Constructing a positive nursing identity: Love for the job
- Constructing the (un)deserving patient: "I don't mind being hit by someone who's genuinely unwell" P02 L225-226
- Professional identity threats related to violence and aggression: "Nursing is a pretty dangerous job to honest" P06 L343
- Mediating factors and support following violence and aggression

3.2.1 Constructing a Positive Nursing Identity: Love for the Job

Participants interviewed were actively involved in constructing their views of a positive professional identity for nursing and mental health. This was performed through their speech about the positive aspects of their role, what motivated them; as well as by their communication of what they did not feel fitted. Threats to the ideal professional identity will be explored in the next section.

It seemed important to participants to express their love for the work. While talking about their experiences of VA, the majority of people contrasted these negative experiences with their of their love for the job.

> "I do appreciate my job […] I really love it when I'm being able to help somebody to achieve something, especially when they can't. So for me, that's my job satisfaction." P04 L557-561

The positive experiences and feelings they shared constructed a narrative of a positive professional identity for nursing based on helping or supporting others; caring, and empathising; building relationships, rapport, and trust; and leading and working in teams.

> "[…] as a Mental Health Nurse, you-, you kind of-, a massive part of your role is building relationships – so it's talking to people, listening to people, observing behaviour and body language and stuff while you're doing that." P08 L178-180

Relationships were seen as central to the role, and integral to prevention and de-escalation of potential incidents of VA:

> " […] someone who they've got a good rapport with as well, because that that's really important in terms of that de-escalation […] being able to have those meaningful conversations" P01 L308-310

Two participants highlighted that it was harder for students and bank staff to build relationships with patients, as they were not in wards long enough, or consistently enough, to gain that trust from patients.

Many of the values and behaviours outlined above as comprising a positive professional identity were often conceived of as being under threat by VA. The next theoretical category explores the narratives and social processes involved with making sense of VA, which present a threat to the above positive professional identity desired by staff.

3.2.2 Constructing the (Un)deserving patient: “I Don't Mind Being Hit by Someone Who's Genuinely Unwell” P02 L225-226

There were two subcategories within this theoretical category:

- The deserving patient
- The undeserving patient

Participants employed a variety of narratives about patients to frame their understanding of the reasons for VA. All but one made some kind of comparison between different reactions to VA depending on aspects of the patient such as: perceived capacity, type of diagnosis, perceived severity or legitimacy of their illness, and their assumed intent at the time of the incident of VA. These kinds of comparisons were often discrete categories: patients who were seen as more deserving of understanding or forgiveness, and those who were less so, though two participants framed this as more of a continuum.

3.2.2.1 Deserving Patient

Participants expressed experiencing more empathy and understanding following VA if they perceived the patient to have lacked capacity at the time of the incident. One way that staff seemed to decide if a patient lacked capacity was through use of medicalised notions of mental illness, with VA framed as part of the illness presentation, for example via symptoms such as delusions. The illness narrative seemed to allow nursing staff to understand VA as a threat-response grounded in the person’s inability to orient to reality and was referred to by all participants. The narrative included judgements on the severity of the illness and the perceived veracity of the person’s experience: patients framed as lacking capacity were also talked about as not meaning to hurt people, more unwell than other patients, and more genuine.

> “[…] for someone who's […] in a very high state of arousal or […] lacks that capacity. […] There's a phrase that kind of had been passed around of: “I don't mind being hit by someone who's genuinely unwell”, has been said a lot in my line of work, I suppose, and I'd go out of my way for someone who I know didn't mean it.” P02 L223-227

This may mean that some participants or their colleagues were applying capacity as a blanket concept, not considering it as dynamic, and situation specific. Others may feel the lack of choice about being in hospital could exacerbate someone’s distress to the extent they are more likely to lose their capacity in the moment. There was some indication that participants were more understanding about incidents of VA in patients who were detained under the MHA, compared with informal patients, seeing those detained as more genuinely unwell.

> “If someone who's say informal and […] they came in voluntarily, the frustration comes more well-, ‘you chose to kind of be here, so why are you acting this way?” P05 L138-140

The illness narratives of VA were associated with clients who had diagnoses or experiences associated with psychosis such as paranoia, delusions, and hallucinations by five of the participants. Through the use of these medicalised narratives, participants contextualised VA as an understandable response – a way of patients protecting themselves from perceived threat when they could not escape by leaving the ward.

Although perceived lack of capacity aided empathy, and so reinforced valued professional identity roles such as caring; this narrative also contained within it social processes of minimising and normalising VA, potentially a threat to professional identity (see section 3.2.3.3). One participant explained how this understanding of VA made it hard for them to seek help:

> “[…] it's difficult because […] people [are] unwell and need help and support. And I think that knowledge can kind of, prevent help seeking […] if you try to seek support from people, it would have a mixed response. Like sometimes

> people would be really supportive. But other times people on the ward would be like […] “oh yeah but it's just so and so”, like, they didn't know what they were doing […]” P07 L15-27

Another narrative that three participants used to construct the ‘deserving patient’ was that of contextualising the VA as an understandable and automatic threat-response given the level of distress, and the inability to escape the restrictive nature of the ward environment – a means of self-defence. Again, this narrative was more readily applied to understanding the experience of those patients who were detained involuntarily, than voluntary patients.

> “[…] for a person that is – that frightened, is that like fight or flight response isn’t it? It’s either-, well you can't actually go anywhere, so the flight has been like taken away from you-, and if you want to protect yourself.” P05 L43-45

Finally, narratives around VA as potentially related to past experiences including trauma, and difficult experiences in childhood impacting on attachment, were also used to contextualise VA by three participants. This was used trans-diagnostically.

> “[…] we understood the-, the violence and aggression in the context of that person's trauma. […] the person did have quite a significant history of, sort of, childhood trauma, and abuse and neglect.” P08 L47-49

In response to a question in the interview schedule about their understandings of TIAs, six of the eight participants were familiar with TIAs, of these one had learnt about it for themselves by reading research, one had some teaching during their nursing training but mainly learnt more about it working in teams on the wards, as did the remaining four. Three participants specifically mentioned that their understanding of TIA came from the input of psychology to their MDTs. One participant was not familiar with the term TIA, another was familiar of the importance of understanding someone’s history of trauma but shared that it was not talked about on the ward where they work and these aspects of the patients’ histories were often overlooked.

3.2.2.2 The undeserving patient

Conversely some VA was understood through narratives that constructed an 'undeserving patient', harder to empathise with and understand. One aspect that made a difference on how five participants felt about VA was intentionality of the incident. In order to construct their view about whether they thought an incident was intended, participants presented a range of narratives of the person's perceived capacity and awareness of, or orientation to, reality.

> "[…] when it is someone that is making that capacity decision. It's-, it's just anger. It is purely just anger and real annoyance and just kind of, yeah. What? Why should I put up with this?" P05 L186-188

When an incident of VA was perceived as intended, participants described taking this personally. This internalising of the VA as personal seemed to result in two key outcomes: anger at the patient; and the professional doubting their ability to do the job.

The language used to describe VA was varied between participants, and between examples. The main terms used to describe VA were incident, and assault. Some people used one or the other regardless of the features of the VA they were referring to. Others changed between the two terms. Participant 02 highlights below the struggle to choose the right words for VA, acknowledging there is a difference in the meaning behind the terms, but highlighting the complexity in expressing VA in the inpatient MH context:

> "[…] there's stereotypes of what is an incident versus what is assault versus what is, you know, all those different. What's the word I'm looking for? […] I know it's just what your interpretation of each one of those words are really, and the connotations involved with it."; "[…] it feels like, an assault, as opposed to an incident […]" P02 L82-85; L292

Assault is a legal term associated with VA for which premediated intent must be established, so it may be that the difference being constructed is again whether the person intends to harm someone. There will no doubt be incidents of VA where this

is the case, it is important not to deny that there are assaults that take place. In terms of social process however, the language staff use may give some indication of their understanding of what has happened case-by-case. Using language common in legal and judicial contexts, such as assault, intent, or premeditation, may serve the function of criminalising some patients. Participant 06 resisted colleagues responding differently in terms of police-reporting whether they were using a medicalising narrative or a criminalising one to understand an incident of VA on the ward. She argued that decisions about reporting VA to the police ought to be based on public safety concerns, not the perceived cause of the VA or notions of punishment:

> "[…] some people may view it […] they're unwell. Which, absolutely […] we need to care for people, we need to understand that sometimes people don't necessarily have control […]. But it still needs to be […] escalated because […] that […] stops somebody else getting assaulted […]. But then you've […] got the other end of the spectrum where […] it might be perceived at that person has [acted] with an element of premeditation. And then people become angry at that […] like, "I'm gonna report this to the police and I'm going to pursue this", because they need to be punished […]." P06 L108-121

While VA was linked to diagnoses by a process of medicalisation to construct the deserving patient narrative; the undeserving patient was constructed in terms of instrumental behaviour by four participants. VA was understood by some participants to be a way of deliberately manipulating staff to get needs met, or get attention.

> "I've seen someone assault another patient because they know it gets them moved." P02 L309

Only two participants mentioned PD diagnoses specifically and none admitted to perceiving people with PD diagnoses as undeserving patients themselves. It may be that narratives around PD are changing, and people use this less to make sense of VA. One participant actively resisted this narrative, that they observed frequently by

colleagues, implying that it is still a way in which intent behind VA is understood by nursing staff:

> "I found it difficult when staff would treat different people differently […] people who had […] schizophrenia or bipolar that kind of diagnosis would be treated quite differently to people who had personality disorder diagnosis. And I think I was quite conscious when I was assaulted of like not doing that." P07 L57-61

Given this participant's experience of colleagues' perceptions, it may be that this narrative remains persistent, but participants' increased awareness of the stigma associated with PD diagnoses meant some people were more reluctant to discuss it, not wanting to be seen to perpetuate this. There was some suggestion that nursing staff felt guilty about perceiving patients differently to one another, for example:

> "I don't want to think " […] that person has definitely done that to me on purpose because X, Y and Z" and-. or "he's unwell and he just hits everybody all the time, it's such a shame". […] I don't wanna *be* that nurse and I don't think anybody wants to- […] I can't control the way I *feel* about it and I think-. Yeah, I think that sometimes you do have different opinions and different views on different patients" P06 L525-529

Again, this is seemed to link to a threat to professional identity.

3.2.3 Professional Identity Threats Related to Violence and Aggression: "Nursing Is a Pretty Dangerous Job to Be Honest" P06 L343

There were five categories integrated under the theoretical code: VA related threats to professional identity:

- Oppression, deprivation of liberty, and human rights: "Not the nurse I want to be"
- Constructing the hierarchy: Imbalances of power: who matters?
- It's (not) part of the job: (resisting) normalising and minimising VA
- "Fighting a fire that never goes out": staffing and system pressures

- It’s not just what you do, but why: “Targeted […] It feels quite personal […] I felt quite personally hurt by that.” P05 L314-315

3.2.3.1 Oppression, deprivation of liberty, and human rights: “Not the nurse I want to be”

The concept of trauma-informed approach was associated by some participants with the attempt to minimise iatrogenic harm, or re-traumatisation within services. Restraint in particular was considered to have the potential for (re)traumatising people according to four participants. Three participants spoke about the importance of using restraint only as a last resort. It seemed to be a part of the role that served as a threat to the positive professional identity:

> “it's heart-breaking when you have to […] restrain the service user […]. If there's […] like past trauma […] it's just absolutely horrific and […] just makes you not love the job at all” P05 L170-173

As documented in the deserving patient section above, another threat to nursing staff identity was the extent of deprivation of liberty and freedoms in the inpatient MH context. Five participants expressed empathy with patients who were scared or anxious about having their liberties restricted and recognised the imbalance of power between staff and patients.

> “[…] once situations deescalated you could get a sense that people felt a lot out of control and quite powered by staff and the nature of being sectioned in a PICU and so not being able to have many freedoms within that […]” P01 L13-16

Two staff contextualised their understandings of VA in terms of potential human rights breaches by highlighting issues of dignity. One referenced the recent Panorama documentary highlighting serious abuses at the Edenfield MH inpatient unit in Manchester. The footage of staff assaulting patients was shocking for the participant, and she related her reflection on the revelations to the potential for VA from patients. Another gave an example which highlights the lack of dignity for patients in the use of seclusion practices. Being expected to comply with a system

that breaches people's rights was another threat to building a positive professional identity as a nurse.

> "How do you […] trust everybody […] to treat people with dignity and respect? When clearly not everybody does […] I would be frustrated and I would be annoyed […] if I had my liberties, […] removed […] then I had staff treating me with disrespect or pinching me […] or doing whatever they were doing on-, on that Panorama. And then I reacted out of frustration with violence and all of my progress […] unravelled. I'd be frustrated, I'd be a-, mad, I'd be annoyed, I'd be angry" P06 L439-446

> "[…] the security team […] put them into solitary confinement […] I was left to watch. […] individuals shouldn't be in that situation, in underwear, being watched by someone. The whole thing felt unbelievably unsafe and uncaring and unthoughtful on every front." P03 L91-97

3.2.3.2 Constructing the hierarchy: Imbalances of power

Another threat to a positive nursing identity, was the way that VA intersected with the hierarchical nature of the staffing structures within NHS inpatient MH contexts. There was a narrative of separation between the nursing and support staff, and senior staff such as ward managers and the MDT – including psychology, psychiatry, and occupational therapy. Nursing and support staff constructed three main interlinking narratives that served as identity threats for nursing staff in relation to hierarchy and separation. Firstly, three participants felt that senior staff were not understanding of the extent of VA that nurses and support staff experienced on the ward, they were out of touch, due to being able to leave the ward and not work the same shifts:

> "[…] it felt that those that were, you know, had the means and the power to provide that support didn't even know what it really felt like to be there." P01 L383-385

Half of participants spoke about managers' and MDT members' failure to act adequately to protect staff from, acknowledge, or respond to support staff after incidents of VA.

> "[…] somebody said to the Psychiatrist once, and could you just come […] and see like how bad it is? And he said "no, that's not my job." […] "it's your job to restrain people, and like that means that you gonna get hurt sometimes". So I think that *that* felt like more of a kick in the teeth than the lack of support from Nurses." P07 L484-490

Thirdly, there was a sense from the narratives of some participants that nursing and support staff were devalued; considered less worthy of care, that it was not taken as seriously when they were hurt, compared with more senior colleagues

> "[…] staff have reacted differently because they've injured a certain member of staff, of a higher level, as opposed to […] "if it was one of us, he'd still be here", but because he hit the doctor or because he hurt this consultant then that means more." P02 L312-316

The importance of hierarchy was also noticed by one participant who felt they were less cared for as a bank worker, than permanent members of the nursing and support team, while others reflected that it was harder to build relationships as bank staff or students. Another who had experienced more than one serious physical assault said she felt that lower banded staff experienced the worst of the VA as they are spending most time with patients. Conversely, two participants who held management roles at the time of VA talked about how this meant there was no support for them, as they would be the ones expected to provide support following incidents:

> "[…] because of my position […] [Clinical Nurse Lead] I am, the one that has debriefs with other people. So when the CNL gets injured, there's nobody to have a debrief with me […]" P04 L441-443

So as well as there being a distinction between nursing and support staff, and the MDT and leadership staff; there was a hierarchical imbalance within the nursing and support staff whereby lower-banded, and pre- or non-qualified staff were more impact by VA.

3.2.3.3 It's (not) part of the job: (Resisting), normalising, and minimising violence and aggression

One of the central threats to professional identity, was the process of normalizing and minimising VA against nursing staff. This is a theme that comes up regularly in the literature around VA in nursing, that it is seen as part of the job, by exploring the narratives and social processes involved in constructing this idea – we can see that this is a complex and multifaceted issue. There was ambivalence about how much VA was an unavoidable occupational hazard, given the restrictive nature of inpatient MH contexts, and the acute distress and at times disorientation of the people admitted to the wards.

> "[…] part of our job is to manage risk […] and we don't come to work to be assaulted, or injured in any way but event-, unfortunately I think it does happen. Accidents happen." P02 L730-732

Despite the recognition that VA did occur on the wards, some participants still resisted the normalisation and minimisation of VA by peers, refusing to construct it as inevitable or acceptable.

> "[…] this thing of [other nursing staff] giggling when they saw that I was small, or they saw that I was scared. Something in that makes me feel that they were not aware that these situations are not OK, it's not OK that any individual here is being placed in the situation." P03 344-347

Staff appeared to receive mixed messages from leadership and peers about reporting, especially to the police. The tension between the rights of the nurses to be safe at work, and the rights of the patient to be protected presented an unresolvable moral dilemma. An example of this can be seen in the except below, where this nurse is contemplating the issue of reporting an incident of violence to the police:

> "I did this job, because I really cared, and I really wanted to help people […] and then I'm […] I'm gonna be […] going to the police […] and like affecting the rest of their life when all I ever wanted was to, like, affect their life in a positive way." P07 L242-245

There was no consensus about an alternative way to frame VA. Some staff spoke about feeling they were misled to an extent about the role of inpatient MH nurses and support staff, and reflected that had they known more about how much VA occurs, they might have reconsidered if the role was for them.

> "[…] student nurses […] come onto wards and you see it, you see it, you hear it. It […] makes you [not] want to come into nursing." P05 L204-206

Another staff member who felt similarly about not having known the full extent to which VA was part of the role, admitted to protecting their student nurses from the full realities of VA on the wards, in part because they need new staff and are concerned it might put them off.

> "[…] you shield a lot of Students from the reality of it, because you don't want them to leave. […] Which sounds terrible, but it is what it is, 'int it?" P06 L710-711

So although there are narratives of minimising and normalising VA in inpatient MH nursing, this is contentious, and actively threatens the construction of a positive professional identity. It is seen simultaneously as unacceptable, and somewhat inevitable. Despite participants resisting this narrative, it was also a narrative they used regularly to make sense of incidents of VA when they occurred. It was also a narrative that to some extent might be concealed from prospective and new student nurses at times, out of concern for the impact on recruitment and retention.

3.2.3.4 "Fighting a fire that never goes out": Staffing and system pressures

Seven of the eight participants mentioned staffing pressures and/or underfunding as exacerbating VA.

> "[…] you're basically, constantly fighting a fire that's never going out. […] you kind of just think, why am I bothering? And that-, that's really heart-breaking because you go into nursing to really help people […] it's just really horrific […] when you see your staff […] getting really stressed and […] if they have been hurt." P05 L161-168

Staffing levels were seen as important in relation to VA for four participants. Having enough staff was central to facilitating therapeutic interventions to meet patient need and for allowing staff to leave the ward for proactive reflective practice. It was also seen as important to allow staff time away from the routine of the ward for recovery, reflection, and debriefing after incidents.

> "[…] if you've got more staff, you've got more time for meaningful activities and more time for one-to-ones with people to establish how they're feeling. […] to facilitate staff to leave the ward, to have […] important debriefs and reflections" P01 L270-274

Short staffing was seen as threat to the professional identity of nurses because it meant not being able to provide the standard of care that they see as central to the role.

3.2.3.5 It's not just what you do, but why: "Targeted […] it feels quite personal […] I felt quite personally hurt by that." P05 L314-315

Participants compared different types of VA, for example verbal or physical, discussed the seriousness or severity of incidents, and at times gave rich descriptions and examples of the VA experienced and witnessed. Five participants explained that the perceived severity of the incident often impacts on the response in terms of support for the staff member or further action such as reporting or support, with physical VA responded to more consistently than verbal VA. Whether incidents and threats of VA were constructed by participants as serious or severe seemed to comprise levels of VA that would result in acute or long-lasting injuries for example: VA that could lead to broken bones, scalding with oil, sustained instances of punching or kicking. One participant, who was a bank support worker, mentioned that she had been told rumours about nurses who had been killed as a result of incidents of VA on inpatient MH wards, which understandably worried her.

> "You hear-, when you're on these wards you hear about so many stories of-, of nurses dying, um. Because it's not safe." P03 L311-312

Three participants reported feeling that even in the cases of serious incidents of VA there was a lack of adequate response:

> “In an ideal world, it would have been nice if [the manager] kind of stepped up a bit- […] because of how aggressive it was. I know that a couple of us had to be checked at A&E afterwards.” P02 L395397

Physical violence was not perceived as more distressing than intimidation or verbal assaults in all instances. Two participants spoke about the impact of repeated verbal aggression over a long time period as some of the most difficult incidents to understand and cope with.

> “The thing that affected me the most […] was the *daily*, […] verbal abuse [and] […] physical intimidation […] I actually I found that harder to deal with than […] the big incidents that we had with this person. P08 L16-17

Though the types and severity of VA were described and compared, the perception of VA as personal, or targeted was described as more distressing. In part, this linked with the narrative of intentionality in constructing the undeserving patient, as participants found it harder to understand VA that intended. In searching for meaning, two participants questioned whether they had done something wrong, or if they were bad at their job, which presented a threat to professional identity.

> “[…] the level of violence […] felt very similar [..] despite that someone's done it by accident […] just as, um, intense and still just as severe […] that [it was intentional] made things feel a lot more, um distressing […] regardless of the type, I think it still makes you reflect. Is there something that I've done that provoked this? […] is there something I could have done differently or […] I'm just in the wrong place at the wrong time?” P02 L40-51

Two participants highlighted that racism was a common occurrence as part of verbal VA on the wards they had worked in. One participant had lived experience of such racist abuse.

> “But then she does it every day, […] for like, 2-3 years or so. So at a point it starts getting to me like… This is not right. You know, calling people all sort of names, you know, some race-, racism words as well that you would not accept naturally or normally.” P04 L183-186

Another mentioned that the majority of their peers as a junior member of the ward support staff were women, racialised as Black. She reflected that it seemed these colleagues’ experiences of being endangered and ignored on the ward had parallels to discriminatory experiences of racialised women in wider society.

Gender was spoken about in relation to VA by four participants – all participants in this research identified as women. Two participants spoke about VA being more targeted toward women, three mentioned smaller stature, and one mentioned instances of unwanted sexualised touch. Two participants alluded to the increased difficulty of managing VA from men due to differences in strength and size. Gendered understandings of VA may be useful in further deconstructing VA on inpatient wards, both for the support and protection of staff and patients.

The narratives and social processes outlined above presented threats to the construction of a positive professional identity. Some important ways that staff responded to such threats are explored as parts of the next theoretical code, mediating factors and support following VA.

3.2.4 Mediating Factors and Support Following VA

The theoretical code mediating factors and support following VA comprised three categories:

- Emotional and behavioural responses
- Acknowledgement and support
- Reflection: Importance of dedicated time to understand violence and aggression

3.2.4.1 Emotional and behavioural responses

Participants reported a variety of emotional and behavioural responses following incidents of VA which were consistent with common post-trauma experiences.

During and immediately after incidents of VA all participants reported feeling scared or anxious. Other common experiences that participants reported immediately during and after incidents were crying, shock, urge to escape, and freeze responses. Half of the participants experienced feelings of anger toward the patient(s).

The experiences of VA led to anticipatory anxiety about returning to the ward in all cases for a period after the incident, which varied by person, and four participants described a sense of hypervigilance. For some people anxiety went away over time, others decided to leave the context temporarily or more permanently so it is unclear if this would have continued had they stayed. None of the participants reported experiencing anxiety or trauma they would consider clinically significant. Some were explicit about denying experiences of mental illness, possibly due to the associated stigma:

> "I never had PTSD or anything like that, but it was still that, that sense of threat that my body was feeling" P02 L382-383

Four participants mentioned feeling shame, embarrassment, or guilt after incidents of VA. Though shame is a common post-trauma experience, it is a taboo topic and difficult to talk about, so it may be that more people felt this but did not talk about it. In some cases the shame was around showing a reaction to VA in front of colleagues; and half of participants related to experiencing negative feelings toward patients which did not reconcile with their perception of their values and identity as nursing staff.

> "[…] I found that quite difficult […] what that meant about me, if I held these views about people? […] I liked the patients. […] it felt almost like I was letting them down for being angry at them." P07 L115-119

In the longer-term, people described a range of experiences that resulted from VA including feeling desensitised, detached, dissociated, distanced, or numb; helplessness and loss of confidence; and feeling emotionally and physically exhausted. Half of the participants found their home lives impacted by such experiences which included the sense of 'taking it home', sleep disruption, and in

once case reduced motivation for valued activities such as exercise which lasted until the patient moved off the ward. Half of participants specifically mentioned burnout as a result of VA, with two highlighting increased cynicism toward the nursing role.

> "[…] it's not an easy environment to just go in and get on with without feeling really burnt out by it" P01 L389-390

Four participants said the experiences they had following incidents of VA resonated with feelings and experiences from their past and personal lives. Two said they did not think at the time there were any similarities, but reflected on prompting by the researcher's question that there were some parallel experiences or feelings from their personal lives or past experiences. Two said they did not have experiences outside of work that related to or reminded them of any personal experiences.

Participants coped with the experiences and emotions following VA in a variety of ways including supressing their feelings, constructing narratives of not taking things personally and post incident growth, and understanding the cause of VA as the responsibility of others, for example managers. One participant found that faith and prayer helped her to cope and feel resilient. Five participants said they took advantage of support from others which included post-incident debriefs, reflective practice sessions, peer support, and external professional help. Half of the participants shared that they took time away from the ward on a temporary basis of hours, days, weeks, or months.

Of the eight participants half stayed in their roles following the incidents of VA we discussed, though one was finishing maternity leave and considering not returning due to the risk of VA. Two left the ward where it happened due to the VA but continued MH nursing, one in a specialist ward for eating disorders where risk of violence was lower, and the other in community MH nursing. Two left inpatient MH to pursue MH roles outside of nursing (for example, psychology), but not as a direct result of VA. Half reported colleagues having left or having considered leaving as citing VA as part of the reason. Below, the participant who moved into a role in

community MH nursing describes how VA in inpatient impacted their perception of the role of nursing:

> **"[…]** I hated being a nurse […] I really hated my job. I really felt that my purpose of wanting to care, that wasn't there anymore." P05 L306-309

3.2.4.2 Acknowledgement and support

One key factor that seemed to impact how people felt they could cope with risk and incidents of VA was the extent to which they felt that there was appropriate acknowledgement and support from peers and senior colleagues.

Some people found peer support was a help after incidents, and reported feeling their colleagues supported them when VA occurred.

> "Your colleagues […] scoop you up and take you somewhere […] and you get a bloody cup of tea, and a biscuit, and it's amazing." P06 L585-587

One participant felt that although peers were supportive it was not possible for them to help one another, as everyone was feeling and experiencing the same thing without any time to reflect on what was happening or process it:

> "[…] all the staff were great, but […] it was very hard to reflect, or feel *better* about it, because everyone was feeling the same. […] you went on to a shift and into the handover it was like 'oh, can't wait to see what *this* shift's gonna bring.'. […] just constant negativity." P05 L228-232

Not everyone reported peers that were supportive and in two cases nursing colleagues showed a lack of empathy when participants were upset following VA; this was related both to the narratives of minimising and normalising VA, and experiences of shame.

> "I just felt like embarrassed and a bit ashamed that […] I wasn't like all these other people that could just like brush things off […] the thing that sticks with me is like the people just laughing and I just started laughing." P07 L294-297

Two participants who were senior nurses described feeling they were unable to offer the support they feel is needed after incidents due to staffing issues. Two

participants felt that they were mainly well supported. Four people described feeling that senior management and MDT staff did not seem to care about nursing and support staff when they experienced VA, which participants understandably found distressing.

> "[…] nursing, I think is-, is an unsustainable profession now. And some of that is the violence and aggression. And it wasn't […] the violence and aggression from the *patients*, but it was the way it was dealt with, and the fact that, like, nobody cared. P07 L523-526

Two people mentioned that support from external professionals such as GPs and people to talk through the experience was of benefit.

3.2.4.3 Reflection: Importance of dedicated time to understand violence and aggression

Reflective practice and post-incident debriefs that were led by psychology were seen as useful avenues to reflect on incidents of risk and VA, and to make sense of patient VA in the context of the environment, or the person's experiences.

> "[The] Psychology Team […] would facilitate clinical discussion groups, which I think everybody always finds useful, especially if there has been incidents with patients that have resulted in violence and aggression. […] I find those helpful to […] understand that deeper meaning of why this person may react in a certain way […]" P06 L85-91

Though people valued debriefs and reflective practice both for processing VA and understanding contributing factors, they described not being able to leave the ward to complete them due to staffing pressures.

> "[…] the ideal situation is that you have like a debrief. Learning from experience, what can we do better […]" P04 446-447

Debriefing seemed to be more likely to occur after a serious incident of physical VA, and less with verbal VA, threats, or sustained smaller incidents over time.

3.3 Integrating Theoretical Codes and Categories

The social processes and narratives from the theoretical codes were integrated into a tentative theory of how social processes inform various narratives of VA, which then support or threaten the construction of a positive professional identity. A model was developed to depict the impact of narratives of VA on professional identity construction (Figure 1, Appendix M). The social processes which inform these narratives were explored so potential mediating factors might be proposed.

The narratives within the categories which comprised the code ‘constructing the undeserving patient’ tended to be perpetuated informally via peers’ or senior colleagues’ impressions of certain patients, including those with diagnoses of personality disorders. Intent seemed to be established either on the basis of the type of diagnosis attributed to a patient, or where VA seemed to result directly in the patient getting a need met – for example being moved off the ward. Capacity similarly seemed to be decided somewhat informally between peers in participants’ accounts, not only used as a term for when a formal assessment had been carried out. Again this seemed to be often linked with diagnoses, so those who did not have a diagnosis related to psychosis seemed more likely to have capacity attributed to them than those with psychosis. Through reinforcement between colleagues on the wards, these narratives seemed to feed into identity threat, as nurses seemed to find it harder to empathise with these ‘undeserving patients’.

Some of the professional identity threats related to VA appeared to be similarly maintained by informal peer processes of sense making, with senior nursing colleagues seemingly inducting junior colleagues by reinforcing narratives such as normalising and minimising VA. Additionally, this minimising and normalising was something that participants reported that managers and other senior MDT members actively contributed to through maintaining that VA was part of the job and not offering care and support following incidents of VA. External organisations such as the police and criminal justice systems reportedly reinforced this further according to some participants’ accounts through refusing to intervene or attend during incidents

of VA, and not progressing with action even when nursing staff felt that there had been an assault with intent and capacity.

If the associated threats to identity following VA were not addressed by the system, participants shared that this sometimes led to themselves or colleagues leaving the ward, or the profession. In terms of systemic processes, the professional obligation for nursing staff to be complicit in deprivation of liberty, and enact restrictive measures was a key threat. This seemed to be maintained by professional teaching and training, with nursing staff knowing the expectations and obligations placed on them, and the associated laws, for example the MHA. While such formal processes seemingly supported some nursing staff to accept these measures when used within principles of least restriction through narratives of protecting patients; in some cases this did not seem to fully stop the coercive nature of inpatient MH environments from threatening professional identity. While lack of support from peers was mentioned, it seemed that lack of support from managers and senior MDT members was more distressing and less understandable to nursing staff. In some people's experiences it seemed that nursing staff were viewed as less important, it was cared about less when nursing staff experienced VA than more senior MDT members; so the hierarchy of teams may support dehumanising some staff members as dispensable and protecting others. The mediating factors then, tended to be more influenced by leadership rather than informal peer processes. Where emotional and behavioural responses were acute, or sustained, it seemed that support to take time away from the ward was helpful: this was something that made possible in some cases by support from managers to arrange reflective practice, breaks, or even temporary transfers. Reflection appeared to be a mediating factor for VA-related threats in two ways. Firstly, it was seen as a means to process the emotional and behavioural responses of staff following VA, as a process of support from managers and senior MDT members, particularly psychologists to nursing staff. Secondly, it was seen as a way that psychologists could support nursing staff and other MDT members to understand and contextualise VA from patients. When these processes of leadership support were in place, it sometimes seemed to offer ways for threatening narratives, such as instrumental VA, to be transformed into narratives that nursing staff found

easier to process and empathise, with fitting better within the context of their desired professional identity.

Additionally to factors that mediated VA-related threats to professional identity, narratives that seemingly served to construct the 'deserving patient' fed into positive aspects of identity for nursing staff. Some of these narratives were supported via professional teaching and training, for example the medical model which dominates nursing training was often valued as an explanation for VA by nursing staff as a good fit for their roles of caring for ill patients. Other narratives such as contextualising VA in terms of threat-responses for patients, and use of TIAs were supported via training and reflective practice groups on the wards, seemingly by psychologists most frequently. Again, narratives around certain diagnoses, particularly psychosis, and the association with an assumed lack of capacity seemed to be more commonly constructed informally between nursing staff and senior staff rather than through formal teaching. While these narratives often fed into valued aspects of nursing identity, there should be caution in terms of capacity being assumed by diagnosis rather than by assessment of mental state at the particular moment an incident of VA occurs, as a blanket assumption of capacity or lack of capacity is not in line with guidance. Processes of detention were important, as VA as a threat-response seemed to be more easily understood by nursing staff when patients were detained formally than informally.

Directly following VA participants discussed a range of different reactions, some felt they could continue with their work, others needed to take time away from the setting where the VA happened in order to regulate their feelings. Some reported a delay in distressing emotions, so it will be important for managers, psychologists, and other MDT members to consider a multi-staged approach to checking in with staff, and offering opportunities for support.

4. DISCUSSION

Firstly, findings are discussed in the context of the current literature. Secondly, a critical review including limitations, quality appraisal, and reflexivity is presented. Thirdly research and clinical recommendations are suggested. Finally, a short conclusion of the study is given.

4.1 Results in the Context of Previous Literature

The first part of the discussion will present an evaluation of the research questions, integrating the research results with the relevant literature presented in the introductory chapter.

4.1.1 Which Social Processes Support Which Narratives of VA for Nursing Staff?

Participants in the study discussed a range of different narratives about VA. In terms of social processes: understandings from participants seemed to be more often learned from peers and leaders on the ward informally – through conversations and daily practice, though some came from structured teaching, reading, or training.

In keeping with previous research the most prevalent understandings of the causes and mediating factors of VA were:

- Medicalisation and mental illness (Asikainen et al., 2020; Bekelepi & Martin, 2022a; Dack et al., 2013; Gildberg et al., 2021; Guest et al., 2006; Harford et al., 2019; Hiebert et al., 2022; Howard, 2015; Jenkin et al., 2022; Pelto-Piri et al., 2020; Salzmann-Erikson & Yifter, 2020);
- Symptom and diagnosis-specific factors, particularly psychosis (Asikainen et al., 2020; Bekelepi & Martin, 2022a; Dack et al., 2013; Jenkin et al., 2022; Salzmann-Erikson & Yifter, 2020) and personality disorders (Asikainen et al., 2020; Benson et al., 2003; Harford et al., 2019; Howard, 2015; Salzmann-Erikson & Yifter, 2020);
- Admission status (formal or informal) (Bekelepi & Martin, 2022a); and
- Intentional and instrumental VA (Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020).

Not discussed by participants in this study were the exacerbating factors of alcohol and substance use on VA (Bekelepi & Martin, 2022a; Bowers et al., 2009; Dack et al., 2013; Gildberg et al., 2021; Hiebert et al., 2022; Pelto-Piri et al., 2020; Salzmann-Erikson & Yifter, 2020). Given the increasing proportion of patients on formal section in contemporary NHS services (Sheridan Rains et al., 2020), restrictions on leave may render access to substances in UK contexts harder than internationally, or at the time of prior UK-based research.

4.1.2 Which of the Available Narratives Support the Construction of a Positive Professional Identity for Nursing Staff?

In line with previous research (Asikainen et al., 2020; Bekelepi & Martin, 2022a; Dack et al., 2013; Jenkin et al., 2022; Salzmann-Erikson & Yifter, 2020) participants in this study understood VA through medicalised understandings of symptoms and diagnoses of psychosis. While medicalised narratives seemed to increase empathy and understanding toward patients, they seemed to be mediated by an erroneous blanket assumption of lack of capacity for those experiencing psychosis. If someone lacks capacity for an act of VA there are less avenues for response, for example from the police (College of Policing, 2017; NPCC, 2020; Quinn, 2016). One participant mentioned feeling that the patient who displayed VA toward her did have capacity, but this was dismissed due to their diagnosis of psychosis.

Contextualising VA in terms of threat-response also appeared to support nurses to empathise with patients, and maintain a positive professional identity. Participants highlighted that patients may feel trapped or unable to escape and that they experience violence such as restrictive interventions, which could trigger their automatic threat responses. These constructs could be understood using the PTMF as they are represented in the foundational pattern of distress (Boyle & Johnstone, 2020). PTMF contributed to reduction of VA and restrictive practices when used for improving staff understandings of patients' distress in inpatient MH populations (Kramarz et al., 2022; Nikopaschos et al., 2020), and it has been well received by some practitioners in forensic MH fields for contextualising patient distress and VA in

reference to MH environments caricaturized by imbalances of power and coercion (Ramsden, 2019).

TIAs seemed to increase empathy toward patients, and aid understanding of VA in some cases by contextualising some incidents of VA as a potential result of past trauma or (re)traumatisation from services (Muskett, 2013; Office for Health Improvement and Disparities (OHID), 2022; SAMHSA, 2014; Saunders et al., 2023).

4.1.3 Which Processes Threaten Professional Identity?

Nursing staff's emotional and behavioural responses could seemingly threaten professional identities if they lasted a long time, or interfered with their ability or confidence to do their jobs. Participants in this study described a number of emotional and behavioural responses that were in keeping with previous research, for example fear (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Hiebert et al., 2022; Pelto-Piri et al., 2020; Välimäki et al., 2022); anxiety, panic or worry (Bekelepi & Martin, 2022a; Hiebert et al., 2022; Jenkin et al., 2022; Välimäki et al., 2022); anger (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Hiebert et al., 2022); hypervigilance (Bekelepi & Martin, 2022a; Ham et al., 2022; Hiebert et al., 2022; Pelto-Piri et al., 2020); and guilt, self-blame, and self-doubt (Hiebert et al., 2022), many of which reduced over time. While PTSD was cited as a potential risk factor for inpatient MH nursing staff who experienced VA in the previous literature (Ham et al., 2022; Hilton et al., 2022), it was not something the participants in this study identified with explicitly. This may as those with PTSD symptoms or being assessed for PTSD were excluded from this study for ethical reasons, though stigma (Burman, 2018) could also play a part. Nursing staff's behavioural and emotional responses to VA included reference to, experiences of violence, feeling trapped on the ward, not being able to predict or control the threat of VA, VA as an interpersonal threat sometimes in the context of previously positive relationships, feelings that the threat was intentional, and that the VA triggered their automatic physiological threat responses. These experiences could be contextualised using the PTMF as all are referenced in the foundational pattern (Boyle & Johnstone, 2020). Participants also referenced feelings of burnout; an occupational phenomenon that has been linked

with reductions in efficacy, cynicism, and exhaustion in staff (Maslach, 2001; WHO, 2019), as well as compassion fatigue (Figley, 2015; Joinson, 1992; Marshman et al., 2022). Burnout was a commonly identified risk factor for PTSD in inpatient MH nursing staff who had experienced VA (Hilton et al., 2022) and has been recognised as a threat to staff wellbeing (NHS Employers, 2022). Whether or not emotional and behavioural responses constituted a threat to professional wellbeing for participants in this study seemed to be mediated in part by whether or not appropriate support and acknowledgement was available, which reinforced findings in previous literature that support from peers (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020; Sutton et al., 2022; Välimäki et al., 2022), managers (Bekelepi & Martin, 2022a; Sutton et al., 2022; Välimäki et al., 2022), and professionals (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020) helped people to cope with VA.

In keeping with prior literature staffing and system pressures were seen as a potential exacerbating factor for VA (Bellman et al., 2022; Gilliver, 2020; HSJ & Unison, 2018; RCN, 2018), and an identity threat due to the moral distress of not being able to perform the role to the standard they would like (Webb et al., 2023).

Deprivation of liberty and use of restrictive practices appeared to present a threat to in different ways. Participants recognised the potential for iatrogenic harm for patients, or (re)traumatization by services (Boyle & Johnstone, 2020; Muskett, 2013; OHID, 2022; SAMHSA, 2014; Saunders et al., 2023), and sometimes understood VA in this context. This involved understandings of the oppressive and restrictive environment of the ward as a potential cause or escalating factor in VA by way of invoking threat responses related to the patients' trauma; but also that the restrictive practices were a form of violence enacted by the system against patients – what could be termed negative operations of power in PTMF parlance (Boyle & Johnstone, 2020). The participants showed a good understanding of the balance between their rights to be safe from violence at work in keeping with guidance and policy (DHSC, 2023; Patel, 2019; WHO & ILO, 2022), with the prioritisation of human rights and dignities of patients (HRA, 1998; Patel, 2019; UDHR, 1948). One participant referenced the recent Whorlton Hall exposé (Triggle, 2019), but that and

other recent exposures of human rights abuses in NHS inpatient contexts (Cafe, 2012; Dispatches, 2022; Panorama, 2022) show that this is an area that requires much improvement (CQC, 2022). Participants in this study empathised with patients who were distressed by restrictions expressed sentiments of moral distress (Jameton, 2017; Jones, 2021), and moral injury (Shay, 2014) in keeping with previous literature (Webb et al., 2023).

Previous literature on VA in MH inpatient contexts cited PD diagnoses as a potential causal or mediating factor in presentation of VA in patients (Asikainen et al., 2020; Harford et al., 2019; Howard, 2015; Salzmann-Erikson & Yifter, 2020), with proposed mediating factors of severe anger (Harford et al., 2019), deregulated emotions (Howard, 2015) and impulsivity (Harford et al., 2019; Howard, 2015). In this study understanding VA in the context of PD seemed to lead to less empathy from nursing staff, or their colleagues. Previous research has found patients with PD stigmatised by professionals as manipulative, attention-seeking, responsible for, and in control of their distress (Kyratsous & Sanati, 2017; Lewis & Appleby, 1988; Sullivan, 2019); discourses which may have informed nursing staff's narratives. PD diagnoses have been criticised as framing understandable responses to adverse circumstances and power imbalances as erroneously pathological (Shaw & Proctor, 2005).

Participants found VA perceived as intentional harder to make sense of and more distressing (Benson et al., 2003; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020). In line with Benson et al.'s findings (2003), in this study intent seemed to be mediated in some cases by medicalised narratives around the type of diagnosis.

4.2 Critical Review

4.2.1 Limitations

The sample was self-selecting so there may be a bias toward participants who view VA as an issue of central importance, while those who do not may have chosen not to take part. Recruitment was via social media. While this may be cost-effective

method, and an effective way to reach minoritized populations (Sanchez et al., 2020); it may also present a skew in terms of age, gender, or level of education of people recruited (Sanchez et al., 2020). Unfortunately, due to time constraints the sample size was fairly small. While large enough to likely cover the most frequently represented categories (Guest et al., 2006) it does somewhat limit the transferability of findings.

VA in MH nursing is a hard topic to discuss. Some participants mentioned shame and embarrassment, and others of losing their confidence in their ability to perform their roles. Shame *itself* is stigmatised and difficult to talk about (Dolezal & Gibson, 2022), that some disclosed this may indicate that others who did not nonetheless had similar experiences, and shame may have resulted in some people deciding not to take part. Similarly, it may have been difficult for people to share how experiences of VA and TIAs resonated with their personal lives. While some participants disclosed experiences from their personal lives that shared emotional resonance, others may have decided not to, given the context of a one-off interview with an unknown clinician with little time to build trust. It may also have felt difficult for people to share feelings of anger or other emotions often construed as negative toward their patients for fear of judgement – being seen as unempathetic; when participants did share such sentiments there were expressions of reluctance and hedging of the discourse.

4.2.2 Quality Appraisal

Quality appraisal of qualitative research is a complex area, and there are different perspectives on how or if to apply concepts such as validity and reliability, with some theorists advocating that the ideas do not fit with the epistemological approaches affiliated with many such research methods' stances of subjectivity; whereas others develop alternative criteria to replace them (Spencer & Richie, 2012). The evaluation of constructivist grounded theory research may be considered in the context of the following criteria: "credibility, originality, resonance, and usefulness" (Charmaz, 2014, pp. 337–338: Appendix N). I will explore each criterion in turn.

Credibility

This criterion was constructed to measure if the research has evidenced sufficient familiarity with the topic and data to evidence claims; systematic comparison of the data, categories, and codes; representation of a range of views; and links between the data, analysis, and argument (Charmaz, 2014, p. 337). The research realised acceptable familiarity with the topic, both in its grounding in previous research and its in-depth exploration of the lived experiences of nursing staff in relation to VA. Data were sufficient to support the analysis constructed: as evidenced by supporting participant quotes, excerpts from research memos (Appendices J and K), examples of conceptual maps (Appendices K and L) showing the evolution from initial coding, though to categories, to theoretical codes; and negative cases were examined and included where views differed. Participants were drawn from NHS inpatient MH service contexts around the UK, not restricted to a single service or trust. This created potential for 'representational generalisation' – that the research may be used to make inferences of what social processes and narratives may be involved in constructing the meaning of VA in similar service contexts (Spencer & Richie, 2012, p. 230). The analysis and recommendations were well linked to the data collected in the study as evidenced through illustrative quotes, and examples of the coding and the analytic process (see Appendices I, J, K and L). Empirical observations of the processes in vivo were not possible as a part of this study, though it provided a theoretical starting point for the possible testing of interventions to support nursing staff with incidents of VA. The researcher would have preferred the chance to collect more data, particularly from underrepresented voices such as those identifying as genders other than female (including cis-male, trans, non-binary and gender-fluid professionals), and racialised nursing staff. This would have added more depth to the observations around VA and intersections with race and gender. Though extending the sample size to 12 participants may have increased the likelihood of identifying the full range of categories; this research still should have identified the most important crude categories (Guest et al., 2006). Results presented variation and nuance between participants, as well as some common theoretical codes, which indicated that participants with a range of perspectives took part in the research. The

method section offered a strong rationale for the chosen study design, and evidenced that alternatives were considered. Ethics were prioritised in line with guidance, and steps taken to minimise risk of detrimental impacts on participants.

Originality

Originality comprises examination of whether the analysis offered new insights or conceptual understandings; social and theoretical meaning; or a challenge or extension to concepts (Charmaz, 2014). The dilemma of how much of this theory construction was inductive from the data, and deductive from the researcher's perspective and prior knowledge of the literature on the subject is a 'tension' between whether the theory 'emerges' or is 'applied' which is not possible to neatly resolve (Charmaz, 2014, p. 151); but the researcher attempted to reflect on where prior knowledge and personal experience have influenced her construction of the theoretical codes in research memos (Appendices J and K), while grounding the theoretical codes firmly in the data. For example, as a psychologist, the researcher's perspective of the emotional and behavioural responses following VA was one of normalisation, of considering these experiences as common and in keeping with the participants' survival mechanisms. Considering the participants were nursing and support staff in a MH setting, there was an expectation that the participants would hold a similar understanding of these experiences, and the process of their attenuation over time in most cases. This did not always seem to be the case, which was a surprise, and challenged the researcher's concepts of the available information and training for nursing staff working in these contexts about what could be expected after experiencing VA:

> "[Physical violence] was quite a new thing for me to experience and process, which I think for the first time that ever happened, that was part of the reason for kind of trying to figure out what-, is that normal healing pathway I 'spose?" P02 L510-512

The study extended the literature through its focus on social processes, bringing a new conceptual understanding of the topic.

Resonance

The resonance of the topic with participants is another measure suggested for quality appraisal (Charmaz, 2014). The topic seemed to resonate, some commented how useful it was to talk about and process their experience, and all requested dissemination of findings. The study linked the individual experience to that of wider institutional contexts. There is some evidence that the research process offered some participants the chance to reflect on their experience in a way that deepened their understanding of the intersection between their personal and professional lives. For example P07 spoke about how reflecting allowed them to make links now that they hadn't noticed at the time:

> "[…] I had been through um (.) something similar is as a child. […] it's interesting […] reflecting back […] it was probably similar sense of […] just get on with it, like, it's just something that some people do. […] those feelings of like "oh you're not a bad person for doing this", like "I can see that you're not a bad person, I don't want to be angry at you, but I do feel angry at you" […] I guess the answer is like at the time *no*. But reflecting back, there probably were like similarities with how I coped." P07 L330-338

It would have been preferable were it not for time constraints, to offer participants the opportunity to review and comment on the findings, to get their perspective on the constructed codes – this may have further evidenced resonance.

Usefulness

The criterion of usefulness includes exploring if the research evidenced applicability to everyday lives and contexts, generation of areas for future research, and a contribution to knowledge that could improve things. The codes that have been identified, and the tentative theory of interaction, could be used by service managers and psychologists in inpatient MH contexts to understand the narratives and social processes used to construct VA, the potential benefits, and disadvantages of different narratives for the construction of a positive professional identity, and to develop appropriate support mechanisms and training. The analysis offers a nuanced understanding of concepts previously identified as important, in a way that

adds to the utility: for example knowing that nursing staff understand diagnosis as important to the causes of VA may have been helpful, but understanding more about how these narratives are formed, some of the assumptions behind them, and the potential impacts (positive and negative) on the formation of professional identity was potentially of more use for the development of effective training and support. Encouraging leaders to offer tailored support to nursing staff who have experienced VA could improve their emotional wellbeing, and may help them to re-engage in processes that help construct positive professional identities. The analysis generates possibilities for further research, particularly into gendered and racialised constructs of VA.

4.2.3 Reflexivity

Researcher reflexivity

VA is a hard topic for nursing staff to speak about. While being subject to VA is potentially distressing in and of itself, VA from patients toward nursing staff has the potential for additional distress for example, loss of confidence in performing the role, a sense of having failed the patient, and the stigma associated with emotional and behavioural responses. I acknowledged in the recruitment that I have seen how traumatic and stressful incidents of VA can be for staff, while this may have reassured some that I would not stigmatise them if they had challenging experiences, it may have put off some professionals who do not experience VA as stressful, or were concerned about being associated with the concept of trauma. There were aspects of my identity that may have enabled participants to feel comfortable to open up about VA. I made clear in my recruitment that I have worked in these contexts which may have lent some credibility, and assured people I would not likely be shocked by anything they chose to share. That I am a trainee clinical psychologist may mean that participants trusted that I would be a safe person to talk to about this, particularly for those who have found psychologists supportive in the past. It may also have been of benefit that I was not a nurse, given peers minimising and normalising VA was an aspect of many participants' experiences. Two of the eight participants I spoke to had moved out of nursing and support work into psychology, so the sample is likely to have been skewed in favour of psychological

thinking. Not all nursing staff will share a positive view of psychology, one person who took part spoke about experiencing criticism of their practice following VA, and people may have had negative encounters with psychologists in their professional and personal lives. The psychologist is a senior member of the MDT, and while some who took part felt able to share their experiences that there seemed to be less concern when they are victims of VA compared to senior staff, others may have decided not to take part if they perceived me as a potential enactor of this process. That I identify as a woman may have enabled my participants, who also all identified as women, to speak more freely about gendered aspects of VA. Conversely, I was not able to recruit male-identifying, non-binary, or gender-fluid participants in the time available, this may be due to a concern that a researcher with a different gender identity might not understand their unique experiences of gendered VA. All but one of the participants in this research identified as White. Racism was raised by three participants as a mediating factor in nursing staff's experiences of VA. Being a White British researcher and psychology professional, I may not be experienced as a safe person to speak to by racialised people. Not only will everyday experiences of microaggressions understandably mean caution is applied when deciding to talk to a stranger about such difficult experiences as VA, but White Eurocentric researchers and psychologists in particular have a history of epistemological violence against people of the global majority, who are racialised and minorized in UK systems (Ahsan, 2020).

Taking part in the research has challenged some of the understandings I held about the profession of nursing, and will change the way I practice in MDTs. I started from a perspective of respect for nursing and support staff, though I knew little about the training that is received for the roles, or the content of their courses. I was naïve about how little training some junior support staff received ahead of being placed in such challenging and complex environments. I had also wrongly assumed that VA would be spoken about more in nurses' university training than it is, and that there would be training on non-medicalised understandings of distress and VA, such as threat-responses, behavioural theory, and TIA. Though some participants were aware of these theories, not all were, which impressed upon me the level of

responsibility an MDT psychologist has for presenting alternative understandings which may be helpful in supporting colleagues and patients. I was pleased to hear that some had positive experiences of psychologists in MDTs, but of more interest were the times when psychologists had made things worse by not dedicating time to supporting colleagues, or by giving critical advice when they were feeling most vulnerable. While it is an important part of the role of psychologists to challenge the way we respond to patients as an MDT, it is clear that VA is a complex area, and that both patients, and colleagues will be distressed. While I had considered the dehumanisation of patients in such coercive environments, I had thought less about senior members of the MDT, including psychologists, dehumanising the nursing staff. This felt painful to acknowledge and will be something that stays with me as a drive to do my job better, and continue to critically interrogate my role as complicit in coercive systems of care.

Epistemological reflexivity

Carla Willig (Willig, 2013) highlighted the importance of epistemological reflexivity – a recognition of the limitations, and that all research starts from subjective assumptions about what will be salient in answering the chosen question(s) which influence the study design, recruitment, analysis, and conclusions. The researcher chose a critical realist epistemology which fit with her understandings from previous literature, and experience of working in inpatient MH contexts of VA as an ontological reality which may be observed in the world, but perceptions of VA in this context as multiple and nuanced. Constructivist grounded theory was chosen for analysis which served to privilege subjective understandings of narratives and social processes as the most important aspect of nursing staff's experience of VA in inpatient MH contexts. These assumptions were built into the research process. For example asking people about their emotions and coping generated research that favoured discourses around these experiences in particular, which are highly relevant to the clinical psychology profession. This criticism is of course not limited to qualitive approaches or psychology research, but it is important to explicitly reflect on the subjective nature of all research and consider the limitations of any one approach to provide a full analysis of complex social issues.

4.3 Recommendations

4.3.1 Research

The following clinical recommendations and suggestions should be considered as additive to the literature and guidance on improving the physical environment of wards (Allen, 2015; Bowers, 2014; Bowers et al., 2009, 2015; DoH, 2013), ensuring adequate staffing levels (Bellman et al., 2022; Gilliver, 2020; HSJ & Unison, 2018; RCN, 2018; Webb et al., 2023), and ensuring restrictive practices and deprivation of liberty are minimised, and conducted in line with human rights law (HRA, 1998; Patel, 2019; UDHR, 1948), the MHA (Mental Health Act 1983, 1983) and MCA (MCA 2005, 2005), and service standards (NAPICU, 2016; NICE, 2015; RCP, 2019b, 2019a, 2020).

As participants held different views about VA and capacity, and decisions about someone's capacity or intent to display VA did not seem to be made in a consistent way between different members of staff, it would be helpful to focus future research into how staff make judgements on capacity in relation to incidents of VA from patients. Service-based research might usefully collect and interrogate data on the outcome of capacity assessments conducted at the time of the incidents of VA in terms of formal definitions such as the MCA (2005), and record whether police response to reported incidents correlates with capacity as assessed by MH professionals, as despite police MOUs (College of Policing, 2017; NPCC, 2020) and enhanced legislation for offences against professionals (UK Parliament, 2018) it was felt by some participants that reporting was futile even they perceived that the person acting with VA had capacity at the time, a view seemingly supported by some media (Quinn, 2016) and research (Archer et al., 2019) accounts.

More research across more inpatient MH services to add to promising early literature that TIA and PTMF team formulation may reduce incidents of VA and use of restrictive practices (Nikopaschos et al., 2020), and increase empathy and

understanding toward patients (Kramarz et al., 2022; Nikopaschos et al., 2020) would be welcome.

The majority of participants in this study (seven of the eight, 88%) identified as White, which compares to 71.9% of registered nursing professionals identified as White in the UK (Nursing and Midwifery Council, 2022). Three participants in this study mentioned racism in relation to incidents of VA from patients toward racialised nursing staff, and VA is specifically mentioned in NHS policy aimed at tackling racism against nursing staff (NHS England, 2022). Given this, further research specifically with nursing staff that are racialised would serve to redress the balance, so their perspectives are represented in the evidence base and go on to inform changes in practice.

All participants in this study identified as female. Recent data shows that 89% of registered nurses and midwives identified as female, 11% as male, with 0.78% identifying with a gender other than was assigned at birth (Nursing and Midwifery Council, 2022). While it might be expected to recruit more cis-gendered female nurses for the study, it would be of benefit to explore the experiences of those identifying as genders other than female to understand a range of perspectives on the issue of VA, especially as some participants mentioned feeling VA was targeted more at female nurses, and previous research has identified not having sufficient staff members of differing genders available for work as a potential causal factor for VA in inpatient MH settings (Jenkin et al., 2022).

4.3.2 Clinical

4.3.2.1 Teaching

Given the majority of NHS professionals work in MDTs, it could be of benefit to share knowledge and skills from different professions though inter-disciplinary teaching on accredited training programmes. VA could be one area where clinical and other practitioner psychologist lecturers could bring useful theoretical and research knowledge such as TIAs, PTMF, and threat-responses, which nurses in this study valued learning more about on the job, but rarely received teaching on as student nurses. Nursing lecturers could reciprocally offer expertise on medical

factors that could influence psychological presentations such as comorbid health conditions, and medication management. Such collaboration could foster mutual professional respect and understanding, and improve holistic patient care.

4.3.2.2 Training

Training on the prevention, and management of and response to VA is already part of the core work of NHS trusts. It could be helpful when designing training to consider the narratives that are being privileged. In keeping with the potential negative impacts of making sense of VA in terms of diagnosis, it may be better to avoid this. It may be of more use to frame understandings of distress, anger, and potential VA in the context of people's experiences (for example, delusions or hypervigilance to threat) irrespective of diagnosis, their life experiences and trauma, and the restrictive environment on the ward. These ways of making sense of VA all seemed to help nursing staff to make sense of VA, empathise with patients, and to maintain a positive professional identity. Additionally, training on TIAs with specific considerations given to the interactions between the VA of coercive interventions, restrictive practices, deprivation of liberty, and the VA of patients may be of benefit.

4.3.2.3 Reflective practice

Participants in this study spoke of the value of reflective practice for supporting understanding of the patients' perspectives, and how the context of inpatient MH wards and their past experiences could precipitate incidents of VA; and in helping the team to process their own feelings of anger and fear following VA. While recommended in guidance for inpatient MH contexts (NAPICU, 2016; RCP, 2019b, 2019a, 2020) RP is not mandatory, and there is not protected time for nursing staff to access it, despite campaigns from unions (Nursing and Midwifery Council, 2019; Unison, 2022). Promoting reflective practice to an essential requirement, and providing some guidelines for suggested use would be of benefit given it seemed to be valued by staff; and has been associated with increasing empathy toward patients, and decreasing judgement of patients (Heneghan et al., 2014), a reduction in self-reported burnout, traumatic stress, and increase in compassion satisfaction (Ragoobar et al., 2021) and even a reduction in VA (Heneghan et al., 2014).

Psychologists would be well placed to support with provision of RP on wards (APC UK & BPS, 2021; Onyett, 2007) and often provide this support already. With time as a barrier (Heneghan et al., 2014), services might consider shorter sessions, integrated into the routine of the ward, as has been trialled with success in one trust (Ragoobar et al., 2021).

4.3.2.4 Responding after VA

Participants in this study and others (Bekelepi & Martin, 2022a; Pelto-Piri et al., 2020; Sutton et al., 2022) highlighted the importance of feeling that senior staff acknowledged the impact of VA and showed they care. It may be of benefit to create a framework for team leaders outlining multiple time points to check in, similar to that of a watchful waiting approach to screening for early signs of PTSD. Any such framework should highlight that experiences of distress are common directly following a trauma, and most people recover with time without developing PTSD (National Institute of Mental Health, 2020). While NICE do not recommend psychological debriefs for the prevention of PTSD (NICE, 2018); it has been helpfully countered that this is not their intended purpose, and they can serve the role of providing people with information on what can happen after a distressing experience, how they can seek support if required (Regel, 2007). Given the importance of perceptions of intent outlined above, it would be of use to establish the nursing staff's perception of the incident of VA as if they believe the incident was intended, they may require more support to process the incident and help them to feel safer.

The following seemed to help participants mitigate distress and reconnect with a positive professional identity: space away from the environment where the VA took place immediately, or for a longer period of sickness absence or temporary transfer as needed; senior colleagues acknowledging what happened, and supporting them; and the opportunity for meaningful reflection in the form of reflective practice, supervision and/or debriefing.

Nursing staff in this study mentioned feeling that VA against them was perceived as less important than if it happened to more senior team members, this was echoed in

another study (Archer et al., 2019) and participants resisted the minimisation and normalisation of VA as part of the role, a narrative that was common in previous literature (Ayhan et al., 2022; Bekelepi & Martin, 2022a; Gildberg et al., 2021; Hiebert et al., 2022; Jenkin et al., 2022; Pelto-Piri et al., 2020). It may be better to avoid such narratives which may exacerbate feelings of distress.

4.3.2.5 Staff mental health support

Mental health support for inpatient nursing staff exposed to VA has been suggested as a promising target for prevention of PTSD (Hilton et al., 2022) and compassion fatigue (Marshman et al., 2022); something which could fit the remit of psychology in MDTs (APC UK & BPS, 2021).

Participants' accounts suggested that informal wellbeing support could benefit staff that have experienced VA. This might consist of checking-in, and provision of psychoeducation on some of the common emotional and behavioural responses following VA if they have concerns about their reaction. Some staff may require additional specialist support following an incident of VA. It could be helpful to follow up with staff at a number of time points, to offer support and screen for potential delayed negative reactions following VA. It may be beneficial to consider processes for allowing staff opportunities to temporarily work elsewhere to avoid staff attrition. Psychology support was mentioned as helpful for making sense of VA, and as a means of informal support for nursing staff following incidents, this is in keeping with guidance that suggest psychologists are well placed to provide staff support interventions (APC UK & BPS, 2021; Välimäki et al., 2022). As shame was a common emotion experienced a shame-sensitive approach – recognising that shame may prove a barrier to engagement, promoting explicit organisational recognition of shame as a common yet taboo emotion, and recognising when shame or shaming may be occurring (Dolezal & Gibson, 2022) will likely be of use. For individual support, interventions that deal specifically with shame in the context of distress or trauma such as compassion-focused therapy (Gilbert, 2010; Lee & James, 2012) may be of benefit.

4.4 Conclusion

The research to set out to gain a deeper understating of the social processes and narratives that nursing staff used in understanding VA, by answering the following research questions:

- Which social processes support which kind of narratives about VA for nursing staff?
- Which of the available narratives support the construction of a positive professional identity for nursing staff?
- Which processes threaten professional identity?

Though a small study, the research contributed to a deeper understanding of the many different narratives that nursing staff in UK inpatient MH contexts use to understand incidents of VA from patients, and the social processes which support them. It presented narratives which support, or threaten the construction of a positive professional identity. It offered some insight into which narratives might be of use to contextualise VA for stakeholders interested in adapting aspects of clinical practice and staff training. Narratives which seemed to support a positive professional identify focused on construction of VA as a threat-response, these may be helpful to disseminate to nursing support staff via training, supervision and reflective practice using approaches such as TIAs, and the PTMF. The research shed some light into areas that would be of benefit to explore in future research with larger samples, such as how perceptions of capacity and intent are constructed on inpatient MH wards in relation to VA. It also identified specific populations who seem disproportionately impacted by VA such as racialised staff, future research would be welcome in gaining the perspectives of such staff who were underrepresented in this sample and in previous literature.

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APPENDICES

Appendix A: Notice of Ethics Review Decision Letter

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Luis Jimenez**
Supervisor:	**David Harper**
Student:	**Laura Middleton Curran**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	**Making sense of incidents of violence and aggression: A constructivist grounded**

	theory analysis of inpatient mental health nursing staff's experiences

Checklist (Optional)			
	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐

All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the

	project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments
Please clearly detail the amendments the student is required to make
Information Sheet needs to include brief concise outline of researcher duty of care for participants during interviews (e.g., allowing participant to not answer a question(s) if not felt comfortable or stop recording/intervierwing/re-negotiating consent if needed. **Interestingly, some of this information was somehow included in the Debriefing sheet and the risk assessment but not in the Information sheet, so just check and paste same info on Information Sheet.** **Participants would also benefit from receiving via e-mail the actual interview schedule so they can also prepare for their research interviews.** **Risk assessment sheet identifies the DoS as also needing some duty of care but the details of who /how this would be provided are not clearly presented and the whole line is highlighted in yellow, so just check if this is needed and amend as appropriate.** **Debriefing sheet includes the Samaritans as appropriate support but this is not included in mahy ethics applications so check with your supervisor and amend as appropriate.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Luis Jimenez**
Date:	**14/06/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Laura Middleton Curran**
Student number:	**U2075217**
Date:	**16/06/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Appendix B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Understanding staff experiences of violence and aggression

Contact person: Laura Middleton Curran

Email: u2075217@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please read this information.

If you have any questions, please contact me on: u2075217@uel.ac.uk

Who am I?

My name is Laura Middleton Curran. I am a Psychology postgraduate student at the University of East London (UEL), studying for the Clinical Psychology Doctorate. This research is part of my studies.

What is the purpose of the research?

I am conducting research into how mental health nursing staff make sense of incidents of violence and aggression on inpatient wards.

Why have I been invited to take part?

I am inviting mental health inpatient nursing staff who have experienced or witnessed one or more incident(s) of violence or aggression from patients to take part, e.g.: physical assaults and verbal aggression, such as spoken threats or harassment.

If you are aged 18 years or over and are currently, or were at the time of the incident, a nursing professional, trainee nurse, or member of nursing support staff in England (e.g. health care assistant, social therapist), you are eligible to take part.

Please only apply if you feel you can talk about the incident without this being too distressing. The incident should have taken place at least two months ago (not more recently). I cannot accept participants who are experiencing ongoing distress related to the incident that is impacting their daily life, for example those who are diagnosed with or being assessed for post-traumatic stress disorder, and who are experiencing active symptoms (e.g. hypervigilance, nightmares, re-experiencing, intrusive images).

It is up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to complete one interview, this will be like be having an informal chat, of up to an hour. The conversation will be recorded, anonymized and confidentially stored. I do not have any connection with your workplace in relation to this research, and will not be feeding back identifiable information to service managers. You will be asked about your experiences of aggression and violence from patients when working in inpatient mental health services.

You do not have to answer any of the questions you do not want to answer, and we can take breaks whenever you want. We can stop the interview and the recording if at any point you need to do so.

If you are happy to take part remotely via MS Teams then you may take part anywhere you feel is sufficiently comfortable and confidential, but it would be helpful if you have access to a video device and reasonably stable WiFi or signal. I am afraid there is no payment available for taking part in this study.

What questions will I be asked?

The interview will be like a conversation, though there are some areas I would like to ask you about if you are happy to discuss them. Some examples are below:

Thinking about the incidents of violence and aggression that you have experienced or witnessed:

- What do you understand from incidents of violence from patients?
- How did you emotionally experience these incidents?

- What do you understand about trauma-informed care/approaches/practice?
- How did you experience the support you received after the incident(s) you experienced or witnessed?
- Is there anything else you would like to add or to discuss that we haven't done already?

Can I change my mind?

You can change your mind at any time before, or during the interview and withdraw without explanation, disadvantage, or consequence. After the interview, you can withdraw if you let me know within three weeks. If you do not withdraw within three weeks, I will use the anonymized data from the interview.

Are there any disadvantages to taking part?

The study involves discussing a potentially distressing topic. We will agree a plan together so the interview feels safe. I will give you information on support providers that you could contact if needed. If you would like support now you can:

- Seek support from your GP if you experience difficulties which persist over time.
- Contact: Mind: https://www.mind.org.uk/

See the debriefing sheet for more support organisations. In the highly unlikely event that the researcher is concerned about a risk of harm to self or others, confidentiality may need to be broken.

How will the information I provide be kept secure and confidential?

I will anonymise the data by using changing your name (pseudonym), and will change or remove any data in your interview transcript that I feel may lead to you being identified. I will securely store your personal contact details separately from the interview transcript, only until the end of the thesis project. Anonymised data will be stored securely on MS One Drive for Business and SharePoint by Professor David Harper, for five years at most, then deleted. Anonymised data will be available to the researchers supervisor, examiners, and in the final thesis report.

General Data Protection Regulation (GDPR)

The University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the GDPR. Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's data repository: https://repository.uel.ac.uk. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public) through journal articles, presentations, magazine articles, and blogs. In all material produced, your identity will remain anonymous.

You have the option to receive a summary of the research findings once the study has been completed if you would like, you will need to give relevant contact details for this.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee, guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please contact me:

Laura Middleton Curran: u2075217@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Professor David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: d.harper@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix C: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding staff experiences of violence and aggression

Contact person: Laura Middleton Curran

Email: u2075217@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw from the study within three weeks from the date of the interview, my data will not be used.	
I understand that the interview will be recorded using MS Teams with transcription on, or with a recording device.	

I understand that my personal information and data, including video or audio recordings, from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview will be used in a thesis that will appear online, and in addiction may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……

Researcher's Name (BLOCK CAPITALS)

LAURA MIDDLETON CURRAN

……

Researcher’s Signature

……

Date

……

Appendix D: Recruitment Poster

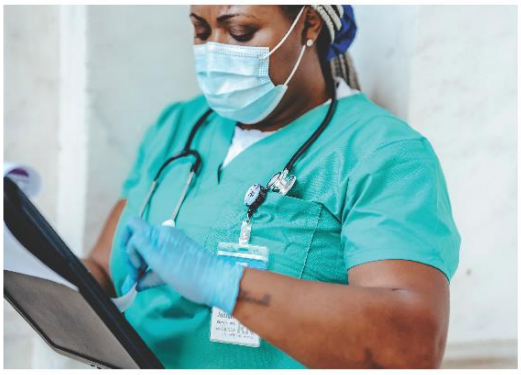
University of East London

INPATIENT MENTAL HEALTH NURSING STAFF

Violence & Aggression

Have you experienced or witnessed violence or aggression at work?

Would you be willing to talk about how this made you feel, and how you made sense of it?



If you are 18 years or over, and would be happy to talk about an incident you experienced, or saw, that happened more than two months ago, please get in touch

CONTACT ME:

u2075217@uel.ac.uk

WHO I AM:

My name is Laura. I am a Trainee Clinical Psychologist.
I have worked in forensic and general inpatient mental health services. I have seen first-hand how traumatic and stressful incidents of violence and aggression can be for nursing and other front-line staff.

Appendix E: Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Understanding staff experiences of violence and aggression

Thank you for participating in my research study on violence and aggression. This document offers information that may be relevant now you have taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) for example, through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous. Anonymised research data will be securely stored by Professor David Harper for a maximum of five years, following which all data will be deleted. If you have given relevant contact details, receive a summary of the research findings once the study has been completed.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Given the nature of the study it is however possible that this discussion – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you feel you need any additional support see the below information for ways to seek support:

For everyone

Seek support from your GP if you experience difficulties which persist over time.

Mind: https://www.mind.org.uk/

Samaritans: https://www.samaritans.org/

Call (open 24 hours every day): 116 123

Email (response within 24 hours): jo@samaritans.org

Campaign Against Living Miserably (CALM)

https://www.thecalmzone.net/help/get-help/

"5pm – midnight 365 days per year; helpline and webchat for those who are down or have hit a wall for any reason, who need to talk or find information and support"

0800 58 58 58

https://www.thecalmzone.net/help/webchat/

For NHS staff

Via your employer's employee assistance programme

If you work for the NHS or Local Authority, your employer will most likely give you access to an employee assistance programme, where you can access confidential support. This is usually easy to find on your trust's or organisation's intranet site.

Staff mental health and wellbeing hubs

"The staff mental health and wellbeing hubs have been set up to provide health and social care colleagues rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer is confidential and free of charge for all health and social care staff."
Check on their website for your local hub:

https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/

Support available for our NHS people

"This support line is available to all our NHS colleagues who have had a tough day, who are feeling worried or overwhelmed, or who have a lot on their mind and need to talk it

through. Trained advisers will be available to help with signposting and confidential listening."

Confidential staff support line, operated by the Samaritans and free to access from 7:00am – 11:00pm, seven days a week. Please call 0800 069 6222 to speak to an advisor.

If you would prefer to speak to someone through text, you can access support by texting FRONTLINE to 85258 for support 24/7.

https://www.england.nhs.uk/supporting-our-nhs-people/support-now/

Royal College of Nursing (RCN) Members

RCN Counselling Service:

- https://www.rcn.org.uk/get-help/member-support-services/counselling-service
- https://www.rcn.org.uk/get-help/contact-advice
- To make an appointment, call RCN Direct on 0345 772 6100
- https://www.rcn.org.uk/get-help/online-advice-form

RCN Help after experiencing violence in the workplace:

https://www.rcn.org.uk/get-help/rcn-advice/violence-in-the-workplace

Access to free of charge wellbeing apps for all NHS staff

https://www.england.nhs.uk/supporting-our-nhs-people/support-now/wellbeing-apps/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please contact me.

Laura Middleton Curran: u2075217@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Professor Dave Harper. School of Psychology, University of East London, Water Lane, London E15 4LZ

Email: d.harper@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix F: Interview Schedule

Interview Schedule

As you are aware, we are going to have a discussion about one or more occasions when you have experienced, or witnessed, violence and aggression during your work in mental health inpatient settings. If at any time you would like to stop, or take a break, please let me know and we will do that.

Broad topics of discussion for interviews, with prompts:

- Thinking about the incidents of violence and aggression that you have experienced or witnessed:

- What do you understand from incidents of violence from patients?
    - What meanings do you derive from incidents, how do you understand them?
    - How do you explain them when they happen?
    - Where do these ideas or understandings come from?
    - Has the way you make sense of the incidents changed over time? If so, how or why?

- How did you emotionally experience these incidents?
    - What feelings come up when you experience or witness violence and aggression at work
    - How did you cope with these feelings?
    - Do these emotions resonate with experiences you have had in your life outside of work?

- What do you understand about trauma-informed care/approaches/practice?
    - What training or guidance have you had about this kind of approach?

    - Does this experience, or understanding, resonate with experiences you have had in their own lives?

- How did you experience the support you received after the incident(s) you experienced or witnessed?
    - What happened right away? What happened later?
    - How did this inform your view of the nursing or support role?
    - What, if anything, could have been done differently?

General prompts:

- Where feels like a good place to start?
- Could you say more about that?
- And why do you think that is/was the case?
- What happened after that?
- What do you think about, that?
- What do others' think?

Ending:

Is there anything else you would like to add or to discuss that we haven't done already?

Appendix G: Transcription Conventions

(?)	not able to decipher to transcribe
(.)	Noticeable pause
(..)	silence
…	Speech trails off to silence
Especially	Notable emphasis on a word or phrase
Becau-	interruption of a word or phrase
(left hand on neck) (laughs)	Important or pronounced non-verbal communication
[replacement]	e.g., replacing identifiable information with a de-identified descriptor
(yeah)	Brief interjection of participant during researcher's speech, or vice versa

Appendix H: Excerpt from Transcript

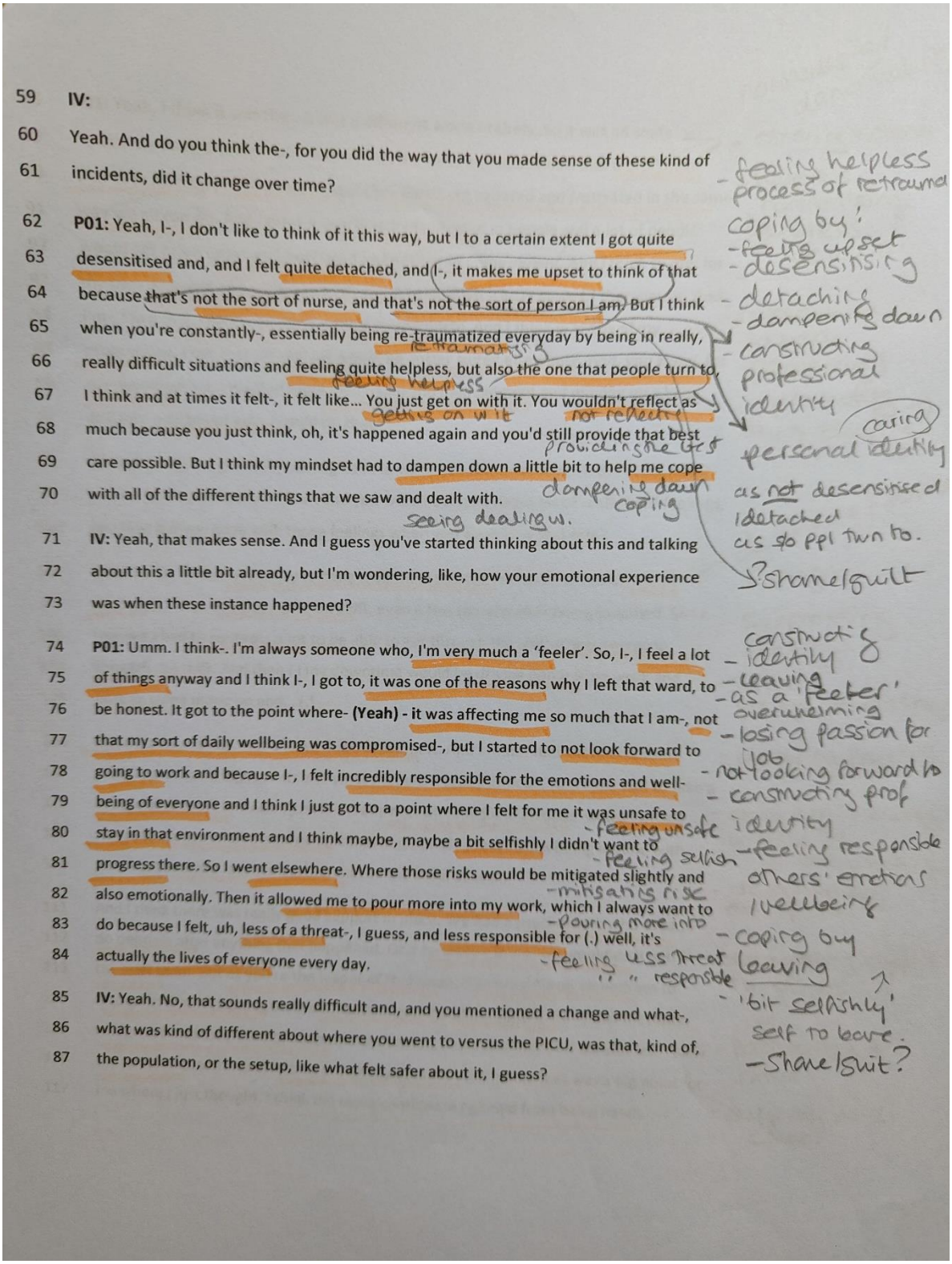
He wrote me a letter and (.) *that* was quite impactful, in a way, and I felt that it was quite, um, it helped me come to terms with-, with, kind of, the severity of the assault. And it helped me understand his, kind of, mental state and his intentions at the time um(.).

But yeah, I think like, I don't know, what was the question again? sorry, I've just gone and rambled. Yeah, sorry.

IV: OK. And I think like and that's fine if you want me to repeat the question **(Yeah, sorry)**, I suppose you're sort of also you're thinking of a few different incidents **(Yeah.)**, so like it's fine to come back **(Yeah.)** and think about the question from different perspectives as well. But no, you're absolutely answering the question. So it was really just thinking about what you-, what meanings you, kind of, make from incidents, how you understand them when they happen?

P06: And I think sometimes I think that things happen because- (.) things can snowball like there's no, there's not always one root cause of an incident, and I think that sometimes, as an individual, and as a team can be quite hard to understand. I think when-, post incident, everybody's, kind of, looking for answers like why did this happen? Like what could we have done differently? What-? Like, not attributing fault or blame to anybody, but if this hadn't happened, would the incident still have happened? Or if this would have happened, would it have still been-, would have been this severe? And I think definitely post incident you get quite a lot of, um, self-doubt, a lot of self-doubt, and that-, I think that that can be quite impactful for quite a significant period of time afterwards, to be honest.

Appendix I: Coding with Gerunds



IV: Yeah. And do you think the-, for you did the way that you made sense of these kind of incidents, did it change over time?

P01: Yeah, I-, I don't like to think of it this way, but I to a certain extent I got quite desensitised and, and I felt quite detached, and I-, it makes me upset to think of that because that's not the sort of nurse, and that's not the sort of person I am. But I think when you're constantly-, essentially being re-traumatized everyday by being in really, really difficult situations and feeling quite helpless, but also the one that people turn to, I think and at times it felt-, it felt like... You just get on with it. You wouldn't reflect as much because you just think, oh, it's happened again and you'd still provide that best care possible. But I think my mindset had to dampen down a little bit to help me cope with all of the different things that we saw and dealt with.

IV: Yeah, that makes sense. And I guess you've started thinking about this and talking about this a little bit already, but I'm wondering, like, how your emotional experience was when these instance happened?

P01: Umm. I think-. I'm always someone who, I'm very much a 'feeler'. So, I-, I feel a lot of things anyway and I think I-, I got to, it was one of the reasons why I left that ward, to be honest. It got to the point where- **(Yeah) -** it was affecting me so much that I am-, not that my sort of daily wellbeing was compromised-, but I started to not look forward to going to work and because I-, I felt incredibly responsible for the emotions and well-being of everyone and I think I just got to a point where I felt for me it was unsafe to stay in that environment and I think maybe, maybe a bit selfishly I didn't want to progress there. So I went elsewhere. Where those risks would be mitigated slightly and also emotionally. Then it allowed me to pour more into my work, which I always want to do because I felt, uh, less of a threat-, I guess, and less responsible for (.) well, it's actually the lives of everyone every day.

IV: Yeah. No, that sounds really difficult and, and you mentioned a change and what-, what was kind of different about where you went to versus the PICU, was that, kind of, the population, or the setup, like what felt safer about it, I guess?

Appendix J: Excerpts from Researcher Memo, Initial Coding Stage

Personal reflection

My role in inpatient settings in central London has been as part of the multidisciplinary team (MDT) often distinguished apart from the nursing team in the setting I have worked. I can relate to the 'us and them' that P02 mentioned, about the safety of team members who are higher banded or are allied rather than 'on the floor' staff being prioritized over the nurses. For me, this was observed when I was trained to always ask the nursing team for help as soon as a patient became aggressive or dysregulated. This was put to their being trained in restraint, and able to admin medication, which is true, but it did sit uncomfortably. I remember reflecting with a supervisor about the team feelings like 'bodies, shields' for others against harm, and we talked about the disparity between the nursing team and MDT.

Constant comparison: Initial coding for P03 and comparisons with P02 and P01

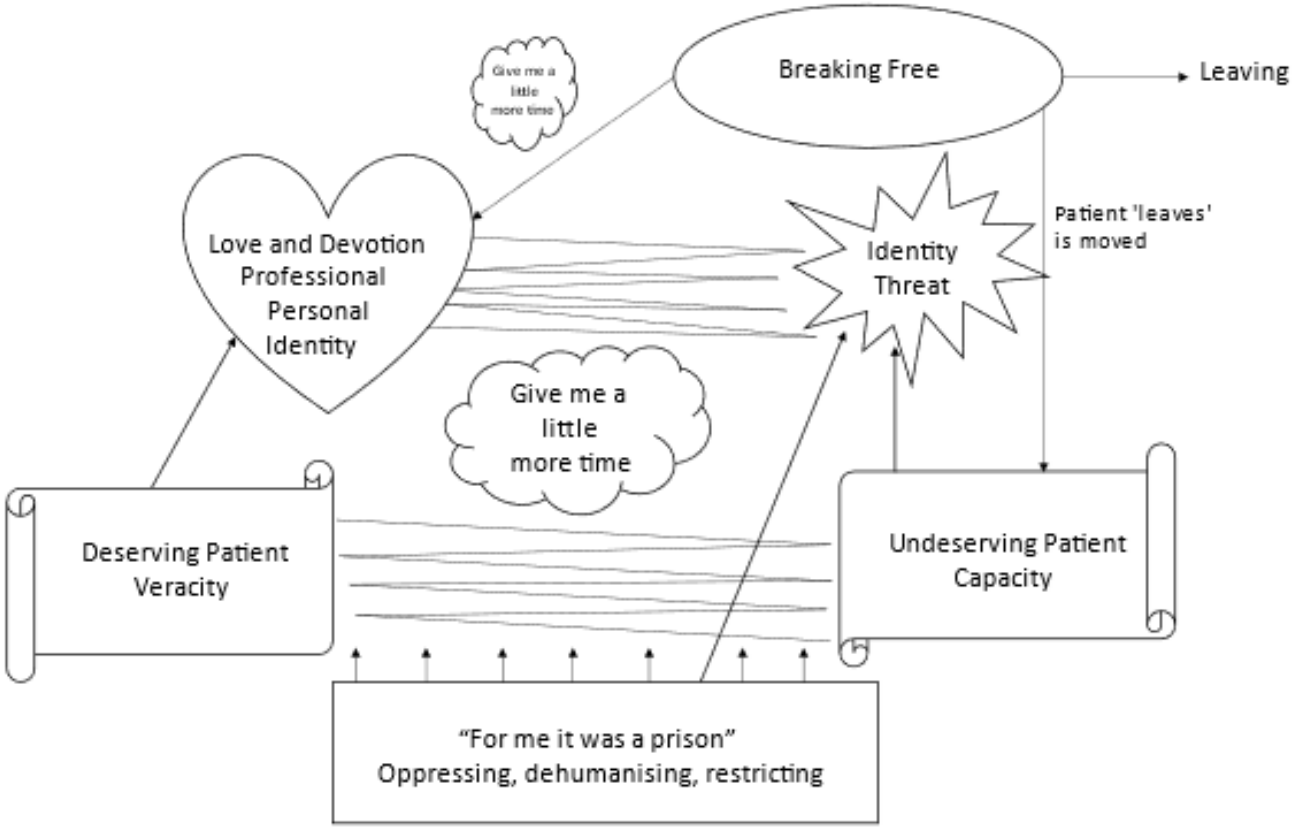
- Some codes coming up similar to the above but a lot of difference
- Using narrative to construct different meanings and processes:
    - Resistance to narratives of coercion and control
    - Explicitly comparing to a prison
    - Using words that humanize and re-value those devalued such as 'people' versus 'patients' or 'nurses'
- Narratives of Whiteness and power: racializing and dehumanizing/devaluing staff (many Black female nurses, low SES and mothers esp. on Bank).
- Contextualizing the VA as threat responses but with more understanding of the causes in terms of the environment and ward contexts as well as previous 'trauma'
- Viewed as small, young, disrespected by other staff/patients?
- TIA as helpful for context, but also not benevolent – raising issue of them being trauma-focused so reductive – person is more that their trauma

- Coping: detaching. Resisting coping by minimizing as above like others have had to (but acknowledging own privilege to leave). Again, narratives of leaving for safety.

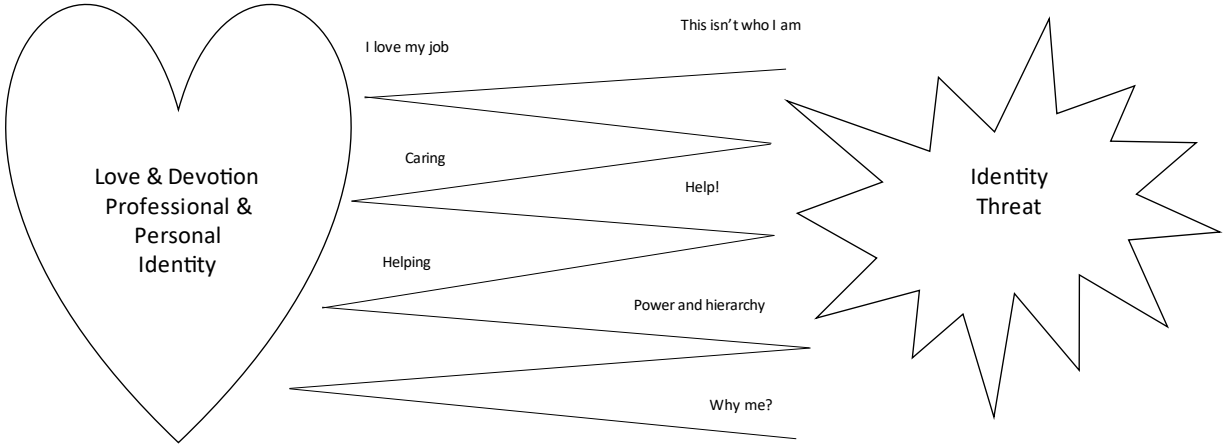
Appendix K: Excerpt from Researcher Memo Re-Examining Conceptual Categories

Initial category development: Early conceptual maps

Need to consider the subthemes and how they connect as it might be better to reorganise the key themes. Focus on what is being conceptualised: nature of incidents, the impact, things that improve or exacerbate to construct a narrative to explain how factors link.



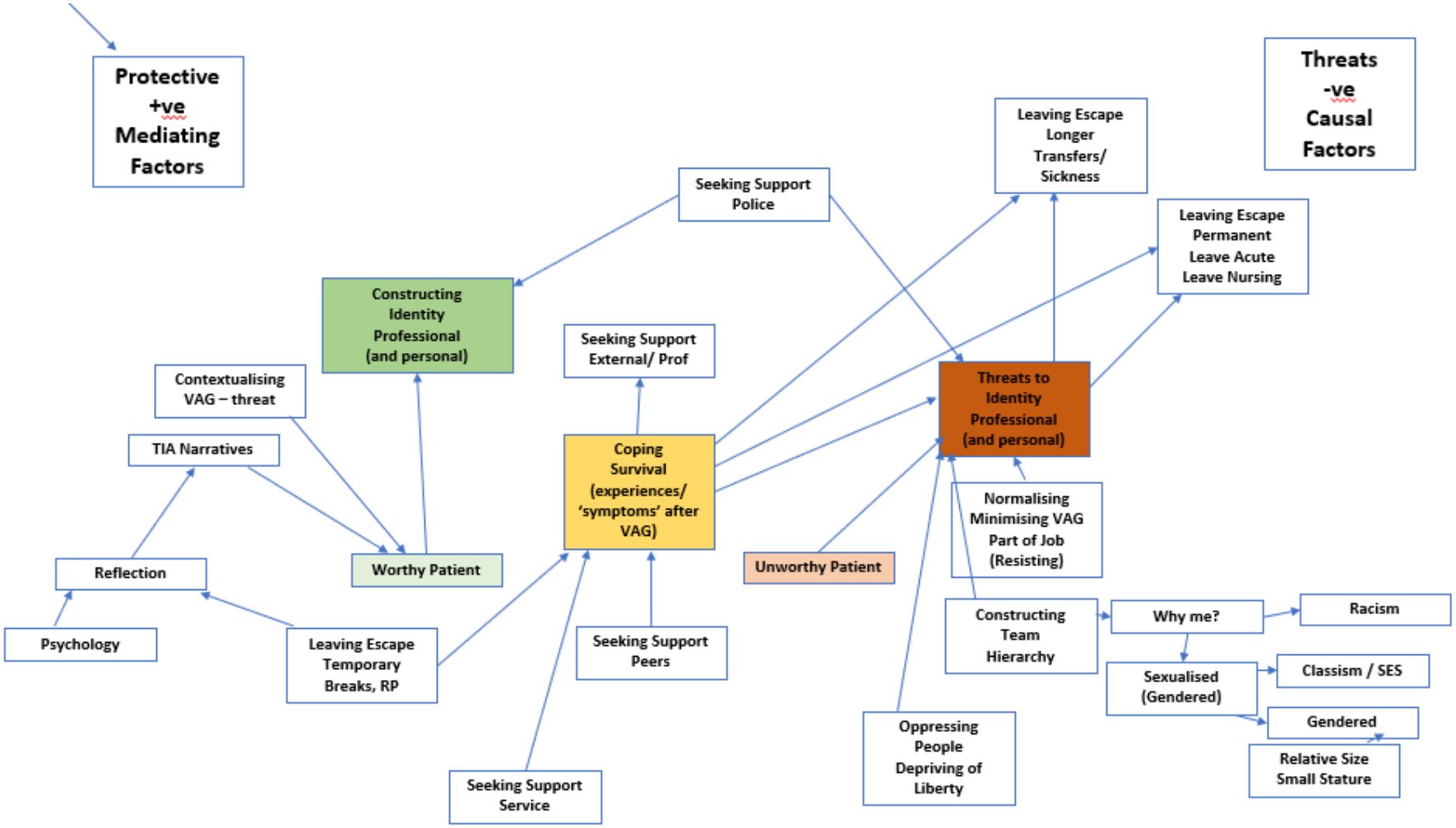
Ambivalence and oscillation between the deserving and undeserving narratives is interesting but may be better as part of the narrative, perhaps it is confusing in the diagram. Consider how the social processes mediate each other, for example which of the codes help with identity construction, and which make it harder or threaten it.



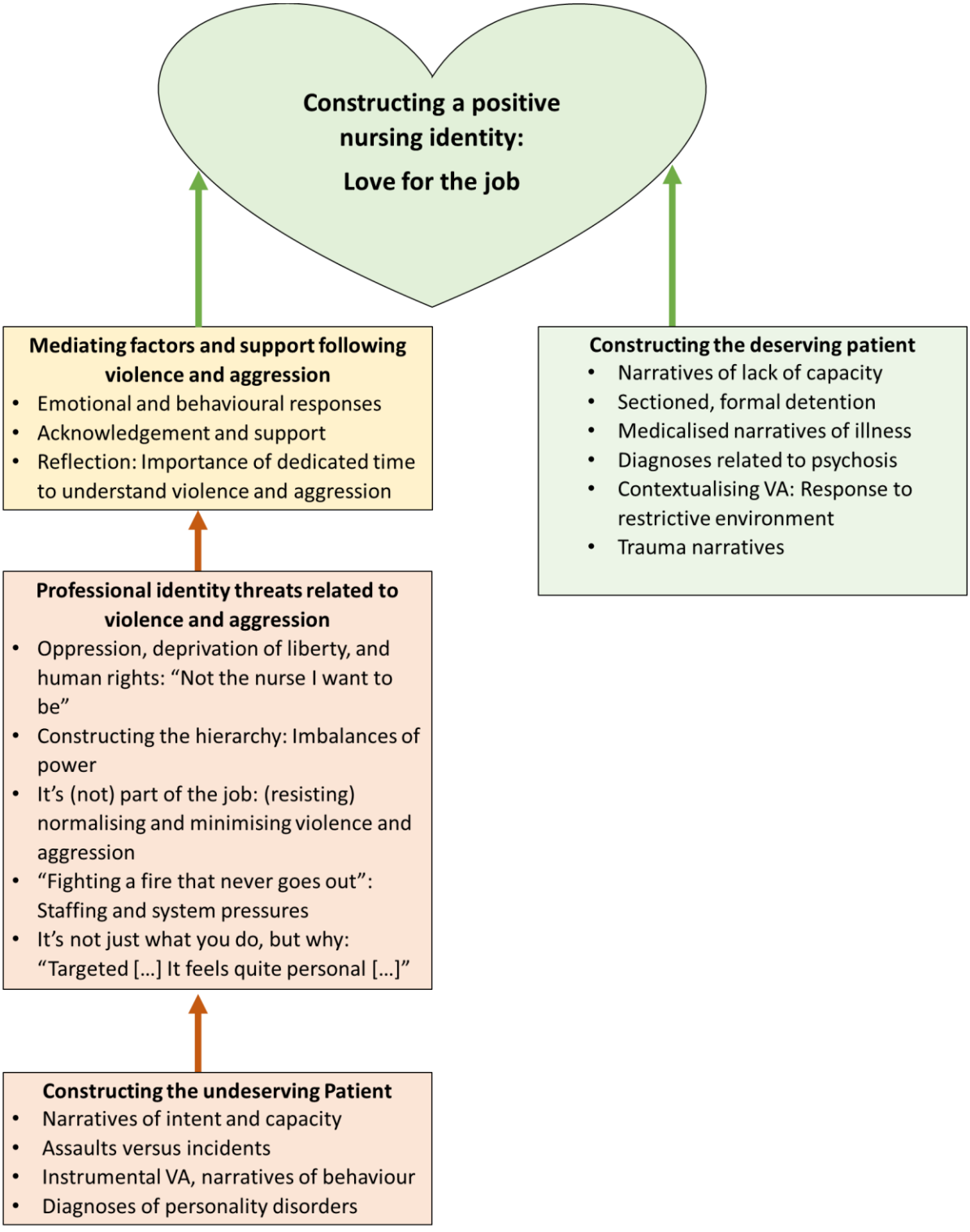
Process note on continuous comparison:

After identifying initial categories I returned to the data to check if they represented the ideas coming from the text well enough. Where some initial codes were represented only by one reference to the text, I checked to see if was less of a central concept, or if the data fit with another focused code and had been superseded. For example, "othering de-normalising VA as threat response" had only one reference for one participant: "And I think it was how it manifested in people and a lot of people would get more upset and frustrated rather than become violent. And I think to me, for my own personal and professional development, if felt a little more (.) therapeutic." P01 L91-93. This refers to comparing patients with certain diagnoses and experiences (eating disorders) to others. As this is the only reference to patients with ED diagnoses, it may not be an important example for this piece of research, where most comparisons of this sort are drawn between experiences of 'psychosis' and labels of 'personality disorder'.

Appendix L: Example of Early Conceptual Map



Appendix M: Model: Impact of Narratives of VA on Professional Identity Construction



Appendix N: Criteria for Quality Appraisal of Constructivist Grounded Theory Research and Suggested Questions

Credibility

- Has your research achieved intimate familiarity with the setting or topic? • Are the data sufficient to merit your claims?
- Have you made systematic comparisons between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment - and agree with your claims?

Originality

- Are your categories fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts, and practices?

Resonance

- Do the categories portray the fullness of the studied experience?
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deep insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic categories suggest any generic processes? If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world

(Charmaz, 2014, pp. 337–338)