

“It’s your job, you can handle it”

A grounded theory study of ward staffs’ views on the experiences, causes and consequences of verbal aggression in an acute psychiatric ward.

Prarthana Shetty

A thesis submitted in partial fulfilment of the requirement for the Professional Doctorate
in Counselling Psychology

London Metropolitan University

January 2019

In memory of my little Avinash; you will always be part of my whole.

Abstract

Aim: The aim of the study was to investigate staff perspectives on verbal aggression. More specifically, it aimed to explore how staff experience and understand verbal aggression in an acute psychiatric ward, as well as their views on individual and organisational influences on the occurrence and maintenance of verbal aggression.

Method: Individual semi-structured interviews were conducted with eight ward staff. The transcribed interview data was analysed in accordance with the principles of constructionist grounded theory (Charmaz, 2006).

Findings: Incidents of verbal aggression were said to affect staff deeply on an emotional and psychological level. Participants described the organisational culture as one that normalised verbal aggression, and shared an awareness of an unspoken expectation that they should be able to cope with verbal aggression. Staff sought to alter their working practices to accommodate organisational expectations, which negatively influenced the staff-patient interactions, thereby perpetuating further verbally aggressive behaviour from patients.

Conclusions: The themes observed in the study have conceptualised verbal aggression as more than a negative interaction on an individual level, highlighting the influence of organisational factors as having a significant bearing on staffs' psychological wellbeing and staff-patient relational dynamics. The clinical implications of the study are explored, followed by recommendations for future research.

Table of Contents

Abstract	i
Table of contents	ii
List of acronyms	v
Acknowledgements	vi
1 Reflexive statement – part one	1
2 Introduction	4
3 Literature Review	8
3.1 Impact of aggressive behaviour	8
3.1.1 <i>Physical injury</i>	9
3.1.2 <i>Psychological and emotional outcomes</i>	10
3.1.2.1 <i>PTSD symptoms</i>	10
3.1.2.2 <i>Intense emotional reaction</i>	11
3.1.2.3 <i>Burnout</i>	14
3.1.2.4 <i>Impaired therapeutic relationship</i>	15
3.2 Factors that may contribute to inpatient aggression	17
3.2.1 <i>Internal factors</i>	18
3.2.2 <i>External/environmental factors</i>	19
3.2.3 <i>Situational/interactional factors</i>	20
3.3 Prevailing perception regarding the causes of aggression	22
3.4 Summary	24
3.5 Relevance to counselling psychology	25
3.6 Rationale for the current study	27
4 Methodology	29
4.1 Rationale for using qualitative methodology	29
4.2 Epistemological perspective	29
4.3 Rationale for using GT	30
4.4 The researcher	32
4.5 Recruitment	33

4.6	Participants	33
4.7	Materials	34
4.8	Procedure	34
4.9	Data analysis	35
	4.9.1 Initial coding	36
	4.9.2 Focused coding	37
	4.9.3 Constructing the theoretical model	37
	4.9.4 Memo writing	38
4.10	Ethical considerations	38
	4.10.1 Informed consent	38
	4.10.2 Confidentiality	39
	4.10.3 Distress	39
5	Findings	40
5.1	Theoretical model	40
5.2	Overview of the model	41
5.3	Table of categories	43
5.4	Model categories	45
	1. Deficit of institutional empathy from the Trust	45
	2. Perceived lack of support from the Trust	46
	3. Impact of setting and VA on staff	48
	4. Staffs' learned responses to the setting and VA	49
	5. Emotional defences	51
	6. Non-therapeutic engagement with patients	53
	7. Patients disavow their need to be on the ward/treatment	55
	8. VA as an attempt of negotiation of needs	56
	9. Institutional culture of minimisation of VA	57
6	Discussion	60
6.1	Staff needs relating to VA: lack of adequate support structures	60
6.2	Conceptualisation of VA as a work related risk	62
6.3	Emotional impact on staff	64
6.4	Staff feel obliged to demonstrate professional competence	66
6.5	Emotional defences	67

6.6	Engagement with patients after VA	70
6.7	Patient frustration and powerlessness	72
6.8	Clinical implications	75
6.9	Suggestions for future research	77
6.10	Limitations of the present study	79
7	Reflexive Statement – part two	81
8	Conclusions	85
9	References	87
10	Appendices	108
	Appendix A: Letter of ethical approval (London Metropolitan University)	109
	Appendix B: Letter of ethical approval (NHS)	110
	Appendix C: Participant information sheet	112
	Appendix D: Participant consent form	114
	Appendix E: Distress protocol	115
	Appendix F: Interview schedule – Phase 1	117
	Appendix G: Sample of line-by-line coding	119
	Appendix H: Initial model	121
	Appendix I: Interview schedule – Phase 2	122
	Appendix J: Example of creation of a higher-order code	124
	Appendix K: Data analysis sample	125
	Appendix L: Theoretical model	128
	Appendix M: Example of a Memo	129
	Appendix N: Page from researcher’s reflexive diary	130

List of acronyms

ACT:	Acceptance and Commitment Therapy
BPS:	British Psychological Society
CBT:	Cognitive Behavioural Therapy
CoP:	Counselling Psychology
CPN:	Community Psychiatric Nurse
GT:	Grounded Theory
IPA:	Interpretative Phenomenological Analysis
MAVAS:	The Management of Aggression and Violence Scale
NHS:	National Health Service
PD:	Personality Disorder
PMVA:	Prevention and Management of Violence and Aggression
PTSD:	Post-traumatic Stress Disorder
UK:	United Kingdom
VA:	Verbal aggression

Acknowledgements

This has been a long journey in the making, and I am indebted to the people who helped me reach this stage. Firstly I must acknowledge my research participants, without whose contribution there would have been no thesis to write. Thank you for generously giving your time and sharing your experiences. I am humbled by your kindness and remain ever grateful to you. I am particularly thankful to Adewunmi Odubanwo at ELCMHT for championing my research and going above and beyond to help me with participant recruitment.

Sincere thanks are due to my research supervisor Dr. Philip Hayton, who has been a source of wisdom and motivation through each stage of the research process. I left every one of our supervision sessions feeling more positive about my progress than when I went in. He provided me with insightful feedback, gentle guidance, and challenged me to push myself further, which I hope is reflected in my work.

I have had the good fortune to be able to count my fellow counselling psychology trainees at London Metropolitan University amongst my support network. Aris, Catherine, Eva, and Sunna; no more drafts to read, you lucky things! But in all seriousness, your counsel helped ease my workload and focus my thinking. I cannot thank you enough. Andrew, you were my information access genie when I was writing up, thank you for your timely help.

And finally, my beloved family, who have given me everything. Thank you Amma, Appa, and Pava, for your love and encouragement. Amma, thank you for making sure I ate regularly, and for staying up late into the night with me. Pathusa, I am so grateful you came all the way from Mumbai to help. Your confidence in me has given me strength in times when I doubted myself. Amy, you are more sister than sister-in-law, thank you for your many kindnesses. To my unbelievably wonderful husband James, you have been my rock through it all. Thank you for your constant love, patience, ready supply of hugs and tea, for putting your life on hold for me, and for taking stellar care of our son while I was holed up in my study. I am very lucky to have you. The last word goes to my precious little boy, Ashwin. You give my life so much joy and purpose; this is for you.

Reflexive statement – part one

Reflective practice is one of the defining features of counselling psychology training and professional development, including research (Donati, 2016). Researcher reflexivity provides the researcher the opportunity to acknowledge their views, assumptions, and skills, and the effect these may have on the research process (Morrow, 2005). Therefore I will describe how my personal experiences led me to select my research topic, my positioning regarding the topic, as well as my attempts to manage the influence of this positioning on the research process. This section will clarify the position from which I write, while the second reflexive statement (presented after the Discussion chapter) will describe how I anticipated and managed my influence on the research process.

At the time I was deciding on a research topic, I was employed in an acute psychiatric ward in London. I had worked there for two years prior to the commencement of my doctoral training. While I really enjoyed the work, there was one aspect of the job that I sometimes struggled with; certain episodes of verbal aggression. For instance, on one occasion a patient threw her cup of tea at me and cursed me. She did not use profanity, but she uttered a curse that wilfully wished evil upon me. I was more able to ignore my stained shirt than I was the curse. While I understood intellectually that they were just words, I come from a sub-culture where curses are taken seriously. She and I were both Hindu women of Indian origin, and I believe she knew the effect her words would have on me due to our shared cultural background. On another occasion, a patient shouted a crude racial slur at me – the first time I had experienced racist abuse in my 12 years in England. Both incidents occurred in my first month on the job, and there have been several others since. These episodes were very upsetting; I was angry and embarrassed and as a result I found it quite difficult to engage with these patients for some time afterward. During supervision my ward manager and I had a discussion about my reactions to these episodes, which marked the beginning of my awareness and interest in this topic.

When reflecting on these experiences, I recalled not just the fear and anger, but also my feelings of disappointment at the reactions I got from more experienced colleagues. When I shared my distress about being verbally abused, my peers' reactions ranged from mocking ('what a princess') to dismissive ('it's to be expected, X is really unwell'). It began to dawn on me that my teammates seemed resigned to the experience of being verbally abused. At this juncture I was gradually reducing my working hours in order to

focus on my doctoral training, so I was moderately successful at distancing myself from the experience. I however found it difficult to make peace with the notion that it was deemed acceptable to have to endure verbal aggression on almost a daily basis. While reviewing relevant literature on inpatient aggression, I observed that considerable research had been conducted examining staffs' experiences of physical aggression, but found very few accounts of staffs' experiences of verbal aggression. It felt to me that no one appeared to be talking about this very real phenomenon that seemed to have a very real impact on staff. I therefore wanted the opportunity to give a voice to my colleagues, and understand their thoughts and perspectives about verbal aggression. On reflection, I wonder whether my focus on this research area was an unconscious desire for my own voice and experience to be heard and validated.

As I have indicated, the choice of research topic was influenced by my previously mentioned experiences on the ward. This initially caused me some concern, as I wondered whether my views would be biased. Having worked at the research site, I considered myself as an insider (Mitchell, 2008), due to my shared experiences with participants. At first glance being an insider researcher seemed advantageous especially in terms of benefiting from relatively easy access to participants, however while reflecting on this in more depth I began to wonder whether holding this position was in fact a 'double-edged sword' (Mercer, 2007, p.3). I could see the advantages of this position, such as an awareness and sensitivity to the research topic, and participants experiencing a sense of comfort with sharing their experiences with me (Berger, 2015). I also anticipated it would reduce the power differential, equalising the relationship between the participants and myself (in the position of trainee counselling psychologist and former employee at the Trust) during the interview (Hanson, 2013). Conversely there was the possibility of participants failing to provide suitable detail in their accounts of verbal aggression because they might assume I already knew what was being described or alluded to (Mitchell, 2008). Equally problematic was the danger of over-identifying with participants' accounts, and mapping my experience onto theirs (Hofman & Barker, 2016). In addition to these potential pitfalls, I was new to the grounded theory method (and indeed to qualitative research), so there was the risk of bias affecting the research process - from the construction of the interview schedule to the actual interview and analysis process. Therefore it was imperative to be mindful of the influence of my own identity on the research process to minimise the impact of personal bias (Berger, 2015). This will be discussed in more detail in the

subsequent reflexive statement, but in brief, one of the ways I did this was by trying to be mindful of my own process by documenting and examining my thoughts and actions in a reflexive diary (Appendix N). This has proven to be an extremely useful tool to scrutinise my research motives, and ascertain whether I was being driven by my own presuppositions and agenda (Kasket, 2012). Having maintained this diary for a few years now I observe a gradual shift in my stance towards verbal aggression. While it had great emotional resonance at the conception of my research, its intensity has diminished to a degree because I no longer work on the ward. My anxieties about being too close to the topic are assuaged somewhat, however the personal relevance of the topic and my interest in the area has undoubtedly persisted.

2. Introduction

Workplace aggression and threats of violence are said to constitute a major occupational risk for staff in mental health facilities (d'Ettorre & Pellicani, 2017). Aggression and violence on psychiatric inpatient units is an issue of increasing concern throughout the United Kingdom (UK), as well as internationally (Bowers et al., 2011). Staff in mental health settings frequently experience workplace aggression, ranging from verbal aggression (VA) to physical abuse (Royal College of Psychiatrists, 2007). A report by NHS Protect stated that 70,555 assaultive incidents were recorded against National Health Service (NHS) staff in 2015/2016. Of these, 46,107 (65%) assaults were said to have occurred against staff in mental health units (NHS Protect, 2016). If these figures were to include incidents of VA it is likely they would be significantly higher. Foster, Bowers and Nijman (2007) investigated the nature and prevalence of inpatient aggressive behaviour in acute psychiatric wards in the UK, and reported that VA was the most frequently reported type of aggression on inpatient wards, and that it is most likely to precede physical aggression. Patient aggression can take many forms; staff at psychiatric units are frequently confronted by varied aspects of patient aggression, including severe physical violence, verbal threats, and sexual harassment in their day to day practice (Nijman, Palmstierna, Almvik & Stolker, 2005). However, because inpatient aggression occurs so consistently, staff tend to accept it as an inevitable part of mental health care (Stevenson, Jack, O'Mara & LeGris, 2015).

There is a high prevalence of aggression perpetrated by inpatients in psychiatric hospitals. Tomagová, Bóriková, Lepiešová & Čáp (2016) investigated psychiatric nurses' experiences of inpatient aggression and observed that 98.5% of participants had experienced inpatient aggression over the course of the previous year. A meta-analysis of studies conducted by Iozzino, Ferrari, Large, Nielssen and de Girolamo (2015) revealed that almost one in five patients admitted to acute psychiatric wards committed an act of physical violence while in hospital. Bowers et al. (2011) conducted a large review of 424 studies from 11 countries, which showed that incidents of inpatient violence and aggression occurred frequently; 182.8 incidents per 100 admissions per month. In another international systematic review, Spector, Zhou, and Che (2014) reported that 55% of nurses in psychiatric settings had been physically assaulted, and 73% experienced verbal aggression during the previous year. While there is said to be variation in rates and prevalence of inpatient aggression across settings, professions and diagnostic groups (Hankin, Bronstone

& Koran, 2011), these figures highlight the pervasive nature of inpatient aggression, and therefore it seems likely that the majority of psychiatric staff may encounter some form of inpatient aggression during their professional career.

Inpatient aggression is reported to have significant psychological and emotional effects on staff, such as anger, self-blame (Flannery, 2007), low self-esteem, fear (Uzun, 2003), low morale (Sprigg, Armitage & Hollis, 2007), and an increased risk of developing Post-Traumatic Stress Disorder (PTSD) (Richter & Berger, 2006). In addition to affecting the psychological and emotional wellbeing of staff, inpatient aggression has significant financial implications. Flood, Bowers and Parkin (2008) estimated the costs of different types of conflict and containment using events from 136 adult acute inpatient psychiatric wards in the UK. They estimated that the cost of actual staff time managing aggressive incidents for all inpatient psychiatric wards in England was £72.5 million per annum, while the most expensive conflict behaviour – VA – was estimated to cost £10.5 million annually. The authors clarified that this was a conservative estimate, as it did not consider wider costs associated with conflict, such staff training and staff injuries.

In addition, less obvious consequences which also have significant financial implications have been identified. At an organisational level, inpatient aggression may affect staff retention (Kindy, Petersen & Parkhurst, 2005). Nursing staff have expressed a desire to leave the profession altogether as a consequence of inpatient aggression (Kisa, 2008). Staff absenteeism is another consequence of exposure to patient aggression (Stevenson et al., 2015). In a survey of 148 nurses in East London, Nijman et al. (2005) found that just over one in five nurses (22%) revealed that they had called in sick at least once due to workplace violence. Gournay, Carson and Spence (2000) observed that nurses who had been assaulted at work had sickness and absenteeism rates twice that of staff who had not been assaulted. These nurses also had higher levels of emotional distress and lower levels of job satisfaction. When staff call in sick, their colleagues on the ward may be obliged to rely on agency staff, who in addition to being expensive, may not be familiar with the dynamics of the ward and unlikely to be trained in the management of violence and aggression, putting them at risk of aggression (National Collaborating Centre for Mental Health, 2015). One could speculate that inpatients may experience a lack of continuity of care which might affect the therapeutic culture of a ward.

While mental health staff are said to demonstrate a high level of resilience (Matos, Neushotz, Griffin & Fitzpatrick, 2010), repeated episodes of inpatient aggression may affect staff in terms of loss of enthusiasm towards work, loss of confidence, and burnout (Baby, Glue & Carlyle, 2014). The organisational culture within which staff work may have a bearing on their intention to leave the Trust (Sofield & Salmond, 2003). For instance, it has been suggested that staff may not feel adequately equipped to respond to inpatient aggression (Martin & Daffern, 2006), which may have implications for their sense of personal safety and professional competence (Deans, 2004). Organisational level issues such as staffing levels, policies on inpatient aggression, reporting of aggressive incidents, training, and staff support may either play a role in fostering an organisational culture that may tacitly collude with the perception that aggressive behaviour is part of the job, or one that enhances staff resiliency by creating a positive environment that may serve as a buffer to the adverse effects of inpatient aggression (McAllister & McKinnon, 2009; McKinnon & Cross, 2008). Thus the provision of a culture of responsiveness and safety may influence the manner in which staff respond to patients' aggressive behaviour.

In the research literature, considerable variations exist regarding the definition of aggression, and related terms such as assault and violence; these terms are often used interchangeably (Morrison, Lantos & Levinson, 1998). There is no agreed upon operational definition of aggression because of its multidimensional nature (Abderhalden et al., 2008); the term is applied to a range of behaviours from mild VA to violent physical assault (Nolan, Dallender, Soares, Thomsen & Arnetz, 1999). Wells and Bowers (2002) emphasise the conflation in the literature between the terms violence and aggression, making comparisons between studies problematic. It has been observed that despite the significant body of research on aggressive incidents in mental health inpatient units, differing definitions of what constitutes aggressive behaviour create an element of confusion, and render it difficult to compare results and draw conclusions about prevalence rates, the nature of aggression, and the degree of severity (Spencer, Stone & McMillan, 2010).

A variety of definitions for the terms 'aggression' and 'violence' are used in mental health literature, some of which include physical violence only (e.g. Nolan et al., 1999), while others may include physical and verbal aggression (e.g. Irwin, 2006) or bullying, mobbing or sexual harassment (e.g. Kisa, 2008). The following definition of violent or aggressive behaviour will be used for the purposes of the literature review: 'A range of

behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained, or the intention is clear' (NICE, 2015, p. 6). It will be referred to as inpatient aggression, to specify incidents that occur in psychiatric inpatient settings and minimise any potential ambiguity. While this is a relatively broad definition, it is intended to simplify understanding of the concept, and not to comment on prevalence rates. As the definition illustrates, aggression may be physical or verbal, and its impact may be physical or psychological.

Another view of aggression comes from psychoanalytic literature which emphasises the role of innate aggressive drives, unconscious and present from birth, and conceptualise aggression as an instinctual drive (Freud, 1920). Freud described aggression as 'the derivative and the main representative of the death instinct' (Freud, 1930, p. 122). Freud focused on the tension between the life and death instincts, and proposed that the instinctive drive towards death gives rise to self-directed aggression. However in contrast the life instinct tempers and opposes self-destruction, and hence in most instances aggression is redirected out towards the world (Lemma, 2003). Thus aggressive urges could be directed towards the self or projected outwards to others. Freud was said to use the terms 'aggression' and 'destruction' interchangeably (Parens, 1979), which forms an interesting parallel with the present lack of consistency regarding the relevant terminology pertaining to inpatient aggression.

From the overview of the research presented thus far it would seem that inpatient aggression can have a significant impact at both an individual and organisational level. The impact of inpatient aggression on the psychological and emotional wellbeing of staff may have implications for patient care and is of relevance to counselling psychology practice. Ward staff may not be wholly aware of the influence that wider relational processes may have on their sense of self as well as the therapeutic relationship (Safran & Muran, 2006) and therefore may not be mindful of it during their everyday work. Practitioners within the counselling psychology domain may play a role in encouraging staff to hold diagnostic labels lightly (Cooper, 2009) and support them in developing responsive, empowering and respectful ways of relating to inpatients. Having presented the overarching issues pertaining to inpatient aggression, a review of the relevant literature will be presented in the following chapter.

3. Literature review

Having introduced the wider framework of inpatient aggression, the researcher will present a review of relevant literature on how it impacts on healthcare staff, factors contributing to inpatient aggression, and the issues guiding management strategies in order to situate the study in the context of research and professional practice. Finally, the researcher will explain why this study is of relevance to counselling psychologists, and present the rationale for the study.

The research articles that have been referenced in this literature review were accessed through the following databases on the London Metropolitan University library e-resources catalogue: PsycInfo, Pubmed, Science Direct and Wiley Online Library. All articles published from January 1980 to December 2017 were included in the literature search. The search used key words such as violence, aggression, aggressive, assault, impact, cause, perception, experience, psychiatric, inpatient, in-patient, mental health, ward, staff, and patient. These key words were used in combination with each other and in appropriate truncated form (e.g. aggress*, psychiat*). Reference sections of retrieved articles were manually searched to identify further relevant literature. The researcher was unable to access one of the reviewed articles (Adams & Whittington, 1995), and obtained it by contacting the primary author, Professor Richard Whittington.

For the purposes of this thesis, the term ‘patient’ has been used. As a trainee counselling psychologist, the researcher is mindful that the term tends to be aligned with a medicalised perspective of an individual’s difficulties (Larsson, Brooks & Lowenthal, 2012), however it was used to reflect the language used by the ward staff who participated in the study.

3.1 Impact of aggressive behaviour

The consequences of inpatient aggression can be negative and far reaching. Having briefly discussed the impact of inpatient aggression on an organisational level previously, the researcher will proceed to explore its physical, emotional and psychological sequelae, as well as its effect on the quality of the staff-patient therapeutic relationship.

3.1.1 Physical Injury

Physical injury caused due to assault by a patient can range from mild to moderate injury such as bruises, sprains, or welts (Daffern, Ogloff & Howells, 2003), to severe and potentially life-endangering injuries such as fractures, deep lacerations, and internal injury (Ogloff & Daffern, 2006). A review of 61 research studies on physical injury as an outcome of violence and aggression estimated that 26% of violent incidents resulted in mild, 11% in moderate and 6% in serious injuries, respectively (Bowers et al., 2011). In a study in Germany, Richter and Berger (2000) analysed work-related injuries in employees of psychiatric hospitals over a period of six months. They observed that 10% of staff needed medical treatment, and one nurse suffered life threatening injuries as a result of being beaten. Fortunately most assaults on staff resulting in serious or life endangering physical injuries are said to be the exception, rather than the norm (Erkol, Gokdogan, Erkol, & Boz, 2007). Amongst ward staff, nurses are said to be more likely to be physically assaulted than any other professional group (Ferns, 2006). For example, in an early study of staff injuries from inpatient violence, nurses sustained 120 of the 135 injuries inflicted on all staff (Carmel & Hunter, 1989). Carmel and Hunter (1989) used a narrow definition of injury, ‘an injury, defined in a standard manner, from patient violence’ (p.44). This narrow and somewhat ambiguous definition may have produced a lower response rate than might have been obtained with a broader and clearer definition, and may have yielded fewer responses from other professional groups. Similar results were reported by Owen, Tarantello, Jones and Tennant (1998), who examined the frequency and types of physically aggressive behaviours in an acute psychiatric inpatient setting. Over a seven month period, a total of 1,289 violent incidents perpetrated by patients were recorded. Of these, 78% were directed toward nursing staff, 4% towards doctors, and 2% towards psychologists. In addition to specifying the nature of the physical injuries that occurred as a consequence of inpatient aggression, the authors used a rating system that distinguished between physical incidents and verbal threats, providing a clearer picture of the prevalence of aggression on the ward.

It has been suggested that of all staff groups, nurses have the maximum spatial and temporal proximity to patients (Needham, Abderhalden, Halfens, Fischer & Dassen, 2005), and when coupled with little or no knowledge of appropriate de-escalation techniques (McGill, 2006) may result in nurses bearing the brunt of inpatient aggression. This is an issue of some concern because of reports that physical violence is vastly underreported by nurses (Lanza, Zeiss & Rierdan, 2006). In addition, it has been suggested that nurses may

only report very serious incidents due to a tendency to normalise aggressive patient behaviour (Zuzelo, Curran, & Zeserman, 2012). The resulting lack of follow-up support for victims of aggression from failure to report incidents of aggression (Gifford & Anderson, 2010) may have a bearing on the psychological sequelae of violence, which are discussed below.

3.1.2 Psychological and emotional outcomes

Research has shown that the impact of aggressive behaviour may go beyond physical injury. Negative psychological and emotional reactions are said to be common following physical aggression and VA. These may range from short-term, transient emotional distress, with anger being the most frequently reported (Bowers et al., 2006; Lu, Wang & Liu, 2007), to severe and long term symptoms of anxiety (Phillips, 2007). It has been reported that psychiatric staff can experience higher anger rates following VA than physical aggression (Jalil, Huber, Sixsmith & Dickens, 2017). Similar results were reported by Fernandes et al. (2002) and O'Connell, Young, Brooks, Hutchings and Lofthouse (2000). The researcher speculates that this may be in part due to VA being considered to be 'part of the job' (McLaughlin, Gorley & Moseley, 2009, p. 735) as compared to physical aggression and therefore may have implications for staff suppressing their 'normal' emotional reactions (Howard & Hegarty, 2003, p.7) such as anger (Needham et al., 2005), thus making it difficult to process them. In addition to anger, feelings of depression (Pope & Tabachnick, 1993), embarrassment (Ferns & Meerabeau, 2009), insecurity (Rossberg & Friis, 2003), sadness (Needham, 2006), and frustration (Flannery, 2007) are common. This section will describe in more detail the impact of inpatient aggression upon staffs' psychological and emotional wellbeing.

3.1.2.1 PTSD symptoms

PTSD is defined as 'a severe anxiety disorder that develops after exposure to an event with actual, threatened, or perceived death or serious injury, or a threat to the physical integrity of oneself or others that results in significant psychological trauma' (Wimalawansa, 2014, p. 807). The psychological injuries caused by inpatient aggression may persist for months or years (Rippon, 2000). Caldwell (1992) found that nurses experienced high levels of anxiety and symptoms consistent with a diagnosis of PTSD. Out of 224 participants, 61% reported symptoms of PTSD (e.g. intrusive thoughts), with 10% reporting sufficient symptoms to merit a diagnosis of PTSD. While it seems evident that

participants found the experience of inpatient aggression extremely distressing, it was reported that Caldwell examined traumatic stress reactions using a study-specific unstandardized assessment instrument (Richter & Berger, 2006), which could lead to false positives and potential stigmatisation of individuals when wrongly identifying them as having PTSD (Mouthaan, Sijbrandij, Reitsma, Gersons & Olff, 2014), and also make it difficult to compare the results of the study with that of similar research. The participants in the study had witnessed or been involved in a critical incident involving a serious threat to life or physical safety, however similar results have been reported even when participants experienced the trauma of being assaulted by a patient, but had not suffered any detectable physical injuries (Whittington & Wykes, 1994).

Inoue, Tsukano, Muraoka, Kaneko and Okamura (2006) assessed how nurses working in psychiatric departments psychologically coped with VA or physical violence by patients, and explored the extent of the psychological impact caused by the aggressive experience. A self-rating scale was used to evaluate the psychological impact. Of the 225 participants, 141 reported having experienced VA or violence. 21.3% of these had high scores, and therefore may have experienced PTSD symptoms, according to the authors. The authors did not provide participants with definitions of VA and violence, which may have affected the response rate. In addition, VA and violence were not treated as separate phenomena, but were grouped together, resulting in a loss of specificity. The study demonstrated that being exposed to VA or violence can potentially lead to long term psychological distress for staff. However, as it employed a quantitative research design it was limited in its ability to facilitate a more detailed exploration of the psychological impact of VA and violence on staff.

3.1.2.2 Intense emotional reaction evoked by exposure to VA

VA unaccompanied by physical aggression is also said to have the potential to cause considerable emotional damage. Adams and Whittington (1995) examined the psychological effects of VA on hospital based and community based psychiatric nurses (CPN) over a ten week period. Fifty episodes of VA were recorded, of which only 14% were accompanied by physical aggression. Participants who had experienced an incident were asked to record their anxiety on a 5-point Likert-type scale. CPNs reported significantly higher levels of anxiety than inpatient nurses. The authors suggested that this finding may reflect the relative isolation of CPNs at the time of attack (e.g. visiting patients

in their homes alone), compared to hospital staff and also the fact that they are less likely than in-patient staff to encounter VA. They also suggested that hospital staff may have become habituated to inpatient aggression, or perhaps were less willing to report anxiety as a coping mechanism. However, on the whole, some episodes of VA unaccompanied by physical aggression, generated high levels of traumatic stress, which involved intrusive thoughts about the incident and avoidance behaviour. In addition for participants who had also been physically assaulted, anxiety levels were lower than those of participants who had experienced just VA. The authors urge caution in drawing comparisons because the respondents in this study were a subgroup selected on the basis of experiencing relatively high anxiety on the initial rating scale, however the findings indicate that exposure to VA may cause significant psychological distress for some staff. The study is one of the few prospective studies investigating inpatient aggression, with staff reporting incidents as they happened, as opposed to participants having to recall incidents up to a year in the past. It is therefore more likely to provide an accurate account of incidents of aggression than retrospective studies, thereby improving the validity and reliability of the findings (Hulley, Cummings, Browner, Grady & Newman, 2007).

These findings were corroborated by Flannery, Hanson and Penk (1995). They conducted an enquiry into the prevalence and impact of patient threats and physical/sexual violence against staff in an American psychiatric hospital. They stated that most similar studies have restricted the definition of violence to incidents of ‘unwanted physical or sexual contact’ (p. 451). The authors expanded the definition to include ‘threats that included specific statements of intent to harm specific staff, and specific nonverbal, non-interpersonal acts meant to frighten specific staff’ (p. 451). There were 19 cases of severe threat reported, with six male and 13 female staff victims of threat. They observed that some verbal threats from patients (without physical or sexual assaults) provoked as much psychological distress for staff victims as did some physical assaults. Staff who had been verbally assaulted were reported to be frightened, demoralised, and displayed PTSD-like symptoms; furthermore, these symptoms persisted for as long as ten days after the incident. The expanded definition may have resulted in a more accurate reflection of the rate of inpatient aggression at the unit. However, though the authors specified the occupational backgrounds of participants (e.g. nurses, mental health workers, clinicians) while outlining the method of the study, when reporting the results this information was not included. It would have been useful to learn the severity of traumatic stress reactions for specific

occupational groups. While all mental health professionals, regardless of job role, are at risk of becoming victims of inpatient aggression at some point in their careers (Arthur, Brende & Quiroz, 2003), more clarity about the occupational groups of the affected participants would have added to the current knowledge base about the vulnerability of specific psychiatric staff to aggression, and associated psychological consequences. Nevertheless, these findings suggest that VA can be a significant occupational stressor, considering that participants experienced traumatic stress symptoms after solely experiencing VA.

Kisa (2008) conducted a descriptive study exploring the experience of VA among hospital nurses in Turkey. In this survey study, 339 female nurses completed a questionnaire designed to measure different aspects of VA, specifically the incidence of VA in the work setting, the severity of abuse, the initiators of VA, the location where the VA occurred, and the emotional response and actions taken after the experience. The majority of participants (almost 80%) reported that they had experienced VA in the past year. Nurses who worked in psychiatric inpatient units experienced the highest percentage of VA, compared to nurses who worked in other units (e.g. emergency room). The most common emotional reaction reported by nurses was anger (65.4%), followed by shock/surprise (52.8%), sadness/hurt (42.4%), fear (17.8%), powerlessness (15.2%), shame (10%), embarrassment/humiliation (9.3%), hostility (4.5%), and intimidation (3.7%). VA had a strong impact on the respondents' morale and work productivity. Almost 90% of the participants reported that VA negatively affected their morale. In addition, they reported that VA caused emotional exhaustion (89.6%), decreased productivity (70.3%), and affected the delivery of nursing care. VA was found to be nearly a universal experience, and one that had a profound impact on participants' morale and ability to offer nursing care. Two other studies conducted in Turkey exploring nurses' perceptions and experiences of VA have reported very similar findings (Oztunc, 2006; Uzun, 2003). While self-reporting surveys are the most convenient method of gathering respondent information on inpatient aggression (Hills et al., 2015), it has the limitation of recall bias as participants were required to evaluate their experiences of VA during the 12 months prior to the measure. The study did not differentiate between forms of VA; this is of relevance because certain types of VA might carry greater emotional resonance than others, e.g. threats of physical harm vs. non-specific threats. The generalisability of the results may be affected due to cultural differences in Turkey as compared to UK settings.

3.1.2.3 Burnout

In addition to evoking emotional reactions that impact upon staffs' ability to function within their job role, research literature has suggested that exposure to patient aggression can be a significant source of chronic work stress, and subsequently burnout (Stevenson et al., 2015). Burnout is characterised by emotional exhaustion, depersonalisation and low personal accomplishment (Maslach, Schaufeli & Leiter, 2001). Winstanley and Whittington (2002) examined the extent to which anxiety, coping styles and burnout differed among healthcare staff who had experienced different forms of aggression; physical assault, threatening behaviour, and VA. All departments, professions and disciplines were represented within the sample. Participants completed a questionnaire to report experiences of workplace aggression in the previous 12 months from either patients, or patients' relatives or friends. The authors observed that levels of emotional exhaustion and depersonalisation were significantly higher in participants who experienced more than one aggressive incident (for each form of aggression) than in those who experienced none at all. State anxiety was significantly higher for participants experiencing frequent VA and threatening behaviour than those who experienced these behaviours infrequently. Significant differences were also observed in levels of burnout, with staff who were more frequently victimised having significantly higher levels of burnout. The authors proposed a cyclical relationship between aggressive encounters and burnout, and suggested that other sources of burnout such as workload and occupational conditions may result in staff being more vulnerable to aggression. The elevated levels of burnout might increase vulnerability to aggression through negative changes to the quality of interactions with patients. They argued that aggressive encounters can therefore have a cumulative effect upon the levels of burnout in healthcare staff. The study had a low response rate (32%); 1141 sets of questionnaires were posted and 375 were returned, which may have led to difficulties achieving a representative cross-section of the participant sample. Due to the use of self-reported data, response bias may have affected the accuracy of the results (Althubaiti, 2016). The cyclical model proposed by the authors could not be tested due to the cross-sectional nature of the study. A longitudinal study would be needed for the examination of the temporal relationship between aggression and burnout.

It has been reported that VA is significantly associated with emotional exhaustion and depersonalisation, which can result in burnout (Viotti, Gilardi, Guglielmetti & Converso, 2015), and consequently has implications for increased vulnerability for further

inpatient aggression (Maslach & Leiter, 2005). In a study investigating an aspect of VA – swearing – Stone, McMillan and Hazelton (2010) explored the impact of patients swearing/using curse words on nurses (n = 107) and their nursing practice in three clinical settings – adult mental health, child and adolescent mental health, and paediatric health. This study formed part of a larger quantitative study investigating the incidence of swearing. It employed a questionnaire which included rating scales as well as a qualitative element with open-ended short answer questions. Participants reported high levels of being sworn at by patients, with 32% citing its occurrence from ‘one to five times’ per week and 7% ‘continuously’. Nurses revealed high levels of distress, and one participant described feeling ‘sick and bruised as if it were a physical assault’ after being subjected to extreme profane language (p. 532). The nurses reported limited effective strategies to deal with it, and described ignoring the swearing despite the language having evoked a deep emotional response. There is the risk of nurses distancing themselves from the patient emotionally, and becoming task-focused as a coping strategy, which may have implications for the staff-patient therapeutic relationship. In addition, staffs’ distress tolerance skills may diminish over time, leaving them vulnerable to emotional exhaustion (Stone et al., 2010). The findings from this study were based on self-reports from participants. Given the high rates of swearing reported by participants it seems likely that the less severe incidents may not have been considered to be noteworthy, therefore the potential for recall bias remains. However despite representing diverse service contexts, there remained a consensus among participants that swearing is a significant issue that is considered offensive and distressing. Thus the results on the whole indicate that inpatient aggression can trigger intense distress in staff, even when it results in minor injury and indeed even when there is no actual physical injury.

3.1.2.4 Impaired therapeutic relationship

Staff may find it difficult to maintain supportive and positive relationships with a patient who has been aggressive towards them. In order to manage distress evoked by inpatient aggression, ward staff may become task driven, responding to patients in a mechanical and unempathic manner (Hinshelwood, 2002). Hinshelwood (2002) proposed that staff responded to stress by focusing on symptom and risk management strategies, thus limiting their understanding of the patient’s difficulties and needs.

Inpatient aggression may play a significant role in the breakdown of the staff-patient therapeutic relationship. Zuzelo et al. (2012) used a qualitative research design to explore nursing staffs' responses to physically violent patient interactions in acute wards at a psychiatric hospital. The authors moderated four focus groups (4-6 participants per group, 19 participants in total) to identify the types of patient-nurse behaviours that were likely to be classified by staff as physically violent, and explored their thoughts, emotions and behaviour in response to a physically violent patient, as well as subsequent patient care interactions with the assaulting patient. Several themes were discussed, such as the importance of sharing information about episodes of violent behaviour with colleagues, protecting themselves and others by recognizing triggers for violent behaviour (staying alert, keeping a safe distance), intervening therapeutically (treating patients with dignity and respect), and experiencing emotions after violence (resentment, fear, feeling numb). The study presented instances where participants felt unable to engage therapeutically with patients after a violent encounter. Participants reported withholding empathy, distancing themselves from patients, and caring mechanically, in a perfunctory fashion. On occasion participants reported a conscious decision to provide no more than the basic care requirements they deemed necessary, especially if they perceived the violence as intentional. The authors reported this interactional style prevented authentic engagement and impaired the quality of patient care. There are certain limitations with this study. While the authors described the themes that emerged from the data in exceptional detail, they neglected to clarify which qualitative method they used to analyse the data. Different qualitative methods have different foci and ask different questions of the data, and as such the choice of method may have influenced the insights reported (Harper, 2017). Sharing information in a focus group format can result in some group members dominating the discussion, so less outspoken members may not be able to contribute as often (Leung & Savithiri, 2009). This limitation may be circumvented by using other data collection methods, such as individual interviews.

Kindy et al. (2005) observed that it is a challenging task for staff to maintain a therapeutic environment in psychiatric wards. The authors conducted a phenomenological study to explore psychiatric nurses' personal meanings of working in an assaultive environment. Ten nurses were interviewed and asked to describe their daily experiences of verbal or physical assault, as well as their thoughts and feelings about specific incidents of assaultive behaviour. The authors reported four main categories; safety fortifications,

catalysts for violence, perplexing aftermath and pervasive invasive sequelae. ‘Safety fortifications’ referred to ways of safeguarding against potentially assaultive events, and were accomplished by using learnings from prior training, noting patterns of behaviour in patients, and the use of tangible safety measures (e.g. walkie-talkie). ‘Catalysts for violence’ were factors perceived to increase the risk for violence such as understaffing, insufficient training, and workplace design. The theme ‘perplexing aftermath’ referred to nurses’ feelings after assaultive incidents. Participants felt blamed and punished by management after an assault. Subsequently, they reported being hypervigilant and fearful of future injuries. The final theme, ‘pervasive invasive sequelae’, referred to the pervasive emotional burdens associated with working in an assaultive environment. Participants viewed their work as perilous, and described a need to withdraw from patients and shut down, emotionally. The authors suggested that the nurses’ pervasive fear and anxiety could guide their interactions with patients to follow a custodial routine rather than a therapeutic process, thus increasing the risk of further assaultive behaviour from patients. The authors provided ample evidence of researcher reflexivity, methodological rigor and credibility checks. The authors self-reported limitations of a small sample size and number of psychiatric facilities represented, however they claimed to have achieved data saturation. Finally, the study was conducted in a psychiatric facility in America, and may affect the transferability of the findings to the UK context.

Thus far the review has examined the effect of inpatient aggression on staffs’ physical and mental wellbeing, as well as the consequences for the staff-patient relationship. Now the researcher will explore theories that have been developed to explain the causes of inpatient aggression.

3.2 Factors that may contribute to inpatient aggression

Given that the tangible and intangible costs of inpatient aggression are highly significant, it is of importance to consider the factors that may contribute to aggression in inpatient settings. Nijman (2002) proposed a model of aggression, which narrowed down the determinants of inpatient aggression to three variables; internal, external/environmental, and situational/interactional factors. This model goes beyond viewing patient illness as the main risk factor for aggressive behaviour, and considers inpatient aggression to be the result of the interplay of personal, environmental and interactional factors.

3.2.1 Internal factors

Internal factors within the patients themselves may mediate an inpatient's expression of aggression. Several studies have investigated the association between psychiatric illness and aggression. Various psychiatric diagnoses have been reported to be associated with aggression on inpatient wards, with bipolar disorder, personality disorder (PD), and schizophrenia being the most commonly reported (Cornwall, 2006; Ridenour et al., 2015; Walsh et al., 2004). Numerous studies have reported that schizophrenia is the most common diagnosis among patients who show aggressive behaviour (Chen, Hwu & Williams, 2005; Mullen, 2006). However a diagnosis of schizophrenia does not necessarily translate to aggressive behaviour (Taylor, 2008) and assessment of a patient's potential for aggressive behaviour based on a psychiatric diagnosis can be problematic. As an alternative to diagnosis, some studies have explored certain behaviour clusters, or symptoms of mental illness that may be associated with a propensity to engage in aggressive behaviour. For instance Swanson et al. (2006) reported that particular clusters of symptoms may increase risk (e.g. persecutory delusions) or decrease risk (e.g. social withdrawal) of violence in patients with schizophrenia. Cornwall (2006) asserted that patients diagnosed with bipolar disorder present an increased risk of aggressive behaviour during the manic phase of their illness, characterised by phases of heightened energy, which may cause conflict on the ward. Therefore the nature of the symptoms present in the patient must be considered prior to making judgements about the risk of aggression.

Patients' aggressive behaviour, for instance in the community, may well be the reason they were admitted to a psychiatric ward (Monahan, 1992). There is considerable agreement in the literature that patients admitted involuntarily under mental health legislation prove to be significantly more likely to engage in aggressive acts (Cornaggia, Beghi, Pavone & Barale, 2011; Foster et al., 2007). Studies have shown that the frequency of assaultive incidents tends to be higher upon admission when patients are in an acute phase of a psychotic illness, compared to later in their stay (Daffern & Howells, 2002). Stewart and Bowers (2013) found high levels of VA among acutely unwell psychiatric patients during the first two weeks of admission to hospital. In a grounded theory study by Hinsby and Baker (2004), patients talked about loss of control, and spoke of their mental state as a reason for aggressive behaviour. However, in most studies exploring patient perspectives patients more frequently cite external or interactional factors as reasons for their aggression (Kumar, Guite & Thornicroft, 2001; Meehan, McIntosh & Bergen, 2006).

While aggression may be influenced by a patient's psychiatric diagnosis and other internal factors, it is unlikely that it can act as a sole predictor for inpatient violence.

3.2.2 External/environmental factors

External factors pertain to features within the patient's environment that may contribute to the incidence of aggression. When a patient is admitted to a ward they may find the unfamiliar ward rules illogical, or they may find it difficult to cope with many people in a relatively small ward space, which may increase their anxiety and stress (Johnson & Delaney, 2007). Other external factors may include issues such as overcrowding (Virtanen et al., 2011), lack of privacy (Nijman, 2002), ward design (Ulrich, Bogren & Lundin, 2012), staffing levels (Chaplin, McGeorge & Lelliott, 2006), and a lack of autonomy (Foster et al., 2007).

In a study investigating patients' perceptions of the causes of aggression on inpatient wards, Johnson, Martin, Guha and Montgomery (1997) interviewed 12 patients who had a history of thought disorder. Thought disorder refers to disorganised speech and an unusual or bizarre interpretation of events, which is assumed to reflect disorganised thinking (Gipps, 2016). Patients described themselves as being strongly affected by the external environment (e.g. aspects of the hospital, and other people). Their responses to aspects of the environment were influential in precipitating an aggressive incident. It was observed that the participants more commonly cited external factors (e.g. locked doors, unfair ward rules) as reasons for their aggression; only two participants attributed the cause of their violence to internal factors (i.e. influence of psychotic thoughts). Even for these two participants, external factors were described also, which reflects Nolan et al. (1999) and Duxbury and Whittington's (2005) observations that patients are more likely to perceive external factors to be a significant precursor of aggressive behaviour. The study addressed a gap in the literature - investigation of the relationship between aggressive behaviour and a specific psychotic symptom, thought disorder - but this was not explicitly specified, leaving the reader to guess at it. The authors provided limited detail on the process of content analysis, but themes were laid out clearly and illustrated with verbatim quotes. Credibility checks were described in detail; the analysis was said to have been carried out by all authors including the crosschecking of data, thus increasing methodological rigor.

Shepherd and Lavender (1999) studied the antecedents and management strategies of aggressive incidents in a psychiatric hospital. They studied incident forms regarding aggressive incidents that had taken place over a five month period. They reported that the antecedents could be divided into internal and external factors, but external antecedents were more common than internal ones. The majority of incidents (60%) were preceded by external factors such as staffs' denial of a patient's request, enforcement of ward rules, boredom due to unoccupied passive time, and conflict with other patients. Similar themes were reported by Meehan et al. (2006). The lack of meaningful activities and enforced idleness were perceived as potential sources of aggression by almost all participants. Certain aspects of the environment were viewed as intolerable, such as the lack of personal space, and being confined with other volatile patients, which left patients with a feeling that aggression was inevitable.

Certain times of day have been associated with the increased occurrence of aggressive incidents. Hunter and Carmel (1992) reported that the risk of inpatient violence was amplified during times of transition and increased activity such as handover, meal times, and medication administration. The handover period may reflect reduced staff presence on the ward, while the latter two periods may reflect times where large numbers of patients may be congregated in a relatively small area. Omerov, Edman and Wistedt (2002) suggested that aggressive incidents had two distinct peaks, occurring at morning and the evening. The authors posited that these peak times were related to the times the patients are confronted with everyday decisions, which may prove stressful (e.g. having to take medication). Chou, Lu and Mao (2002) found that most assaults occurred during mealtime (noon-2pm), and in the evening (5pm-7pm). Based on these findings, one could speculate that acts of aggression tend to occur high activity periods, which may be overstimulating and stressful for patients. It has been proposed that there may be increased verbal interaction during these periods, and therefore increased opportunities for confrontation (El-Badri & Mellsop, 2006).

3.2.3 Situational/interactional factors

Situational/interactional factors are aspects of staff-patient dynamics and interactions that may provoke inpatient aggression. It has been argued that incidents are more likely to be preceded by a combination of environmental and interpersonal antecedents than by symptomatic behaviour (Shepherd & Lavender 1999). Patients may be

unhappy about being in the hospital; when staff perform tasks they perceive as aversive, they may feel angry and frustrated. Indeed research suggests that when staff impose limits or deny requests, patients may respond in an aggressive manner (Daffern, Howells & Ogloff, 2007).

Studies suggest that most assaults are precipitated by staff-patient interactions (Ilkiw-Lavalle & Grenyer, 2003). Spokes et al. (2002) interviewed mental health nurses about staff behaviours which they perceived were likely to contribute to inpatient violence. These nurses acknowledged that staff factors affect the likelihood of a violent incident occurring. The three main themes identified by participants as affecting the likelihood of violence occurring included staff clinical skills (e.g. de-escalation skills), interpersonal skills (e.g. listening skills and rapport), and personal characteristics (e.g. being calm, self-awareness). Speaking of their colleagues' weaknesses, participants reported that some of their colleagues were confrontational ('getting into arguments with patients'), authoritarian ('telling people what to do'), and tended to be over-controlling in their behaviour towards patients ('giving no choices to the client'). It is interesting that participants did not report these issues about their own practice, but it is possible that they were attempting to provide a 'moral' response (Spokes et al., 2002, p. 206). Nevertheless, when staff act in a confrontational, controlling and authoritarian manner it is likely to be perceived as aversive by patients, creating the potential for violence. Similar findings were reported by Winstanley and Whittington (2004), who examined the dynamics of the interaction between staff and patient prior to an aggressive incident. They reported that almost 80% of aggressive incidents involved staff attempting to impose their will upon the patient (e.g. enforcing treatment or personal care). Patients may view this behaviour as threatening, which may therefore evoke an aggressive response.

In a study exploring patient perspectives on the factors contributing to inpatient aggression, Meehan et al. (2006) conducted focus groups with 27 patients undergoing treatment in a high-secure forensic facility. The transcribed data was analysed using content analysis. Patients reported that the way in which staff interacted with them was a major source of dissatisfaction. Staff were perceived as being controlling, and adopting a superior attitude in their interactions with patients rather than engaging therapeutically. There was a sense that staff lacked empathy and were unable to understand the problems associated with their illness. Staffs' perceived lack of caring was a source of frustration. In addition, staff

were said to ignore requests for assistance, and withdraw patients' privileges for no apparent reason. This was a source of resentment and perceived as a source of aggression. The authors suggested that some of the staff may have had some difficulty achieving a balance between custody and care, which may have affected the social climate in the unit. The sample was self-selecting; selection was not based on actual involvement in an aggressive incident. In addition, patients chose to discuss incidents that they had witnessed rather than directly experienced, resulting in a lack of specificity. However the findings are supported by similar trends observed in other studies reporting patients' perspectives in diverse psychiatric settings (acute ward, forensic ward, veteran centre) pertaining to staff interaction as a precipitant to inpatient aggression (Fagan-Pryor et al., 2003; Johnson et al., 1997; Kumar et al., 2001).

Other factors reported to contribute to the occurrence of inpatient aggression may be attributed to a coercive style of interaction, where staff acts in a controlling manner at the expense of fostering a relationship with the patient (Bowers, 2014), deliberately provoking patients (Finnema, Dassen & Halfens, 1994), trivialization of patients' requests (Bowers et al; 2011), and the perception that staff are not listening to the patients' concerns (Jansen, Dassen & Jebbink, 2005). Therefore it appears that incidents of inpatient aggression are usually precipitated by situational and interactional antecedents, rather than a spontaneous manifestation of the patient's clinical characteristics (Daffern, Howells & Ogloff, 2007).

3.3 Prevailing perception regarding the causes of aggression

There appears to be a significant difference between staff and patient perceptions of the cause of aggression. Duxbury and Whittington (2005) devised the Management of Aggression and Violence Attitude Scale (MAVAS), designed to measure views on the aetiology and management of aggression and violence, and compared the views on aggression held by staff and patients from three psychiatric wards. A sample of 82 nurses and 80 patients completed the MAVAS and of these, five nurses and five patients were interviewed. The interview data was analysed using content analysis. The authors reported that patients and staff had very different views about the causes of inpatient aggression. They observed that patients perceived that aggressive behaviour was triggered by external, environmental factors and controlling attitudes from staff, and did not see mental illness as a contributory factor. Poor communication was most frequently identified by patients as contributing to aggression. However staff in comparison did not view their interactions with

patients as problematic, and attributed aggression to patient-centred factors such as psychiatric illness. The results suggest that nurses tend to predominantly make internal attributions, citing the patient's mental illness as causative, while patients tend to make situational attributions, citing external and interactional factors as a precursor to aggression. The authors stated the number of participants interviewed for the study but did not provide any further information about them such as demographic data or any other contextual information, which made it difficult to 'situate the sample' (Elliot, Fischer & Rennie, 1999, p. 220). Selection of participants was based on participant interest rather than being based on actual involvement in an aggressive event, which may have affected the validity of the findings.

In another study employing content analysis as a research method, Ilkiw-Lavalle and Grenyer (2003) interviewed 29 patients and 29 staff from four psychiatric inpatient units, who had been involved in aggressive incidents. Participants were interviewed on their perceptions of causes of these incidents, the current management of them, and ways of reducing them. Significant differences were found between staff and patient perceptions of the causes and management of aggression. Patients described interpersonal conflict, factors associated with their illness, and limit setting as the main causes of aggression. The majority of patients recommended improvements in interactions with staff, especially communication and the way disagreements are managed as measures to decrease aggression. However staff almost overwhelmingly perceived inpatient aggression to be a function of the patient's mental illness, and medical management of patients to be the key to managing aggression. The study employed a prospective research design, which has the advantage of circumventing difficulties with inaccurate recall of incidents (Kushnir, Cunningham & Hodgins, 2013). There was detailed evidence of author reflexivity, credibility checks, as well as mindfulness of ethical considerations. While the participants' interviews highlighted significant differences between staff and patients' perceptions of aggression, the findings were presented in a table without much elaboration of the themes. The paper would have benefited from the inclusion of illustrative quotes to substantiate participants' views more clearly to the reader.

The researcher speculates that staff may find it easier to rationalise the experience of inpatient aggression if they are able to cite mental illness as its cause, because then they have in effect removed themselves from the equation, framing the issue as a problem that is

centred in the patient's behaviour rather than influenced by theirs. In addition, attributing aggression to the patient's internal characteristics may provide a justification for the use of medication following an incident of inpatient aggression (Duxbury, 2002), as well as absolving staff from personal responsibility (Hahn et al., 2006). Such stark contrasts between staff and patient viewpoints do not bode well for respectful and therapeutic patient care. Staff perceptions about inpatient aggression may have a bearing on the strategies used by staff to manage aggression. If staff attribute aggression to mental illness then this may influence their choice of intervention. Duxbury (2002) examined the types of interventions used by staff to manage aggression, and found that despite the fact that 70% of reported incidents involved VA and only 13.5% of the incidents involved physical aggression, traditional aggression management strategies were used, such as seclusion and physical restraint in 47% of incidents, medication in 25% of incidents, and verbal de-escalation in 22% of incidents. Given that the majority of aggressive incidents were verbal in nature, the author suggested that methods in managing inpatient aggression seem to be underpinned by an emphasis upon control and symptom reduction. A similar trend of results was observed in the study by Ilkiw-Lavalle and Grenyer (2003). Out of 44 incidents of aggression, staff interventions included giving oral medication in 14 incidents (32%), seclusion in 12 incidents (27%), isolating the patient in six incidents (14%), giving an intramuscular injection in five incidents (11%), using restraints in four incidents (9%). Staff talked to patients in only three incidents (7%), demonstrating an over-reliance on traditional methods of managing aggression. Duxbury and Whittington (2002) reported that patients viewed staffs' reliance on medication and traditional approaches to aggression and violence management as controlling, and part of the problem. Thus traditional approaches used by staff are perceived as aversive by patients (Duxbury & Whittington, 2005), and could serve to maintain, rather than mitigate aggression.

3.4 Summary

The review of relevant literature suggests that inpatient aggression has severe consequences for the physical and mental health of staff working in psychiatric units. Though the research has encompassed diverse service contexts, there was great congruence amongst the psychological and emotional injury reported by staff, which suggests that inpatient aggression is a significant issue for them. In addition, the reviewed studies span over two decades, yet the narratives on inpatient aggression have not altered greatly, which suggests that problematic staff-patient relational dynamics have been an issue for a

significant amount of time. Most of the studies employed quantitative methods, which mainly used self-reports or surveys where participants indicated the extent of their exposure or reaction to inpatient aggression (e.g. Inoue et al., 2006, Kisa, 2008, Winstanley & Whittington, 2002). The majority of qualitative research in this area has utilised content analysis, which does not seek to provide a theoretical explanation of the processes related to inpatient aggression. There is limited knowledge of staff perspectives of inpatient aggression by way of a theory that is grounded in their views and experiences. With studies that reported both qualitative and quantitative data, more information was provided on the quantitative results, perhaps detracting from the richness of detail available (Duxbury & Whittington, 2005; Ilkiw-Lavalle & Grenyer, 2003). Studies that presented staff and patient perspectives on causes of inpatient aggression reported clear contrasts between the nurse and patient views, with patients emphasising the interactional and external factors as determinants of aggressive behaviour (Duxbury & Whittington, 2005; Meehan et al., 2006). The findings from the reviewed studies suggest that psychiatric wards may be challenging environments for staff and patients alike, in relation to VA.

3.5 Relevance to counselling psychology (CoP)

CoP is growing as a profession and there are increasing opportunities for employment in a range of clinical settings, including the NHS (Strawbridge & Woolfe, 2010). Thus it is likely that counselling psychologists may work at a psychiatric ward and have to face the challenges and demands of interacting with distressed or agitated patients. Despite their extensive training, counselling psychologists are fallible human beings, and it is not unreasonable to assume they may experience emotional injury after experiencing inpatient aggression. An important issue that contributes to clinician vulnerability is exposure to primary and secondary trauma and violence (Lawson & Venart, 2005). In addition, a lack of awareness of the risks involved may leave them unprepared, resulting in apprehension about working with a potentially violent patient. Therefore for a counselling psychologist to be in a position where they can assess and manage the risk, should it arise, they need to gain an understanding of the interactional factors or contexts that may increase the chances of a patient demonstrating aggressive or violent behaviour. This is of importance because psychologists may only want to perceive themselves as helpers due to what Barnett (2014, p. 33) terms ‘professional blind spots’, and as a consequence may be reluctant to seek support after aggressive incidents.

There is call for fostering a psychological approach to patient care in acute psychiatric wards (Holmes, 2002). The ethos on a psychiatric ward is predominantly that of the medical model, which focuses on diagnostic classifications and symptomatology (Howells, Daffern & Day, 2008). Patients on a busy ward may feel they are not listened to, or that their needs are not priority for clinical staff especially with the small amount of time allocated to speak to their consultant or primary nurse (Gilburt, Rose & Slade, 2008). Fagin (2001) makes the provocative claim that the atmosphere in acute wards may be not so much un-therapeutic as much as anti-therapeutic. The broadly humanistic philosophical underpinnings of CoP may serve to privilege a 'respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience' (Lane & Corrie 2006, p.17). Counselling psychologists may therefore be in a position where they can work collaboratively with patients and staff, to try and understand their perspectives.

There is great potential for counselling psychologists to make a positive contribution towards enhancing the ward atmosphere. Besides the obvious role of working with patients on a one-to-one basis, the researcher believes counselling psychologists can play an important role in enriching the quality of care by working collaboratively with ward staff to identify suitable interventions for patients (e.g. Cognitive behavioural therapy (CBT) or Acceptance and commitment therapy (ACT) for psychosis). A large proportion of ward staff may not have a psychology background and may not be working from the perspective of psychological mindedness (Wilkinson, 2004). Therefore psychological interventions such as psycho-education of ward staff, reflective groups, behavioural/cognitive therapy (progressive muscle relaxation training/ coping skills), and learning reflexivity may help them better understand patients' difficulties from a psychological perspective.

Counselling psychology is a relatively young discipline in the UK (Feltham & Hanley, 2017). Traditionally psychological work in mental health units has been carried out by clinical psychologists, however counselling psychologists are increasingly being considered for these positions (Gillon, 2007). It is hoped that through their work with multi-disciplinary teams, counselling psychologists will eventually be able to create a ripple effect and contribute towards the psychological thinking of the team. During individual

work with the patient, assessments and formulation may reveal concerns or issues that clinical staff may not necessarily be privy to. Where appropriate, these can be communicated with the team such that the patient can obtain support during their stay on the ward. This is important because if the patient is to feel that they are viewed as a person, and not just a group of symptoms, the focus on a patients' psychological wellbeing needs to extend to the whole ethos of the ward.

3.6 Rationale for the current study

Most of the reviewed studies - with the exception of Kisa (2008) and Stone et al. (2010) - have examined inpatient aggression in a broad sense, inclusive of verbal and physical aggression, which reflects research on inpatient aggression in the main (Wells & Bowers, 2002). Studies exploring psychiatric nurses' beliefs about inpatient aggression typically combine verbal and physical aggression in their definition of inpatient aggression, placing greater emphasis on physical aggression (McKenna, Poole, Smith, Coverdale & Gale, 2003). Acts of physical aggression by inpatients on psychiatric wards have been said to occur 'out of the blue', without apparent warning (Crownier, Peric, Stepic & Lee, 2005, p. 244). Yet studies have shown that physical assaults are often preceded by VA, which is reported to be the most common form of aggression on psychiatric wards (Chapman, Styles, Perry & Combs, 2010; Foster et al., 2007). There seems to be a gap in the literature in terms of staff experiences of inpatient aggression in general, and VA in particular. The findings from the existing research have suggested that staff may find it difficult to maintain positive and supportive relationships with patients in the face of inpatient aggression (Zuzelo et al., 2012). An exploration of staff experiences of VA may provide a better understanding of the circumstances that may influence staffs' ability to provide compassionate patient care. Therefore further research is needed to facilitate an understanding of staffs' experience, thinking and practice regarding VA. This gap in the literature led to the aims of the present study, namely an exploration of:

- The views of ward staff about the nature of VA in acute psychiatric wards.
- Organisational influence on staffs' thinking and practice regarding VA.
- Implications of VA, and its influence on staffs' professional practice and patient care.

The existing research on patient VA has examined specific aspects of VA, such as swearing (Stone et al., 2010), and the frequency of VA (Kisa, 2008), predominantly using a

quantitative research framework. To the researcher's knowledge there have been no quantitative or qualitative studies exploring individual and systemic issues that may influence how ward staff experience and respond to patient VA. Based on the existing research the researcher proposes that VA does not occur in a vacuum; hence it is necessary to explore the wider context within which it occurs. Therefore the current study will address this gap in the literature by constructing a grounded theory of ward staffs' experiences of VA in an acute psychiatric ward, paying particular attention to factors that may mediate staffs' response to VA. Most of the studies in this review, and indeed in the overall literature on inpatient aggression have focused on the views of a particular occupational group – nurses. However it is likely that all staff who interact with patients are at risk of experiencing VA. It was decided to interview participants from different professional groups at different levels of the organisational hierarchy in order to gain a holistic understanding of how ward staff are affected by VA.

One of the requirements of a professional doctorate in counselling psychology is to produce a body of research that is not only original, but addresses real-world challenges encountered by professionals in the field by 'producing knowledge that practitioners can readily use' (Kasket, 2011, p. 2). It has been suggested that CoP trainees may be reluctant to situate their research in practice contexts such as the NHS in part due to the complications of obtaining ethical clearance (Kasket, 2016). Indeed, the researcher has noted a paucity of research published in CoP journals regarding aggression on wards or indeed experiences of working on psychiatric wards in general, and presents the current study as an original contribution to knowledge in counselling psychology as it has expanded on the limited extant research on how ward staff think about and respond to VA.

4. Methodology

This chapter will present an overview of the methodological framework within which this research is situated. This is followed by a discussion of the epistemological assumptions that guide this research, as well as a description of grounded theory (GT) and the rationale for choosing this method. An account of research procedures, data collection and analysis will be outlined before presenting the ethical considerations relevant to the study.

4.1 Rationale for using qualitative methodology

Psychology is a field where research is historically rooted in positivist tradition and associated quantitative methods, ‘regarding the world as made up of observable, measurable facts’ (Glesne & Peshkin, 1992, p.6). It has been suggested that positivistic, hypothesis-testing models do not necessarily capture the complexity and meaning of the social world (Ponterotto, 2005). Qualitative methods are said to be well suited to counselling psychology research because of the congruence of their underlying philosophies in that they both emphasise the depth and complexity of lived human experience, and focus on an exploration of processes and meanings (Clarke & Braun, 2013; Morrow, 2007).

In relation to the present field of enquiry, the majority of existing research in the area of inpatient aggression, while tending to focus primarily on physical aggression, is also predominantly quantitative. There is a paucity of research on psychiatric staffs’ subjective experiences of VA, and a lack of understanding of these experiences has resulted in an ‘impoverished map of psychological knowledge’ (Smith, 1996, p. 265). Qualitative approaches are said to be particularly suited to exploratory research (Morrow, 2007) that gives importance to the context, setting and the participant’s frame of reference (Marshall & Rossman, 2011), therefore lending themselves well to the objective of gaining an understanding of staffs’ experiences of VA.

4.2 Epistemological perspective

Epistemology is a philosophical belief system that is concerned with ‘the grounds upon which we believe something to be true’ (Oliver, 2010, p.35), and the relationship between knower (the research participant) and the would-be knower (the researcher) (Ponterotto, 2005). In essence, the researcher’s assumed epistemological position takes into

consideration what they believe to be knowable. The researcher's epistemological stance is central to the process of research, as it lays the foundation for the knowledge building process (Hesse-Biber & Leavy, 2010).

Qualitative research is informed by a variety of epistemological positions, from forms of positivism to constructionism. In brief, a positivist epistemology implies that knowledge is out there to be found, and the goal of research is to investigate and discover generalizable information that illustrates a universal truth (Markula & Silk, 2011). By contrast, the relativist constructionist paradigm proposes that reality is constructed in the mind of the individual and therefore multiple realities exist (Hansen, 2004). Constructionist epistemology holds that 'there is no objective truth to be known' (Hugly & Sayward, 1987, p.278), and that reality is socially constructed. That is, what we perceive as reality is constructed through a system of social, cultural and interpersonal processes (Berger & Luckmann, 1991). From an epistemological standpoint, the researcher does not believe that there is an absolute truth to be measured, but subscribes to the view that there exist multiple realities, which are subjective. The constructionist approach aligns with the researcher's beliefs, values, and philosophical position, and was used to explore the research question.

4.3 Rationale for using GT

GT was considered the most suitable qualitative method for conducting this research due to the congruence between the research aims, and the defining characteristics of the method; namely theory development (Hood, 2007) and explanatory focus of the theory (Glaser & Strauss, 1967). GT consists of guidelines for collecting and analysing qualitative data, and producing a theoretical framework with which to understand the phenomenon under investigation (Willig, 2013).

GT was originally developed by two sociologists, Barney Glaser and Anselm Strauss, who defined GT as 'the discovery of theory from data – systematically obtained and analysed in social research' (1967, p.1). Glaser and Strauss (1967) described theory as something that is discovered and emerges from the data independently of the analyst, thereby being unaffected by bias. Strauss and Corbin (1990) began to move from this positivist orientation to a post-positivist position, which still assumed an objective, external reality but sought to represent an external reality as accurately as possible, acknowledging that respondents' views of reality might conflict with their own.

As GT continued to evolve, Charmaz proposed a constructionist design to ‘take a middle ground between postmodernism and positivism and take qualitative research into the 21st Century’ (2000, p. 510). While classical GT suggests that theory emerges from data separate from the researcher as a scientific observer (Glaser & Strauss, 1967), Charmaz (2006) takes the view that both data and analysis are social constructions created from interpreting one version of reality, mutually constructed by researcher and participant (Charmaz, 2006). Accordingly, constructionist grounded theorists take a reflexive position towards the research process and analysis of the data. This more flexible version of GT seems to resonate with the philosophy of counselling psychology, both by accounting for subjectivity and promoting researcher reflexivity in the construction of reality (King & Kitchener, 2002), as well as congruent with the epistemological stance of the researcher.

The selection of constructionist GT for the analysis of the data was made after the consideration of a number of possible qualitative research methods. For instance, the main focus of Interpretative Phenomenological Analysis (IPA) is to access the participant’s lived experience, and the subjective essence of this experience, to provide a rich and complete description of human experiences and meanings (Smith, 1996). GT retains some sympathy for phenomenological assumptions and techniques by attempting to capture the subjective experience of participants (Suddaby, 2006). Indeed Smith (1995) has acknowledged the affinity between GT and IPA in that both methods ‘adopt a broadly similar perspective’ (p.18). However researchers using GT are not focused on the description of human experiences per se, but also on the study of social processes, and constructing an overarching theory or framework for understanding the phenomenon being explored (Smith, Flowers & Larkin, 2009). Thus the use of IPA would have shifted the focus of the research to an exploration of participants’ lived experience, as opposed to the emphasis on identifying contextualised social processes, and therefore was not congruent with the research aims of the current study.

Thematic Analysis (Braun & Clarke, 2006) is an approach to qualitative data that focuses on ‘what’ is said, rather than ‘how’ it is said (Bryman, 2004). It is defined as ‘a method for identifying, analysing and reporting patterns within data’ (Braun and Clarke, 2006, p. 79). It is less dependent on theoretical and technological knowledge than other qualitative methods such as GT or Discourse Analysis (Braun & Clarke, 2006), and is

considered to be an accessible form of analysis particularly for those with limited experience in the qualitative field (Grant, 2018). However, unlike GT, thematic analysis does not aim to create a theory but rather to identify meaningful patterns in the data (Braun & Clarke, 2006) and therefore was not in line with the aims of this research.

Discourse analysis is ‘the study of language in use’ (Wetherell, Taylor & Yates, 2001, p.3), and adopts a social constructionist view of language as context bound, functional and constructive (Wetherell et al., 2001). Discourse analysis does not use language as a means of gaining access to the participant’s psychological and social worlds, but rather focuses on how they use language to construct and position identities, relationships and activities (Putnam, 2010). Thus the focus of discourse analysis is upon how meaning is socially constructed through language and discourse (Green & Thorogood, 2004). Therefore this approach did not seem well suited to the analysis that would be required to theorise contextualised social processes.

As GT involves the generation of theory from gathered data rather than testing hypotheses about reality, it is considered to be a well suited approach for theory building when there is limited pre-existing research in a specific area (Moriarty, 2011; Strauss & Corbin, 1998). It has been claimed that ‘the strongest case for the use of grounded theory is in investigations of relatively uncharted waters’ (Stern, 1980, p. 20). As there was a significant gap in knowledge within the current research area, GT was considered to be the most appropriate qualitative method to construct a theory that was grounded in participants' views and experiences. Therefore GT was used in this study in order to understand staff perspectives on VA, and to propose a tentative theoretical model situated in the inpatient psychiatric setting.

4.4 The Researcher

The study was conducted by a British Asian female, third year trainee Counselling Psychologist who had been employed as a Life Skills Recovery Worker at one of the wards at the research site for over two years. It has been argued that investigators always believe something about the phenomenon in question (Morrow, 2005) and that for researchers to strive to be value-free is a misplaced aim (Remer & Oh, 2012). Due to the researcher’s constructionist stance she believes that she played a role in actively constructing data with the participants. In order to be transparent about what the researcher brought to the scene

(Charmaz, 2006), she maintained a reflexive diary throughout the research process, in which she recorded her observations about the research. This facilitated reflexivity and served to clarify the researcher's thinking about the analytic process.

4.5 Recruitment

The research site was an inner-city NHS psychiatric hospital in London. After obtaining ethical approval from the research ethics committee of London Metropolitan University (Appendix A) as well as research and development (R&D) approval from the relevant NHS Trust (Appendix B), the Modern Matron at the research site was approached to obtain consent to interview staff. Having secured consent the researcher attended four staff meetings (in order to be able to meet staff working on different shifts) and made a verbal presentation about the study. A copy of the participant information sheet with the researcher's contact details (Appendix C) was displayed in the nursing office and staff room to provide potential participants with relevant information about the study. Participants contacted the researcher via email. The researcher then briefed them about the study and obtained informed consent.

4.6 Participants

Eight staff members from two acute psychiatric wards volunteered to participate in the study. Participant ages ranged from 25 to 51 years, with a mean age of 37.2 years (see Table 1 on the following page for demographic details). There was no restriction on participants' occupational group, which included two consultants, two life skills recovery workers, two healthcare assistants, one nurse, and one nurse manager. Indeed, in line with a GT approach, some heterogeneity in the study sample is of value in theory building, thus broadening and deepening the scope of the study (Charmaz, 2009). Within the purposive sample the inclusion criterion was that participants were staff members who engaged with inpatients on a daily basis, and had been working on the ward for at least one year. Staff members who worked part-time or those who worked for less than a year were excluded; the former because their views about VA may have differed from those of full-time staff, and the latter because they may not have been exposed to VA on the ward for long enough to have considered their own experiences of it.

Table 1. Participants' demographic details.

Participant (pseudonym)	Age	Gender	Job Role	Duration worked on the ward (in years)
Anya	33	F	Nurse	7
Bree	35	F	Healthcare Assistant	9
Cam	51	M	Consultant Psychiatrist	12
Diya	37	F	Nurse Manager (Ward)	10.5
Ella	25	F	Life Skills Recovery Worker	3.5
Flor	27	F	Life Skills Recovery Worker	5
Greg	42	M	Healthcare Assistant	8
Hugo	48	M	Consultant Psychiatrist	7

4.7 Materials

A semi-structured interview schedule of open-ended questions was used to elicit participants' views and experiences regarding VA (Appendix F). The researcher used the interview schedule as a flexible guide by outlining questions of interest, while also encouraging deeper exploration of the topic via follow-up questions based on the participants' responses. This style of interviewing fits well with GT as a data collection method because it is both 'open-ended yet directed, shaped yet emergent' (Charmaz, 2006, p.28). As recommended by Smith (2008) the researcher used neutral, jargon-free language in the interview schedule, and attempted to retain the participant's terminology during prompts or follow-up questions. This was done in order to avoid imposing the researcher's perspective on participants' narratives, thus allowing the discussion to unfold as the participant viewed it, rather than as the researcher viewed it (Marshall & Rossman, 1995).

4.8 Procedure

Prior to commencing data collection, the interview schedule was piloted with two trainee counselling psychologists, which is recommended in order to rehearse interview technique, and assess the clarity and phrasing of the questions (Castillo-Montoya, 2016). This involved informal conversations and role play, which helped refine some of the interview questions. The process of doing a pilot study served as a useful prelude to the data collection process by affording the researcher the opportunity to practice recording, listening, interviewing and making notes simultaneously.

Participants were interviewed in a private room at the research site. The interviews lasted between 60 and 90 minutes. They were recorded with a digital recorder and transcribed verbatim by the researcher. Prior to each interview participants were provided with an information sheet (Appendix C) and consent form (Appendix D). They were encouraged to raise any queries they felt were relevant regarding their involvement in the research. This was followed by a preamble aimed at clarifying the nature of the interview, whilst also putting participants at ease.

Once the interviews commenced, the researcher paid specific attention to establishing a 'trusting, open relationship with the participant and tried to focus on the meaning of the participant's life experiences rather than on the accuracy of his or her recall' (Polkinghorne, 2005, p.142). The researcher opened with a broad question about VA, to allow participants to start with what they felt was important to them. When certain themes of relevance were raised by participants they were explored with non-judgemental prompts, thus allowing unanticipated statements and stories to emerge (Charmaz, 2006). A distress protocol (Appendix E) was available should any participants have experienced distress but the researcher did not have cause to use it. Once the interview process was concluded, participants were debriefed and offered the opportunity to discuss their experiences and raise any queries they had about the interview.

4.9 Data Analysis

Data was analysed in line with the constructionist GT approach proposed by Charmaz (2006). Constructionist GT methods offer a set of systematic and flexible guidelines for collecting and analysing qualitative data rather than a set of formulaic rules (Charmaz, 2006). The aim of this approach is for the researcher to engage with the data and develop a conceptual understanding of the studied phenomena, in this case, staffs' views on patient VA. In order to immerse herself in the data from the outset, the researcher chose to transcribe the recorded interviews herself. The process of data transcription was used by the researcher as an opportunity to get a feel for the data and an attempt to learn nuances of her participants' language and meanings (Charmaz, 2006) as it is not uncommon for researchers to be preoccupied during the interview process (e.g. thoughts of the next interview question; Charmaz, 1991).

4.9.1 Initial Coding: Following Charmaz's (2006) guidance on coding, all the interview transcripts were analysed in two main phases – initial and focused coding. The researcher started initial coding by working through each transcript line-by-line and made a note of phenomena occurring in each line of text in the margin (Appendix G). This involved coding segments of data represented by each line of the transcript, rather than each complete sentence articulated by the participant (Charmaz, 2006).

The researcher used in-vivo codes to retain participants' meanings of their views and actions (Charmaz, 2006, p. 55). Detailed labels were used to be able to describe the underlying meanings of the participants' words while also retaining contextual information (e.g. Tacit acceptance of VA on the ward as nurses feel patients 'don't always have capacity'). Using in-vivo codes that were reflective of participants' meanings and experiences of VA ensured that the coding was grounded in the data, and prevented the researcher from moving too quickly into developing higher level abstractions (Maher, Hadfield, Hutchings & de Eyto, 2018). Charmaz (2006) recommends coding with gerunds (verbs ending in '-ing'), to focus the analysis on actions and processes. The researcher did code with gerunds in some instances (e.g. Stepping in to support colleague during VA incident). However, there were many occasions where the researcher needed to code for context which did not represent an action per se (e.g. Noisy and unsettled psychiatric ward), and therefore using gerunds was not appropriate in those instances. A key principle of constructionist GT coding guidelines is that they are flexible, with a focus on staying close to the data and remaining open to emerging insights, rather than on the application of a set of prescriptive instructions (Charmaz, 2006). In this spirit the researcher did not rigidly code using gerunds as the sole linguistic device, but focused on defining categories and considering the relationships between them using the most appropriate wording, which is how GT researchers achieve 'depth of theory' (Urquhart, 2007, p. 352).

After initial concepts were developed from the first three interviews, the researcher revised the interview schedule (Appendix I) to aid theoretical sampling. Theoretical sampling is a data collection strategy which focuses questions on emerging conceptual ideas rather than gathering extensive but irrelevant information (Charmaz, 2014). The interview schedule was amended in response to themes emerging from the transcribed data, some of which resonated with research presented in the literature review (Kindy et al., 2005; Kisa, 2008). Therefore after examining the emergent themes, as well as revisiting the

relevant literature, the initial interview schedule was revised to incorporate wider organisational issues that might influence how staff respond to VA (e.g. provision of staff support). Finally, the process of initial coding was repeated with the remaining five interviews.

4.9.2 Focused coding: Focused coding is a process designed to select the most frequent and significant codes, and use them to synthesise large amounts of data into more elaborated categories (Charmaz, 2006). Initial codes (from both sets of interview data) were clustered or integrated by comparing the most salient or frequently occurring initial codes with each other to identify patterns of similarities and differences between them (Charmaz, 2006). Through this process conceptual categories began to take shape. In line with the constant comparison process which is at the heart of GT analysis (Dey, 2004), the researcher constantly compared data within interviews and across interviews. Codes that were similar in meaning were combined under a higher order code that captured the meaning of the grouped codes (Appendix J). This iterative process helped to highlight the emerging theoretical concepts while still retaining the rich detail that had been obtained during the initial coding phase (Charmaz, 2006). Focused coding continued until an appropriate level of ‘theoretical sufficiency’ was reached for the emergent categories, where the researcher achieves a suitable depth of understanding that can allow them to build a theory (Dey, 1999, p. 257). The researcher was not aspiring to reach theoretical saturation, which is said to occur when new data does not generate new insights or add further variation to the theoretical categories (Charmaz, 2006). It has been claimed that theoretical saturation is an ideal that is not necessarily achievable (Daly, 2007) or appropriate (Mason, 2010) as it has ‘connotations of completion’ (Dey, 1999, p. 116). Accordingly the researcher continued data analysis until theoretical sufficiency was reached; that is, categories were suggested by the data, rather than saturated by the data (Dey, 1999).

4.9.3 Constructing the theoretical model: The researcher devised a model to represent the links between categories identified in the data, the final version of which is presented in the Findings chapter. This is an approach recommended to conceptualise relationships between categories (Charmaz, 2006) and was used to visually represent the influences of different processes on the way participants responded to patient VA. During the first stage of analysis this was a tentative model (Appendix H) but over the course of

expanding and refining categories the researcher came to realise that it did not adequately account for the complexity in the data, and gradually the categories were integrated into a theoretical model that could account for the majority of the data. This was not a linear process, and the researcher frequently had to re-evaluate the data and revisit concepts to confirm that the emerging theory was reflective of the participants' experiences. Memo writing was integral to recording analytical insights and formulating the theoretical model.

4.9.4 Memo writing: Memo writing started at the first interview and consistently thereafter throughout the research process to conceptualise ideas that arose during data collection and analysis (Appendix M). Memos are analytic notes that help crystallise questions and directions for the researcher to pursue, and are constructed to explore and reflect on codes and categories (Charmaz, 2006). The researcher wrote memos by hand, in free-writing style, noting down ideas as they came to her without being constrained by concerns of immediate relevance of ideas or grammar. Thus through memo writing the researcher was able to remain immersed in the data as the analytic process progressed, as well as keep the participant's voice and meaning present in the theoretical outcome (Charmaz, 1995, 2001).

4.10 Ethical considerations

This research study was conducted in accordance with the British Psychological Society's (BPS) guidelines on ethical principles for conducting research with human participants (2010), and London Metropolitan University research ethics policy and procedures (2010). As stated previously, the study received ethical approval from the London Metropolitan University ethics committee (Appendix A), as well as R&D approval from the Joint Research Management Office of the pertinent NHS Trust (Appendix B).

4.10.1 Informed Consent: The researcher secured written consent from participants for participation as well as audio recording of interviews, prior to the research interview. Participants were made aware that excerpts from their interviews may be used in the study, and informed that any identifying characteristics would be changed. Participants were informed of what the study involved, and assured that they had the right to withdraw from the study at any time. Participants were given an information sheet to provide them with an overview of the study and confidentiality measures (see below).

4.10.2 Confidentiality: Concrete procedural steps were implemented to maximise confidentiality. Interviews were conducted in pre-booked private rooms at the research site so conversations could not be overheard. Participants were assigned unique codes, and the researcher ensured that interview notes, recordings and transcripts contained no personal identifiers. Recorded data was stored on a password encrypted computer and immediately deleted from the dictaphone. Signed consent forms with the participants' names and personal details were stored securely in a locked filing cabinet in the researcher's home office.

4.10.3 Distress: It was not anticipated that participants would experience undue distress over the course of the interview, however there remained the possibility that participants might experience distress of some nature while describing their experiences of VA. The researcher was responsive to participants and continually monitored their emotional states. None of the participants exhibited signs of distress, therefore the researcher did not need to utilise the distress protocol (Appendix E).

5. Findings

Data analysis yielded nine categories that captured staffs' experiences of VA in an acute psychiatric ward. These categories were organised into a theoretical model (Figure 1, below). An overview of the model will be presented, with a description of the nature of interactions between the categories. The categories and subcategories will be discussed and illustrated using verbatim quotes from the participants.

5.1 Theoretical model

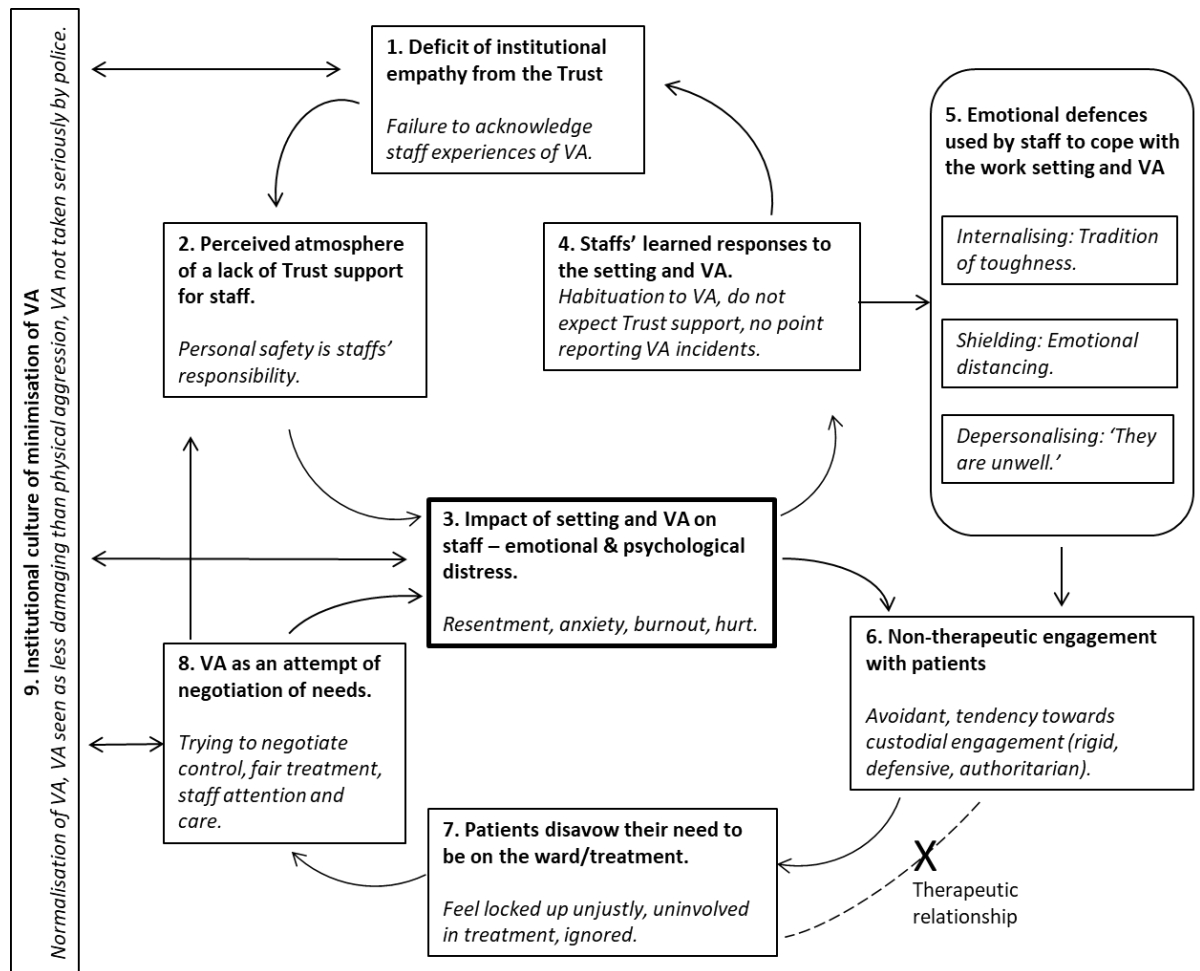


Figure 1. Model representing acute psychiatric staffs' experiences and perception of VA (see Appendix L for full-size diagram).

5.2 Overview of the model

This section will offer an overview of the theoretical model, with a narrative of how the categories of the model (outlined in Table 2, p. 43) relate to each other.

‘Deficit of institutional empathy from the Trust’ (category 1) refers to the participants’ sense of not being nurtured or cared for by the Trust, in the context of their frequent exposure to patient VA. Participants appeared to experience VA on a daily basis, and they suggested that the Trust was not able to empathise with their experiences on the ward. Participants stated that the Trust did not seem to understand how they felt after experiencing VA. They proposed that unlike themselves, Trust management were not typically exposed to patient VA, and hence might not have considered VA to be a pressing issue.

Consequently the participants appeared to be sensitive to the *‘perceived atmosphere of a lack of Trust support’* (category 2). The message participants seemed to absorb was that taking care of their welfare was their own responsibility. Participants did not appear to have a formal system of staff support, nor access to training in techniques to manage VA. Participants seemed to experience *‘emotional and psychological distress’* (category 3) – not just because of the experience of VA per se, but because they may have felt alone in the experience, ill-equipped to cope with it, and unsupported. This has tended to leave participants feeling resentful, hurt, unhappy, anxious, and burnt out. They reported experiencing diminished motivation and passion for the job, and also seemed unsure if the remuneration they received was worth the experience of being verbally abused daily. In addition, staff were said to go off sick because they did not want to deal with VA anymore.

Management was described by participants as a cautioning presence, not a supportive one. Participants observed that they only heard from Trust management if there was threat of disciplinary action - not in the context of providing support. They seemed to indicate that though they wanted support from the Trust they had learned not to expect it. It appears that in order to reconcile with the position they found themselves in, they may have learned to function as autonomous agents who did not need recourse to support from the Trust (*‘learned responses to the setting and VA’*, category 4). Participants may have habituated to VA and accepted that it was an inevitable part of their job. They also tended not to report incidents of VA to the police or the Trust because no action had been taken

after previous complaints. On the other hand, the Trust might justifiably be able to claim that VA is not a particularly serious problem on the ward given the lack of reports, and thus the cycle of the Trust not offering support and staff making do without support may well continue.

The findings suggest that participants found themselves having to demonstrate their ability to cope in the face of continual VA, coupled with a lack of acknowledgement of their experiences. Therefore they may have consciously or unconsciously employed '*emotional defences*' (category 5) in order to simultaneously make their job more manageable, and protect themselves. Participants may have *internalised* unspoken organisational rules regarding VA (e.g. staff should be able to cope with VA). Another defence mechanism was *shielding*, in order to protect staff from the emotional impact of VA. Participants described a gradual distancing from the emotional fallout of VA over time. A final coping mechanism was *depersonalising*; attributing VA to the patient's mental illness. It is suggested that staff may make sense of their work environment by viewing patients through the lens of their mental illness, as it may be less painful to ascribe the abuse to the illness rather than to view it as a deliberate personal attack.

These coping strategies (along with staffs' emotional state) may have influenced staffs' interactions with the patient by way of '*non-therapeutic engagement*' (category 6). Participants described themselves and colleagues as engaging with verbally aggressive patients in an avoidant or custodial way. They tended to try to stay away from verbally aggressive patients, avoiding doing more with them than they needed to. Participants also spoke of staff tending towards disrespectful and authoritative engagement with patients due to feelings of resentment after experiencing VA. The pre-existing staff-patient therapeutic relationship may therefore be compromised, and the warmth and rapport may be lost, thus impairing the working relationship.

If patients do not believe they are unwell, it is possible that they may feel angry about being admitted to the hospital. Patients may '*disavow their need to be on the ward*' (category 7) and communicate with staff aggressively to make their feelings known. In this context, especially if the staff member had experienced VA previously (and received no emotional support after the experience), they may respond to the patient in a rigid or defensive manner, which in turn could contribute towards further VA. Participants observed

that when staff fail to interact therapeutically with patients, they may be creating a situation where the patient does not feel listened to or respected. The patient may become verbally abusive in an attempt to ‘*negotiate their needs*’ (category 8) for fair treatment, control, and staff attention, thereby perpetuating the cycle of VA.

The relational dynamics described thus far seem to occur in the context of an ‘*institutional culture of minimisation of VA*’ (category 9). The institutional culture seems to have normalised VA and framed it as an unavoidable part of the job. For instance, participants observed that while there were prominent posters advising patients that the ward follows a zero tolerance policy towards VA, in reality it was not enforced. Participants stated that VA occurred so often that it had become a normalised part of the work culture. They appeared to believe that VA was not treated with the same gravitas as physical aggression; on the ward, by the Trust, or by the police. In the main there was a sense that VA is less damaging than physical aggression; staff were said to minimise it and prioritise other tasks over responding to VA, especially when they were busy. Thus on an institutional level there was an implicit sense that VA is minor, and there was a tendency to view it as part of the job.

5.3 Table of categories

Table 2. Summary of the categories and subcategories, and participants who contributed.

Category	Subcategory	Participant
1. Deficit of institutional empathy from the Trust	‘I don’t think they get it at all’	Anya, Diya, Ella, Flor
	Trust management is out of touch	Anya, Diya, Flor, Greg
2. Perceived lack of support from the Trust	Staff ‘should be able to’ handle VA	Anya, Diya, Ella, Flor, Greg
	Disclaimer about VA	Ella, Flor, Greg
	Lack of training specific to VA	Anya, Bree, Cam, Diya, Ella, Greg
	Absence of formal staff support	Anya, Diya, Ella, Flor, Greg, Hugo
3. Impact of setting and VA on staff	Emotional and psychological impact of VA	Anya, Bree, Cam, Diya, Ella, Greg, Hugo
	Emotional and psychological impact of lack of support after VA	Anya, Bree, Cam, Diya, Flor, Greg, Hugo
4. Staffs’ learned responses to the setting and VA	Staff habituate to VA	Anya, Bree, Cam, Diya, Ella, Flor, Greg, Hugo
	Staff do not expect support from the Trust	Diya, Ella, Flor, Greg,

	Staff do not report VA	Diya, Ella, Flor, Greg, Hugo
5. Emotional defences	Internalising	Anya, Diya, Ella, Greg, Hugo
	Shielding	Bree, Cam, Ella, Flor, Greg
	Depersonalising	Anya, Bree, Cam, Diya, Ella, Greg, Hugo
6. Non-therapeutic engagement with patients	Avoidant	Anya, Diya, Ella, Hugo
	Authoritative and inflexible	Anya, Bree, Cam, Diya, Greg, Hugo
	Disrespectful and patronising	Anya, Bree, Cam, Diya, Greg, Hugo
	Altered practice after VA	Anya, Cam, Diya, Flor, Greg
	Lost rapport	Anya, Bree, Cam, Diya, Ella, Flor, Greg, Hugo
7. Patients disavow their need to be on the ward/treatment	Ward environment/feeling locked up	Anya, Bree, Cam, Diya, Ella, Greg, Hugo
	Feeling uninvolved in their treatment	Anya, Bree, Diya, Greg
	Patients are angry about being admitted	Cam, Diya, Ella, Greg, Hugo
8. Attempt of negotiation of needs	Patients do not feel heard	Anya, Bree, Cam, Diya, Ella, Greg
	Patients' attempts to regain control	Anya, Bree, Diya, Ella, Hugo
	Patients treated unfairly	Anya, Bree, Diya, Greg, Hugo
9. Institutional culture of minimisation of VA	VA not taken as seriously as physical aggression	Anya, Diya, Ella, Flor, Greg, Hugo
	VA becomes normalised	Anya, Bree, Diya, Ella, Flor
	VA seen as less damaging than physical aggression	Anya, Bree, Diya, Flor, Greg
	The police do not take VA seriously	Anya, Diya, Greg, Hugo
	Zero tolerance policy is not enforced	Anya, Bree, Diya, Flor, Greg

Researcher's note:

At first glance subcategories 2.1 (Perceived lack of support from the Trust), 4.2 (Staff do not expect support from the Trust) and 9.1 (VA is not taken as seriously as physical aggression) may appear to overlap in meaning. Though they may seem similar, they differ in that they illustrate different phases of staff feeling unsupported by the Trust. The researcher proposes that staff are initially sensitive to signs that they are not being supported by the Trust (e.g. lack of training) (2.1), but after processing this information

emotionally and intellectually they may then compensate for the absence of support by positioning themselves as not needing it after all (4.2), and therefore do not expect any demonstrations of support or concern from management after having experienced VA (9.1).

5.4 Model Categories

The following section will present an account of participants' experiences of VA in an acute psychiatric ward. The main components of the research model and the sub-categories within them will be elaborated upon below, and will be contextualised by quotations from participants (*italicised*), in order to represent the data in which this analysis is located.

Category 1 - Deficit of institutional empathy from the Trust

Subcategory	Participant
'I don't think they get it at all'	Anya, Diya, Ella, Flor
Trust management is out of touch	Anya, Diya, Flor, Greg

Subcategory 1.1: 'I don't think they get it at all' - Participants suggested that the Trust were removed from the experience of VA, and as a consequence were unlikely to relate or empathise with staff. They added that Trust management may write policies about VA, but as they do not experience it they may not understand how staff feel after an incident of VA. *"They pop in and out, so they don't get to see the reason behind it. I don't think they get it at all"* (Ella). Participants observed that the Trust could well be implementing plans to support staff after VA, but that in reality it did not feel that way to them. They went on to express doubts about whether the Trust cared that VA affects staff. *"They won't really even follow things up like that. Unless it's a, an incident report that has been written but they need more information, so they'll ask for a 48 hour report. But otherwise....I don't, I don't feel like they care. I don't feel like they care unless it's physical aggression and if the Trust are likely to be at fault, otherwise I don't think they care"* (Flor).

Subcategory 1.2: Trust management is out of touch - Participants observed that Trust management claim to understand what VA is like because they had ward experience in the past. However participants stated that while that may have been true, they suggested that management had lost touch with the emotional fallout of the experience because it

occurred some time ago. In addition, as changes within the NHS are a constant, the wards of today are very different from the wards of a few years previously, therefore participants felt like the two sets of experiences were perhaps not necessarily comparable. *“Uh, I don’t know, I feel like a lot of those higher ups say things like ‘oh I used to work on a ward and I’ve experienced this myself’ and blah blah blah. I think when they get higher up they, they forget everything that they may have experienced on the ward. Even if they haven’t forgotten everything that they experienced on the ward, things are different. Things are constantly changing.”* (Flor). Though one of the participants (who is now a ward manager) stated that they could empathise with staff having experienced VA personally, other participants felt that once a member of nursing staff moved to management, they adapted to the less arduous work routine and consequently were less mindful of life on the ward. *“You know, even if they’ve been a nurse, you know, as humans I think we adapt very easily to an easy life. I’ve been here 8 years now. I’m sure if I get a job in those big offices I’ll be saying, oh very nice. Of course then I’ll forget whatever I went through here and just spin in my chair [laughs]. You know?”* (Greg).

Category 2 - Perceived lack of support from the Trust

Subcategory	Participant
Staff ‘should be able to’ handle VA	Anya, Diya, Ella, Flor, Greg
Disclaimer about VA	Ella, Flor, Greg
Lack of training specific to VA	Anya, Bree, Cam, Diya, Ella, Greg
Absence of formal staff support	Anya, Diya, Ella, Flor, Greg, Hugo

Subcategory 2.1: Staff ‘should be able to handle VA’ - Participants reported being aware of an unspoken expectation from the Trust, that they should be able to deal with VA without requiring support. *“If someone gets verbally abused, you’re not going to get top managers emailing them or sending you know, their sincere warmth or apology whereas if somebody gets physically abused, you get managers from the top end, coming down to visit them or sending emails sometimes. So, for me the message there is that we should be able to handle VA without needing so much pat on the back sometimes”* (Anya). Participants seemed to think that the Trust did not view VA as a problem, because they saw it as an expected part of the job. *“I think they see it [VA] as part of the job that has to be done. And I think when it comes to staff it’s like it’s your job, you can handle it”* (Greg).

Subcategory 2.2: Disclaimer about VA – Participants revealed that when they were interviewed for the job, they were advised that they might experience some VA at work; in reality they observed that levels of VA were significantly higher than expected. Participants reported a sense of let down, and observed that the Trust seemed to be acting in a self-serving manner by providing them with a less than accurate impression about VA. *“They’ve made that disclaimer in the beginning, in the interview, you will experience some form of VA. But that’s their disclaimer. They’ve covered their backs. They’ve told us that we are going to experience it, so if we turn around and say oh I wasn’t expecting this, they can turn around and say ‘well I told you’ (Flor).* It was suggested that the Trust was deliberately vague about the level of VA on the ward in order to have a plausible defence against complaints from staff. *“They say there may be a certain level of violence, it could be from 1 to 10 on a scale of violence. So I think that that small line just covers them, even though it’s so vague” (Greg).*

Subcategory 2.3: Absence of formal staff support - Participants observed that there was a lack of an adequate system in place to offer staff support at work after VA. *“Uff [exhalation] I don’t think there’s much. There’s no systematic staff support, there’s nothing, there’s no, there’s no staff support really” (Anya).* Participants stated that they relied mainly on their colleagues for emotional support, *“Partly using humour, partly being there for others when they are in need, and you always get that back. So it’s about mutual support” (Hugo).* Given the absence of Trust policy regarding staff support, participants stated it was up to individual ward managers to support staff after VA, however not all ward managers were seen as equally supportive. *“Um, but if I didn’t have her as a manager I think yeah, I think I would have felt unsupported. I don’t think I would have felt supported at all. Because when I go to other wards, it doesn’t feel like there’s support” (Ella).*

Subcategory 2.4: Lack of training specific to VA - The findings suggest that staff do not appear to receive training on how to manage verbally aggressive behaviour. Participants reported that there was no provision for training specific to helping staff manage VA on the ward. They stated that the skills they had were learnt through experience, on the job. *“I don’t see any, what d’you call it, well-structured formal training that this is what you should do, etc. But I just think in the course of your training as a doctor you pick those things up (Cam).* They also confirmed that the only mandatory training available was to help staff safeguard against physical aggression. *“Of course when*

– also we have this MAPA [Management of Actual or Potential Aggression] training that is about managing physical aggression. But how to manage the verbal aggression whereby I don't have to touch you to defend myself, it's not, there's not much training, not much support for that" (Greg). It was observed that if staff need to employ their skills from restraint training, then it is likely that the situation has escalated drastically. "There is training, which helps you to deal with physical aggression but by that time we've, you're far gone really, isn't it?" (Anya).

Category 3 - Impact of setting and VA on staff

Subcategory	Participant
Emotional and psychological impact of VA (fear, distress, hurt, anxiety, low morale, burnout, go off sick)	Anya, Bree, Cam, Diya, Ella, Greg, Hugo
Emotional and psychological impact of lack of support after VA (burnout, diminished motivation, go off sick)	Anya, Bree, Cam, Diya, Flor, Greg, Hugo

Subcategory 3.1: Emotional and psychological impact of VA - Participants reported a range of emotional responses to VA, from feeling deeply distressed, to feeling resentment towards the patient. "I think it's very painful and hurtful.....it was very painful, and you do get a bit of resentment actually towards the patient" (Anya). Participants also reported feeling guilty, and wondering whether they had done something to provoke the incident of VA. "You know, so you may feel oh, you know, you've done something wrong" (Bree). One participant revealed that hurtful comments from patients cut deep, and stayed with her long after the end of her shift. "You'll never have kids, and you wouldn't make a good mum anyway, you can't even look after your patients....things like that resonate with you....that's something that you will remember" (Ella). She went on to add that she has developed anxiety due to the stress caused by VA. "I now get anxiety....finding it difficult to sleep....up all night with your heart racing, thinking how am I going to deal with this tomorrow?" (Ella). Participants admitted to feeling threatened and afraid for their safety, regardless of whether the patient was likely to fulfil their threats in reality "I think it's the perception you know, what it makes you feel unsafe.... I think the fact that a patient is saying those things um, it puts, it removes the safety net around you and you feel really scared and threatened" (Diya). One participant described an instance where a patient was said to deliberately attempt to provoke him, which was also seen as threatening. He claimed that a patient who hailed from his country falsely accused him of saying certain things in

their local dialect, which could not be confirmed or denied by his colleagues as they did not speak the particular dialect. He reported that the experience left him feeling quite anxious and unsettled. *“Knowing that somebody is intentionally distorting things to provoke you. That I felt very uncomfortable with. To me, that I found quite threatening” (Cam).*

Subcategory 3.2: Emotional and psychological impact of lack of support after VA – It was suggested that a lack of support after VA could have an effect on participants’ emotional and psychological wellbeing. Participants felt that VA could potentially erode their zest and motivation for the job and leave them wondering if the job is worth it. *“It makes me feel uncomfortable and at times even question the job. I say ‘oh, did I sign up for this stuff’ (Greg).* Participants observed that incidents of VA could affect staff morale, especially if not addressed, or if staff did not feel equipped to manage it appropriately. *“I think it could be demoralising, especially if you don’t know how to deal with it” (Cam).* They also reported that if staff felt unsupported they tended to stop making an effort at work. *“They’ve lost the zeal for the job which isn’t always their fault, it usually stems from how the Trust have treated them. Like, have they really been supported by the Trust in times of need” (Flor).* It was suggested that if staff continue enduring VA with no acknowledgement of their experience, they may well feel burnt out and go off sick because they don’t feel able to continue dealing with VA. *“If we are stressed we can deal with stress less, so we might feel more tired or the work becomes a burden, or you don’t turn up for work, find a reason to go off sick, all of that” (Hugo).*

Category 4 - Staffs’ learned responses to the setting and VA

Subcategory	Participant
Staff habituate to VA	Anya, Bree, Cam, Diya, Ella, Flor, Greg, Hugo
Staff do not expect support from the Trust	Diya, Ella, Flor, Greg,
Staff do not report VA	Diya, Ella, Flor, Greg, Hugo

Subcategory 4.1: Staff habituate to VA - Participants unanimously agreed that they tended to expect VA at work. *“So to think that it is not part of the job would be I think, uh, I’m trying to find a polite word [laughs] – I think it’s unreasonable to think that it’s not” (Hugo).* Participants stated that VA occurs so frequently that it was seen as part of the job, whether they liked it or not. *“I don’t think VA should be part of the job but in reality it*

is taken as part of the job” (Greg). While VA was seen as part of everyday work life, physical aggression was not expected. “It’s definitely part of the job – I expect it now. I expect VA; I don’t expect to be hit but I expect VA” (Flor).

Subcategory 4.2: Staff do not expect support from the Trust - Participants observed that they only heard from Trust management in the context of disciplinary action. Participants suggested that the Trust was an entity that staff had to answer to, and that it was not a good sign when Trust management became involved. *“It’s not always good news when they come to see you. It’s mostly when there’s something wrong” (Greg).* The findings suggested that participants had learned not to expect support from the Trust. They reported a sense that if anything undesirable happened, the Trust would not show solidarity with them or support them. *“You’re always told anyway, anything negative happens this Trust will sell you up, up the riv-, sell you under a bus” (Ella).*

Subcategory 4.3: Staff do not report VA – Majority of participants stated that they were very busy during their shift, and did not have time to report VA. *“We’ve only got um, 11.5 hours to do everything that we would need to do during the day including escort, write ups, lunch, dinner....there’s too much to do....there’s no time for Datix [electronic incident reporting system]” (Flor).* They observed that on occasions when they had reported VA to the police in the past, it was not taken seriously once the police learned the patient was on a psychiatric ward; consequently they did not seem to see any benefit in reporting it. *“I can call the police because somebody is threatening to kill me, but nothing really happens so what is the point” (Hugo).* Over time participants were said to become less inclined to report VA, because nothing had come of it when they reported it. *“Even if I cry, if I do this, it’s not going far, it’s going nowhere. Why bother” (Greg).* One participant stated that she chose not to report VA because of maternal feelings towards patients, however this sentiment was not expressed by other participants.

Category Five - Emotional defences

Subcategory	Participant
Internalising	Anya, Diya, Ella, Greg, Hugo
Shielding	Bree, Cam, Ella, Flor, Greg
Depersonalising	Anya, Bree, Cam, Diya, Ella, Greg, Hugo

Subcategory 5.1: Internalising - It seemed like participants may have gradually begun to internalise a tradition of toughness that mirrored institutional thinking around VA. Participants stated that they felt the need to be able to take on VA and be resilient enough to do the job. *“I just think it’s becoming a bit of the culture amongst the unit, that VA is something that we should be able to shake off, or have a thick skin to deal with” (Diya).* The findings suggested that this ethos appeared to have become so entrenched in participants’ thinking that they might hesitate to access what support was available to them. For instance, participants reported that they did not believe experiencing VA was serious enough to justify their need to see a psychologist. There was a sense from participants that VA was seen as part of their job and that they should be able to handle it. *“It’s not always that easy to just say I’m going to go and see the psychologist because you feel silly. This is your job....this is like a normal occurrence in your job” (Ella).*

It is proposed that participants may have learnt to ‘just deal with it’, carrying on even though they might have been affected by VA. *“You’re expected to just deal with it. I’m not saying that’s the stance that the Trust holds, I’m just telling you that that’s the general observation....when people have been verbally abused not a lot of people go off sick for it” (Anya).* A potential consequence of internalising this unspoken message may be that staff may become critical of colleagues who are struggling after an event of VA. Participants observed that while support was offered in the event someone was physically assaulted, their colleagues could sometimes be critical of colleagues who needed time off after an episode of VA. *“The patient didn’t touch you, didn’t hit you, they just shouted at you....why do you need to be off sick for that?” (Diya).* It was observed that showing vulnerability was not seen as a desirable quality on the ward. Therefore staff who needed time off after VA were said to be the subject of ridicule amongst their colleagues. *“If I say this patient has called me names and I can’t handle it....you know it just appears that you are being weak. It’s like you are making yourself more vulnerable....a subject of laughter for colleagues” (Greg).*

Subcategory 5.2: Shielding - It appeared that participants learned to shield themselves from the emotional impact of VA in order to be able to do their job. They described gradually distancing themselves from the emotional fallout of VA over time. *“At the moment, nowadays, you know, emotionally I don’t get - I kind of de-emotionalise myself from it....It’s something I’ve learnt to do over the years” (Bree)*. Participants also described a tendency to frame their job role using metaphors of strength and protection, thus creating some distance between themselves and the experience. *“When you come in to work you put your nursing hat on....it’s kind of like this shield....you know there’s violence and aggression you’re trying to avoid it, so it’s kind of like a battlefield” (Ella)*.

Subcategory 5.3: Depersonalising - Another defence mechanism highlighted in the data was a tendency to depersonalise verbally aggressive behaviour by attributing it to the patient’s mental illness. Presumably this partially diminished the distress evoked by VA because it implied that the VA was triggered by the patient’s mental illness, rather than something participants did or said, making it easier to continue with patient care. Most of the participants stated that patients were verbally aggressive because they were unwell; they seemed to view VA as an inevitable part of the patient’s illness. *“The fact that they are in an inpatient ward...they’re taking medication....so you know that um, it’s because they’re unwell” (Bree)*. Participants claimed that VA was triggered by symptoms of the patient’s mental illness, unrelated to staff interaction. *“They might be responding to stimulus, you know, they might have persecutory ideation, so all those things can lead to a patient being verbally aggressive whether staff has said anything to them or not” (Any)*. Participants observed that the level of VA on the ward varied as a function of the mental health of the patient; the more unwell the patient, the more they anticipated VA. *“Patients that are acutely unwell, or becoming more and more unwell, you expect them to become, that they may become verbally aggressive” (Cam)*.

Patients diagnosed with PD were not seen as mentally ill by participants. Therefore VA from those patients was seen as ‘bad’, deliberate behaviour. *“Then of course you could have patients that are just, how can I call it, with bad behaviours. For example, individuals with personality disorders” (Cam)*. Unlike patients who had a diagnosis of schizophrenia or bipolar disorder, patients with PD were seen as having insight into their behaviour, and as a consequence participants tended to be less understanding if they became verbally abusive. *“I think we nursing team are slightly less empathic towards them when they are verbally*

aggressive. ‘Coz we think....they’re not mentally ill, so they must mean what they’re saying” (Bree).

Category 6 – Non-therapeutic engagement with patients

Subcategory	Participant
Avoidant	Anya, Diya, Ella, Hugo
Authoritative and inflexible	Anya, Bree, Cam, Diya, Greg, Hugo
Disrespectful and patronising	Anya, Bree, Cam, Diya, Greg, Hugo
Altered practice after VA	Anya, Cam, Diya, Flor, Greg
Lost rapport	Anya, Bree, Cam, Diya, Ella, Flor, Greg, Hugo

Subcategory 6.1: Avoidant – The findings highlighted strategies employed by participants to avoid engaging with verbally aggressive patients. They were said to occupy themselves with paperwork in the office to avoid having to spend time on the ward with potentially confrontational patients. *“Going into the nursing station and locking themselves up. And oh, trying to become invisible because or you know, almost staying away from the patients” (Hugo).* When staff expected VA from a particular patient, they tended to keep away from them, and avoided doing more with them than they needed to. *“I think maybe the patient would continue to be verbally aggressive because they just feel like they don’t have that person’s attention....if I feel that you’re treating me in a certain way I’m going to want to avoid you....you know, meeting their needs and no more” (Diya).*

Subcategory 6.2: Authoritative and inflexible – Speaking of their colleagues, participants described how they might attempt to exert their authority over patients, expecting patients to comply with a request without providing a rationale or explanation. *“Like you know, ‘because I’m a nurse and I said so’, you know, who think because they are qualified nurses they might have more power or something like that” (Bree).* Participants observed that sometimes they could be inflexible, focusing more on adhering to ward rules rather than trying to accommodate patient requests, which could provoke patient VA. *“When you become quite rigid and restrictive....you switch the TV off and say this is the rule and that’s it....it plays out in a bad way” (Diya).*

Subcategory 6.3: Disrespectful and patronising - Participants spoke of disrespectful and patronising communications and attitudes as having the potential to

trigger VA. It was suggested that as patients are on a psychiatric ward, sometimes staff talk down to them, or infantilise them, treating them like they do not have a grasp on reality. *"I've observed nurses do speak to patients almost like they're little children....like they're not really linked in with reality"* (Anya). Participants observed that ward staff may occasionally lose focus of the fact that patients have a life outside the hospital where they are loved and respected. *"Some of the patients on the ward are professionals, they're fathers, they're mothers.....sometimes when patients come into hospital we lose focus of that person being a human being, a well-respected person"* (Diya). This may be very upsetting for patients and might elicit an aggressive response from them. *"Uh for most of them it is already too much, being mentally unwell and being stigmatised. So when you talk to them in a certain way....they may feel diminished....it just triggers VA"* (Greg).

Subcategory 6.4: Altered practice after VA - Participants described how staff may begin to alter their style of working after experiencing VA, especially if they felt unsupported. They were said to put their guard up and act more rigid with patients, in a bid to protect themselves. *"I think when people feel....they haven't been supported, they start changing without realising it....they might be more boundaried, more firm, more strict"* (Anya). Participants suggested that staffs' interaction with the patient was impacted not necessarily because they were upset with the patient but because of how staff felt about their position in the organisation. *"Feel like there's no support....that can come out in how people interact with patients. It's not always the patient making staff angry, but there's something about how the staff feels in the organisation"* (Diya).

Subcategory 6.5: Lost rapport – All participants described how staffs' feelings of resentment and hurt after VA might jeopardise staff-patient relationships. One participant stated that staff tended to take a step back from the relationship with the patient after VA, and likened the situation to a car that had been repaired after an accident, *"There's that one scratch or dent in the car that won't go. Your car looks so good and new but that dent is still there"* (Ella). VA was said to have the potential to create distance between staff and patient. *"There is always a risk of um, malignant alienation of patients, seeing that one patient as trouble"* (Hugo). Participants reported a tendency to do their job by the book after they had been verbally abused by a patient; they stated that they would perform their tasks and fulfil patient requests as needed, but nothing further. Thus the previously established therapeutic relationship was perhaps adversely affected. *"I made sure the*

relationship was by the book. I was doing exactly what my job description was....but we didn't have the kind of relationship we used to have because of her behaviour" (Flor).

Category 7 - Patients disavow their need to be on the ward/treatment

Subcategory	Participant
Ward environment/feeling locked up	Anya, Bree, Cam, Diya, Ella, Greg, Hugo
Feeling uninvolved in their treatment	Anya, Bree, Diya, Greg
Patients are angry about being admitted	Cam, Diya, Ella, Greg, Hugo

Subcategory 7.1: Ward environment/feeling locked up - Participants observed that patients may feel angry about being detained under section. *"They feel like because they're under section we've locked them up" (Ella).* They proposed that a lack of diverting activities may frustrate patients and exacerbate their sense of being locked up. *"They just feel that all they can do is move from their room to the dining table, move back and nothing more, of course that may cause agitation....including verbal aggression" (Cam).* Being detained on the ward, and encountering unfamiliar ward rules was seen to be anxiety provoking for patients. *"It really makes patients feel edgy and uncomfortable....away from their familiar environment, being on restrictions like section....no smoking, uh, not being able to watch TV" (Greg).* In addition, some wards may be noisy and chaotic, which may be upsetting for patients. *"The music is blaring and the television screaming and that's you know, for a psychotic patient that's actually quite distressing" (Hugo).* Participants described the ward environment as volatile and changeable; the behaviour of just a couple of patients can alter the atmosphere on the ward. *"If you have a couple of patients who are quite manic, and they are quite loud....you see that taking over....sets off like a chain reaction"(Bree).* Therefore if there is a lot of stimulus and patients feel trapped on the ward with no respite from it, it may agitate them and may contribute to VA.

Subcategory 7.2: Feeling uninvolved in their treatment - Participant accounts indicated that when patients were not provided with adequate information on their medication, it was distressing to them. Participants revealed that patients may not understand why they have to take a particular medication, or they may be unprepared for its side-effects. *"How come this medication you're giving me is making me sleep the whole day and I can't function" (Greg).* When patients do not feel involved in their treatment, and

feel like they have no say in their treatment, they may feel anxious and upset. *“A doctor has just increased their medication and no one’s told them....I think that increases the anxiety and they feel like somebody is making decisions on their behalf” (Anya).*

Subcategory 7.3: Patients are angry about being admitted - Thoughts about patients’ feelings about being on the ward were discussed. Participants suggested that if patients do not believe they are unwell, they do not understand why they have to be on the ward. They may therefore become agitated or angry, and become verbally abusive towards staff. *“Patients with psychosis lack insight so they may not think that they are unwell....so even being in hospital to them is unfair.... you can see why their hostility may be directed towards the staff” (Hugo).* It was suggested that when patients do not agree with being admitted to the ward, they may see staff as the face of the system that put them there, and direct their frustration towards them. Participants reported that even if staff did everything right, it would make no difference if the patient was angry about being on the ward. *“Even the nicest nurse on earth cannot please them....so maybe that person is quite disgruntled or angry, they’re just not happy about being in hospital” (Diya).*

Category 8 - VA as an attempt of negotiation of needs

Subcategory	Participant
Patients do not feel heard	Anya, Bree, Cam, Diya, Ella, Greg
Patients’ attempts to regain control	Anya, Bree, Diya, Ella, Hugo
Patients treated unfairly	Anya, Bree, Diya, Greg, Hugo

Subcategory 8.1: Patients do not feel heard - Participants stated that it was likely patients would become verbally aggressive if they did not feel heard. Patients may struggle to secure the attention of ward staff on occasion. Participants agreed that they were not always able to attend to patients in a timely manner due to short staffing. *“Patients don’t get enough time....sometimes you don’t get to speak to all of them because....you’re running around like a headless chicken, trying to do stuff for twenty patients, you don’t have enough time to see them” (Ella).* When patients feel they are being ignored by the people they are meant to rely on, it may exacerbate their frustration. *“You will understand why the patient was saying that, because he’s frustrated, he wanted staff attention and couldn’t get it, but it wasn’t staffs’ fault, because staff had a lot of patients to attend to” (Cam).* One participant speculated that for a patient to become very aggressive, they must

not feel listened to. *“I think if they feel listened to they might not have to resort to being verbally aggressive to get their voice across” (Anya).*

Subcategory 8.2: Patients’ attempts to regain control - Participants framed VA as an issue of control. They noted that quite often on the ward, the patient who raises their voice is the one who receives staff attention; patients see that people who scream get what they want. *“If I don’t shout and scream nothing’s gonna happen” (Bree).* It is possible that when the patient is verbally aggressive and obtains what they wanted, they may feel a sense of power or control. Participants indicated that VA could be a means of exerting power and control in an environment where they have almost none. *“It’s almost they-they they’re trying to negotiate something but they are also feeling quite helpless” (Hugo).*

Subcategory 8.3: Patients treated unfairly - Participants discussed patients’ sense of fair treatment and its relationship to VA. They proposed that when patients feel their needs are not being met to their satisfaction, they may become verbally aggressive. For the patient, the item they are asking for may be very important to them, but staff may be busy with other tasks and may not prioritise the request. *“I’ve been asking to get my charger for the last seven minutes, everybody’s busy” (Hugo).* So patients may feel they are not being treated fairly. *“When they feel their needs are not being met, they’ve been treated unfairly, whether it’s the way staff spoke to them, staff didn’t give them what they – that’s where VA comes from” (Diya).*

Category 9 - Institutional culture of minimisation of VA

Subcategory	Participant
VA not taken as seriously as physical aggression	Anya, Diya, Ella, Flor, Greg, Hugo
VA becomes normalised	Anya, Bree, Diya, Ella, Flor
VA seen as less damaging than physical aggression	Anya, Bree, Diya, Flor, Greg
The police do not take VA seriously	Anya, Diya, Greg, Hugo
Zero tolerance policy is not enforced	Anya, Bree, Diya, Flor, Greg

Subcategory 9.1: VA is not taken as seriously as physical aggression - It was suggested that participants and staff in general treat physical aggression with more gravitas than VA. They were said to be more likely to brush aside instances of VA even though it

can be quite distressing, but take prompt action against physical aggression. *“It is noted immediately....highlighted and reported. But VA can go completely unchallenged, unnoticed, can be low grade but quite, quite distressing”* (Hugo). Trust Management were said to respond very differently when staff are subjected to VA or physical aggression; the latter prompting demonstrations of concern. *“You’re not going to get top managers....sending you know, their sincere warmth or apology, whereas if somebody gets physically abused, you get managers....coming down to visit them”* (Anya). Most participants observed that VA is not seen widely as a priority by Management. *“In terms of VA? Ummm, I’ve never had to deal with them. They don’t really get involved unless it’s physical”* (Flor).

Subcategory 9.2: VA becomes normalised - Participants admitted that when they were busy, they prioritised other tasks over responding to VA. *“There’s other things that maybe are seen as more important....we’ll deal with that later....but it kind of doesn’t get dealt with”* (Ella). It was observed that ward staff can become accustomed to VA because it happens so regularly; it may end up becoming a normalised part of work. *“I think it happens so very often, as I said before it’s almost become acceptable”* (Anya). VA was said to have become so much a part of the work culture that staff tended to downplay its seriousness. *“You’re facing aggression on such a regular basis....you walk away from it but....you’re not like ‘that was actually serious VA, that was threatening behaviour, that needs to be Datixed’”* (Bree).

Subcategory 9.3: VA seen as less damaging than physical aggression - Participants reported that they saw VA as more impactful than physical aggression because it was more wounding. *“VA actually penetrates a bit more in terms of your emotion, and how you feel as a person”* (Anya). It was observed that when patients deliberately say something that is intended to hurt, it is far more hurtful than physical aggression. *“They kind of know where to hit you. And that for me is ten times worse than being physically hit”* (Flor). However participants observed that in the main, VA was not spoken of as something that affects people. They suggested that perhaps because it is verbal, and the extent of the damage is not obvious, VA was not seen to be damaging as physical aggression in their work culture. *“We’re almost not taking VA as serious anymore because if someone’s not being hit or punched, then it feels like not much damage has been done”* (Bree). There was

a sense that if the impact of the injury is not visible, it does not count. *“I can say I’ve got a wound here, okay, I can show it. But it’s really hard to say I’m emotional” (Diya).*

Subcategory 9.4: The police do not take VA seriously - Participants pointed out that when they had called the police to report VA, the police often did not follow up or take action. *“Even when you call the police, ‘Oh, mental health? They are unwell, it’s normal for them to shout, to say words.’” (Greg).* Participants reported that they are often informed the police can do nothing because the patient is under section in hospital. *“The police often don’t have the – you know ‘oh, the patient is in a hospital’. They might avoid.” (Hugo).* Participants suggested that the police were not as supportive as they could be in response to complaints about patient VA. *“Lack of support from police in terms of taking it more seriously....someone is not making contact with you it’s perceived that there’s no damage being done”(Diya).*

Subcategory 9.5: Zero tolerance policy is not enforced - Participants stated that the Trust has a formal zero tolerance policy to verbal and physical aggression towards staff but that staff understand that enforcing the policy is not always feasible due to the nature of the patient cohort. *“We have a certain level of tolerance on an individual basis....in regards to the patient’s mental state....how they can understand or comprehend things.” (Bree).* Participants pointed out that more often than not zero tolerance policy was not really enforced. *“I’ve been to some wards where the patient is just effing and blinding and just being absolutely disgusting and staff members are just sitting there” (Flor).* Participants observed that at the present time, the zero tolerance policy was just signage displayed on the wall; not enforced in reality. *“It’s just a poster....we as staff are not doing what we are meant to do to stop those behaviours” (Diya).*

6. Discussion

The theoretical model presented in the previous chapter captured participants' perspectives on VA in an acute psychiatric ward. The main themes portrayed therein will be discussed and examined in relation to the existing literature. This will be followed by a consideration of the implications of the findings for clinical practice, suggestions for future research, and an evaluation of the limitations of the study.

6.1 Staff needs relating to VA: lack of adequate support structures

Participants reported being aware of an institutional expectation that they 'should be able to handle VA', but it did not seem like there were suitable support structures in place to facilitate this. Participants suggested that the provision of a formal system of staff support and access to training specific to VA, both of which were currently not available to them, would enable them to feel better equipped to manage VA appropriately.

Participants stated that they felt supported on a local level, within their own team, and by their ward managers. Conversely they revealed that they did not feel supported or valued by senior management. These descriptions reflect findings by Bilgin and Buzlu (2006), who explored the nature of support nurses receive following verbal and physical aggressive incidents. The respondents reported that they received the most emotional support from colleagues in their team (83.3%), whereas only half the respondents (50.6%) perceived nursing management as emotionally supportive. Several studies portray staff consistently identifying the need for increased support from management when caring for abusive patients (Farrell & Shafiei, 2012; Speroni, Fitch, Dawson, Dugan & Atherton, 2014). It seems that staffs' sense of feeling unsupported at work is problematic, given the frequency with which VA occurs (Stewart & Bowers, 2013), the psychological toll it may exert on them (Adams & Whittington, 1995), and suggestions that appropriate support to the traumatised staff member can play a pivotal role in their recovery (Deans, 2004). Therefore organisational responses to staffs' experience of inpatient aggression may have a bearing on staffs' attitude towards VA.

Participants reported being aware of an unspoken message, that they were expected to deal with VA independently without recourse to organisational support. They stated that they did not expect support from the Trust; some participants appeared to be resigned to the situation, while others reported feelings of unhappiness and frustration. It has been reported

that being expected to cope, while not having their emotions and experiences acknowledged, can be a devastating experience for staff and may create and sustain negative emotions towards their work and workplace (Deans, 2004). It would seem that the expectation that staff should be able to cope, characterised by the attitude ‘if you can’t stand the heat get out of the kitchen’ (Paterson, Leadbetter & Miller, 2005, p.811), has in effect reframed patient aggression as a problem of individual staff skill deficits, whilst de-emphasising the responsibility of the organisation (Leadbetter & Paterson, 2004). When staffs’ expectations of fair treatment and supportive organisational responses are let down, the Trust’s failure to adequately fulfil expected obligations may be seen as a breach of a psychological contract (van Emmerik, Euwema & Bakker, 2007). Staff are therefore likely to feel insecure and evaluate their employer in a negative light, decreasing their commitment to the Trust (Parzefall & Salin, 2010).

Participants reported that there was a lack of formal training relevant to managing VA, and that they learned how to assess and intervene with patients’ aggressive behaviours over time, on the job. Similar findings were reported by Kisa (2008); 97% of respondents in his study stated they had not had training on how to deal with VA. While staffs’ practical experience in managing aggressive situations is of value, it may not be adequate to manage conflict or de-escalate VA effectively and therapeutically. All the participants in the current study experienced VA on a regular basis. It is therefore an issue of concern that staff working in acute mental healthcare are reported to be ‘starved of skills training’ (Currid, 2009, p.40). It has been reported that the training offered to psychiatric staff mainly focuses on manual restraint and practical reactions to aggression, including enforced medication (Jansen et al., 2005), which held true for all participants. It seems to be the case that staff training is geared towards managing physical aggression but not VA, which has implications for staff management of VA and the provision of therapeutic patient care. A lack of relevant skills may lead staff to feel anxious and fearful of conflict situations and to develop a sense of incompetence and inadequacy (Pelto-Piri, Engstrom & Engstrom, 2012). Staffs’ attitudes towards their therapeutic relationship with the patient, and how they interpret the patient’s aggressive behaviour, may be influenced by their training experiences. For instance, staff who have confidence in managing patient aggression, enhanced by knowledge of appropriate responses, are more likely to be able to calmly reassure an agitated patient than those who doubt their self-efficacy (Lee, 2001). There appears to be a lack of clarity in terms of precisely what training should entail, especially in

relation to VA (McLaughlin, Bonner, Mboche & Fairlie, 2010). However training that empowers staff to be willing to engage in dialogue with patients, recognise conflict situations (Ren & Ferns, 2005), and practice techniques to regulate emotions (McLaughlin et al., 2010), may help staff learn more collaborative ways of dealing with VA.

6.2 Conceptualisation of VA as a work related risk

The reported lack of organisational responsiveness regarding issues considered important by participants in terms of coping with VA (e.g. staff support), seems to occur within a wider context of downplaying or minimising the consequences of VA at an organisational and judicial level. Participants suggested that VA occurs so frequently that it has become accepted as part of the job. This perception is reported to be a ‘culturally and professionally sanctioned and reinforced norm’ (Alexander & Fraser, 2004, p. 388).

Participants in the present study revealed that when they were interviewed for their job roles, they had been advised that they might experience ‘some form of VA’, which they believed minimised the actual level of VA they were to experience on the job. Bishop, Korczynski and Cohen (2005) proposed that violence is not just minimised but systematically denied by the organization, via management, formal policies, or official procedure. For instance, management might downplay the level of VA based on the number of incident forms filed by staff, or they might portray inpatient aggression as a relatively infrequent occurrence. Interestingly, participants appeared to contribute towards the minimisation of the impact of VA themselves by failing to report incidents of VA. Participants stated that they did not see the point of reporting incidents of VA, which suggests they may have been socialised into an ethos of acceptance of the inevitability of VA. Indeed, the majority of the study participants seemed to consider VA as inevitable because of the nature of the job. The findings from the study suggested that some of the participants seemed to have become habituated to VA, which may be related to their diminished expectations of organisational support. There is the danger that staff may assume a victimised role in response through habituating to workplace violence, which puts them in a poor position to care for the patient (Erickson & Williams–Evans, 2000).

This group of participants perceived VA as more emotionally wounding than physical aggression. This finding is in congruence with previous studies that have demonstrated that VA can have greater psychological consequences than physical

aggression (Adams & Whittington, 1995; Walsh & Clarke, 2003). Participants were of the opinion that VA was not considered to be as damaging as physical aggression in the main, and therefore was not taken as seriously as physical aggression in their professional environment. Accordingly, participants stated they tended to report incidents of physical aggression promptly, whereas they were less likely to report VA, which is a frequently identified trend (Gunenc et al., 2015; Zarola & Leather, 2006). Participants observed very different responses from management depending on whether they had experienced VA or physical aggression. Experiences of physical aggression were met with demonstrations of concern, while experiences of VA were seen not to merit a response. This is a theme that has been demonstrated in numerous studies; management response to incidents of VA is believed to be inadequate, with a tendency to trivialise non-physical sequelae of patient aggression (Needham, 2006; Rippon, 2000). Participants spoke of their difficulty in justifying the need for assistance and support after VA, because there was no visible evidence of injury. They added that they would have no hesitation talking about their physical injuries. This may be an unconscious mirroring of the organisational ethos that frames the psychological consequences of inpatient aggression as ‘petty’, therefore for staff to voice expectation of support after VA may bring their sense of professional competence into question (Needham, 2006, p. 297).

Participants reported that the zero tolerance policy had a negligible impact on levels of VA. Participants saw the zero tolerance policy as little more than a poster on display, and stated that it was not feasible to enforce the policy universally because of the nature of patients’ mental illness. It may be that the policy is too general, and does not reflect the complexity of patient behaviour or recognise the institutional imbalance of power between staff and patients as a source of conflict (Paterson & Duxbury, 2007). As per the zero tolerance policy, patients who threaten, intimidate or assault staff may be subject to legal consequences (Paterson, Bowie, Miller & Leadbetter, 2008). However, prosecution was not always a feasible option for participants. They reported a lack of support from the police in taking legal action against patients. They claimed that police tended not to take their complaint further once informed that it was an inpatient behaving aggressively. It has been documented that the police are reluctant to proceed with charges due to the assumption that psychiatric patients are unwell and have no control over their actions (Kumar, Fischer, Ng, Clarke & Robinson, 2006). However this assumption is heavily rooted in a view of the patients’ internal factors as a determinant of patient aggression, and offers an impoverished

account of the contributory factors to VA (Duxbury, 2002). Participants conveyed a sense of resignation when they described being informed the police could not take action because the patient was under section. Likewise Baby et al. (2014) reported a lack of support from police, which was attributed to the perception that nurses had to expect aggression as part of their job role. One of the participants stated that she would be unable to press charges against her patients, as she felt a responsibility for taking care of them. Staff who choose not to report aggressive incidents to the police may do so because of a fear of undermining the therapeutic alliance they have built with the patient (van Leeuwen & Harte, 2011). However it is doubtful that this attitude is sustainable in the long run, as repeated incidents of VA may almost inevitably play a role in the weakening of the therapeutic relationship (Stone et al., 2010). Reporting the incident to the police has been said to be viewed as a therapeutic intervention, by causing patients to accept responsibility for their actions, and thereby encouraging the patient to learn less aggressive means of communication to obtain their goals (Dinwiddie & Briska, 2004). However the researcher queries the extent to which such an action may serve as a therapeutic intervention. When staff report incidents of patient aggression to the police, typically the police may visit the ward to issue a warning to the patient (Wright, 2002). However the researcher speculates that this action may be perceived by the patient as staff initiated censure from an external figure of authority and power, and may adversely affect the staff-patient therapeutic relationship. Viewed through the CoP lens, the therapeutic relationship is considered the vehicle for change (Laughton-Brown, 2010) and therefore a rupture in the relationship has implications for patient care and treatment outcomes. It is suggested that taking an action that shifts focus from a therapeutic milieu to a punitive, prosecutorial one should not be taken lightly. This is not to suggest that VA should not be reported to the police, but that there should be an emphasis on clear communication of the consequences of VA to the patient, and any actions should be taken within the context of clear, consistent guidelines to obtaining legal recourse coupled with support from the police. If a clear reporting system is not in place, reporting VA will merely be a hollow gesture that may compound staffs' disinclination to report it, and may also have implications for the staff-patient therapeutic relationship.

6.3 Emotional impact on staff

Exposure to VA appeared to evoke significant negative emotional and psychological reactions in participants. They spoke of experiencing feelings of fear, deep hurt, sadness, self-blame and resentment towards verbally abusive patients. These are frequently reported

emotional responses to VA, as described in a number of studies (Kisa, 2008; Needham, 2006). Research suggests that the distress caused by staffs' perception of threat is a common reaction, and may result from the appraisal of what might happen, rather than the objective level of threat (Foster et al., 2007). Participants' emotional reactions to VA were said to be long lasting. Participants in the current study were not speaking of physical violence, but they observed that certain statements made by patients were so wounding that they were not likely to be forgotten for a long time. This description resonates with findings from Kindy et al. (2005), who stated that nurses may experience pervasive emotional burdens as a consequence of working in an assaultive environment. In the same piece of research participants described anxieties about having to return to the stress of work (Kindy et al., 2005), which parallels the experience of participants in the current study. Participants in the current study reported difficulties disengaging from thoughts of work stress even in their personal time, which triggered somatic symptoms of anxiety, such as difficulty sleeping. It has been reported that a sense of feeling supported by management and colleagues is seen as imperative to staff exposed to patient violence (Gillespie, Gates, Miller & Howard, 2010). While equivalent research regarding VA is not currently available, it seems likely that the absence of such support may contribute to staff stress and play a role in ineffective coping with VA.

Participants unanimously concurred that their emotional response to VA was exacerbated by a lack of support from the Trust, and had an effect on their psychological wellbeing through diminished motivation for work, low morale, and feeling burnt out. They were of the opinion that incidents of VA could adversely affect staff morale, especially if staff did not feel equipped to manage the aggression, or if VA were allowed to continue unchecked. These views are in line with a study describing the experience of VA among hospital nurses, which noted that the majority of the participants (over 88%) reported that VA negatively affected their morale and adversely affected their nursing care (Kisa, 2008). The expectation that staff should be able to cope with the demands of the job, as well as the frequency of VA and the lesser likelihood of support compared to physical aggression, may deplete their mental and emotional reserves (McLaughlin et al., 2009).

Findings from the present study suggest that participants had doubts about whether the job was worth it; they reported a decrease in motivation and an increase in sickness levels and burnout due to a lack of organisational support after incidents of VA. None of

the participants overtly mentioned plans to leave the job, but they seemed to feel disillusioned after experiencing VA repeatedly, which could have implications for staff retention. Experiencing high levels of VA has been observed to be the form of conflict most associated with decreased motivation and increased levels of staff burnout (Virkki, 2008). It seems reasonable to suggest that staffs' emotional processes may be coloured by accumulated negative affect and burnout, which in turn may contribute to poor staff-patient interactions, in line with findings from Winstanley and Whittington (2002). Indeed, participants described finding it difficult to engage with aggressive patients in a therapeutic manner after VA because they harboured resentment towards them. The disinclination of staff to form and maintain therapeutic relationships with patients can be seen to not only increase their vulnerability to further aggressive behaviour, but may also have implications for the patient's treatment outcomes. The quality of the therapeutic relationship is said to play an important role in emotional containment of patients, and facilitating therapeutic change (Gilburt et al., 2008), thus VA may have negative psychological impact on patients as well as staff.

6.4 Staff feel obliged to demonstrate professional competence

The findings suggested that participants were calling for support from the Trust authorities, but after being repeatedly disappointed they had reached the stage where they no longer expected support. Participants shared their disappointment that the Trust seemed to prioritise the wellbeing of patients over their own. There were suggestions that management was more intent on assigning blame to staff than supporting them. Similar themes were observed in a study by Bimenyimana, Poggenpoel, Myburgh and van Niekerk (2009); respondents stated that management did not provide moral support, and were more likely to take the side of the patient after incidents of aggression and violence. Levin, Hewitt and Misner (1998) reported that nurses expressed a lack of support from management after they made complaints about VA and learned to tolerate it as part of the job. The researcher queries whether participants in the current study are in a similar situation at work, and tolerate VA as part of the reality of their job role. Participants from the current study positioned themselves as capable of doing a good job in spite of the lack of support. Despite these declarations of self-sufficiency the researcher queries the sustainability of such a stance in light of findings that a value incongruence between the employee and organisation can leave the employee feeling increasingly dissatisfied (Edwards & Cable, 2009). Therefore it is suggested that staffs' ability to deliver an

appropriate quality of care in the context of diminishing expectations of justice and support merits further exploration.

The current study indicates that participants tend not to report incidents of VA despite being exposed to VA almost as a matter of course. One of the reasons described by participants is that there is no point in reporting it due to a perceived lack of support from management and the police. It is probable that this is staffs' way of coping with the perceived lack of support; giving the appearance of being able to carry on despite a lack of support. However Kennedy and Julie (2013) describe this coping strategy as maladaptive, as they suggest that this perpetuates the problem and may increase the likelihood of a reoccurrence of patient aggression. There is evidence suggesting that staff may refrain from reporting violence due to a lack of support from managers of the institution, or because incidents of abuse are not taken seriously by management (Lanza, 2011). Participants in the study also cited a reluctance to complete lengthy incident forms as a factor contributing towards non-reporting. Beale (1999) reported that aside from a perceived lack of support from management, the administrative burden of incident reporting could affect the numbers of incident reports being submitted. Similarly, Schnieden and Marren-Bell (1995) have stated that the reporting process is viewed as too time-consuming, and may affect nurses' willingness to report violent incidents. In addition, incidents of VA are not considered to be as serious as physical aggression, and largely remain under-reported (Foster et al., 2007). Completing an incident report was seen as an almost futile task by participants, due to their belief that there would be no positive outcome from reporting VA. Nursing staff may choose not to report violent or aggressive events because there may be no noticeable follow-up (McKinnon & Cross, 2008), therefore staff may believe no action will be taken in response to their complaint (Jansen, Dassen & Moorer, 1997). However staff failing to report incidents of VA may be problematic because necessary interventions can only be developed on the basis of clearly identified needs (Anderson, FitzGerald & Luck, 2010). If management is not provided with accurate information, then it limits their ability to acknowledge the problem and make an attempt to rectify problems in the workplace (Viitasara & Menckel, 2002).

6.5 Emotional defences

In the context of participants doing a challenging job whilst holding little expectation of organisational support, it could be interpreted that they employed certain

emotional defences in order to moderate the negative impact of VA, namely internalisation, shielding, and depersonalisation. It is possible that these defences served to contain their anxieties as well as make their jobs more manageable.

As discussed previously, participants seemed to hold an expectation of VA at work as inevitable, coupled with an unspoken organisational expectation that they should be able to manage it independently. The researcher wonders whether participants may have gradually *internalised* the unspoken rules about VA as their own professional values. The organisational culture is often derived from the behavioural norms and standards of the organisation – both implicit and explicit – that people receive about what is considered to be acceptable behaviour in the workplace (Victorian Taskforce on Violence in Nursing, 2005). It may be that participants have become socialised to a cultural norm that ostensibly turns a blind eye to VA, characterised by a reported disinclination to report VA and a tendency to seemingly view VA as part of the job.

A potential repercussion of staff internalising the unspoken message that they should be able to cope with VA is that they might become critical of colleagues who may be struggling to cope after an event of VA, which was a theme reported by participants. Participants observed that showing vulnerability was not a desired trait at work, and a demonstration of distress after experiencing VA might make them the object of ridicule. The researcher speculates that in this context participants might find it difficult to express their own feelings after VA. This suppression of valid emotional responses by participants (and possibly by their colleagues) due to fear of criticism could perhaps contribute to the perpetuation of the organisational culture of minimising VA and ‘just dealing with it’.

A further fallout of participants feeling the need to appear to be coping was their inability to access what support was available to them; they reported that they could not justify seeking counsel from a psychologist. It would seem that the participants in the study found it difficult to engage in appropriate self-care, and elected to minimise the event and subsequent emotional impact. Thus staff may internalise messages of what behaviour is acceptable and appropriate, adapt their behaviour and act in ways that reinforce the culture (Howard & Hegarty, 2003); in this instance, by minimising trauma and suppressing their emotions.

VA was seen to evoke a strong affective response in participants. Consequently, it was observed that participants seemed to engage in emotional *shielding* through personal detachment from the emotional sequelae of VA. Participants reported gradually distancing themselves from the emotional impact of VA over time; they framed it as a conscious decision designed to protect themselves. They also described visualising images of strength (e.g. clinical armour), to shield themselves from distress. In other studies in this area, staff have been reported to emotionally detach themselves from the aggressive patient in response to the negative affect it evokes (Stone et al., 2010). When VA occurs at a high frequency, it may cause staffs' initially strong emotional response to gradually diminish in intensity with repeated incidents, as staff become desensitised to it (Deans, 2004). Becoming emotionally detached from aggressive situations may also lead to 'compassion fatigue', which may affect staffs' ability to empathise with the patient's difficulties (Hoffman, 2000, p. 198). Xanthopoulou et al. (2007) conceptualise emotional disengagement as a form of cynicism, which may lead to indifference towards the patient. It is unfortunate that emotional detachment was viewed as a protective mechanism by participants, because it is possible that it may contribute towards further VA. By psychologically distancing themselves from the distress evoked by VA, participants may widen the therapeutic gap between themselves and the patient. Participants described withdrawing emotionally from patients after VA, and restricting their role to the fulfilment of no more than their basic responsibilities towards the patient. This may result in the patient receiving therapeutically superficial care. It is likely that patients may sense when staff engagement is not authentic, which could potentially provoke an aggressive response from the patient.

The majority of participants seemed to attribute patients' VA to their mental illness; they described VA as inevitable due to symptoms of the patient's mental illness, independent of situational or interactional influences. Staff may prefer to believe that inpatient aggression was triggered by mental illness rather than an intentional act, which may be seen as a form of cognitive avoidance (Brewin & Andrews, 2000). By choosing to exclude disagreeable thoughts about the intentionality of VA, it is possible that staff may be less affected by the aggressive experience. It has been suggested by Adams and Whittington (1995) that staff may *depersonalise* the aggressive incident as a coping strategy. That is, staff who had experienced VA would not see it as a personal attack, but as a manifestation of the patient's mental health issues. Two participants in the current study were seen to be

less tolerant of VA from patients diagnosed with PD. These patients were seen as having insight into their behaviour, so VA was seen as ‘bad’ behaviour. It has been observed that staff may be troubled by encounters with patient groups who trigger moral judgements, including those diagnosed with PD (Hill, 2010). Research has consistently shown that psychiatric staff tend to hold stigmatising or disparaging attitudes towards patients diagnosed with PD; for instance they have been described as manipulative (Deans & Meocevic, 2006), difficult (Lakasing, 2006), less deserving of treatment (Haigh, 2006), abusive (Wright, Haigh & McKeown), attention seeking and challenging to work with (Aviram, Brodsky & Stanley, 2006). It would seem that these negative attitudes may cause staff to make value judgements and influence their emotional and behavioural response towards patients with PD. In addition, it has been proposed that staff consider challenging behaviour from patients with PD as separate to mental illness, and therefore view the patient as being in control of their negative behaviour (Aviram et al., 2006, Markham, 2003, Markham & Trower, 2003). It is suggested that participants may therefore perceive acts of VA from patients with PD as intentional, and consequently they may be less tolerant of VA from these patients than they might be of others with different diagnostic labels.

Staff’s attitudes towards aggression may influence the way they respond to it (Jansen et al., 2005). Depersonalising acts of aggression and rationalising VA as illness driven (or indeed intentional, based on a diagnosis of PD) may be problematic because staff may not be sensitive to patients’ signs of distress, and react defensively to aggressive behaviour by using containment methods such as restraint (Duxbury, 2002). In addition, staff may fail to consider their own role in the genesis of VA, which may leave them vulnerable to repeating the pattern and perpetuating a vicious cycle of VA.

6.6 Engagement with patients after VA

The findings suggested that the interaction of staffs’ emotional state, and the emotional defences they may employ may cause them to struggle to engage with aggressive patients in a therapeutic manner. Participants described avoidant and custodial styles of engagement in themselves and their colleagues, after experiencing VA.

The findings of the study highlighted participants’ attempts to identify self-protective strategies, such as avoiding verbally abusive patients. This took the form of appearing to be occupied with tasks in the nurses’ office, or physically keeping away from

particular patients. Patient avoidance appears to be a relatively common coping strategy followed by staff in a bid to alleviate their anxiety. Whittington and Wykes (1994) described escape and avoidant strategies by staff, such as avoiding parts of the ward to which patients have ready access by staying in the nurses' office, thus creating an atmosphere of social distance. Kennedy and Julie (2013) reported similar findings; nurses in their study stated that their attitude towards the patient was affected, and they chose to have minimal contact with the patient who perpetrated the aggressive incident by avoiding or ignoring them. This distancing may mean that staff struggle to respond to patients therapeutically, and may create the very conditions that made the patient behave aggressively in the first place. It has been consistently documented that patients find distancing behaviour aversive (Needham et al., 2005), and thus may increase the risk of hostile interactions.

Participants in the study described a tendency of staff to interact with patients in a manner that was more custodial than caring after experiencing VA. Participants described attempts to exert their authority over patients, such as expecting immediate compliance with instructions. Duxbury (2002) reported that staffs' focus on limit setting and applying rules is seen by patients as controlling and restrictive. It seems that a negative pattern emerges when staff adopt aspects of 'parentalistic' care (Cavadino, 1999, p.527); limit setting, followed by a directive, followed by the threat of consequences. It may be likely that the patient will not be inclined to comply, and a power struggle may ensue, which may exclude the possibility of establishing a therapeutic relationship. Indeed there could be the danger that by acting punitively in an attempt to control the situation, staff may unintentionally model the very style of behaviour they deem disruptive and aggressive in their patients.

Some participants identified certain attitudes in themselves and their colleagues that could contribute towards patient VA. They described instances when staff acted disrespectfully or patronisingly towards patients, which they saw as a trigger for VA. Lewis (2002) observed that a lack of respectful communication from staff could cause patients to respond aggressively. Studies exploring patients' experiences of acute psychiatric care revealed that patients are sensitive to disrespect from staff (Kumar et al., 2001). Patients have an identity outside the hospital, and want to be treated with dignity and respect, and it is possible that staff may not always be mindful of this. Duxbury and Whittington (2005)

illustrated this theme with a quote from a patient, ‘There is no respect. Just because we are patients they think they can tell us to shut up’ (p.474). In the context of inpatient aggression, nurses may face a dilemma about whose needs come first – the patients’ or their own (Baby et al., 2014). Zuzelo et al. (2012) noted that nurses saw respectful interaction with patients as important, but were also concerned about self-protection. The researcher queries whether participants prioritise their personal safety through the adoption of a custodial pathway of care if they feel less equipped to safely manage VA, however this needs to be explored further in future research.

6.7 Patient frustration and powerlessness

The current study indicated that patients admitted to the ward (especially on an involuntary basis) may feel powerless in the face of the various restrictions they may experience on the ward, and consequently may become verbally aggressive towards staff in order to negotiate their needs.

Participants stated that patients who do not think they are unwell may be angry about being on the ward. They expressed some understanding as to why these patients might direct their frustration and hostility towards staff. When patients are admitted involuntarily under mental health legislation, they may be likely to act in an aggressive manner due to a perceived threat to their liberty or personal safety (Daffern, Day & Cookson, 2012). In addition, if patients do not believe they are unwell, they may not understand why they require medication and accordingly resist treatment and see it as an act of provocation (Briner & Manser, 2013). It has been suggested that when staff are confronted with aggressive behaviour, they typically respond to it in a manner aimed at retaining control, but patients may feel like they are being coerced and may feel disempowered (Daffern, Martin & Thomas, 2010). This emphasis on control by staff may increase the risk of aggressive behaviour from patients. Participants speculated that patients may become verbally aggressive in an attempt to regain power and control (e.g. attention of staff, negotiation of demands). Powerlessness is a prominent theme in studies exploring patient perspectives on aggression (Johnson et al; 1997; Meehan et al; 2006). In this context patient VA may be considered as the patient’s attempt to secure a moment of empowerment, where the act is rooted in feelings of powerlessness (Johnson et al., 1997).

The study participants suggested that patients might become verbally aggressive because they may feel they are not being treated fairly by staff. They cited the example of patients kept waiting by staff for a requested item despite repeated prompting. Having to wait on staffs' convenience might seem humiliating for patients; they may feel powerless and ignored. Staff have been portrayed as ignoring frequent requests for assistance, which was perceived as demeaning and a source of friction among patients (Meehan et al., 2006). Coming from a position of relative powerlessness it is likely that patients may be sensitive to a power differential between themselves and staff. Staff may manifest their power by providing a rigid, procedural response to patients instead of dealing with the patient's frustrations. This may reinforce the power imbalance, paving the way for the power struggle that could escalate to control and restraint, diminishing the quality of the therapeutic environment (Secker et al., 2004).

Participants in the study spoke of how patients might consider the ward atmosphere to be volatile and unsettling, and expressed an understanding of how patients might feel trapped when confined to a locked ward. This observation echoes themes reported by Adams (2000); six patients in his focus group likened their locked acute ward to a prison-like environment. Participants observed that patients might find it frustrating to have no real activity to do other than walk around the ward. This perception has been confirmed in several studies (Ashmore, 2008; Barker & Buchanan-Barker, 2007). Participants highlighted that being subjected to various restrictions on the ward could precipitate aggressive behaviour in patients. It has been suggested that patients are subject to restrictions beyond being confined to a locked ward, such as restrictions on personal possessions, and not being allowed to smoke (Lamanna et al., 2016). Thus the ward may be perceived as a provoking and aversive place to be, with an atmosphere that may feel more custodial than therapeutic.

Participants recognised that their patients might not feel completely involved in their own health and care. They went on to speak of patients not being given information about side-effects of medication, which risked their becoming alarmed and angry. Given the nature of patients' mental illness staff might not be able to offer them as much choice about their medication as they might prefer, however it has been advised that patients should be kept informed about the benefits and side-effects of their medication in language they can understand (Bhugra, 2016). In a survey by the Care Quality Commission (CQC, 2009), over

50% patients reported that they were not given understandable information about potential side-effects of prescribed medication. Insufficient communication about medication has been cited as a cause of aggressive behaviour (Lamanna et al., 2016). It is possible that patients may experience this behaviour as disempowering and disrespectful, and may refuse medication; depending on staffs' response, the situation may escalate to aggressive behaviour (Ilkiw-Lavelle & Grenyer, 2003). It must also be considered that when patients are hospitalised against their will, they are more likely to resist engaging with staff, inescapably leading to friction over care and control (Sullivan, 1998).

Related to the theme of disempowering and disrespectful communication (previous paragraph) are instances of patients being talked down to, or treated in a patronising manner by staff. Participants disclosed that there were times when they did not treat patients as respectfully as they could have. Talking down to patients has been described as a 'non-supportive element' in the therapeutic relationship (Gentile & Jackson, 2008, p. 54). While limit setting, request denials and activity demands are a standard part of working with patients on an acute ward, it is the way that these are communicated that may be perceived as aversive by patients (Fagan-Pryor et al., 2003). The researcher queries the extent to which the wider organisational culture may influence staffs' communication with patients. Kindy et al. (2005) point out that the organisational dynamics mean that it is very often staff who are criticised by management after an aggressive incident. Management are also said to side with the patient in the case of any incidents (Bimenyimana et al., 2009). While ward staff are said to function as a secure base for patients (Holmes, 2001), the researcher speculates that staff in turn may be looking to management to fulfil that role for them by way of providing a responsive and supportive space. The findings of the current study suggest that participants feel the absence of appropriate support keenly. It is suggested that staff may feel diminished and alone after experiencing VA (coupled with no expectation of support), and may unconsciously reenact the dynamics of a lack of empathy and compassion they perceive from the Trust in their own interactions with patients (e.g. "Because I'm a nurse and I said so"). Therefore it may be of value to explore the systemic issues that may have a bearing on aspects of staffs' professional practice that undermine therapeutic relationships with their patients.

6.8 Clinical Implications

The study has yielded insights into psychiatric staffs' experiences of VA. The themes that emerged from the interview data may have implications for clinical practice and training, as well as for the wider organisational context within which staff and patients interact, which are examined further. The researcher also explores potential avenues where counselling psychologists might contribute to clinical practice.

Participants reported a lack of organisational support, however the study raised questions about the extent to which staff are using the support systems that were available. Participants may have internalised the unspoken message that they should be able to handle VA, and they were therefore reluctant to reveal their vulnerabilities at work by requesting formal support. This can result in staff becoming task driven and distant in their interactions with patients (Stevenson et al., 2015). Crawford, Brown, Kvangarsnes and Gilbert (2014) have proposed that the responsibility for provision of compassionate patient care should not be solely dependent on staff; it should occur in the context of an organisational culture of care. The current research suggests that in the aftermath of an aggressive incident (physical or verbal) ward staff ought to have recourse to accessible avenues of support in order to minimise the emotional and psychological effects of the incident. Not every staff member who has experienced VA might want to receive support, but for those that do, the option should be available. The researcher suggests that there needs to be a shift in the traditional thinking around staff's ability to cope, as currently it appears that staffs' professional competency is called into question should they feel the need to access support after VA. Counselling and applied psychologists may play a valuable role in this environment through emphasising the value of self-reflection (Sinitsky, 2010). Psychologists have the potential to facilitate reflective practice groups, which may offer staff the space for self-reflection and authentic self-expression, and in turn empower them to question the organisational expectation that staff will 'deal with it' (VA).

The study revealed that staffs' emotional needs remained largely unacknowledged, with VA considered a normalised aspect of the job. The wounds caused by VA are not readily apparent because they do not visibly manifest themselves, but they can cause severe distress (Kisa, 2008). In order to protect themselves staff may engage psychological defences which may make them vulnerable to further VA and consequently, to burnout. It is an issue of concern that staff who experience high levels of emotional exhaustion receive

minimal emotional containment in their work (Bowers, Nijman, Simpson & Jones, 2011). This raises implications for the staff-patient relationships, and therapeutic practice. Enabling staff to manage their emotional responses to their clinical work is of great value (BPS, 2001). Dykes, Hilton and Ross (2017) observe that psychologists are ‘uniquely placed to be able to straddle the position of team member and external observer’ (p. 12). Staff may benefit from timely supervision with a psychologist to enable them to reflect on the relational dynamics with their patients. Having the space to express their feelings without fear of judgement staff may become more able to process the experience in a genuine manner. By providing staff with opportunities to feel emotionally held, and reflect on the implications for their practice, psychologists may help with ‘containing the containers’ and enhance staff’s ability to regulate their emotional response towards patients (Rifkind, 1995, p. 209).

Participants almost unanimously confirmed a lack of training opportunities beyond physical restraint training. A lack of knowledge on how to engage with verbally abusive patients may influence the way staff interact with them, therefore there are implications for staff training at the service. While it is unclear what training in relation to VA should consist of (O’Laughlin et al., 2010), as a starting point it would be useful for staff to have training on how to work with patients in more collaborative ways, including communication skills and verbal de-escalation. It may be helpful for staff to have training in CBT techniques to moderate their negative cognitions to challenging behaviour and increase feelings of perceived self-efficacy (Cully & Teten, 2008). Counselling psychologists may play a valuable role through ‘developing focus in the work of helpers on facilitating well-being as opposed to responding to sickness and pathology’ (Strawbridge & Woolfe, 2003, p8.). They may provide training to help staff formulate the patients’ difficulties with a focus on their subjective experience, rather than a narrower focus on diagnostic categories (Elliott & Williams, 2003), which may encourage staff to adopt a psychotherapeutic approach to patient care. It is suggested that staff training as a stand-alone intervention may not have a lasting impact on staffs’ attitudes. It is proposed that the underlying reasons for VA need to be addressed at an organisational level. That is, there needs to be a shift from framing VA as an issue of a staff skill deficit to recognising the role of the culture of the organisation in the genesis of VA (Paterson et al., 2008).

6.9 Suggestions for future research

There is a paucity of quantitative research exploring staffs' experiences of VA on psychiatric wards, and the number of qualitative studies in this area are fewer still. The findings of the current qualitative study add to this literature by casting light on staff experience of VA on a psychiatric ward. While staff at other psychiatric units may experience similar relational dynamics regarding VA, the qualitative nature of the study does not lend itself to generalisation of the findings. Therefore it would be useful to carry out the study on a larger scale across a few other psychiatric units with a view to learning if the themes identified in this study are reflected in participants' responses at those units. This may help build a case for ways in which staff may be supported by the organisation, and enable them in turn to support their patients. It is suggested that future research should consider replicating the study on a larger scale by obtaining data from unstructured interviews as well as observational data, to consider multiple perspectives and to capture staff-patient interactions in real life situations that may not be necessarily be divulged during interviews for fear of judgement or anxieties about confidentiality.

When participants were asked if they could share their personal definition of VA, most of them described it in a relatively general sense. For instance they did not overtly describe specific manifestations or nuances of verbally aggressive behaviour (e.g. swearing, racist abuse) and reported a tendency to overlook the 'usual' VA. The varying terminology on aggressive behaviour can mean definitions of VA may be open to interpretation, and may have implications for the underreporting of VA. Given participants' overall reluctance to report VA, their perception of certain forms of VA as minor may make them even less inclined to report those incidents. Consequently it would be of value to develop an understanding of what exactly the participants mean by VA, and whether they perceive certain forms of VA to be more distressing than others. The development of a comprehensive and consistent definition of VA to facilitate such an understanding may be an appropriate objective for future research.

The research findings indicate that the organisational culture may influence how staff respond to VA. The influence of the organisational culture on staffs' emotional vulnerability to VA therefore requires further investigation. Further research might explore staff and management views on the unspoken institutional rules regarding VA. Focus groups may be used to explore the topic, as they encourage dynamic interaction between

participants (Barbour, 2007) and have the potential to examine topics perceived to be sensitive (Oliveira, 2011). The theoretical model constructed in the current study could be used as a tool to encourage reflection and dialogue about the various facets of organisational support, including availability and accessibility.

The findings of this study suggest the need for examination of the function VA serves for patients. Typically research findings suggest an overemphasis on the patient's mental illness as a contributor to patient aggression (Duxbury & Whittington, 2005). Indeed, participants in the current study subscribed to this view to a large extent. Staff may be uninformed on how patients experience the world (Gudde, Olso, Whittington & Vatne, 2015), which could explain why staff and patient perspectives on the causes of patient aggression can be very different. In order to have a balanced and informed understanding of VA on the ward, patient experiences must be considered also. The inclusion of both staff and patient perspectives rather than just a single viewpoint of the phenomenon would complement this research, and provide more insights into the interactions between staff and patients.

The current research indicates that staffs' response to VA is influenced by the wider context within which they are situated, which implies that staffs' responses to VA cannot be examined in isolation from organisational influences on the work culture. It is argued that workplace environments that do not acknowledge VA place the onus of dealing with it on staff (Jackson, Clare & Mannix, 2002). When staff believe that VA is part of the job, they may learn to cope with it by minimising the impact of VA in order to be able to fulfil their professional responsibilities. Given that participants reported a shift in their attitudes over time (e.g. gradual increase in emotional detachment towards VA), it may be of value to examine changes to staffs' coping strategies. This could be effected by employing a longitudinal study to examine staffs' coping strategies at different periods of time in their professional careers. Doing so may provide valuable information on how staffs' attitudes towards VA may change and why, thus gaining some insight into factors that may perpetrate and maintain the culture of VA as a normal part of the job.

6.10 Limitations of the present study

The present study has certain limitations, which will be discussed. The study used a relatively small sample of eight participants who were recruited from two wards within a psychiatric unit. Therefore the researcher offers tentative judgements regarding the findings. While the categories were grounded in the data, theoretical saturation was an unrealistic expectation, given the sample size. Therefore the researcher aimed for ‘theoretical sufficiency’, where the categories are suggested by data, rather than saturated by data (Dey, 1999, p. 257). This perspective sits well with the researcher as it acknowledges the view that ‘we can never know everything and that there is never one complete truth’ (Marshall & Rossman, 2011, p. 220).

All the participants in the study volunteered to take part. The self-selection process could have potentially produced a volunteer bias, where those who feel strongly about the topic of discussion may be more likely to respond (Althubaiti, 2016). If there were staff whose views could have provided different insights into staffs’ experience of VA, the omission of such participants would constitute a limitation. The researcher had been a member of staff at the research site for over two years, which the participants were aware of. The researcher however had no prior personal or professional relationship with the participants. While it is likely that our shared experience of VA may have helped put participants at ease and facilitated rapport, it also may have introduced the possibility of social desirability bias. That is, a tendency to portray a socially acceptable image of themselves on topics they may deem sensitive (van de Mortel, 2008). Participants were assured that their responses would be kept anonymous and confidential, but the knowledge of the researcher’s personal relationships with some of their peers may have influenced their decision to provide seemingly preferred responses. The researcher did not observe evidence of this during data analysis, however the possibility remains.

Most studies exploring staffs’ responses to inpatient aggression tend to focus on nurses’ views, as it is believed they have the most contact with aggressive patients (Alexander & Bowers, 2004). However given the pervasive nature of VA and the high levels of emotional distress it is reported to evoke in staff, it seemed likely all staff who interact with patients regularly would have personal experience of the phenomenon and consider it relevant to their professional lives. The researcher made the decision not to impose restrictions based on occupational background, with the expectation that different

perspectives would contribute towards the generation of ‘rich data’ (Ogden & Cornwell, 2010, p. 1060). Participant narratives revealed similar themes, which speaks to the universality of the experience. Participants were given the option of receiving a copy of their interview transcript for validation, but they declined the offer. The researcher sought to validate the accuracy of the transcripts by listening to the digital files whilst simultaneously proofreading the transcript. It would have been useful to follow up with the participants and present them with a description of the theoretical model that emerged from the interview data, in order to confirm that the theory remained ‘embedded in the narrative’ of participants (Charmaz, 2006, p. 173). The researcher was unable to do this because of time constraints, however other credibility checks were performed including an independent audit of the data analysis by the researcher’s academic supervisor, and peer debriefing. The latter involved peer debriefing sessions with two fellow trainee counselling psychologists over the course of the research process. It was an opportunity to discuss reflections and queries pertaining to data analysis and research findings, in an attempt to minimise researcher bias and enhance the credibility of the study (Creswell, 2014).

The study was restricted to an exploration of the perspectives of staff, which may have limited the scope of the work. The researcher considered whether to broaden the study by including the perspectives of patients, but decided against it as it was beyond the remit of the current research. Based on the literature in the field, there is a strong sense that patients consider environmental, interactional factors as responsible for triggering conflict incidents whereas staff tend to attribute aggressive behaviour to patient-centred factors, i.e. psychiatric illness (Meehan et al., 2006). As practitioners, counselling psychologists have an obligation to consider ‘all contexts that might affect a client’s experience’ (BPS, Division of Counselling Psychology, 2005, p.7). Patients are as intrinsic a part of the ward environment as staff, therefore the inclusion of patients’ views may have facilitated a more balanced narrative on how VA is experienced on the ward. One of the categories in the theoretical model – patients disavowing treatment – comprises staffs’ inferences about reasons for patient VA, which is highly speculative as it is not substantiated with patients’ perspectives on the influence of organisational and interactional processes on conflict and the manifestation of VA. In addition, conclusions about institutionalised imbalances of power between staff and patients could be deduced more realistically if the research had included the views of patients. This limitation does, however, present a promising opportunity for future research.

7. Reflexive statement – part two

Following on from the initial reflexive statement, this section will examine how my experience and positioning may have influenced my interviews with participants, as well as the analysis. That is, a consideration of “How does who I am, who I have been, who I think I am, and how I feel, affect data collection and analysis?” (Pillow, 2003, p.176).

Qualitative researchers recognise the inevitability of the researcher’s influence on the research process and interpretation of their participants’ experiences (Yardley, 2008). I acknowledge the fact that my prior experience of verbal aggression might have influenced the interviews, in terms of construction of the interview schedule and consequently the participants’ responses. When coding the transcribed interview data, there were occasions when I struggled to separate my personal experiences of verbal aggression from the coding process. This is an issue that was explored on more than one occasion in supervision, as I was anxious about ‘grinding my axe’, as my research supervisor phrased it. Voicing these anxieties in supervision made it easier to gain perspective. I utilised memo writing to enhance transparency about my thought process by documenting my ideas and clarifying the reasoning behind my observations. It was the start of the process of learning to tolerate the ‘not knowing’, and becoming more cognizant of my grounded theory researcher identity.

I had a hiatus in my studies from January 2015 to June 2016 because of a personal bereavement; I had developed complications in my pregnancy and lost one of my twin sons. As the time to resume my doctoral studies drew close, I became acutely anxious because I did not think I would be able to continue my research. There were times when I wondered whether I would be able to finish my thesis at all. Having reflected on this with my personal therapist I was able to acknowledge that there was no small amount of displaced anxiety about the care of my baby son and being a good mother. Having acknowledged my anxieties I was more able to contain them and prevent them from leaching into my research space. With my therapist’s support and encouragement from my husband, I was able to slowly refamiliarise myself with my research. I attended a GT workshop to reacquaint myself with the fundamentals, and immersed myself in the transcripts and recordings from the initial three interviews I had conducted.

I observed a tension between my dual role of trainee counselling psychologist and researcher while conducting interviews. For instance, there were occasions when participants revealed something they found particularly hurtful. My instinct was to respond empathically, but I had reservations about being placed in a therapeutic role by participants. As an inexperienced interviewer, I had to resist the natural inclinations of my trainee counselling psychologist identity. While research interviews are not intended to be therapeutic, it has been suggested that research interviews can mirror therapy sessions, in that both provide a space for people to divulge personal information to someone who is invested in the experience (Dickson-Swift et al., 2006). I was mindful that my position was that of a researcher, and not a therapist, and managed the professional boundary between us while maintaining rapport and demonstrating sensitivity.

As noted previously, I have maintained a reflexive diary since the conception of my research. It has proven to be an invaluable tool as it gave me the opportunity to engage in self-reflection and be mindful of my expectations and hopes for the research. While it was of value during the initial stages of the research (constructing the interview schedule), it proved particularly useful during data collection and analysis. I will discuss some of the reflections selected from the diary to provide brief snapshots of my relationship with the research. I carried the diary with me to interviews, and noted questions, hunches, or anything that I wanted to examine further, such as themes to explore in following interviews. I made it a point to sit in solitude immediately after each interview to record my impressions of the session. My initial lack of confidence as a researcher was evident as I relied quite heavily on my interview schedule for the first interview and fourth interview (when I resumed data collection after my intermission). As I grew in confidence I engaged with participants more flexibly and did not feel compelled to rigidly follow the schedule. As the interviews progressed I began to notice a repetition of certain themes (e.g. distancing from the patient); I realised that I had been listening out for these themes during subsequent interviews and mentally evaluating how they fit together. By doing so I risked imposing my own narrative over participants' responses, therefore I worked on bracketing my preconceptions (Creswell, 2007) and was more mindful of remaining in the moment with the participant.

During the data analysis stage I became overwhelmed by the sheer volume of data, especially as I did not use a computer for analysis. I became aware of a need to have a neat

and tidy theory about verbal aggression, and observed that by trying to impose control over the analysis I was creating categories that were too broad. I struggled to capture nuances in the data and create a theoretical model that represented the complex relationships in the data. My first attempt at a theoretical model was quite literally four squares connected with arrows. I realised that I craved structure and order because it was difficult to tolerate the uncertainty of grounded theory. By interrogating my process in my reflexive diary I came to the undeniable conclusion that there were no quick fixes, and that uncertainty is part of the research process. I also became aware that I was putting pressure on myself to create a perfect piece of work in order to represent the participants' experiences to the best of my ability. Diarising my dilemmas and engaging in honest reflection about my thinking was extremely useful, as was scrupulous memoing and diagramming of my ideas. It happened indiscernibly but finally, after innumerable iterations of data analysis I had my 'aha' moment.

While writing the Findings and Discussion chapters I found myself being drawn into a more positivist set of assumptions that were in conflict with my given epistemological position. That is, I noticed that on occasion I would state the findings of the study as facts, rather than present them as tentative observations. My belief in my paradigmatic inclinations as being constructionist had not altered, therefore this conflict puzzled and frustrated me. I was aware of experiencing considerable stress about the deadline to submit my thesis, and I wonder if in my anxiety I unconsciously reverted to 'positivist orthodoxy', made familiar by my years of quantitative research experience (Steinmetz, 2005, p.280). Consulting with my research supervisor and my peers enabled me to recognise and acknowledge my actions. Ironically some weeks previously I had somewhat complacently noted in my diary that I was becoming more confident in my ability to tolerate the not knowing. It was an exercise in humility for me appreciate that there are things we simply cannot truly know, which helped me make peace with my epistemological frustration to an extent.

The experience of researching and writing this thesis has been one of the most challenging things I have done in my life, and consequently one of the most meaningful. It has been a daunting, exhausting, yet strangely enjoyable process. The research has enriched my understanding of peoples' experiences, especially the ones that may not be overtly acknowledged. Acknowledging my role and position in the research has certainly increased

the rigor and quality of my research, while the process of continued reflexivity has also enhanced my own self-knowledge and awareness.

8. Conclusions

The themes reported in the current study revealed that VA was a frequent occurrence for participants. Although they reported a tendency to consider it as an expected part of the job, experiencing VA was a hurtful and stressful experience for them nevertheless. Participants' attitudes towards VA were coloured by their perceptions of how supported they felt by the Trust. It is possible that staff were experiencing unresolved conflict between their emotional needs and their need to present themselves as competent. This was reflected in their maladaptive coping mechanisms and disinclination to report VA. Participants were able to acknowledge the impact of their and their colleagues' interactional styles on the incidence of VA.

The findings of the study highlighted participants' sense of a lack of organisational acknowledgement or empathy regarding their experience of VA, which may have influenced the way they interacted with patients. Participants reported that they perceived a lack of empathy and understanding from Trust management, which they found distressing. When speaking of their perceptions of determinants of patient VA, participants suggested that patients may feel that staff may fail to consider certain issues from the patient's perspective, which patients may find distressing. Therefore it would seem like the dynamics of a lack of empathy or understanding from the Trust towards staff may be replicated on the ward by staff in their interactions with patients. If staff fail to interact therapeutically with patients, they may create a situation where the patient does not feel listened to or respected, thereby perpetuating the cycle of VA.

It is suggested that perceived and actual organisational attitudes towards VA may shape staffs' own reactions towards it. The findings indicated that staff might adopt the strategy of normalising VA as a coping tactic in the context of a perceived lack of staff support in the Trust; that is, avoiding thoughts of the incident and getting on with their job despite experiencing distressing emotions. While a tendency to normalise patient aggression as a strategy to defend against the negative effects of aggression may be successful for some staff in the short term, holding this attitude may undermine patients' social recovery, as well as raise the limit for tolerating violence by normalising patient aggression and in effect absolve the wider organisation from its duty to recognise and address the issue of VA.

As counselling psychologists aim to work with people in a holistic way there is a role for them to consider the broader underlying influences on staffs' capacity to deliver therapeutic care to patients, and develop suitable interventions to enhance the psychological wellbeing of staff and patients alike. It is suggested that staff need to be supported in aspects of their role that may affect their own mental wellbeing if they are to successfully support the mental health of patients. While there is a need to deal with the issue of VA at the ward level, action is required at a broader, organizational level in order to alter the narratives that position VA as part of the job, and to provide more institutionally 'joined-up' support and acknowledgement to ensure that such everyday work challenges are properly accounted for at all levels of an organisation. While this is an extremely complex task, it is hoped that this research may help to make a contribution towards that aim.

9. References

- Abderhalden, C., Needham, I., Dassen, T., Halfens, R., Haug, H.J., & Fischer, J.E. (2008). Structured risk assessment and violence in acute psychiatric wards: Randomized controlled trial. *The British Journal of Psychiatry*, 193(1), 44-50.
- Adams, B. (2000). Locked doors or sentinel nurses? *Psychiatric Bulletin*, 24, 327-328.
- Adams, J., & Whittington, R. (1995). Verbal aggression to psychiatric staff: traumatic stressor or part of the job? *Psychiatric Care*, 2, 171-174.
- Alexander, J., & Bowers, L. (2004). Acute psychiatric ward rules: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 11, 623-631.
- Alexander, C., & Fraser, J. (2004). Occupational violence in an Australian healthcare setting: implications for managers. *Journal of Healthcare Management*, 49(6), 377-92.
- Althubaiti, A. (2016). Information bias in health research: definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare*, 9, 211-217.
- Anderson, L., FitzGerald, M., & Luck, L. (2010). An integrative literature review of interventions to reduce violence against emergency department nurses. *Journal of Clinical Nursing*, 19(18), 2520-2530.
- Arthur, G. L., Brende, J. O., & Quiroz, S. E. (2003). Violence: Incidence and frequency of physical and psychological assaults affecting mental health providers in Georgia. *Journal of General Psychology*, 130(1), 753-757.
- Ashmore, R. (2008). Nurses' accounts of locked ward doors: ghost of the asylum or acute care in the 21st century? *Journal of Psychiatric and Mental Health Nursing*, 15, 175-185.
- Aviram, R.B., Brodsky, B.S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry*, 14, 249-256.
- Baby, M., Glue, P., & Carlyle, D. (2014). Violence is not part of our job': a thematic analysis of psychiatric mental health nurses' experiences of patient assaults from a New Zealand perspective. *Issues in Mental Health Nursing*, 35(9), 647-55.
- Barbour, R. S. (2007). *Doing Focus Groups*. London: Sage Publications.
- Barker, P., & Buchanan-Barker, P. (2007). *The Tidal Model: Mental health, recovery and reclamation*. Newport on Tay: Clan Unity International.
- Barnett, J. E. (2014). Clinical competence: Essential obligation and ongoing activity. *The Specialist*, 33(2), 32-34.
- Beale, D. (1999). Monitoring violent incidents. In P. Leather, C. Brady, C. Lawrence, D. Beale & T. Cox (Eds.), *Work-related violence: assessment and intervention* (pp.69-86). London: Routledge.

- Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15, 219–234.
- Berger, P., & Luckmann, T. (1991). *The Social Construction of Reality*. London: Penguin Books.
- Bhugra, D. (2016). Mental health for nations, *International Review of Psychiatry*, 28(4), 342–374.
- Bilgin, H., & Buzlu, S. (2006). A study of psychiatric nurses' beliefs and attitudes about work safety and assaults in Turkey. *Issues in Mental Health Nursing*, 27(1), 75–90.
- Bimenyimana, E., Poggenpoel, M., Myburgh, C., & Van Niekerk, V. (2009). The lived experience by psychiatric nurses of aggression and violence from patients in a Gauteng psychiatric institution. *Curationis*, 32(3), 4–13.
- Bishop, V., Korczynski, M., & Cohen, L. (2005). The invisibility of violence: constructing violence out of the job centre workplace in the UK. *Work, Employment and Society*, 19(3), 583–602.
- Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499–508.
- Bowers, L., Nijman, H., Simpson, A., & Jones, J. (2011). The relationship between leadership, teamworking, structure, burnout and attitude to patients on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology*, 46, 143–148.
- Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H., & Jeffrey, D. (2011). Inpatient Violence and Aggression: A Literature Review. *Report from the Conflict and Containment Reduction Research Programme*. Institute of Psychiatry, King's College London.
- Bowers, L., Simpson, A., Eyres, E., Nijman, H., Hall, C., Grange, A., & Phillips, L. (2006). Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins Acute Ward Study. *International Journal of Mental Health Nursing*, 15(4), 226–234.
- Braun V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Brewin, C. R., Andrews, B. (2000). Psychological defence mechanisms: The example of repression. *The Psychologist*, 13, 615–617.
- Briner, M., & Manser, T. (2013). Clinical risk management in mental health: a qualitative study of main risks and related organizational management practices, *BMC Health Services Research*, 13(1), 1–11.
- British Psychological Society. (2001). *Working in teams*. A report by the Division of Clinical Psychology. Leicester: BPS.

- British Psychology Society, Division of Counselling Psychology. (2005). *Professional practice guidelines*. Leicester: BPS.
- British Psychological Society. (2010). *Ethical principles for conducting research with human participants*. Leicester: BPS.
- Bryman, A. (2004). *Social Research Methods*. (2nd ed.). Oxford: Oxford University Press.
- Caldwell, M.F. (1992). Incidence of PTSD among staff victims of patient violence. *Hospital & Community Psychiatry*, 43, 838-839.
- Campbell, J., Messing, J., Kub, J., Agnew, J., Fitzgerald, S., Fowler, B., . . . Bolyard, R. (2011). Workplace violence: Prevalence and risk factors in the safe at work study. *Journal of Occupational Health Environment*, 53(1), 82–89.
- Care Quality Commission (2009). Supporting briefing note: issues highlighted by survey of mental health acute inpatient services. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/20120910_mh12_national_briefing_note_final.pdf.
- Carmel, H., & Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital & Community Psychiatry*, 40, 41-46.
- Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report*, 21(5), 811-831.
- Cavadino, M. (1999). The psychiatrist as gaoler. *The Journal of Forensic Psychiatry*, 10(3), 525-537.
- Chaplin, R., McGeorge, M., & Lelliott, P. (2006). The National Audit of Violence: in-patient care for adults of working age. *Psychiatric Bulletin*, 30(12), 444-446.
- Chapman, R., Styles, I., Perry, L. & Combs, S. (2010). Examining the characteristics of workplace violence in one non-tertiary hospital. *Journal of Clinical Nursing*, 19, 479–488.
- Charmaz, K. (1991). Discoveries of self in illness. In K. Charmaz & D. Paterniti (Eds.), *Health, illness, and healing: Society, social context, and self: an anthology* (pp.72-82). Oxford: Oxford University Press.
- Charmaz, K. (1995). Grounded theory. In J. Smith, R. Harré, & L. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-65). London: Sage.
- Charmaz, K. (2000) Grounded theory: Objectivist and constructivist methods. In N.K. Denzin and Y.E. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 509-535). Thousand Oaks, CA: Sage.
- Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 675-694). Thousand Oaks, CA: Sage.

- Charmaz, K. (2006). *Constructing Grounded Theory: a practical guide through qualitative analysis*. London: Sage.
- Charmaz, K. (2009) Shifting the Grounds: Constructivist Grounded Theory Methods for the Twenty-first Century. In J. Morse, P. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. Clarke (Eds.), *Developing Grounded Theory: The Second Generation* (pp.127-154). Walnut Creek, CA: Left Coast Press.
- Charmaz, K. (2014). *Constructing grounded theory. (2nd ed.)* Thousand Oaks, CA: Sage.
- Chen, S. C., Hwu, H. G., & Williams, R. A. (2005). Psychiatric nurses' anxiety and cognition in managing psychiatric patients' aggression. *Archives of Psychiatric Nursing*, 19(3), 141-149.
- Chou, K., Lu, R. & Mao, W. (2002). Factors relevant to patient assaultive behaviour and assault in acute inpatient psychiatric units in Taiwan. *Archives of Psychiatric Nursing* 6(4), 187-195.
- Clarke, V., & Braun, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. London: Sage.
- Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3-4), 119–129.
- Cornaggia, C. M., Beghi, M., Pavone, F., & Barale, F. (2011). Aggression in psychiatry wards: A systematic review. *Psychiatry Research*, 189(1), 10–20.
- Cornwall, C. J. (2006). The client with a mood disorder. In W.K. Mohr (Ed.), *Johnson's psychiatric-mental health nursing* (6th ed.) (pp. 577–618). Philadelphia: Lippincott Williams & Wilkins.
- Crawford, P., Brown, B., Kvangarsnes, M., & Gilbert, P. (2014). The design of compassionate care. *Journal of Clinical Nursing*, 23, 3589–3599.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Thousand Oaks, CA: SAGE Publications.
- Crowner, M.L., Peric, G., Stepic, F., & Lee, S. (2005). Assailant and victim behaviors immediately preceding inpatient assault. *Psychiatric Quarterly*, 76(3), 243–256.
- Cully, J.A., & Teten, A.L. (2008). *A Therapist's Guide to Brief Cognitive Behavioral Therapy*. Houston: Department of Veterans Affairs, South Central Mental Illness Research (MIRECC).
- Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. *British Journal of Nursing*, 17, 880-884.

- Daffern, M., Day, A., & Cookson, A. (2012). Implications for the prevention of aggressive behavior within psychiatric hospitals drawn from interpersonal communication theory. *International Journal of Offender Therapy and Comparative Criminology*, 56, 401–419.
- Daffern, M., Martin, T., & Thomas, S. (2010). Reducing the use of seclusion in a forensic psychiatric hospital: assessing the impact on aggression, therapeutic climate and staff confidence. *Journal of Forensic Psychiatry and Psychology*, 21 (5), 737-760.
- Daffern, M., Howells, K., & Ogloff, J.R.P. (2007). What's the point? Towards a methodology for assessing the function of psychiatric inpatient aggression. *Behavior Research and Therapy*, 45(1), 101-111.
- Daffern, M., Ogloff, J., & Howells, K. (2003). Aggression in an Australian forensic psychiatric hospital. *British Journal of Forensic Practice*, 5(4), 18-28.
- Daffern, M., & Howells, K. (2002). Psychiatric inpatient aggression: a review of structural and functional assessment approaches', *Aggression and Violent Behavior*, 7: 477-97.
- Daly, K. (2007). *Qualitative methods for family studies and human development*. Thousand Oaks, CA: Sage Publications.
- Deans, C. (2003). The effectiveness of a training program for emergency department nurses in managing violent situations. *Australian Journal of Advanced Nursing*, 21, 17-22.
- Deans, C. (2004). Who cares for nurses? The lived experience of workplace aggression. *Collegian: Journal of the Royal College of Nursing Australia*, 11, 32-36.
- Deans, C., & Meocevic, E. (2006). Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. *Contemporary Nurse*, 21, 43-49.
- d'Ettorre, G., & Pellicani, V. (2017). Workplace violence toward mental healthcare workers employed in psychiatric wards. *Safety and Health at Work*, 8(4), 337-342.
- Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. London: Academic Press.
- Dey, I. (2004). Grounded theory. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative research practice* (pp. 80–93). London: Sage.
- Dickson-Swift, V., James, E., Kippen, S., & Liamputtong Rice, P. (2006). Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research*, 16(6), 853-871.
- Dinwiddie, S. H., & Briska, W. (2004). Prosecution of violent psychiatric inpatients: Theoretical and practical issues. *International Journal of Law and Psychiatry*, 27(1), 17-29.

- Donati, M. (2016). Becoming a reflective practitioner. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 55-73). London: SAGE Publications Ltd.
- Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *Journal of Psychiatric and Mental Health Nursing*, 9, 325–337.
- Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing*, 50(5), 469–478.
- Dykes, K., Hilton, C., & Ross, K. (2017). The key psychological offer. In K. Ross & S. Dexter-Smith (Eds.), *Psychological best practice in inpatient services for older people* (pp. 11-18). Leicester: The British Psychological Society.
- Edwards, J. R., & Cable, D. M. (2009). The value of value congruence. *Journal of Applied Psychology*, 94, 654–677.
- El-Badri, S., & Mellsop, G. (2006). Aggressive behaviour in an acute general adult psychiatric unit. *Psychiatric Bulletin*, 30, 166–168.
- Elliott, M., & Williams, D. (2003). The client experience of counselling and psychotherapy. *Counselling Psychology Review*, 18(1): 34-38.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.
- Erickson, I., & Williams-Evans, S.A. (2000). Attitudes of emergency nurses regarding patient assaults. *Journal of emergency nursing*, 26, 210-215.
- Erkol, H., Gokdogan, M.R., Erkol, Z., & Boz, B. (2007). Aggression and Violence towards Health Care Providers—A Problem in Turkey? *Journal of Forensic and Legal Medicine*, 14, 423-428.
- Fagan-Pryor, E.C., Haber, L.C., Dunlap, D., Nall, J.L., Stanley, G., & Wolpert, R. (2003). Patients' views of causes of aggression by patients and effective interventions. *Psychiatric Services*, 54(4), 549-553.
- Fagin, L. (2001). Therapeutic and counter-therapeutic factors in acute ward settings. *Psychoanalytic Psychotherapy*, 15, 99-120.
- Farrell, G.A., & Shafiei, T (2012). Workplace aggression, including bullying in nursing and midwifery: A descriptive survey (the SWAB study). *International Journal of Mental Health Nursing*, 49, 1423- 1431.
- Feltham, C., & Hanley, T. (2017). What are counselling and psychotherapy? In C. Feltham, T. Hanley, & L. A. Winter (Eds.), *The Sage handbook of counselling and psychotherapy* (4th ed.) (pp. 2–11). London: Sage.

- Fernandes, C., Raboud, J., Christenson, J., Bouthillette, F., Bullock, L., Ouellet, L., & Moore, C. (2002). The effect of education program on violence in the emergency department. *Annals of Emergency Medicine*, 39(1), 47–55.
- Ferns, T. (2006). Violence, aggression and physical assault in healthcare settings. *Nursing Standard*, 21(13), 42-46.
- Ferns, T., & Meerabeau, E. (2009). Reporting behaviours of nursing students who have experienced verbal abuse. *Journal of Advanced Nursing*, 65(12), 2678-2688.
- Finnema, E.J., Dassen, T., & Halfens, R. (1994). Aggression in psychiatry: a qualitative study focussing on the characterization and perception of patient aggression by nurses working on psychiatric wards. *Journal of Advanced Nursing*, 19, 1088-1095.
- Flannery, R. B. (2007). Precipitants to psychiatric patient assaults: Review of findings, 2004–2006, with implications for EMS and other health care providers. *International Journal of Emergency Mental Health Services*, 9, 5–11.
- Flannery, R., Hanson, M., Penk, W., Flannery, G., & Gallagher, C. (1995). The Assaulted Staff Action Program: An approach to coping with the aftermath of violence in the workplace. In L. Murphy, J. Hurrell, S. Sauter & G.P. Keita (Eds.), *Job Stress Interventions* (pp.199-211). Washington, DC: American Psychological Association.
- Flood, C., Bowers, L., & Parkin, D. (2008). Estimating the costs of conflict and containment on adult acute inpatient psychiatric wards. *Nursing Economics*, 26(5), 325–330.
- Foster, C., Bowers, L., & Nijman, H. (2007). Aggressive behaviour on acute psychiatric wards: Prevalence, severity and management. *Journal of Advanced Nursing*, 58(2), 140–149.
- Freud, S. (1920). Beyond the pleasure principle. In *Standard Edition*, Vol. 18 (pp. 3-64). London: Hogarth Press.
- Freud, S. (1930). Civilization and its discontents. In *Standard Edition*, Vol. 21 (pp. 64-145). London: Hogarth Press.
- Gentile, J.P., & Jackson, CS. (2008). Supportive Psychotherapy with the Dual Diagnosis Patient: Co-occurring Mental Illness/Intellectual Disabilities. *Psychiatry (Edgmont)*, 5(3),49-57.
- Gifford, M. L., & Anderson, J. E. (2010). Barriers and motivating factors in reporting incidents of assault in mental health care. *Journal of the American Psychiatric Nurses Association*, 16(5), 288-298.
- Gilbert, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8(1), 92.

- Gillespie, G.L., Gates, D.M., Miller, M., & Howard, P.K (2010). Workplace violence in healthcare settings: risk factors and protective strategies. *Rehabilitation nursing*, 35(5), 177–184.
- Gillon, E. (2007). *Person-Centred Counselling Psychology*. London: Sage.
- Gipps, R.G.T. (2016). Schizophrenic discourse as disturbed relating. *Journal of Psychopathology*, 22, 71-78.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine de Gruyter.
- Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction*. White Plains, N.Y: Longman.
- Gournay, K. , Carson, J. , & Spence, A. (2000). *Special Hospitals' Stress Survey*. London: Institute of Psychiatry . Unpublished report, available from the Institute of Psychiatry.
- Grant, A. (2018). *Doing EXCELLENT social research with documents: Practical examples and guidance for qualitative researchers*. Abingdon: Routledge.
- Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. London: Sage.
- Gudde, C. B., Olso, T. M., Whittington, R., & Vatne, S. (2015). Service users' experiences and views of aggressive situations in mental health care: a systematic review and thematic synthesis of qualitative studies. *Journal of multidisciplinary healthcare*, 8, 449-462.
- Gunenc, C., O'She, L.E., & Dickens, G.L. (2015). Prevalence and predictors of verbal aggression in a secure mental health service: Use of the HCR-20. *International Journal of Mental Health Nursing*, 24, 314-323.
- Hahn, S., Needham, I., Abderhalden, C., Duxbury, J., Halfens, R.J.G., & Feans, J.G. 2006. The effect of a training course on mental health nurses' attitudes on the reasons of patient aggression and its management. *Journal of Psychiatric and Mental health Nursing*, 13, 197–204.
- Haigh, R. (2006). People's experiences of having a diagnosis of personality disorder. In M. J. Sampson, R. A. McCubbin & P. Tyrer (Eds.), *Personality disorder and community mental health teams: A practitioner's guide* (pp. 161-178). London, UK: John Wylie & Sons.
- Hansen, B. (2004). What's Wrong with Subjectivity Anyway? *Australian and New Zealand Journal of Family Therapy*, 25: 21–26.
- Hanson, J. (2013). Educational development as researchers: The contribution of insider research to enhancing understanding of role, identity and practice. *Innovation in Education and Teaching International*, 50(4): 388–398.

- Hankin, C.S., Bronstone, A., & Koran, L.M. (2011). Agitation in the inpatient setting: A review of clinical presentation, burden and treatment. *Journal of Psychiatric Practice*, 17 (3), 170 – 185.
- Harper, D. (2017). Clinical Psychology. In C. Willig & S. and W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology* (2nd ed.) (pp. 473-495). London: Sage Publications Ltd.
- Hayward, R.M., & Tuckey, M. R. (2011). Emotions in Uniform: How nurses regulate emotion at work via emotional boundaries. *Human Relations*, 64(11), 1501-1523.
- Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. Thousand Oaks, CA: Sage Publications.
- Hill, T. E. (2010). How clinicians make (or avoid) moral judgments of patients: Implications of the evidence for relationships and research. *Philosophy, Ethics, and Humanities in Medicine*, 5, Article No. 11.
- Hills, D.J., Ross, H.M., Pich J., Hill, A.T., Dalsbo, T.K., Riahi, S., Guay, S., & Martínez-Jarreta, B. (2015). Education and Training for Preventing and Minimising Workplace Aggression Directed toward Healthcare Workers [Protocol]. *Cochrane Database of Systematic Reviews*, Issue 9.
- Hinsby, K., & Baker, M. (2004). Patient and nurse accounts of violent incidents in a medium secure unit. *Journal of Psychiatric and Mental Health Nursing*, 11, 341–347.
- Hinshelwood, R.D. (2002). The psychosocial process. In R.D. Hinshelwood & M. Chiesa (Eds.), *Organisations, Anxieties and Defences: Towards a Psychoanalytic Social Psychology*, London: Whurr.
- Hoffman, M.L. (2000). *Empathy and moral development: Implications for caring and justice*. New York: Cambridge University Press.
- Hofmann, M., & Barker, C. (2017). On Researching a Health Condition That the Researcher Has Also Experienced. *Qualitative Psychology*, 4(2), 139-148.
- Holmes, J. (2001). *The Search for a Secure Base: Attachment Theory and Psychotherapy*. East Sussex: Brunner-Routledge.
- Holmes, J. (2002). Acute wards: problems and solutions. Creating a psychotherapeutic culture in acute psychiatric wards. *The Psychiatrist*, 26, 383-385.
- Hood, J.C. (2007). Orthodoxy vs. Power: The defining traits of grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 151-164). Thousand Oaks, CA: Sage.
- Howard, R., & Hegarty, J.R. (2003). Violent incidents and staff stress. *The British Journal of Developmental Disabilities*, 49, 3–21.

- Howells, K., Daffern, M., & Day, A. (2008). Aggression and violence. In K. Soothill, P. Rogers, & M. Dolan (Eds.), *Handbook of forensic mental health* (pp. 351-374). Cullompton, UK: Willan Publishing.
- Hugly, P. & Sayward, C. (1987). Relativism and Ontology. *The Philosophical Quarterly*, 37(148), 278-290.
- Hulley, S.B., Cummings, S.R., Browner, W.S., Grady, D.G., & Newman, T.B. (2007). *Designing Clinical Research* (3rd ed). Lippincott Williams & Wilkins: Philadelphia.
- Hunter, M., & Carmel, H. (1992). The cost of staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 43(6), 586-588.
- Ilkiw-Lavalle, O., & Grenyer, B. (2003). Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services*, 54(3), 389-974.
- Inoue, M., Tsukano, K., Muraoka, M., Kaneko, F. O., & Okamura, H. (2006). Psychological impact of verbal abuse and violence by patients on nurses working in psychiatric departments. *Psychiatry and Clinical Neurosciences*, 60(1), 29-36.
- Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & Girolamo, G. (2015). Prevalence and risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis. *PLoS One*, 10(6), e0128536.
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace: a factor in recruitment and retention. *Journal of Nursing Management*, 10, (1), 13-20.
- Jalil, R., Huber, J., Sixsmith, J., & Dickens, G. (2017). Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: Cross sectional questionnaire survey. *International Journal of Nursing Studies*, 75, 130-138.
- Jansen, G. J., Dansen, T.W.N., & Jebbink, G. (2005). Staff attitudes towards aggression in health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 12, 3-13.
- Jansen, G. J., Dassen, T., & Moorer, P. (1997). The perception of aggression. *Scandinavian Journal of Caring Sciences*, 11(1), 51-55.
- Johnson, M. E., & Delaney, K. R. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association*, 13(1), 42-52.
- Johnson, B., Martin, M., Guha, M., & Montgomery, P. (1997). The experience of thought disordered individuals preceding an aggressive incident. *Journal of Psychiatric Nursing and Mental Health Services*, 4(3), 213-220.
- Jonker, E., Goossens, P., Steenhuis, I., & Oud, N. (2008). Patient aggression in clinical psychiatry: Perceptions of mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 15, 492-499.

- Kasket, E. (2011). *Counselling psychology research in training and beyond*. Paper presented at the British Psychological society Division of Counselling Psychology Trainee Talk, London, November.
- Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, 27(2), 64-73.
- Kasket, E. (2016). Carrying out research. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 228-243). London: Sage Publications.
- Kennedy, M., & Julie, H. (2013) Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. *Health SA Gesondheid*, 18(1), 1-9.
- Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: Nurses' experiences in psychiatric units with high risks of assault. *Archives of Psychiatric Nursing*, 19(4), 169- 175.
- King, P.M., & Kitchener, K.S. (2002). The reflective judgment model: Twenty years of research on epistemic cognition. In B. K. Hofer and P. R. Pintrich (Eds.), *Personal epistemology: The psychology of beliefs about knowledge and knowing* (pp. 37-61). Mahway, NJ: Lawrence Erlbaum.
- Kisa, S. (2008). Turkish nurses' experience of verbal abuse at work. *Archives of Psychiatric Nursing*, 22(4), 200-207.
- Kumar, S., Fischer, J., Ng, B., Clarke, S., & Robinson, E. (2006). Prosecuting psychiatric patients who assault staff: a New Zealand perspective. *Australasian Psychiatry*, 14, 251–255.
- Kumar, S., Guite, H., & Thornicroft, G. (2001). Service Users' Experience of Violence within a Mental health System: A Study Using Grounded Theory Approach. *Journal of Mental Health*, 10(6), 597-611.
- Kushnir, V., Cunningham, J. A., & Hodgins, D. C. (2013). A prospective natural history study of quitting or reducing gambling with or without treatment: protocol. *JMIR Research Protocols*, 2(2), e51.
- Lakasing, E. (2006). How to define and manage difficult patients. *Practice Nursing*, 18(1), 15-20.
- Lamanna, D., Ninkovic, D., Vijayaratham, V., Balderson, K., Spivak, H., Brook, S., Robertson, D. (2016). Aggression in psychiatric hospitalizations: a qualitative study of patient and provider perspectives. *Journal of Mental Health*, 25(6):536–42.
- Lane, D.A., & Corrie, S. (2006). Counselling psychology: Its influences and future. *Counselling Psychology Review*, 21(1), 12–24.
- Lanza, M.L. (2011). Assault on nursing staff: Blaming the victim, then and now. *Issues in Mental Health Nursing*, 32, 547-548.

- Lanza, M.L., Zeiss, R.A., & Rierdan, J. (2006). Non-physical violence: A risk factor for physical violence in healthcare settings. *American Association of Occupational Health Nurses Journal*, 54(9) 397-402.
- Larsson, P., Brooks, O., & Lowenthal, D. (2012) 'Counselling psychology and diagnostic categories: a critical review', *Counselling Psychology Review*, 27(3), 55-67.
- Laughton-Brown, H. (2010). Trust in the therapeutic relationship: psychodynamic contributions to counselling psychology practice. *Counselling Psychology Review*, 25(2): 6-12.
- Lawson, G., & Venart, B. (2005). Preventing counsellor impairment: Vulnerability, wellness and resilience. In G. R. Waltz & R. K. Yep (Eds.), *VISTAS: Compelling perspectives on counselling* (pp. 243–246). Alexandria, VA: American Counselling Association.
- Leadbetter, D., & Paterson, B. (2004). Developing an agency approach to safe physical intervention. *Nursing and Residential Care*, 6(6), 280-283.
- Lee, F. (2001). Violence in the A&E: the role of training and self-efficacy. *Nursing Standard*, 15, 33-38.
- Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*. Sussex: John Wiley & Sons.
- Leung F-H., & Savithiri, R. (2009) Spotlight on focus groups. *Canadian Family Physician*, 55(2), 218–219.
- Levin, P. F., Hewitt, J. B., & Misner, S. T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30(3), 248–254.
- Lewis, D. M. (2002). Responding to a violent incident: Physical restraint or anger management as therapeutic interventions. *Journal of Psychiatry and Mental Health Nursing*, 9(1), 57–63.
- London Metropolitan University. (2010). *Research Ethics Policy and Procedures*. Research & Postgraduate Office. Retrieved from <http://www.londonmet.ac.uk/media/london-metropolitan-university/london-metdocuments/professional-service-departments/research-office/coursedocuments/Research-Ethics-Policy-and-Procedures.doc>
- Lu, C-H., Wang, T-F, & Liu, C-Y. (2007). Psychiatric nurses' reactions to assault upon them by inpatients: a survey in Taiwan. *Psychological Reports*, 100, 777-782.
- Maher, C., Hadfield, M., Hutchings, M., & de Eyto, A. (2018). Ensuring Rigor in Qualitative Data Analysis: A Design Research Approach to Coding Combining NVivo With Traditional Material Methods. *International Journal of Qualitative Methods*, 17, 1-13.

- Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, 12(6), 595–612.
- Markham, D., & Trower, P. (2003). The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology*, 42, 243–256.
- Markula, P., & Silk, M. (2011). *Qualitative Research for Physical Culture*. London: Palgrave Macmillan.
- Marshall, C., & Rossman, G. B. (1995). *Designing qualitative research* (2nd ed.). Newbury Park, CA: Sage.
- Marshall, C., & Rossman, G. B. (2011). Managing, analyzing, and interpreting data. In *Designing qualitative research* (5th ed.) (pp. 205–227). Los Angeles, CA: Sage Publications.
- Martin, T., & Daffern, M. (2006). Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. *Journal of Psychiatric and Mental Health Nursing*, 13(1), 90–99.
- Maslach, C., & Leiter, M. P. (2005). Stress and burnout: The critical research. In C. L. Cooper (Ed.), *Handbook of stress medicine and health* (2nd ed.) (pp. 153–170). London: CRC Press.
- Maslach, C., Schaufeli, W.B., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422.
- Mason, M. (2010). Sample size and saturation in Ph.D. studies using qualitative interviews. *Forum: Qualitative Social Research*, 11(3), article 8.
- Matos, P.S., Neushotz, L.A., Griffin, M.T., & Fitzpatrick, J.J. (2010). An exploratory study of resilience and job satisfaction among psychiatric nurses working in inpatient units. *International journal of mental health nursing*, 19, 307–12.
- McAllister, M., & McKinnon, J. (2009). The importance of teaching and learning resilience in the health disciplines: A critical review of the literature. *Nurse Education Today*, 29, 371–379.
- McGill, A. (2006). Evidence-based strategies to decrease psychiatric patient assaults. *Nursing Management*, 37(11), 41–44.
- McKenna, K.J., & Paterson, B. (2006). Locating Training within a Strategic Organizational Response to Aggression and Violence. In: D. Richter, R. Whittington (Eds.), *Violence in Psychiatry: Causes, Consequences and Control* (pp. 231–251). Springhouse: New York.
- McKenna, B.G., Poole, S.J., Smith, N.A., Coverdale, J.H., & Gale, C.K. (2003). A survey of threats and violent behaviour by patients against registered nurses in their first year of practice. *International Journal of Mental Health Nursing*. 12(1), 56–63.

- McKinnon, B., & Cross, W. (2008). Occupational violence and assault in mental health nursing: a scoping project for a Victorian Mental Health Service. *International Journal of Mental Health Nursing*, 17, 9-17.
- McLaughlin, S., Bonner, G., Mboche, C., & Fairlie, T. (2010). A pilot study to test an intervention for dealing with verbal aggression. *British Journal of Nursing*, 19(8), 489-494.
- McLaughlin, S., Gorley, L., & Moseley, L. (2009). The prevalence of verbal aggression against nurses. *British journal of nursing*, 18(12), 735-739.
- Meehan, T., McIntosh, W., & Bergen, H. (2006). Aggressive behaviour in the high-secure forensic setting: The perceptions of patients. *Journal of Psychiatric and Mental Health Nursing*, 13, 19-25.
- Mercer, J. (2007). The challenges of insider research in educational institutions: wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education*, 33(1), 1-17.
- Mitchell, H. (2008). The Insider Researcher. In J. Johnson and C. DeSouza (Eds.), *Understanding Health and Social Care: An Introductory Reader* (pp. 37-44). London: Sage.
- Monahan, J. (1992). Mental disorder and violent behavior: Perceptions and evidence. *American Psychologist*, 47, 511-521.
- Moriarty, J. (2011). *Qualitative Methods Overview*. (SSCR Methods Reviews). London: National Institute for Health Research School for Social Care.
- Morrison, J.L., Lantos, J.D., & Levinson, W.J. (1998). Aggression and violence directed toward physicians. *Journal of General Internal Medicine*, 13(8), 556-61.
- Morrow, S.L. (2005). Quality and Trustworthiness in Qualitative Research in Counselling Psychology. *Journal of Counselling Psychology*, 52 (2), 250-260.
- Morrow, S.L. (2007). Qualitative Research in Counseling Psychology: Conceptual Foundations. *The Counselling Psychologist*, 35(2), 209-235.
- Mouthaan, J., Sijbrandij, M., Reitsma, J.B., Gersons, B.P., & Olff, M. (2014). Comparing screening instruments to predict post-traumatic stress disorder. *PLoS One*, 9(5), e97183.
- Mullen, P.E. (2006). Schizophrenia and violence: From correlations to preventive strategies. *Advances in Psychiatric Treatment*, 12, 239-248.
- National Collaborating Centre for Mental Health. (2015). *Violence and aggression: short-term management in mental-health, health and community settings. NICE guideline [NG10]*. Update. Leicester and London, UK: British Psychological Society and the Royal College of Psychiatrists.

- Needham, I. (2006). Psychological responses following exposure to violence. In D. Richter & R. Whittington (Eds.), *Violence in Mental Health Settings: Causes, Consequences, Management* (pp. 296–318). New York: Springer.
- Needham, I., Abderhalden, C., Halfens, R.J.G., Fischer, J.E., & Dassen, T. (2005). Non-somatic effects of patient aggression on nurses: A systematic review. *Journal of Advanced Nursing*, 49, 283–296.
- NHS Protect. (2016). *Reported physical assaults on NHS staff figures. Physical assaults against NHS staff 2015/16* [Online] PDF. London: NHSBA. Available at: http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Reported_Physical_Assaults_2015-16_Final.pdf
- Nijman, H. L.I., Palmstierna, T., Almvik, R., & Stolker, J. J. (2005). Fifteen years of research with the Staff Observation Aggression Scale: a review. *Acta Psychiatrica Scandinavica*, 111, 12–21.
- Nijman, H.L.I. (2002). A model of aggression in psychiatric hospitals. *Acta Psychiatrica Scandinavica*, 106, 142–143.
- Nolan, P., Dallender, J., Soares, J., Thomsen, S., & Arnetz, B. (1999). Violence in mental health care: The experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, 30, 934–941.
- O'Connell, B., Young, J., Brooks, J., Hutchings, J., & Lofthouse, J. (2000). Nurses' perceptions of the nature and frequency of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing*, 9(4), 602–610.
- Ogden, J., & Cornwell, D. (2010). The role of topic, interviewee and question in predicting rich interview data in the field of health research. *Sociology of Health and Illness*, 32(7), 1059–1071.
- Ogloff, J.R.P., & Daffern, M. (2006). The Dynamic Appraisal of Situational Aggression: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients. *Behavioral Sciences and the Law*, 24, 799–813.
- Oliveira, D. L. (2011). The use of focus groups to investigate sensitive topics: An example taken from research on adolescent girls' perceptions about sexual risks. *Ciência & Saúde Coletiva*, 16(7), 3093–3102.
- Oliver, P. (2010). *Understanding the Research Process*. London: Sage.
- Omerov, M., Edman, G., & Wistedt, B. (2002). Incidents of violence in psychiatric inpatient care. *Nordic Journal of Psychiatry*, 56(3), 207–213.
- Owen, C., Tarantello, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services*, 49(11), 1452–1457.
- Oztunc, G. (2006). Examination of incidents of workplace verbal abuse against nurses. *Journal of Nursing Care Quality*, 17(6), 360–365.

- Parens, H. (1979). *The Development of Aggression in Early Childhood*. New York: Jason Aronson.
- Parzefall, M.R., & Salin, D. (2010). Perceptions of and reactions to workplace bullying: A social exchange perspective. *Human Relations*, 63(6), 761-780.
- Paterson B., Bowie V., Miller G., & Leadbetter D. (2008). Discourse, Rhetoric and Failure: Zero Tolerance and Violence in Services for People with Mental Health Needs. *Mental Health Practice*, 11(8), 26-31.
- Paterson, B., & Duxbury, J. (2007). Restraint and the question of validity. *Nursing Ethics*, 14(4), 535-545.
- Paterson, B., Leadbetter, D., & Miller, G. (2005). Beyond zero tolerance: A varied approach to workplace violence. *British Journal of Nursing*, 14(13), 810-815.
- Pelto-Piri, V., Engstrom, K., & Engstrom, I. (2012). The ethical landscape of professional care in everyday practice as perceived by staff - A qualitative content analysis of ethical diaries written by staff in child and adolescent psychiatric in-patient care. *Child and Adolescent Psychiatry and Mental Health*, 6(1), 18.
- Phillips, S. (2007). Countering workplace aggression: an urban tertiary care institutional exemplar. *Nursing Administration Quarterly*, 31(3), 209-218.
- Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education*, 16(2), 175-196.
- Polkinghorne, D.E. (2005). Language and Meaning: Data Collection in Qualitative Research. *Journal of Counselling Psychology*, 52, 137-145.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52, 126-136.
- Pope, K.S., & Tabachnick, B.G. (1993). Therapists' anger, hate, fear and sexual feelings: national survey of therapist response, client characteristics, critical events, formal complaints, and training. *Professional psychology, research and practice*, 24(2), 142-152.
- Putnam, L.L. (2010). Negotiation and discourse analysis. *Negotiation Journal*, 26, 145-154.
- Remer, P.A., & Oh, K. H. (2012). Feminist therapy in counselling psychology. In C. Z. Enns & E. N. Williams (Eds.), *The Oxford handbook of feminist counselling psychology* (pp. 304-322). New York: Oxford University Press.
- Rew, M., & Ferns, T. (2005). A balanced approach to dealing with violence and aggression at work. *British Journal of Nursing*, 14 (4), 227-32.

- Richter, D., & Berger, K. (2000) Physische und psychische Folgen bei Mitarbeitern nach einem Patientenübergriff: Eine prospektive Untersuchung in sechs psychiatrischen Kliniken. *Arbeitsmedizin, Sozialmedizin, Umweltmedizin* 35(8), 357-362.
- Richter, D., & Berger, K. (2006). Post-traumatic stress disorder following patient assaults among staff members of mental health hospitals: A prospective longitudinal study. *BMC Psychiatry*, 6, 15.
- Richter, D., & Whittington, R. (2006). *Violence in Mental Health Settings: Causes, consequences, management*. New York: Springer Science and Business Media.
- Ridenour, M., Lanza, M., Hendricks, S., Hartley, D., Rierdan, J., Zeiss, R., & Amandus, H. (2015). Incidence and risk factors of workplace violence on psychiatric staff. *Work*, 51(1), 19–28.
- Rifkind, G. (1995). Containing the containers: the staff consultation group. *Group Analysis*, 28(2), 209-222.
- Rippon, T. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31(2), 452-460.
- Rossberg, J.I., & Friis, S. (2003). Staff members emotional reactions to aggressive and suicidal behavior of inpatients. *Psychiatric Services*, 54, 1388–1394.
- Royal College of Psychiatrists. (2007). *Healthcare Commission National Audit of Violence 2006-2007*. London: Royal College of Psychiatrists.
- Safran, J. D., & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy*, 43, 286 –291
- Schnieden, V., & Marren Bell, U. (1995). Violence in the accident and emergency department. *Accident and Emergency Nursing*, 3, 74-78.
- Secker, J., Benson, A., Balfe, E., Lipsedge, M., Robinson, S. & Walker, J. (2004). Understanding the social context of violent and aggressive incidents. *Journal of Psychiatric and Mental Health Nursing*, 11, 172-178.
- Shepherd, M. & Lavender, T. (1999). Putting aggression into context: An investigation into contextual factors influencing the rate of aggressive incidents in a psychiatric hospital, *Journal of Mental Health*, 8(2), 159-170.
- Sinitsky, G. (2010). A trainee's experience of counselling psychology's contribution to therapeutic work with children and adolescents. *Counselling Psychology Review*, 25(1), 52-56.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre & L. van Langenhore (Eds.), *Rethinking Methods in Psychology* (pp. 9-26). London: Sage.

- Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*, 261-271.
- Smith, J. A. (2008). *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.
- Smith, J.A., Flowers. P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. Los Angeles: Sage.
- Sofield, L., & Salmond, S. W. (2003). Workplace violence: A focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing, 22*(4), 274-283
- Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. *International Journal of Nursing Studies, 51*, 72-84.
- Spencer, S., Stone, T., & McMillan, M. (2010). Violence and aggression in mental health inpatient units: an evaluation of aggression minimization programs. *HNE Handover: Nurses and Midwives, 3*(1), 42-48.
- Speroni, K.G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing, 40*(3), 218-228.
- Spokes, K., Bond, K., Lowe, T., Jones, J., Illingworth, P., Brimblecombe, N., & Wellman, N. (2002). HOVIS – The Hertfordshire/Oxfordshire Violent Incident Study. *Journal of Psychiatric and Mental Health Nursing, 9*, 199-209.
- Sprigg, C.A., Armitage, C.J., & Hollis, K. (2007). Verbal abuse in the National Health Service: impressions of the prevalence, perceived reasons for and relationships with staff psychological well-being. *Emergency Medicine Journal, 24*, 281-82.
- Steinmetz, G. (2005). Scientific authority and the transition to post-Fordism: the plausibility of positivism in U.S. sociology since 1945. In G. Steinmetz G (Ed.), *The Politics of Method in the Human Sciences: Positivism and its Epistemological Others* (pp. 275-323). Durham, NC: Duke University Press.
- Stewart, D., & Bowers, L. (2013). Inpatient verbal aggression: content, targets and patient characteristics. *Journal of Psychiatric and Mental Health Nursing, 20*, 236-243.
- Stone, T., McMillan, M., & Hazelton, M. (2010). Swearing: Its prevalence in healthcare settings and impact on nursing practice. *Journal of Psychiatric and Mental Health Nursing, 17*, 528-534.
- Strawbridge, S. & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe R, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling Psychology* (2nd ed.) (pp. 3-22). London: Sage.

- Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed.) (pp.3-22). London: Sage.
- Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative Research: Techniques and procedures for developing grounded theory* (2nd ed.), London: Sage Publications.
- Stern, P.N. (1980). Grounded theory methodology, its uses and processes, *Image*, 12(1), 20–23.
- Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered Nurses' experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. *BMC Nursing*, 14(35), 1–13.
- Suddaby, R. (2006). From the editors: What grounded theory is not. *Academy of Management Journal*, 49(4), 633-642.
- Sullivan, P. (1998). Care and control in mental health nursing. *Nursing Standard*, 13, 42-45.
- Swanson, J. W., Swartz, M. S., Van Dorn, R. A., Elbogen, E. B., Wagner, H. R., Rosenheck, R. A., . . . Lieberman, J. A. (2006). A national study of violent behaviour in persons with schizophrenia. *Archives of General Psychiatry*, 63, 490-499.
- Taylor, P. J. (2008). Psychosis and Violence: Stories, Fears, and Reality. *The Canadian Journal of Psychiatry*, 53, 647-659.
- Tomagová, M., Bóriková, I., Lepiešová, M., & Čáp, J. (2016). Nurses' experience and attitudes towards inpatient aggression on psychiatric wards. *Central European Journal of Nursing and Midwifery*, 7(3), 462-469.
- Ulrich, R.S., Bogren, L., & Lundin, S. (2012). *Toward an evidence-based design theory for reducing aggression in psychiatric facilities*. Paper presented to the conference: ARCH12: Architecture, Research, Care, Health. Gothenburg: Chalmers University.
- Urquhart, C. (2007). The evolving nature of grounded theory method: the case of the information systems discipline. In K. Charmaz and T. Bryant (Eds.), *The Handbook of Grounded Theory* (pp. 339-359). Thousand Oaks, CA: Sage Publications.
- Uzun, O. (2003). Profession and society. *Journal of Nursing Scholarship*, 35, 81–85.
- van de Mortel, T.F. (2008). Faking it: social desirability response bias in self-report research. *Australian Journal of Advanced Nursing*, 25(4), 40-48.
- van Emmerik, J.H., Euwema, M.C., & Bakker, A.B. (2007). Threats of workplace violence and the buffering effect of social support. *Group & Organization Management*, 32, 152-175.

- van Leeuwen, M.E., & Harte, J.M. (2011). Violence against care workers in psychiatry: is prosecution justified? *International Journal of Law and Psychiatry*, 34(5), 317-323.
- Victorian Government Department of Human Services. (2005). *Victorian taskforce on violence in nursing. Final report*. Melbourne: Nurse Policy Branch.
- Viitasara E., & Menckel E. (2002). Developing a framework for identifying individual and organizational risk factors for the prevention of violence in the health-care sector. *Work: A Journal of Prevention, Assessment and Rehabilitation*, 19, 117-123.
- Viotti, S., Gilardi, S., Guglielmetti, C., & Converso, D. (2015). Verbal Aggression from Care Recipients as a Risk Factor among Nursing Staff: A Study on Burnout in the JD-R Model Perspective. *BioMed Research International*, 215-267.
- Virkki, T. (2008). Habitual trust in encountering violence at work: attitudes towards client violence among Finnish social workers and nurses. *Journal of Social Work*, 8(3), 247–267.
- Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., & Kivimäki, M. (2011). Overcrowding in psychiatric wards and physical assaults on staff: data-linked longitudinal study, *British Journal of Psychiatry*, 198, 149–155.
- Walsh, E., Gilvarry, C., Samele, C., Harvey, K., Manley, C., Tattan, T., . . . Fahy, T. (2004). Predicting violence in schizophrenia: a prospective study. *Schizophrenia Research*, 67, 247–252.
- Walsh, S., & Monaghan, L. (2014). Preventing organisational fibrillation: The role of the development of supervision skills. *Clinical Psychology Forum, Special Issue: The Francis Report*, 263, 64-67.
- Walsh, B.R., & Clarke, E. (2003). Post-trauma symptoms in healthcare workers following physical and verbal aggression. *Work and Stress*, 2(1), 170-181.
- Wells, J., & Bowers L. (2002). How prevalent is violence towards nurses working in general hospitals in the UK? *Journal of Advanced Nursing* 39(3), 230–240.
- Wetherell, M., Taylor, S., & Yates, S. J. (Eds.) (2001). *Discourse theory and practice: A reader*. London: Sage.
- Whittington, R., & Wykes, T. (1994). The prediction of violence in a health care setting. In T. Wykes (Ed.) *Violence and Health Care Professionals* (pp.155-174). London: Chapman and Hall.
- Wilkinson. J. D. (2004). Personal communication. In: D. A. Lane & S. Corrie (Eds.), *The Modern Scientist-Practitioner: A Guide to Practice in Psychology* (pp. 112-126). London, UK: Routledge.
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Buckingham: Open University Press.

- Wimalawansa, S. (2014). Mechanisms of Developing Post-Traumatic Stress Disorder: New Targets for Drug Development and Other Potential Interventions. *Bentham Science Publishers*, 13(5), 807-816.
- Winstanley, S., & Whittington, R. (2002). Anxiety, burnout and coping styles in general hospital staff exposed to workplace aggression: A cyclical model of burnout and vulnerability to aggression. *Work & Stress*, 16(4), 302-315.
- Winstanley, S., & Whittington, R. (2004). Aggressive encounters between patients and general hospital staff: Staff perceptions of the context and assailants' levels of cognitive processing. *Aggressive Behaviour*, 30(6), 534-543.
- Wright, S., Gray, R., Parkes, J., & Gournay, K. (2002). *The Recognition, Prevention and Therapeutic Management of Violence in Acute In-Patient Psychiatry: A Literature Review and Evidence-Based Recommendations for Good Practice*, prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. London: UKCC.
- Wright, K., Haigh, K. & McKeown, M. (2007). Reclaiming the humanity in personality disorder. *International Journal of Mental Health Nursing*, 16, 236-246.
- Xanthopoulou, D., Bakker, A.B., Dollard, M.F., Demerouti, E., Schaufeli, W.B., Taris, T.W., & Schreurs, P.J.G. (2007). When do job demands particularly predict burnout? The moderating role of job resources. *Journal of Managerial Psychology*, 22(8), 766-786.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed.) (pp. 235-251). London: Sage Publications Ltd.
- Zarola, A., & Leather, P. (2006). *Violence and Aggression Management Training for Trainers and Managers: A National Evaluation of the Training Provision in Healthcare Settings*. Norwich: HSE Books.
- Zuzelo, P. R., Curran, S. S., & Zeserman, M. A. (2012). Registered Nurses' and Behavioural Health Associates' responses to violent inpatient interactions on behavioural health units. *Journal of the American Psychiatric Nurses Association*, 18(2), 112-126.

10. Appendices

Appendix A: Letter of ethical approval (London Metropolitan University)

Appendix B: Letter of ethical approval (NHS)

Appendix C: Participant information sheet

Appendix D: Participant consent form

Appendix E: Distress protocol

Appendix F: Interview schedule – Phase 1

Appendix G: Sample of line-by-line coding

Appendix H: Initial model

Appendix I: Interview schedule – Phase 2

Appendix J: Example of creation of higher-order codes

Appendix K: Data analysis sample

Appendix L: Theoretical model

Appendix M: Example of a Memo

Appendix N: Page from researcher's reflexive diary

Appendix A: Letter of ethical approval from the research ethics review panel, London Metropolitan University.



**London Metropolitan University,
School of Psychology,
Research Ethics Review Panel**

I can confirm that the following project has received ethical approval to proceed:

Title: *What are views of ward staff on the experiences, causes and consequences of verbal aggression in an inpatient mental health setting? A grounded theory investigation.*

Student: **Prarthana Shetty**
Supervisor: Dr. Philip Hayton

Ethical approval to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

A handwritten signature in blue ink, appearing to read "Dr Chandler".

Date: 14/06/13

Dr Chris Chandler
(Chair - School of Psychology Research Ethics Review Panel)

A solid black rectangular bar used to redact contact information.

Appendix B: Letter of ethical approval, NHS.

Joint Research Management Office

Queen Mary Innovation Centre
5 Walden Street
London
E1 2EF

FINAL R&D APPROVAL

19 June 2013

Ms Prarthana Shetty
[REDACTED]
[REDACTED]
[REDACTED]

Tel: 020 7882 7260

Fax: 020 7882 7276

Email: Sponsorsrep@bartshealth.nhs.uk

Dear Ms. Shetty,

Protocol: What are views of ward staff on the experiences, causes and consequences of verbal aggression in an inpatient mental health setting?

ReDA Ref: AF1305/3

REC Ref: None given

I am pleased to inform you that the Joint Research Management Office for Barts Health NHS Trust and Queen Mary University of London has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of [REDACTED]. Approved study documents are as follows:

Type	Version	Date
REC approval	London Met. University	14.06.2013
Protocol	v.1	12.02.2013
Participant Information Sheet	v.1	12.02.2013
Participant Consent Form	v.1	12.02.2013
Distress Protocol	v.1	12.02.2013

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BH and QMUL policies that reinforce them, you can obtain details from the Joint Research Management Office or go to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint Research Management Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 020 7480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely

A handwritten signature in black ink, appearing to be 'GL' with a stylized flourish.

Gerry Leonard, Head of Research Resources

Copy to: Supervisor – Dr. Philip Hayton

Appendix C: Participant Information Sheet



I am conducting research to explore the phenomenon of verbal aggression in acute psychiatric wards in the NHS. This research is conducted as part of my Professional Doctorate in Counselling Psychology at London Metropolitan University.

I am contacting you to request your participation in my study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I am happy to answer any questions you may have.

Purpose of the study: This research aims to add to the existing literature in this area, and explore staff members' perspectives on verbal aggression and its perceived impact on a psychiatric ward.

Study Title: What are views of ward staff on the experiences, causes and consequences of verbal aggression in an inpatient mental health setting?

What would be involved in participation:

Participants will be ward staff on acute wards at the [REDACTED]. Your ward managers have given consent for staff participation. If you agree to contribute to this study, you will be requested to participate in a face to face interview with the researcher. The interview will be recorded and is expected to last approximately 60-90 minutes. This will allow time to answer questions regarding the research so that informed consent can be obtained and also allows for a debrief following participation.

Participation:

All participation is voluntary; should you wish to withdraw from the study, or retract your contribution, you are free to do so and you do not need to provide a reason. Should you reconsider your decision to participate, you are requested to inform the researcher within two weeks of participation. Your data will be securely destroyed.

Confidentiality:

In line with the British Psychological Society's guidelines on Ethical Principles for Conducting Research with Human Participants, the researcher guarantees anonymity and confidentiality of any collected information. All data will be kept confidential between the participant and the researcher. You will be asked to give written consent for your participation as well as consent to be audio recorded. Recorded data will be stored on a computer that is password encrypted and participant details will be stored securely in a locked cabinet on the university premises. Participant data may be kept securely for up to five years after the research has been completed, for publication purposes.

Study findings:

Should you wish to obtain a summary of the research findings, please inform the researcher and provide your contact details.

Location:

All interviews will take place within the premises of the [REDACTED], within work hours. The interview session will be treated as protected time.

Benefits and Risks:

In terms of direct benefit to participants taking part in the study, it is anticipated that the interview process may provide participants with the opportunity to reflect about their practice and experience. Indeed, Hutchinson et al. (1994) have identified several benefits of qualitative interviews, including catharsis, self-awareness and healing.

While it is not anticipated that participation in this study will expose participants to unusual or undue distress, it must be acknowledged that the interviews may touch upon emotive topics at certain moments. If you do happen to feel unsettled, I am happy to provide you with emotional support during the interview process. However if you subsequently feel distressed, do contact occupational health ([REDACTED]), your GP or the Samaritans on 08457 909090.

How to participate:

If you are interested in taking part in this study, please call me on [REDACTED] or contact me by email so that we can arrange a suitable time to conduct the interview - (prs0265@my.londonmet.ac.uk). If you have any concerns or queries about any aspect of this study, please contact me directly and I will do my best to answer your questions.

Principal Investigator: Prarthana Shetty, Trainee Counselling Psychologist.

Research Supervisor: Dr. Philip Hayton, Senior Lecturer (P.Hayton@londonmet.ac.uk).

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the East London Foundation Trust Research & Development (R&D) Committee.

Appendix D: Participant Consent Form



Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that in the debriefing session at the end of my participation I will have a further opportunity to ask any questions about this study. ☐
3. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without experiencing any repercussions. ☐
4. I give consent for my interview with the researcher to be recorded. ☐
5. I understand that any information given by me may be used in future reports, articles or presentations by the researcher. ☐
6. I understand that the data collected for this study is strictly confidential and I will not be identifiable in any report based on this study. ☐
7. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Researcher	Date	Signature

When completed, please return to the researcher. One copy will be given to the participant and the original will be stored securely by the researcher.

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in my research into verbal aggression. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. The researcher has experience in managing situations where distress occurs. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. However it is included in the protocol, in the event that participants may experience undue emotional distress.

Mild distress:

Signs to look out for:

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

Action to take:

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Intrusive thoughts of the specific event

Action to take:

- 1) The researcher will intervene to terminate the interview
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation

- 4) If any unresolved issues arise during the interview, acknowledge and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
- 5) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

- 1) Severe agitation and possible verbal or physical aggression

Action to take:

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns for the participant's or others' safety, she will inform them that she has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix F: Interview Schedule - Phase 1

(The use of 'VA' in the interview schedule is for the researcher's convenience; the complete term 'verbal aggression' was used in the interview)

Preamble: Thank you very much for agreeing to participate. You can take breaks anytime you like, I'm happy to pause the recording. This is an interview where I'm really interested in your point of view. If over the course of the interview you want to go back and amend something you've said, that's fine also. The interview will be structured about three main blocks – your experience of verbal aggression, influences on your thinking and practice regarding verbal aggression and implications of verbal aggression. If you don't mind I'll be taking notes as we go along, is that alright? Do you have any questions at this stage?

Nature of VA –

1. Based on your personal experience, how would you define VA?
 - What do you think VA looks like on an inpatient ward?
 - Is there anything about VA on an inpatient ward that is specific or different compared to other settings?
2. What examples of VA have you experienced?
 - Specific behaviour – e.g. threatening, swearing?
 - Witnessed or experienced?
 - Direction – towards an individual/the ward?
 - What goes through your mind/what do you think goes through other peoples mind when VA is happening? Do you think it's general what you experience, or do you think it's particular to you?
3. How do you think about VA in your ordinary working day?
 - How do you think about VA in relation to your role as a(job role)?
 - Any patterns to VA? (e.g. frequency, time of day)
 - What is your attitude/ mind-set towards VA while on the ward?
 - What do you think the experience is like for the patient? For the team?
4. How, if at all, have your experiences of VA changed over time?
 - How did it feel when you first encountered VA on an inpatient ward?
 - When you first started working on an inpatient ward was your experience of VA any different to what it's like now?

Influences on thinking and practice regarding VA in an inpatient ward –

Now I'd like to think a bit about the influences on your thinking and practice regarding VA-

5. How predictable do you think occurrences of VA can be?
 - What events do you think might commonly precede an event of VA?
 - What factors or triggers do you think may be related to increased frequency of VA?
6. What are your thoughts about the possible relationship between VA and individual members of staff?
7. In what way if at all do you think managers influence how VA is handled on the ward?
8. Is there is there any training that you've had that you found helpful in relation to dealing with VA, or not?
 - Helpful? Unhelpful?
9. In what way do you think –if any – is staff support and the availability of staff support is related to VA?
 - Do you think staff support is relevant in terms of how VA is dealt with on behalf of the staff? (how staff cope with the VA that already is there)

Implications of VA for staff on the ward, and its influence on response and practice –

10. What do you think the main implications are of having to deal with VA?
11. It has been suggested that experiencing VA potentially can lead to staff having a certain stance or a certain attitude towards VA. In your view can that happen?
 - Implications?
12. How have you / your team / learned to manage VA?
13. Learning from episodes of VA
 - How do you think incidents of VA can be minimised in the future?
 - What advice would you offer to someone who may be at risk of experiencing VA?

Closing question - Is there anything I have not asked you about VA that you believe is important for me to know?

Prompts to elicit further information - Can I ask you please just to say a bit more about that?

Affect - How did that make you feel?

Awareness - What do you think about that?

Appendix G: Sample of line-by-line coding of interview transcript.

18		
459	should support them. Just check in with them, you know 'Are you okay? Do you	458 Staff will I should check on them colleagues after VA,
460	need to go off the ward for a minute?' just to give that person a bit of a break,	459 see if they're okay.
461	for everyone else to share the load together, so that's one way of doing it. Uh, I	
462	think as a manager you want to see how that person is feeling, I would want to	462 - As a manager M.M. checks on staff after VA to
463	check in with that person, 'are you alright, is there anything I can do, do you	464 see if there's anything she can do / if staff feel safe.
464	feel safe being on the ward with that patient?' And then what we also do is we	465 - Staff have a reflective group where a psychologist
465	have a reflective group every week where we talk about patients we are finding	469 does a formulation of what's difficult behaviour; make
466	challenging on the ward or that have been difficult in their presentation. So we	it easier for staff to understand the reason for the VA.
467	have like a formulation with a psychologist where we will talk about a particular	469 - When staff understand the reason behind VA (explained
468	patient, try and get a bit of a history on them, what's led to them behaving this	471 by the psychologist) they feel more empathetic & that
469	way. Because by understanding that person, we learn. Most of the time staff go	they can make it the VA without being angry at
470	away feeling a bit more positive, feeling like they can work with that patient	them.
471	without being angry with them, or feeling a bit more empathetic towards them.	
472	The Trust also offers counselling sessions....	474 M.M. doesn't know of many people who have made
473	I: Do people make use of them?	use of counselling sessions (after VA).
474	P: I, I do not know a lot of people that actually have. So there are free	475 Staff aren't aware of free counselling sessions/
475	counselling sessions, but I don't think a lot of people are a) aware of it or b) just	476 don't have the time to engage in it after VA.
476	have the time to go and engage in it. Because a lot of people feel like they don't	
477	need counselling, it's a big step to feel like you need counselling and it makes	476 People think needing counselling means something
478	you feel like something's wrong with you if you need counselling because that's	479 is wrong to you (∴ don't use counselling service after
479	what people think of counselling. So I don't think a lot of staff engage in that	VA).
480	actually, unfortunately.	
481	I: Do you think that the Management feel there is a need for staff support for	483 Management do feel there is a need for staff
482	VA?	support after VA (because of the stress on staff).
483	P: I think so because when you look at how much people go off on sickness	483 - Staff go off work because of stress at work/physical
484	because of maybe stress at work or physical aggression, I think the challenge is	485 aggression, but not for VA (this has an impact on staff).
		486 - Staff tend to deal with it (not go off work time and)
		487 on the surface but however the impact plays
		out in different ways (e.g. stress).

bruises/les more visible than emotional hurt. none

19

485 a lot of people, you won't see them going off for VA. It's not very popular. You
486 know, people just tend to deal with it. But it's a big problem coz I think it plays
487 out in other ways. So when someone is physically assaulted everyone will
488 support you, because people can see the bruises. There's evidence. But when
489 people are verbally abused, I think a lot of colleagues struggle to see why
490 someone should go off sick, or why they need a bit more support. It's become a
491 bit of a norm, which is not acceptable but I think there has been a culture
492 whereby you know if you say you've gone off sick because a patient has been
493 verbally aggressive towards you, some people might not take you seriously. And
494 that's really bad, because it's really serious. Because it's aggression and it has an
495 impact on people in different ways. And I think we need to start respecting that,
496 and not be judgemental of it.

497 I: What do you think are the consequences of a lack of staff support?

498 P: I think, I think staff.....I think sickness level might go up, because people make
499 more effort to come to work when they're happy. Even though someone might
500 have a cough or they're really tired you still see they'll come to work because
501 they really enjoy it, they're quite passionate about it, and people feel burnt out,
502 they just feel like there's no support, they're not appreciated, they feel what
503 they do isn't valued, and sometimes that can come out in how people interact
504 with patients. It's not always the patient making staff angry, but there's
505 something about how the staff feels in the organisation. When they interact
506 with patients, there's no love, no genuineness in the interaction. You know,
507 they're just doing a job. There's a difference between someone who is doing
508 their job, and someone who is passionate about their work. Some people may
509 end up just coming and doing the hours and just leaving, and that's really sad.

487 when someone is physically assaulted they will get
488 lots of support because people can see the bruises (unlike
489 verbal).

489 when people are verbally abused staff struggle to see
490 why someone should go off sick/receive more support.
(because no obvious evidence of damage/injury).

491 if staff go off sick because of VA, the work
492 culture is such that other staff may not take them
seriously (it's just VA)

494 VA has an impact on staff in different ways
495 (not always obvious); staff should respect this
& not be judgemental.

498 - without staff support, sickness level might go up after
VA.

498 - people make an effort to come in to work when
-499 they're happy (even if unwell) and if they feel unsupported)

500 - Even if staff is unwell they will come in to
501 work because they are personally attached (not if
no support)

501 - staff feel burnt out if they feel there's no
502 support, they're not appreciated

502 - staff feel burnt out if they feel what they
503 do isn't valued (no support).

502 - if staff feel unsupported/burnt out/unappreciated
504 it can affect their interaction & Pts.

Appendix H: Initial model

Unspoken institutional rules re VA

- No VA training available for staff
- No formal staff support available post-VA
- Zero Tolerance policy is not really enforceable on the ward.
- VA is not taken seriously/tick-box exercise.
- An expectation that staff should be able to cope with VA
- VA is seen as less damaging than physical aggression
- VA is seen as part of the job
- VA occurs so frequently that nurses become accustomed to it.
- Consultant sees VA as something of no consequence.
- Consultant sees himself as too senior to benefit from VA training

Deficit of organisational empathy

+
Patient
VA

Trust: Staff

↓ Parallel process ↓

Staff: Patients

Impact of VA/How staff feel/try to cope

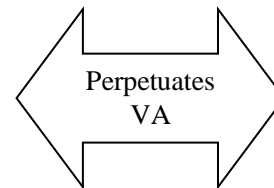
- Self-blame, disheartened, distressed, feeling powerless, frightened, hurt and upset.
- Staff become de-emotionalised to the impact of VA over time.
- Staff try to cope/safeguard themselves (eg. 'clinical armour', being mentally prepared for VA, not allowing themselves to get hurt by VA).
- Staff's psychological wellbeing is affected (eg. Low morale, loss of initial passion for the job, burnt out, go off sick – 'don't want to deal with it').
- Staff shouldn't have to experience VA at work – it's not okay.
- Seeing patients through the lens of their mental illness (eg. PD patients; VA = bad behaviour/ VA is due to the patient's mental illness)

Negative staff interaction with patients ("Just do your job and go home")

- Responding to VA aggressively (level 2)
- Acting overly rigid/authoritarian/issuing ultimatums.
- Walking away and leaving a team mate to deal with the issue (level 2)
- Feelings of resentment/hurt towards the Pt may impair working relationship.
- Staff may alter working practice (after VA; overly strict, aloof), may affect patient care.
- Acting disrespectful/condescending towards patients
- Engaging with patients (e.g. thoughtless remark, style of response to a request).

Ward atmosphere

Deficit of staff empathy



Therapeutic relationship

Dissatisfied patients

- Don't feel like they have staff attention/don't feel listened to
- Don't feel involved in their treatment.
- No faith that the staff will deal with VA properly (level 2).
- Feel trapped on the ward.
- Use VA as a means to regain a sense of control and gain staff attention.
- Angry about being admitted; don't believe they have a mental problem.

Appendix I: Interview Schedule – Phase 2

(The use of ‘VA’ in the interview schedule is for the researcher’s convenience; the complete term ‘verbal aggression’ was used in the interview). Preamble as specified in initial interview schedule.

As a starting point, could I ask you to tell me a little bit about what you think VA is and your experience of VA on the ward?

How VA is thought of on the ward -

1. How do you think staff see VA, in relation to their everyday life at work?
2. Some staff may have an ‘I don’t tolerate VA’ attitude (especially after experiencing VA). What is your experience from what you have observed? What do they do when they do experience VA?
3. How much do you think being busy on the ward is an issue in terms of responding to VA?
4. In terms of how VA is experienced on the ward, how do you see VA compared to physical aggression?
 - a. E.g. Level of harm, effect on staff? Reaction/response from management?
5. One can imagine that ward staff may feel they ‘have to be able’ to cope or deal with VA. What are your thoughts on this?
 - a. To what extent do you think this way of thinking is part of the work culture on the ward?

Perceptions of the causes of VA -

6. What do you think contributes to VA happening on the ward? Let’s look at it in terms of the patient, staff, and the organisation –
 - a. What do you think your patients would say causes their VA?
 - b. In what way, if at all, do you think staff could contribute to the occurrence of patient VA?
 - How do staff and you yourself determine what VA is intentional and what isn’t?
 - To what extent might staff attribute patient VA to their mental illness? What do you think about this?
 - c. To what extent, if at all, do you think the organisation has an impact on the occurrence of VA? If so, what factors would you say contribute to it?
 - How might management respond if asked about the causes of VA?

Staff coping with and management of VA -

7. Staff support:

- a. How far do you think staff feel supported when it comes to experiencing VA and the after-effects? What level - Peers/team/higher level
- b. Do you think that the organisation/Management feel there is a need for staff support for VA? Yes/no – could you explain further, please.
- c. What are the consequences of a lack of staff support?

8. Self-Protection:

- a. How do, if at all, staff try to protect themselves from the emotional impact of VA?
 - How successful would you say this is, as a strategy?

9. Taking VA seriously:

- a. How seriously is VA taken on the ward by the management?
 - To what extent is the zero-tolerance policy/VA policy enforced?
- b. Can you tell me what happens in terms of procedures when staff experiences VA?
 - Would they document/ report/inform anyone else about it?

Organisational influence on the handling of VA -

10. To what extent, if at all, have you considered how the organisation itself, and the way it is set up, might influence how VA occurs, how it is managed, and how staff feel about it?
- Probe: Have you ever thought this might influence how VA is seen and handled?
 - Probe: How would you describe or characterise how you think senior managers view VA towards ward staff?
11. How far do you feel there is an understanding of what VA is like for staff, at a senior level?
- Probe: Is this something that matters to you? Why? Why not?

Implications of VA for the staff-patient relationship -

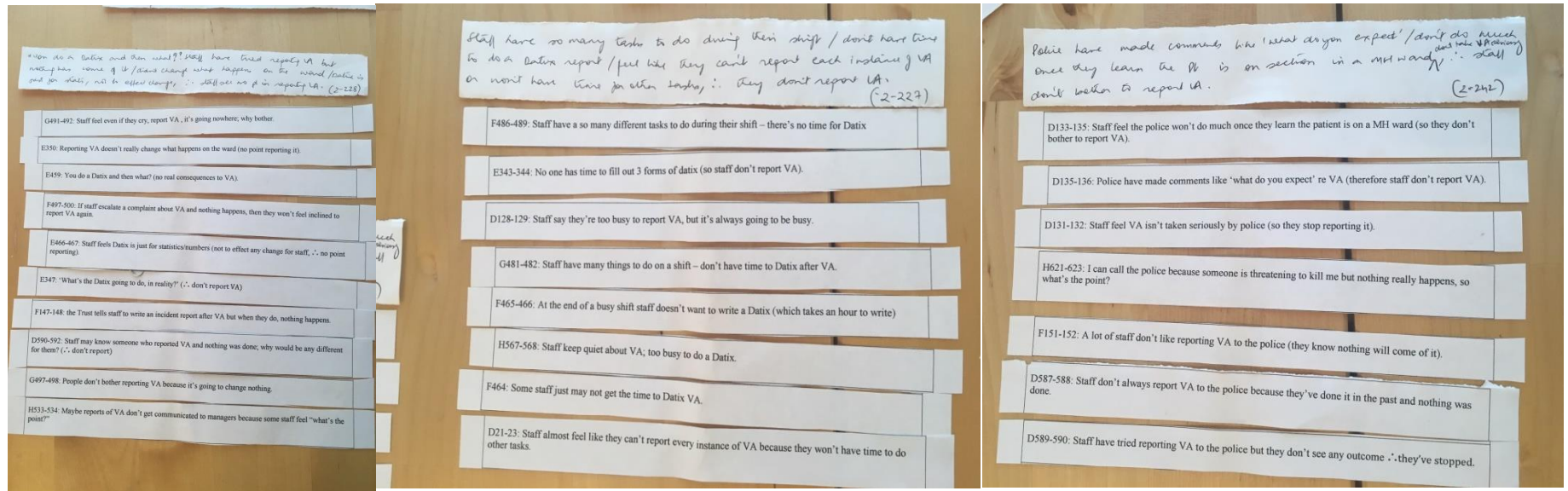
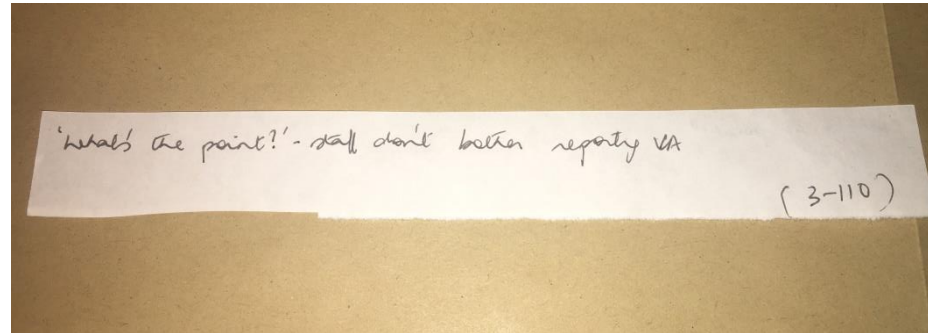
12. What kind of relationship do ward staff and patients have? How would you describe it?
- a. How might the staff-patient relationship be affected after VA?
 - To what extent do you think management sees the staff-patient therapeutic relationship as significant?

Closing question - Is there anything I have not asked you about VA in this team environment, or this organisational setting that you believe is important for me to know?

* Prompts to elicit further information as in initial interview schedule*

Appendix J: Example of creation of a higher-order code.

(3-110 “What’s the point?” - staff don’t bother reporting VA”. This code encapsulates codes 2-228, 2-227, and 2-242, which in turn subsume their respective initial codes).



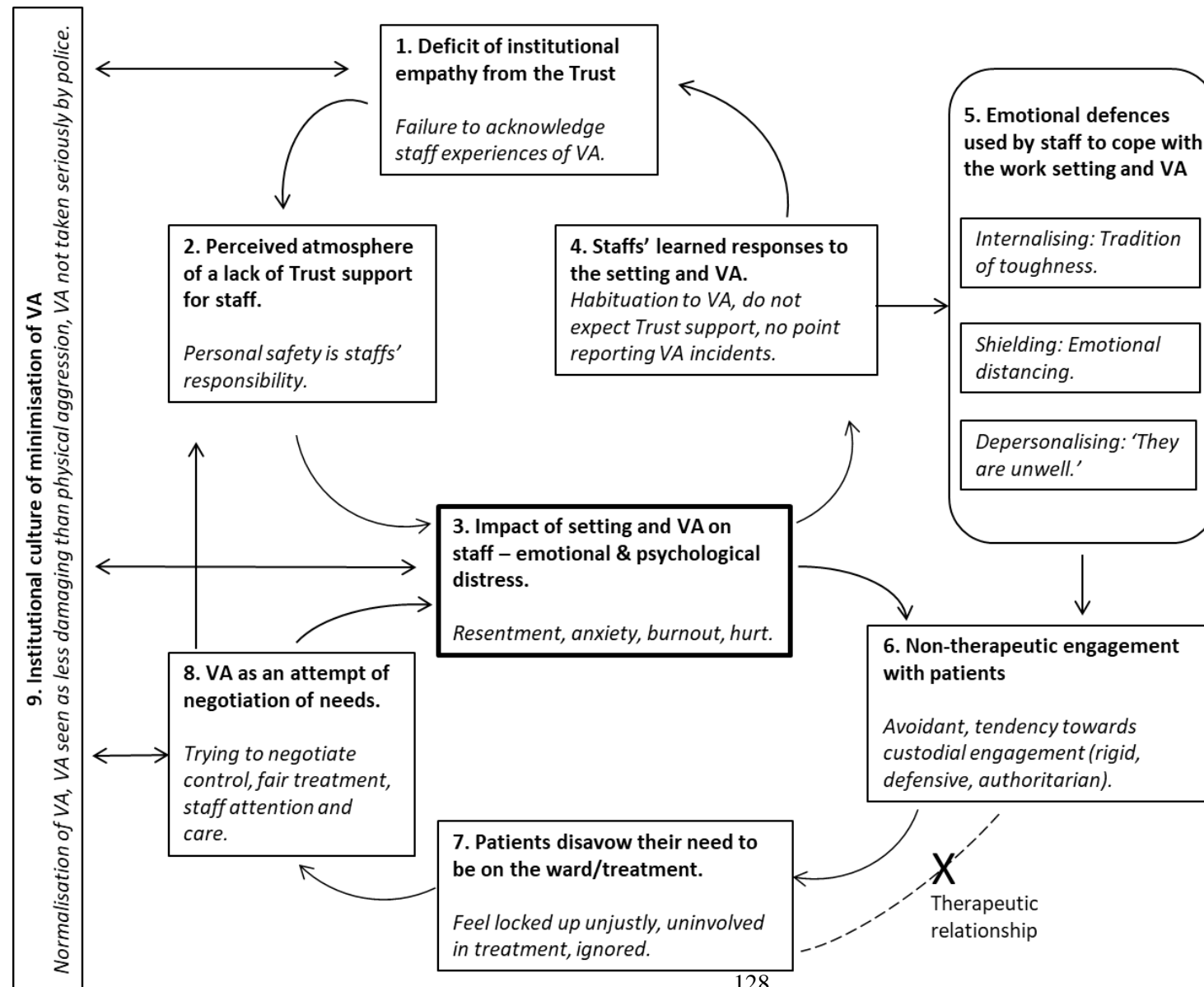
Appendix K: Data analysis sample. Extract of data provided to the researcher’s supervisor for an independent audit of the analysis process. (This extract is an illustration only, and does not represent comprehensive participant data for each sub-category)

Line numbers	Illustrative quotes	Initial codes	Sub-category	Category	Higher order category
E326-328	“Doesn’t necessarily mean we’re coping, it means we’re burning ourselves out just trying to make sure that we do what we need to do for our patients”	Staff may seem like they’re coping, but they’re not – they’re burning themselves out doing their job.	2-67: VA can cause staff burnout (even when they seem like they’re coping).	3-29: Emotional and psychological impact of VA (fear, distress, hurt, anxiety, low morale, burnout, go off sick).	4-01: Impact of setting and VA on staff – emotional and psychological distress.
A602	“You do feel a bit, sort of burnt out, you know, coz you have to go home and deal with this feeling.	VA can make staff feel burnt out (because resentment towards the patient stays with staff)			
A610	“You know so you find that there is high sickness rate”	VA can result in a high staff sickness rate.	2-69: Staff can go off sick because of patient VA (they don’t want to deal with the stress)		
H157	“you know, almost staying away from the patients, and going off sick”.	Staff go off sick to avoid engaging with verbally abusive patients.			
C676	“I think it could be demoralising, especially if you don’t know how to deal with it”	VA can be demoralising for the team	2-71: Incidents of VA or physical aggression can affect staff morale (individual and team)		
A243	“Because it does cause a lot of low staff morale, and people feel quite hard”	Incidents of VA or physical aggression can cause low staff morale.			
G18	“Feeling sad, feeling a bit uh what a terrible way of earning a living”	VA makes staff feel unhappy, “what a terrible way of earning a living”	2-68: VA can diminish staff motivation/passion for the job.		
H133-134	“the person themselves might have to say oh, ‘I’m the staff and I should be able to deal with it’ and finds it difficult”	Staff may feel (about VA), “I should be able to deal with it”, but find it difficult to deal with (and don’t feel like coming to work)			
C61-62:	“I think the patient actually described her as being a prostitute. You know, and that really hurt her very bad”	Being described as a prostitute by a patient upset staff deeply.	2-12: VA is very upsetting and hurtful to staff.		
G22	“So it’s really yeah, it definitely, it	VA definitely hurts.			

	hurts, it hurts”				
B504	“You know, so you may feel oh, you know, you’ve done something wrong”	Staff may blame themselves for VA; feeling like they did something to provoke it.	2-04: Staff may blame themselves for VA; feeling like they did something to provoke it.		
D81-82	“coz you’re quite angry about what’s happened to you [yeah], you’re quite bitter and you feel hurt, you feel violated”	Experiencing VA makes staff feel angry, bitter, hurt and violated.	2-200: Experiencing VA makes staff feel angry, bitter, hurt and violated.		
A179	“I’ve been, I’ve been really scared before”	Staff has felt very scared in response to VA			
D101-102	“the patient didn’t hit them but there was something about the way the patient spoke to them and made them feel really threatened”	Though the patient wasn’t physically aggressive, the way they spoke to staff made the latter feel really threatened.	2-01: VA can make staff feel threatened and afraid for their safety.		
A185	“and you kind of feel really threatened”	VA can leave you feeling really threatened.			
E406-407	“you wouldn’t make a good mum anyway, you can’t even look after your patients”	Staff has been told she’ll be a bad mum as she can’t even look after her patients; the feeling stays with you.	2-202: Staff has been told very hurtful things by patients, that resonate and stay with her for a long time.		
E406	“So, they will definitely say things that just ... ‘you’ll never have kids”	Staff has been told “you’ll never have kids”; the hurt stays with you.			
E90-91	“Although you don’t respond emotionally at that time, and you can shrug it off, you feel it, you still feel it. It still hurts”	Even though staff may not respond emotionally to VA /shrug it off, it still hurts.			
E83-85	“nurses always told me ‘when you get that door, you take your nursing hat off, and you go home’. And that’s life. This is work. That’s life. But it doesn’t work that way at all.”	Staff was advised, at the end of your shift ‘take your nursing hat off’ (but it doesn’t work that way).	2-204: Staff feels unable to take her “nursing hat” off at the end of her shift; she has now developed anxiety from the stress.		
E398-399	“you’re up all night with your heart racing thinking how am I going to deal with this tomorrow?”	Staff is up all night, heart racing, worrying about having to deal with an abusive patient the next day.	2-203: Staff experiences somatic symptoms of anxiety; hard to sleep, heart racing (stressed about having to engage with an abusive patient)		

D498	"I think, I think staff....I think sickness level might go up"	Without staff support, the sickness level may increase after VA.	2-56: If staff feel unsupported, the staff sickness level may increase after VA.	3-23: Emotional and psychological impact of lack of support after VA (burnout, diminished motivation, go off sick).	
B485-486	"you know you don't want the person to be so verbally abused over a certain number of days and then they take sick leave because of the aggression"	Without staff support, staff may take sick leave after repeated VA.			
A813-814	"I think what makes the difference is how much support they feel they've been offered. That's what makes the difference."	What makes a difference to staff burnout is how much support staff feel they've been offered (after VA)	2-55: Staff feel burnt out if they feel there is no support (after VA).		
H525	"And if our heart's not there it's difficult and then burnout sets in"	When staff are unhappy (lack of support after VA) their heart's not in the work and burnout sets in.			
D500-501	"Even though someone might have a cough or they're really tired you still see they'll come to work because they really enjoy it, they're quite passionate about it"	If staff is unwell they make an effort to come in because they are passionate about work (but not if they feel unsupported)	2-210: If staff feel unsupported they stop making an effort at work/stop loving their job.		
F232-233	"They've lost the zeal for the job which isn't always their fault, it usually stems from how the Trust have treated them"	Some staff have lost their zeal for the job (usually stems from how the Trust have treated them).			

Appendix L: Theoretical model representing acute psychiatric staffs' experiences and perception of VA on the ward.



Appendix M: Example of a Memo.

3/5/17

D41 - VA comes with the job. Staff who have MM experience have understand this well, compared to new staff - they don't expect VA, never mind physical aggression. But as time goes by they too learn that VA is going to happen; it comes & the job.

Responded to (maybe threats/alarms?) by staff

Almost part of the background ∴ seen as part of the job

VA on the ward.

No support/acknowledgement of distress.

Also think about - is this their normal???

D70 - If you are a victim of VA it can make you put your guard up. This gets in the way of a therapeutic staff-VR relationship. Staff should be able to model healthy interpersonal interactions that the VR might be able to learn from. Putting your guard up - understandably to protect yourself - is a lost opportunity for open communication & resolution of differences. After a point I presume the VR is going to get fed up of being kept in the cold and become aggressive if only to get a reaction out of staff.

VR

Staff gets upset

Ward Env? Extension?

VR's circle

Preys on further VA.

Put's them guard up

Appendix N: Page from researcher's reflexive diary.

but I guess it's to be expected as part of the process. Doesn't make it easy though. But as [redacted] says, just keep swimming!

22/6/18 - In transcribing E's interviews and reached the bit when she was so hurt about what her Pt said. Negotiating the space between researcher and therapist can be tricky. I did talk to her about it during the debrief but I didn't expect to find it so challenging, wearing both hats (as it were). I spoke to [redacted] about it, and it's reassuring to know that she experienced something similar. I guess there is no 'right' way to be. All I can do is be present in my role and be authentic in my interactions. I must have been successful in my attempt because of her "it's good that someone can hear our stories" comment. God, it made me feel sad, humble, and grateful all at once. In a way it makes me want to shove even harder to do justice to her words. When I started this I didn't consider that this part of the research would have so much meaning. It's a privilege I must be mindful of it.

8/7/17 - I cannot believe it, it sounds like something out of a book. He's got electrocuted at work??? I was feeling positive about arranging an interview with F, and now I will have to move it, I don't know how long she will be off work. Ah this makes me sound heartless but I do hope she's fine. I was feeling on top of things and boom, my time has is messed up. Okay. It's not the end of the