THE PROCESS OF RESPONSE OF MENTAL HEALTH NURSES WHO HAVE EXPERIENCED ASSAULTS BY THEIR PATIENTS: A GROUNDED THEORY STUDY CONDUCTED IN MENTAL HEALTH INPATIENT SETTINGS.

A thesis submitted for the degree of Doctor of Philosophy in Nursing at the University of Newcastle

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December 2009.

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Acknowledgements

The work described in this thesis has been supported by a number of people who have provided me with information, advice and encouragement.

Professor Michael Hazelton provided valuable counsel as the principal supervisor for this study. Professor Hazelton demonstrated a generosity of spirit in affording me his time and expertise in discussing the planning and conduct of the study as well as the development of the thesis. His questioning and constructive criticism has enhanced my learning experiences during my doctoral studies.

Dr. Ashley Kable graciously accepted the role of co-supervisor at a time when the thesis was taking shape and was adept at providing a balance of insightful comments and steadfast encouragement. Dr. Kable encouraged me to re-examine what I had achieved in the study and her fresh sense of perspective is greatly valued.

Thanks must go the many nurses and patients who permitted me to observe them during the observational phase of the study. In particular, I would like to take this opportunity to acknowledge the sixteen nurses who became participants during the interview phase of the study and subsequently gave me their time and generously shared their experiences with me.

Finally special thanks are due to my wife, Karen, and my children Alexandra, Timothy and Nicholas for their steadfast support and understanding of my ambition to complete this thesis. Their love and energy has sustained me.

Charles Harmon

Newcastle, AUSTRALIA

September 2010.

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Abstract

This study examines the experience of inpatient mental health nurses who have been assaulted by their patients. The study was conducted in two phases in the inpatient units of a mental health service in regional New South Wales, Australia. Grounded theory method was used to analyse the data collected during Phase One in which the researcher conducted non-participant observation of three units. This enabled the researcher to explore the nurses' working environment and develop a theory which explained the way in which inpatient mental health nurses interacted with their patients in the provision of care. Phase One findings provided contextual information which facilitated the understanding of subsequent data collected during Phase Two. Mixed methods were used during Phase Two of the study in which sixteen recently assaulted nurse were interviewed within three weeks of their assault and then on two subsequent occasions at three months and six months post-assault. None of the nurses experienced lasting physical trauma as a result of their assault however nine reported psychological effects lasting from several weeks to several months. Data were analysed using descriptive statistics and grounded theory method. The main purpose of this study was to develop a substantive theory which explained the process of response and, by extension, recovery of the mental health nurses to the experience of assault by a patient.

Data analysis during Phase One of the study revealed that the mental health nurses were constantly dealing with the problem of a chaotic work environment and a preoccupation with ensuring the smooth operation of the unit which was done in preference to the provision of therapeutic nursing care. The emergent core category of nurses responding to others in an ad hoc manner explained the tendency of the nurses to constantly deal with the needs of others rather than actively plan patient care. Data analysis during Phase Two of the study revealed that participants tended to use passive coping strategies in the aftermath of their assault by a patient. Whilst some participants were able to forget about their assault and get on with their lives, however, others who were more severely affected by their assault developed a coping pattern characterised by *churning anxiety* which featured assault reminders, passive coping strategies, assault response mediators (which referred to the availability of support from peers and nursing

administrators) and a sense of futility related to the belief about the inevitability of workplace assault. The *churning anxiety* phase of recovery was followed by a later *reintegration* phase in which the participants adopted a more active coping style accompanied by a sense of residual vulnerability and ongoing futility. An important finding was that the participants reported that they were compromised in their ability to effectively engage with patients as they recovered from their assault. The basic social process emerging from the data for the severely affected assaulted nurses was labelled moving from passive to active coping strategies in the context of the nurses overcoming futility focused about the assault.

The significance of this study is that the nurses who experienced more severe post-assault responses had a recovery that was completed in stages as they passed from the churning anxiety phase to the reintegration phase and this finding adds to the understanding of the complex phenomenon of recovery after assault. The finding also has occupational health and safety implications for employers as they assist mental health nurses to recover from the effects of patient assault. It is concluded that, with further research, interventions might be tailored to assist nurses in the recovery process depending upon their phase of recovery. This may enable assaulted nurses to decrease their distress and enable them to more effectively fulfil their professional role by engaging with their patients.

Key to abbreviations and conventions employed in the data transcriptions

In the presentation of transcript material in this thesis the following abbreviations and conventions have been used.

Names: all names used in reference to study participants (e.g. Bruce, Nigel, Krystal, etc.) are pseudonyms or initials (e.g. 'A' for Anne). Other patients and staff referred to in the thesis have been labelled Patient or Staff and numbered (e.g. Patient #3).

The initial 'C': refers to the researcher (as occurs in Chapter 7, p. 166).

The initial 'p': refers to pages.

[Bold letters in brackets]: represent the researcher's coding of the data.

…: signifies a pause in the original interview.

CHAPTER ONE

INTRODUCTION AND OVERVIEW OF THE THESIS

1. BACKGROUND TO THE STUDY

The phenomenon of patient-initiated violence in mental health care settings has become an important issue over the past two decades principally because of a growing awareness that assaults upon mental health professionals may have significant occupational health and safety implications for affected individuals. Moreover there is evidence that mental health professionals may be compromised in their ability to work effectively with colleagues as well as their patients after they have experienced an assault.

1.1 Violence in health care settings

A number of authors have identified staff working in health services as a group at high risk of being assaulted in their workplace compared with other vocations (Farrell & Cubit, 2005; Gournay, Ward, Thornicraft & Wright, 1998; McPhaul & Lipscomb, 2004; Upson, 2004). Studies amongst diverse groups of health professionals such as general practitioners (Magin, Adams & Joy, 2007; Tolhurst, Baker, Murray, Bell, Sutton, & Dean, 2003), social workers (Littlechild, 2005; Newhill, 1995), psychiatrists and other medical officers working in mental health units (Freedman, Ross, Michels, Appelbaum, Siever, Binder, Carpenter, Friedman, Resnick & Rosenbaum, 2007; Kidd & Stark, 1992; Nolan, Dallender, Soares, Thomsen & Arnetz; 1999) have revealed that patient violence affects a wide range of personnel. Additionally violence has been identified as a major problem in a number of health care contexts such as aged care facilities (Badger & Mullen, 2004; Gates, Fitzwater & Meyer, 1999), general hospitals (Wells & Bowers, 2002; Whittington, Shuttleworth & Hill, 1996), emergency departments (Blanchard & Curtis, 1999; Hislop & Melby, 2003; Luck, Jackson, & Usher, 2008; Lyneham, 2001), as well as mental health settings (Carr, Lewin, Sly, Conrad, Tirupati, Cohen, Ward, & Coombs, 2008; Collins, 1996; Lanza, 1983).

Surveys of health professionals conducted internationally consistently place nurses at a high risk of violence compared with other health service occupations (Arnetz, Arnetz &

Soderman, 1998; McPhaul & Lipscomb, 2004; Whittington, et. al, 1996) and this situation is similar in the Australian context (Mayhew & Chappell, 2002). It is also important to note that the under-reporting of assaults greatly affects the ability of researchers to fully determine the extent of the problem (Arnetz, et al, 1998; Badger & Mullen, 2004; Lion, Snyder & Merrill, 1981).

Apart from the personal distress which victims of violence may incur, various studies have provided evidence for a range of other detrimental effects of workplace violence in health care settings including: increased absenteeism and sick leave (Rix, 1987; Rugulies, Christensen, Borritz, Villadsen, Bultmann, & Kristensen, 2007); decreased productivity (Farrell & Cubit, 2005); compromised recruitment and retention of staff (Farrell & Cubit, 2005; Findorff-Dennis, McGovern, Bull & Hung, 1999; Luck, Jackson & Usher, 2008); and difficulties in nurse-patient relationships (Farrell, Bobrowski & Bobrowski., 2006; Levin, Hewitt & Misner, 1998). There is also evidence that patient assault is associated with substantial financial costs to the health care system (Farrell & Cubit, 2005; Hunter & Carmel, 1992; Lanza & Miller, 1989).

2. PURPOSE OF THE STUDY

The researcher aimed to prospectively document the experience of mental health nurses following assaults by their patients and in so doing: explore taken-for-granted responses and coping mechanisms; reveal responses that the participant was not aware of or had minimised; and highlight the scope of reactions of individuals as well as individual differences in coping and adjustment. It was anticipated that the data set would allow the researcher to discover patterns in the way that victims coped or did not cope with events subsequent to their assault such as: returning to work; interacting with colleagues; interacting with patients; and, in particular, interacting with the perpetrator of their assault.

3. JUSTIFICATION FOR THE STUDY

Although there is a significant body of data on the effects of patient-initiated violence upon mental health nurses there are gaps in the information about how mental health nurses respond after they have been assaulted and the subsequent implications for their professional conduct as well as their continued safety at work. Whilst it is known that

assaulted nurses may respond adversely to the experience of assault, for example, information about their process of recovery is sketchy at best with the implication that assaulted nurses may not be receiving the type and frequency of support that could assist them to recover from the effects of assault and return to their role as effective providers of quality patient care (Bonner & McLaughlin, 2007; Lanza, Zeiss & Rierdan, 2006; Nolan, et al., 1999). Moreover the studies undertaken thus far have largely provided quantitative analyses of the responses of victims. Certainly researchers such as Conn and Lion (1983), Ryan and Poster (1989) and Wykes and Whittington (1991) have included some qualitative data in the findings of their otherwise quantitative studies. There have also been some qualitative studies undertaken by Collins (1996), who employed a grounded theory method, and Cutcliffe (1999) and Duxbury (1999), who both used a phenomenological approach to data analysis. However neither Collins (1996), Cutcliffe (1999) or Duxbury (1999) used a research design which involved the prospective collection of data. Indeed Collins' (1996) data was gathered well after the participants in her study had been assaulted with one interview being conducted with a mental health nurse some seventeen years after the participant had been assaulted (Collins, 1996, p. 57) which, in all probability, affected the immediacy of the data and the subsequent ability of the participant to accurately recall steps taken toward recovery. Further, there is only a small body of information about the role of social support and, in particular, the support given to nurse victims of patient assault by nursing administrators and nor does there appear to have been any prior concerted attempt to connect these components to form a substantive theory about the process of response of mental health nurses to the experience of patient-initiated assault. In consideration of this situation the researcher envisaged a prospective examination of the responses of a convenience sample of mental health nurses to the experience of patient-initiated assault employing mixed methods of enquiry and principally using a grounded theory method.

Finally there have been many studies which have been designed to measure and/or describe the dimensions of human suffering in the aftermath of events involving interpersonal violence. For example there have been studies involving people who have been traumatised because they have been: victims of common assault and battery (Cuthbert, Lovejoy, & Fulde, 1991; van Zomeren & Lodewijkx, 2009), domestic violence, child abuse and/or sexual assault (Csoboth, Birkas, & Purebl, 2005; Jonker &

Hamlin, 2003; Vidal & Petrak, 2007); refugees from war zones (Fox, Cowell, & Montgomery, 1999; Spencer & Le, 2006); survivors of concentration camps, including the Holocaust (Stessman, Cohen, Hammerman-Rozenberg, Bursztyn, Azoulay, Maaravi, & Jacobs, 2008); or people whose occupation has exposed them to violent incidents such as bank employees (Fleming & Harvey, 2002), soldiers (Adler, Litz, Castro, Suvak, Thomas, Burrell, McGurk, Wright, & Bliese, 2008), police (Santos, Leather, Dunn, & Zarola, 2009), and emergency workers (Suserud, Blomquist, & Johansson, 2001). Generally speaking, however, these studies have tended to describe extreme personal outcomes for victims including pathologies manifested by diagnoses such as acute stress disorder (ASD), posttraumatic stress disorder (PTSD), major depression and other co-morbidities. The researcher anticipated that there was a likelihood that most, if not all, of the incidents described in this study would produce responses that did not lead to diagnoses such as ASD or PTSD (Gournay, Gray, Wright & Thornicraft, 1997) based mainly on findings from the literature which indicated that most injuries sustained by nurses are relatively minor (Fry, O'Riordan, Turner & Mills, 2002; Needham, Adberhalden, Halfens, Fischer & Dassen, 2005; Nolan, et al., 1999). Accordingly it was anticipated that the present study would provide insights into the types and patterns of responses of people to violent incidents that did not lead to such debilitating disorders. Moreover many of the existing studies which examine personal trauma have a pathology focus with the response of victims being characterised by the existence or non-existence of pathology. This study aimed to examine the responses of assault victims that were adaptive as well as maladaptive and, in so doing, facilitate the emergence of data on the plight of the victim from the victim's perspective.

4. RESEARCH QUESTIONS

Liehr and Lobiondo-Wood (2006, p. 157) stated that research questions in a grounded theory study "are those that address basic social processes which shape human behaviour" and "… can be a statement or broad question that permits in-depth examination of a phenomenon". Accordingly the broad research questions for this study were:

What is the process of response of mental health nurses who have experienced assaults by their patients?

What is the effect of recent (patient initiated) assault upon the ability of the mental health nurse to engage therapeutically with his/her patients?

5. RESEARCH APPROACH

It was envisaged that the present study would be conducted in two phases and take place in public sector acute mental health in-patient units located within a regional area health service of New South Wales (NSW), Australia. During Phase One of the study the researcher planned to conduct non-participant observation of three acute mental health inpatient units. It was intended that the subsequent field notes generated during this phase would provide information on the contexts[1] in which the mental health nurses worked and the processes which guided nursing activity[2].

During Phase Two of the project the researcher planned to conduct structured and semi-structured interviews with consenting mental health nurses who had been assaulted by patients whilst working on mental health inpatient units. During the initial interview the recently assaulted nurses would be asked to provide demographic data (see Appendix A) as well as responses to: the Assault Response Questionnaire (ARQ) (Ryan & Poster, 1989) (see Appendix B); and the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983) (see Appendix C). It was planned that all questionnaires would be presented in the form of an interview so that the researcher could ascertain whether the procedure was causing undue distress and all participants would be made aware of

[1] By *contexts* the researcher means aspects of the broader mental health unit environment including: the physical environment, including architectural design and décor; social environment, including the features of patient and staff social networks and their degree of integration; and the therapeutic milieu in which the nurses (and other health workers) and patients construct conditions designed to promote patient health.

[2] By *processes which guide nursing activity* the researcher is referring to a broad range of nursing activities which may be designed to: promote the level of care for patients; service the needs of others (such as medical practitioners or nursing administrators); or meet other requirements determined by legislation such as the relevant mental health or occupational health and safety acts.

counselling options available to them via the Employee Assistance Program (EAP)[3]. The main purposes of the initial interview would be to enable the researcher to establish rapport with the participants and assist them to quantify their initial responses to their assault using the ARQ. It was also envisaged that the use of the ARQ might provide the recently assaulted nurses with a standard language with which to describe their experiences and, subsequently, allow their recorded responses to act as a baseline measurement against which to compare the severity of responses to their assault on future occasions. The researcher also planned to conduct follow-up semi-structured interviews at approximately three months and six months post-assault in which the assaulted nurse would be invited to tell the story of their assault and their subsequent responses to that assault. The timing of the follow-up interviews was planned according to the findings from previous studies which indicated that participants would experience a change in coping patterns over a six month period (Collins, 1996; Ryan and Poster 1989). It was envisaged that these interviews would be audio-taped and the subsequent data transcribed for the purposes of further thematic analysis.

5.1 Analysis of the data

The researcher planned to employ mixed methods of data collection and analysis during this study. Qualitative data from Phase One of the study would be analysed contemporaneously using the grounded theory method developed by Glaser and Strauss (1967) and subsequently further developed by Glaser (1978; 1992; 1995).

During Phase Two of the study the use of questionnaires (such as the ARQ) combined with the employment of semi-structured interviews as the primary source of data would necessitate the use of descriptive statistics in the initial analysis of data provided by assaulted mental health nurses and the subsequent analysis of the qualitative data using grounded theory method (Glaser, 1978; 1992; 1995; Glaser & Strauss, 1967). Using these methods the researcher aimed to construct a substantive theory with the facility to

[3] In NSW EAP is a free and confidential counselling service which is available to all area health service staff members who have been, for example, assaulted by a patient and is funded by the NSW Department of Health.

explore the *process* of response for those mental health nurses in the sample who responded adversely to their assault.

5.2 Personal beliefs underlying the study

Prior to the commencement of the present study the researcher reflected on how being an experienced mental health nurse who had previously been employed in the study settings, and who had previously conducted research with assaulted nurses (Harmon, 1997), may have coloured my knowledge of the profession, the relevant study contexts, and also some of the literature relevant to the phenomenon of patient assaults upon mental health nurses. The researcher acknowledged several personal beliefs about mental health nursing which were held prior to the commencement of the present study including beliefs that:

1. it is a primary role of mental health nurses to engage with their patients to form a therapeutic alliance that is beneficial to the well-being of patients;

2. it is essential for mental health nurses to maintain professional boundaries in the context of their relationships with patients;

3. mental health nurses enter their profession with the expectation that they will be able to engage with their patients to produce therapeutic outcomes;

4. mental health nurses either enter their profession with the expectation, or soon develop the expectation, that they will be assaulted by patients in their care at some point in their careers;

5. in responding to the experience of patient-initiated assault mental health nurses will also respond to things other than the assault *per se*. They might also be distressed, for example, in the event that a colleague or supervisory staff member did not help them after their assault or they might be caused to respond to other stressors in their personal life which existed prior to the assault;

6. the experience of assault would negatively impact upon the nurse's ability to engage with their colleagues and their patients.

Whilst these beliefs were acknowledged prior to the commencement of the present study the researcher was also aware that there may be other beliefs, unforeseen at the

commencement of the study, which may affect the way that the data were interpreted in the path towards developing grounded theory (Glaser, 1978; Glaser & Strauss, 1967). One of the purposes of discussion sessions between the researcher and the researcher's supervisors was to examine potential sources of bias and find ways of setting them aside, or 'bracketing' them, so that the data might be viewed from an objective a view as was possible under the circumstances (Liehr & Biondo-Wood, 2006; Hutchinson, 1993).

5.3 Definitions of terms

A number of terms need to be defined in order to clarify the way that they will be used in this study namely: patient-initiated assault; recent assault; aggression; violence; mental health nurse; mental health inpatient unit; and background stressor.

For the purposes of this study *patient assault* was defined as: i) any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (for example: where the nurse is verbally threatened) OR ii) any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (for example: where the nurse is spat upon)[4].

The term *recent assault* means an assault that has occurred within the past twenty one days and the terms violence, aggression and assault are used interchangeably in this study. The decision to interview participants within twenty one days of their initial assault was taken on the expectation they would be able to retain strong memories of their assault during this period of time (Wykes & Whitington, 1991).

Mental health nurse means any person employed as a nurse in a psychiatric hospital including any enrolled nurse (EN) and any registered nurse (RN) who has completed the appropriate hospital-based certificate training (in the case of some ENs and RNs), technical and further education certificate (in the case of some ENs), or tertiary studies within a college or university toward Diploma or Bachelor of Nursing (or equivalent or higher degree) (in the case of some RNs).

By *mental health inpatient unit* the researcher meant any building used as a gazetted[5] mental health facility under the NSW Mental Health Act[6] (NSW Parliament, 1990) to house patients deemed to be either mentally ill or mentally disordered for their care, control and treatment.

The term *background stressor*[7] is used to describe any stressor, apart from those caused by the assault, which are either work-related or arise from the mental health nurse's personal life which may have influenced the intensity of their responses to the experience of being assaulted by a patient.

The term *coping* refers to an individual's cognitive and behavioural efforts to manage by reducing, minimizing, mastering, or tolerating internal and/or external environmental demands that are perceived as taxing or exceeding one's resources and have the potential to endanger one's well-being (Folkman & Lazarus, 1988; Folkman, Lazarus, Gruen, & DeLongis, 1986).

6. OVERVIEW OF THE CHAPTERS

This thesis is presented in seven chapters. This initial chapter provides an introduction to the study. Chapter Two presents a critical review of the literature including an historical perspective on patient violence in mental health settings, encompassing a description of the changing perspectives on the phenomenon of patient violence which occurred during the decade of the 1980s and onwards. A number of phenomena associated with patient violence in psychiatric hospital contexts are then explored including: the underreporting of assaults by staff; apparent increases in the incidence of assaults upon mental health unit staff; and factors associated with aggressive incidents in psychiatric hospitals (for example the characteristics of assaultive patients, the

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[4] This definition was adapted from the definition used by Ryan and Poster (1989).

[5] The nomenclature 'gazetted' mental health facility has been changed to 'declared mental health facility' with the introduction of the NSW *Mental Health Act 2007* (NSW Parliament, 2007).

[6] Note: The 1990 Act has since been replaced by the NSW *Mental Health Act 2007* (NSW Parliament, 2007).

[7] Background stressors were measured by the Perceived Stress Scale (Cohen, Kamarck and Mermelstein, 1983)

capacity of mental health inpatient facilities to cope with the numbers of patients admitted, and the level of patient acuity). The review of the literature presented in Chapter Two is designed to provide a rationale for the present study and also to provide information which will facilitate a better understanding of the phenomena under investigation. The information discussed in this chapter does not include a review of the literature on the responses of mental health nurses to assaults by patients. The researcher purposely avoided a thorough review of this latter information, even though the material had been examined in a preliminary sense prior to the commencement of the present study, so as to minimise biases in the interpretation of data during the data analysis phase (Glaser, 1978, Glaser & Strauss, 1967).

Chapter Three provides a discussion of the grounded theory method first developed by Glaser and Strauss (1967) and developed by Glaser (1978; 1992; 1995). There will be a justification for the use of this version of the grounded method in preference to the version developed by Strauss (1987) and Strauss and Corbin (1990; 1998). There is also a discussion of methods used to ensure rigour in grounded theory research as well as the limitations of grounded theory.

Chapter Four provides a discussion of the processes employed during the conduct of the two phases of the study. The chapter includes: details of the study settings; procedures used to gain entry to the study contexts and also to recruit participants; a description of the methods used to collect data and facilitate data analysis; and a discussion of ethical considerations associated with the conduct of the study.

Chapter Five entails a detailed account of the data analysis methods employed during the two phases of the study and provides a description of the emerging categories associated with these phases as well as the emergent core category or basic social process.

In Chapter Six the findings of the study are examined in the context of the relevant literature. There is an initial discussion concerning the Phase One findings and the literature about the activities of mental health nurses employed in acute mental health hospital settings. This discussion is followed by an examination of the Phase Two data relating to the responses of the study participants to the experience of patient assault in

the light of findings from previous studies. The discussion that follows examines the responses of mental health nurses to the experience of assault in relation to PTSD theory. Consideration then moves to the implications of the study for the professional lives of the study participants and how the process of recovery might impact upon the participants' ability to engage therapeutically with patients in view of some of the coping strategies reported. There will also be a discussion of the implications for teamwork between the assaulted nurses and professional associates such as peers and nursing administrators. The researcher then examines possible remedies which may assist mental health nurses to recover from the effects of patient assault with appropriate reference to the relevant NSW Government policies.

Chapter Seven provides conclusions relevant to the findings from the study. The chapter begins with a summary of the major findings followed by a discussion of the limitations of the study. The significance of the study will then be considered relative to current knowledge about the responses of mental health nurses who have been assaulted by their patients and also in terms of the theory of personal trauma and PTSD. Suggestions for practice will then be discussed followed by recommendations for future research. The thesis ends with a concluding statement and a reference list and appendices are provided at the back of the thesis.

CHAPTER TWO

PRELIMINARY REVIEW OF THE LITERATURE

1. INTRODUCTION

The aim of this chapter is to provide an outline of what is known about the occurrence of patient aggression in institutional mental health care settings. The chapter begins with a brief historical overview of the research on patient aggression and proceeds toward a discussion of the problems which arise in interpreting research data and in comparing studies. These issues are pertinent, in particular, since studies of the phenomenon of patient aggression often lack a common basis in respect of the definitions of operational terms (for example violence and aggression) and employ various methodological approaches such as the use of retrospective designs and reference to data from local hospital incident reporting forms. During this preliminary review of the literature definitions for terms such as violence, aggression and assault will be provided as they were used by the various authors.

The scope of the problem, both in Australia and internationally, will then be discussed, as well as the factors which contribute to the perpetuation of patient aggression. The reader should note that there are few strong predictors of patient aggression identified in the literature which indicates that much more needs to be done in order to understand this complex issue.

Finally the author will explore nurse attitudes towards patient aggression in mental health settings. This, of course, leaves one substantive area of the body of literature on patient aggression unexplored: the effects of incidents of patient aggression upon nursing staff. The literature related to this particular issue will be reviewed in the discussion of findings chapter (Chapter Six) in conjunction with a discussion of research findings from the present study.

2. ASSAULTS UPON MENTAL HEALTH NURSES IN PSYCHIATRIC HOSPITALS

The researcher noted that there was a discernable difference in the direction taken by various authors and researchers writing about phenomena associated with patient

aggression during the early 1980s. The main reasons for this phenomenon appear to be pragmatic, based upon the realisation that assaults in psychiatric hospitals had become a significant occupational health and safety issue by the end of the 1970s (Lion, Snyder, & Merrill, 1981; Tardiff & Sweillam, 1980; 1982), as well as socio-political, as the post-World War II belief that people with a mental illness were no more dangerous than the rest of the community gave way to the view that a small group of people with a mental illness were a potential source of danger to health service personnel and the community more generally (Harmon, 1997).

2.1 Historical perspective: The study of violence in psychiatric care facilities prior to 1980

According to Ekblom (1970) there have been studies examining the frequency of violent assaults by patients in psychiatric care facilities dating back to Laehr (1889, cited in Ekblom 1970, p. 9) who examined seven incidents where psychiatrists had been killed by their patients. Subsequent research into patient aggression appears to have been minimal quite possibly because violence was infrequent in these settings or, alternatively, because violence was tolerated and even expected (Whittington, 1994).

Steirlin (1956, cited in Ekblom, 1970) studied German newspapers and scientific reports over a 140-year period and discovered 37 cases where mentally ill patients had dangerously assaulted physicians and nursing staff. Steirlin also surveyed 164 "heads of hospitals" (Ekblom, 1970, p. 9) to ascertain the extent of the problem of patient aggression against staff and also to investigate the association between psychiatric diagnosis and violence. Although the researcher reported that 60% of the violent incidents had been allegedly caused by patients with a diagnosis of schizophrenia there were serious procedural issues, such as a low survey return rate, which compromised the validity of the study data.

More contemporary studies were conducted by Folkard (1957), who examined the frequency and severity of assaults in the wards of English hospitals for *disturbed* men and women, and Ekblom (1970), who conducted a study in Swedish psychiatric hospitals. As a result of these studies both researchers concluded that hospital employees ran only a small risk of being assaulted by their patients. Larkin, Murtagh

and Jones (1988, p. 226) opined that the main purpose of the studies by Folkard and Ekblom was not to expose the extent of patient aggression in a pejorative sense but to provide evidence supporting the current *open door* policies, which came into being in post-World War II Europe, both in terms of the risk to workers in the psychiatric hospitals and, by extension, to the populations that were served by the particular health facilities.

In keeping with the European studies mentioned above, researchers in the United States (US) became active in investigating violence in psychiatric hospital settings as part of a broader agenda aimed at the provision of community-based service models. Much of this research investigated the incidence of violence as well as the characteristics (such as sex, age and psychiatric diagnosis) of the patients who were violent (Bach-Y-Rita, Lion, Climent & Ervin, 1971; Climent, Hyg, Ervin & Boston, 1972; Damijonaitis 1978; Depp, 1976; Evenson, Sletten, Altman & Brown, 1976; Hagen, Mikolajczak & Wright, 1972; Kaliogerakis, 1971). Kaliogerakis (1971), for example, conducted a study of incidents of patient aggression reported by staff at the Bellevue Hospital in New York and determined that the reported numbers of assaults by patients had remained steady during the years 1964 to 1969 inclusive (for example there were fifty reported assaults in 1964 and sixty six reported assaults in 1969). Kalogerakis (1971, p. 374) concluded that:

> … violence against staff is most uncommon, a striking observation when we consider the violent feelings with which many psychiatric patients are struggling.

2.2 The study of patient assaults in the 1980s

The number of studies of aggression in mental settings published during the 1980s increased steadily. The research measures of the 1970s, such as the frequency and severity of assaults as well as the characteristics of aggressive patients, continued to appear in the literature along with the emergence of new measures such as the: prediction of patient assault; underreporting of assaults by nurses; human cost of patient assaults upon (mostly nurse) victims; financial cost of patient assaults to employer groups, insurers and taxpayers; and apparent increases in assaults upon staff. Significantly the belief that patients in mental health units were no more violent than the rest of the community was replaced by the more sober conclusion that, whilst the

majority of mentally ill people tended to be non-violent, a relatively small segment of the population of mentally ill people were likely to engage in violence which represented a potential risk to the broader community.

Fottrell (1980) prospectively surveyed ward sisters and charge nurses at three English psychiatric hospitals over a three-month period in respect of the extent and severity of patient aggression. For the purposes of this study violence was defined as "… intentional personal physical violence … including self harm … irrespective of provocation" (Fottrell, 1980, p. 216). Fottrell found rates of violence of ten per cent, three per cent and ten per cent respectively amongst the patient populations at the three hospitals. In reference to the study by Fottrell, Larkin et al. (1988, p. 226) concluded:

> Subsequent work … has largely confirmed Fottrell's (1980) findings: a) that the vast majority of patients in psychiatric hospitals are non-violent, and b) that despite many incidents of petty violence, serious violence is rare.

Studies of assaultive patients by Tardiff and Sweillam (1980; 1982) are interesting not only because of their findings but also because of the methods used to record patient assaults. In their initial study Tardiff and Sweillam (1980) extracted information from a data base on 9,365 patients admitted to two public hospitals on Long Island (US) from the beginning of April 1974 to the end of March 1975. The authors found that some ten per cent of patients admitted to the hospitals had a history of assaultive acts prior to admission. Further, assaultive patients were more likely to have been referred to the hospitals by the police or via a magistrate and the authors speculated that reluctance by private psychiatrists to treat this group led to a concentration of potentially assaultive patients in the public health system.

In addition to their 1980 study Tardiff and Sweillam (1982) assessed 5,146 patients who had been a resident for longer than one month in one of two large Long Island public hospitals. In a departure from previous studies Tardiff and Sweillam (1982, p. 213) used a more specific definition of assault as a reference point being "… physically directed [activity] towards other persons [which] included a time frame during which the assault occurred". In addition the researchers did not rely on reports of violence from hospital staff or official hospital incident reporting data which, they suspected, " …may not be

the ideal method of assessing the actual frequency of assaults on the wards because of the problem of underreporting for certain types of patients" (Tardiff & Sweillam, 1982, p. 212). Using a standardized instrument to assess patient assaults the authors were able to report that 7.8 per cent of the male patients and 7.15 per cent of the female patients had physically assaulted other persons at least once in the previous three months. According to Tardiff and Sweillam (1982, p. 214):

> The fact that the rates of assaultive behaviour that we found in this study and in our previous study ... are higher than the rates reported in other studies ... suggests that the use of incident reports by other authors resulted in underreporting of assaultive behaviour. This major finding suggests that assault is a serious problem in hospitals.

2.3 Underreporting of patient assaults in US psychiatric hospitals

In their seminal paper Lion, Snyder and Merill (1981) conducted a study at a 1,500 bed (US) state hospital in which they compared all formal reports of patient aggression which occurred during the year 1977 with less formal accounts of violence documented in ward reports. Whilst official reports of violence were freely available the researchers chose to scrutinize ward reports using a selection of key words (such as "combative" and "assaultive"), as descriptors of patient activity, over a three-month period in order to ascertain the level of unreported patient aggression. The researchers found that there had been 203 formal reports of violence during 1977 compared with an estimated annual number of 1,108 'actual' assaults extrapolated from their study data. The researchers offered reasons for this apparent five-fold underreporting including: staff becoming so used to minor assaults that they did not bother to report them; some staff regarding the reporting of their assault as an indicator of poor personal working practices; and avoidance of scrutiny and investigation into any unethical behaviour such as striking the patient in self defense (Lion, et al., 1981, 497).

Since the study by Lion, et al., (1981) there have been a number of attempts to produce a standardized instrument for the reporting of aggressive incidents. United States researchers Silver and Yudofsky (1987) developed a one-page reporting form known as the Overt Aggression Scale (OAS) which is designed to facilitate the documentation and measurement of a range of aggressive behaviours over four domains: verbal aggression; physical aggression against objects; physical aggression against staff; and physical

aggression against other. Staff at two large state psychiatric hospitals in New York State conducted a trial of the OAS using observers to compare the efficiency of the instrument with formal reporting tools. At one of the hospitals 98 per cent of all assaults were reported by staff who used the OAS compared with 27 per cent of assaults recorded on the hospital's official reporting form. At the other hospital 87 per cent of assaults were recorded using the OAS compared with 55 per cent of assaults recorded on the hospital's usual reporting form (Silver & Yudovsky, 1987).

Although Infanto and Musingo (1985) and Haller and Deluty (1988) noted that the reliability and accuracy of reporting increases as the severity of assault increases (with almost all injuries requiring medical attention being reported) the underreporting of aggression has a powerful effect upon the ability of researchers to reliably estimate the frequency of assaults (Bricknell, 2008; McPhaul & Lipscomb, 2004; Ryan & Poster, 1989; Wykes & Whittington, 1991). Furthermore it is likely that underreporting continues to be problematic as shown in the study by Bensley, Nelson, Kaufman, Silverstein, Kalat and Shields (1997) who compiled data on the number of patient assaults upon staff recorded on a local hospital incident reporting system (incident reports) and workers compensation claims for the same hospital. In addition Bensley, et al. (1997) conducted a survey of employees (n=262) on the frequency of patient aggression (the response rate was 56 per cent). According to Bensley, et al. (1997, p. 97):

> The results of the present study indicated that there are large differences in the results obtained from different methods of measuring assaults, using an equivalent time frame. Compared to survey data, incident reports underreported assaults by a factor of 5:1. The conservative procedures for estimating total numbers of assaults from survey data … may have obscured larger relative underreporting of incident reports relative to survey data.

Further evidence of underreporting is presented by Owen, Tarantello, Jones & Tennant (1998a) who found significant underreporting in their prospective study of patient violence in Sydney psychiatric units. In a subsequent article, Owen Tarentello, Jones and Tennant (1998b) suggested that underreporting was most significant when the

assaultive patients were identified by staff as recidivists[8], known to frequently assault others. It is possible that this underreporting was due to a perception by staff that hospital regulations, which required the notification of occupational health and safety officers following each assault, in addition to the completion of hospital incident forms, were onerous given their workload constraints and the frequency of assaults from the recidivist group of patients.

2.4 Increases in reported assaults against nurses in psychiatric hospitals

There is evidence which suggests that assaults upon staff in psychiatric hospitals increased during the 1970s and 1980s. Adler, Kreener and Zeigler (1983) documented an increase in reported patient assaults by the staff at a 312-bed US private hospital during the period from 1975 to 1980. Increased reporting was most prominent during the years 1979 and 1980 when there were 145 per cent and 316 per cent increases respectively in the number of reported assaults (i.e. there was an increase in reported assaults from: 79 in 1978 to 137 in 1979; thence to 289 in 1980). Similar findings were reported by: Hodgkinson, McIvor and Phillips (1985) who conducted a two-year retrospective study in a British psychiatric hospital; Inamdar, Darrell, Brown and Lewis (1986) who compared trends in aggressive behaviour amongst US adolescents with psychiatric diagnoses during the years 1969 and 1979; and Noble and Roger (1989) who studied reports of violent incidents perpetrated by inpatients at two British psychiatric hospitals between the years 1976 and 1987. This latter study revealed a substantial increase in reports of violence between the years 1976 and 1984, with a slight fall in reported violence to the year 1986, which was not attributable to an increase in bed numbers.

In their review of the literature on patient aggression British researchers Haller and Deluty (1988, p. 174-5) concluded:

> Considerable evidence has been marshalled (for example: Adler et al., 1983; Snyder, personal communication) to indicate that assaults on staff have increased substantially

[8] In this study patients were considered *recidivists* in respect of acts of aggression when they had committed six or more assaults during the study period (Owen, Tarantello, Jones & Tennant, 1998a).

> over the past ten years. The increased risk of assault has been attributed to a variety of factors: (a) understaffed wards; (b) deinstitutionalisation, which has led to the discharge of more manageable patients; (c) an increasing number of readmissions and involuntary admissions; (d) patients' right to refuse medication, often leading to an increase in patient-staff confrontations; (e) diverse mixtures of patients (in terms of pathology) on each ward; and (f) patients being younger and more difficult to manage than in past years.

Whilst the studies mentioned above appear to indicate an increase in violence in psychiatric hospitals, Whittington (1994) has suggested that caution should be exercised in interpreting the data. Indeed Whittington (1994) noted methodological problems with a number of the studies including: the thin range of evidence cited in the Haller and Deluty literature review; the possibility that the staff in the study settings may have become sensitised by the presence of the researchers; and the use of hospital reporting systems which have been shown to be unreliable. Whittington (1994, p. 24) also speculated upon the possibility that staff in psychiatric hospitals may have become less tolerant of *unacceptable* patient behaviours over the past twenty years observing that patient aggression, which was once seen as "just part of the job", was now unacceptable behaviour with modern definitions of violence expanding to include verbal abuse and threats to staff. Whittington (1994) further speculated that this change in tolerance may be due to factors such as: increased concern amongst trade union officials; a resurgence of concern for victims of violence by the broader society; and a rise in employer concern driven by recent developments in occupational health and safety legislation.

2.5 Interpreting data from studies on violence in health care facilities

A note of caution should be sounded at this stage due to the considerable difficulty which arises when comparing data from the literature on patient aggression not least because few authors agree on definitions for operational terms. Whilst some authors define violence as unwanted physical contact (see: Hislop & Melby, 2003; Walker & Seifert, 1994), for example, other authors use more expansive definitions encompassing threats and verbal abuse (see: Wells & Bowers, 2002; Werner, Yesavage, Becker, Brunsting, & Isaacs, 1983), damage to property (see: Larkin, et al., 1988; Noble & Roger, 1989) and/or self harm (see: James, Fineberg, Shah & Priest, 1990; Larkin, et al.,

1988). Another difficulty exists because different data sources are used to report numbers or rates of assaults. Some studies use local institutional reporting forms (for example: Lawson, 1992; Noble & Roger, 1989) whist other authors use self-report data (for example: Hegney, Plank & Parker, 2003; Holden, 1985) and others use more sophisticated means such as prospective observational studies (for example: Carr et al., 2008) or a combination of data sources (for example: Bensley et al., 1997). Further, whilst most studies are confined to reporting upon aggression to all staff or categories of staff (for example: nurses, psychiatrists) other studies include assaults to patients or "all persons" (for example: Noble & Roger, 1989; Larkin, et al., 1988).

Finally Whittington (1994) speculated that it may be inappropriate to compare trends in patient aggression between British psychiatric hospitals with those in the US firstly because there was evidence that American society may be more aggressive than that of Britain, based upon data from a British Home Office Report (Walmsley, 1986, cited in Whittington, 1994), and also because Edwards, Jones, Reid and Chu (1988) had shown that patient violence in a psychiatric unit in Britain was much lower than could be expected in psychiatric hospitals of similar size in the US.

3. FACTORS ASSOCIATED WITH AGGRESSIVE INCIDENTS IN PSYCHIATRIC HOSPITALS

According to Chou, Lu and Mao (2002) and Stenert (2002) factors related to patient aggression can be divided into three main categories: patient factors, environmental factors and staff factors. There are a number of studies which examine these aspects of patient aggression and there is much variation in opinion based on the outcomes of the considerable amount of research that has been conducted. The following is a discussion of these factors based upon the current research into patient aggression. Most of the studies cited used a prospective design in conjunction with observational data collection methods unless described otherwise.

Patient factors

In respect of patient factors there is consensus that patients with a history of aggression were overrepresented in studies of *current* patient aggression in psychiatric hospitals (Chou, et al., 2002; Grassi, Peron, Marangoni, Zanchi & Vanni, 2001; Owen, et al.,

1998a; Palmstierna & Wistedt, 1989). Another consistent finding is that a minority of patients (around 10 per cent) are responsible for a significant number of the total assaults noted for the relevant study period. In a three year prospective study conducted in a Norwegian psychiatric acute ward setting Mellesdal (2003) found that approximately 10.5 per cent of the patients admitted accounted for all of the major aggressive incidents whilst Barlow, Greiner and Ilkiw-Lavelle (2000) found that 13.7 per cent of the patients admitted to the four Australian adult psychiatric units employed in their study accounted for all acts of aggression. Similarly Grassi et al. (2001), in their Italian study, found that 7.5 per cent of patients admitted to their study setting accounted for all incidents of assaults.

Higher occurrence of patient aggression was associated with: involuntary admission (Carr et al., 2008; Ketelson, Zechert, Driessen & Schulz, 2007; Owen et al., 1998a; Soliman & Reza, 2001) (although Grassi et al. [2001] found no such association); length of stay (Mellesdal, 2003; Ng, Kumar, Ranclaud & Robinson, 2001[9]); the first week of admission (Barlow, et al., 2000; Carr, et al., 2008; Chou, et al., 2002; Grassi, et al., 2001; Ketelson, et al., 2007) and *young* age (defined differently in each of the studies) (Barlow, et al., 2000; Carr, et al., 2008; Ketelson, et al., 2007). It should be noted however that Mellesdal, (2003) found no association between age and aggression, whilst Owen, et al. (1998a) found that younger patients were associated with lower risk of aggression.

Steinert (2002, p.136) opined that other patient factors such as: sex, and psychiatric diagnosis are not strong predictors of patient violence. Otherwise there are significant differences in reporting sex as an indicator of patient aggression. Chou, et al. (2002) reported that whilst men were more likely to be physically violent in their study context women were more likely to be verbally aggressive. Owen, et al. (1998a) reported that men accounted for significantly more aggression however other researchers reported more aggression from female patients (Carr, et al., 2008; Grassi, et al., 2001; Kho, Sensky, Mortimer & Corcos, 1998).

[9] This study was not prospective and was a retrospective examination of incident reports.

In respect of psychiatric diagnosis Barlow et al. (2000) found that a diagnosis of schizophrenia was indicative of aggression, whilst other authors (Chou, et al., 2002 and Grassi et al., 2000) expressed the conservative view that patients were more likely to be aggressive if they were acutely psychotic. In contrast Kho, et al. (1998) found no relationship between specific diagnosis and aggression whilst Carr, et al. (2008, p. 267) found that although patients with personality disorder and bipolar disorder were more likely to be aggressive in the first week following admission to a psychiatric unit there was no significant difference between patients of different diagnoses in the longer term.

Environmental factors

Environmental factors which may contribute to patient aggression include: overcrowding; the time of the day or week; and the staff to patient ratio. Unfortunately environmental factors are frequently the subject of speculation in the literature and it is difficult to find evidence of associations between environmental factors and rates of patient aggression. Steinert (2002, p. 136) commented that there is not only a lack of data related to environmental variables, in relation to patient aggression, but also a lack of studies which examine patient related and environment-related variables together using multivariate analysis.

Crowding of psychiatric units may be an important environmental factor in relation to the occurrence of patient aggression. Ng, et al. (2001) conducted a study at a fourteen bed unit in Rotorua, New Zealand, and found that there was an association between higher bed occupancy rates and rates of either physical or verbal aggression. According to Ng, et al. "(higher) bed occupancy was found to be related to whether or not an incident of either type occurred". The researchers also found that higher bed occupancy was associated more with verbal aggression than physical incidents. Moreover Chou, et al. (2002) found an association between space density and severity of assaults after controlling for the differences between hospitals and ward sizes across the seven units used in their study. Grassi, et al. (2001) also found an association between ward overcrowding and increased aggression when the patient numbers on the 15-bed unit used in their study exceeded 100 per cent.

Staff factors

In respect of the time that assaults occur Barlow, et al. (2000) and Grassi, et al. (2001) respectively reported that a greater number of violent incidents occurred on day shifts and Manfredini, Vanni, Peron, LaCecilia, Smolenskiy and Grassi (2001) reported that there was a peak in the occurrence of aggressive incidents, perpetrated by patients, in early afternoon. In addition Carmel and Hunter (1989, p. 43) reported three peaks in patient assaults: between 0700 hours and 1000 hours; between 1200 and 1400 hours; and then between 1600 hours and 1900 hours.

In respect of staffing levels Lanza, Kayne, Hicks and Milner (1994) reported in their US study that the rate of patient aggression was lower when staff to patient ratios approached 1:1. Other studies, however (for example: Morrison, 1990; Owen, et al., 1998a) reported that rates of patient aggression actually increased as staffing numbers improved. However it is possible that the increase in staff may actually have been in response to patient aggression in these cases (Carmel & Hunter, 1989).

Certain staff characteristics may be relevant to the occurrence of patient aggression. In their study of staff located at two psychiatric hospitals in London, Whittington and Wykes (1994, p. 223) compared characteristics of assaulted staff and concluded that "there is little evidence that certain staff are more prone to assault than others". However the authors did note that repeatedly (three times or more) assaulted staff reported that they had been assaulted by the same patient indicating that problematic relationships were the issue rather than individual characteristics. Moreover Barlow, et al. (2000) noted that their descriptive data suggested that 'limit setting' behaviour by some staff, combined with a confined environment, was an indicator of 'acting-out' behaviour by patients. Similarly Davis (1991), in his critical review of the literature, and Collins (1994), in his research paper, speculated that it may be the case that staff members who are perceived by patients as being punitive may be more vulnerable to acts of aggression.

Other characteristics of staff which have been reported as being associated with increased likelihood of assault include inexperience (Chou, et al., 2002; Owen, et al., 1998a); and lack of training in techniques for the management of aggressive patients

(Chou, et al., 2002; Collins, 1994; Owen, et al., 1998a). In particular student nurses appear to be at a higher risk for violence than other staff. Owen, et al. (1998a, p. 1456) noted that student nurses may be at risk from aggression because they tended to engage more with patients or, alternatively, that a student presence in the ward meant that regular nursing staff had less time to attend to their patients. It is also likely that staff absenteeism and the increased use of agency nurses may contribute to increased patient aggression (Barlow, et al., 2000; Chou, et al., 2002; Owen, et al., 1998a).

4. ASSAULTS UPON STAFF AS AN OCCUPATIONAL HEALTH AND SAFETY ISSUE

There is consistent agreement amongst authors that violence against staff in the health care sector is a serious occupational health and safety issue, particularly in respect of staff working in mental health settings.

US authors Lipscomb and Love (1992 p. 219) observed that the current rate of assaults upon nurses in the (US) health care sector had been noted by the director of the National institute for Occupational Safety and Health (NIOSH) as a major cause for concern. Further, in respect of injuries due to assaults upon nurses working in a large forensic hospital in California (US), reported in a study by Carmel and Hunter (1989), Lipscomb and Love (1992, p. 231) commented that "… [the] rate of injuries from assaults alone puts this group of workers at a higher risk than that of the most hazardous industry in the country, the construction industry".

In their 2002 report NIOSH reported that hospital workers in the US remain at high risk for experiencing violence whilst at work, citing Bureau of Labour and Statistics data from 1999 which reported a rate of 8.3 non-fatal assaults[10] per 10,000 workers being "… much higher than the rate of nonfatal assaults for all private-sector industries[11],

[10] According to McPhaul and Lipscombe (1994) the US Bureau of Labour and Statistics includes only those injuries severe enough to result in time lost from work.

[11] The reader should note that private sector industries include industries, such as transportation and construction, which are not under government control. Clearly this definition does not include occupations such as policing and the armed services.

which is 2 per 10,000 workers" (NIOSH, 2002, p.1). Indeed McPhaul and Lipscomb (2004, p. 2 of 19) commented that health care workers continued to suffer high rates of assaults and that, according to Bureau and Labour and Statistics data, 48 per cent of all non-fatal acts against workers occurred in the health care sector. McPhaul and Lipscomb (2004) reported that nurses were the category of health care worker most likely to experience assault and that assaults were experienced most by nurses working in emergency departments, inpatient mental health facilities, nursing homes and other long term care facilities.

A British Home Office report on the 2002/2003 British Crime Survey (BCS) by Upson (2004) revealed that the risk of suffering work-related violence[12] was low with 1.7 per cent of working adults suffering threats or actual violence during the study period. Significantly, whilst people employed in *protective service occupations* (such as the police force) incurred the highest incidence of assaults (12.6 per cent- or 14 times the national average), people employed in health-related occupations were the second most assaulted group with 3.3 per cent of *health and social welfare associate professionals* (including nurses, paramedics, welfare officers and youth workers) likely to experience a work-related assault (Upson, 2004, p. 9). Indeed it was found that health and social welfare-associated professionals were the group most likely to be worried about workplace violence with 36 per cent of those surveyed in this group reporting that they were very or fairly worried about assaults and 41 per cent of those surveyed reporting that they were very or fairly worried about threats (Upson, 2004, p. 21).

In the Australian context Perrone (1999. p. 20) lamented that:

> attempts to quantify the incidence of workplace violence are notoriously difficult and fraught with fundamental problems … due to … the lack of a single system in operation (either state or national) for the uniform recording, collation, and consolidation of all incidents of work-related violence.

[12] The BCS used a broad definition of assaults including physical assaults and threats.

General trends in workplace violence reported by Perrone (1999) inform the reader that women face a higher risk of victimisation. Moreover, in reference to workers' compensation claim statistics Perrone (1999, p. 45) stated that:

> … the evidence suggests that the risk of violence is greatest for women working in the health and community services industries. By contrast, the risk of violence is greatest for males working in the uniformed services (law and order and security).

4.1 Aggression in mental health settings in the Australian context

There have been few studies which examine patient assaults upon nurses in Australian mental health settings. The first Australian research paper on occupational violence in nursing appears to have been published by Holden (1985), who surveyed nursing staff in general hospitals as well as community settings. It was not until seven years later that Lawson (1992) and Baxter, Hafner and Holme (1992) published the first papers on violence directed towards nursing staff in psychiatric hospitals. Since these early efforts there have been more rigorous multi-centre studies however more investigation is required in order to provide a comprehensive picture of all facets of violence in these settings.

Lawson (1992) conducted a retrospective study into patient aggression at the Cumberland Hospital in New South Wales (NSW) using hospital incident reports for the year 1990 as the main data source. Lawson (1992) found that for the 354 nurses employed by the hospital during the study period a total of 227 injuries were reported being 82 per cent of all patient-related injuries. The researcher then consulted worker's compensation records which revealed the total work time lost due to assaults upon nursing staff was 877 hours compared to 514.4 hours for all other incidents (Lawson 1992, p. 24). During the same year Baxter, et al. (1992) reported on a survey of 425 nurses employed at a South Australian suburban psychiatric hospital. Extrapolating from the data Baxter, et al. (1992) calculated an annual rate of assault of approximately two per nurse, suggesting that there were about 950 assaults upon nurses.

Owen, et al. (1998a) conducted a prospective study in five psychiatric settings including three acute units for adults located in general hospitals and two other acute units for adults located in psychiatric hospitals. All of the units were located in Sydney, NSW.

For the purposes of this study the researchers made the distinction between aggression, which was defined as "… threatening verbal or physical behaviour directed towards self or others", and violence which was defined as "… any physical behaviour that resulted in harm to self or others" (Owen, et al., 1998a, p. 1453). A number of instruments were used to measure study variables: the Violence and Aggression Checklist[13] was used to measure incidents (this was four-point scale with the higher levels one and two indicating levels of physical harm to victims); the Ward Activity Index was used to measure statistics about the patients and patient mix on the units at any given time; and the Staff Level Index was used to measure a range of staffing factors such numbers of staff on duty, the use of agency staff and absenteeism. Data were collected for three months in the units which were a part of the psychiatric hospitals and for six months in the general hospital units. Data revealed that of the 855 patients admitted during the study period approximately half had an involuntary status whilst mean bed occupancy was 89 per cent indicating considerable activity on the units. A total of 1,289 violent or aggressive incidents were recorded which were perpetrated by 174 individuals with most incidents (752 or 58 per cent) being rated in the most serious categories for severity on the Violence and Aggression Checklist. Most of the incidents (1,029) were directed towards a staff member, toward property (220 incidents), or towards other patients (174 incidents) (Owen, et al., 1998a). The authors commented (Owen, et al., 1998a, p. 1456):

> Violence and aggression are a substantial occupational health issue. In this study nursing staff were the most common target of assaults … [with the consequence that there was] … substantial morbidity documented for victims of violence and aggression, with harm occurring in 45 per cent of incidents.

Barlow, et al. (2000) conducted a study in three acute adult mental health inpatient units and one sub-acute mental health inpatient unit located in the Illawarra region of NSW. Data were obtained prospectively using the Aggressive/Assaultive Incident Form (Barlow, et al. 2000) over an eighteen-month period. There was no specific definition of

[13] NB: All instruments used in the study by Owen, et al. (1998a) were designed for use by the researchers.

assault reported in this paper except that nurses reported harm to "staff, self, or another patient" in respect of the reporting instrument (Barlow, et al., 2000, p. 969). A total of 2,536 admissions occurred for 1,269 patients during the study period with 174 patients (or 13.7 per cent of those admitted) being recorded as aggressive. Barlow, et al. (2000, p. 971) commented:

> Not surprisingly nursing staff received the highest rate of injuries and assaults as they were more likely to be permanent staff members on the ward, therefore increasing their opportunity to be involved in incidents. Staff received a total of 45 injuries … and this accounted for 47.7 per cent of the overall injuries incurred.

An exploratory study was conducted by Fry, et al. (2002) in which 92 staff (which included nurses, receptionists, psychologists, occupational therapists, social workers, medical officers and a welfare officer) from three Sydney (NSW) metropolitan community mental health teams were surveyed (response rate 77 per cent) about past incidents of patient aggression experienced during their careers. Most participants (96 per cent) had experienced patient aggression in some way including: abuse made in person (89 per cent); abuse made during a telephone call (81 per cent); threats to property (56 per cent) and actual damage to property (58 per cent); threats with a weapon (eighteen per cent); violence without physical injury (24 per cent) and actual physical injury seven per cent) (Fry et al., 2002, p. 115). Significantly 25 per cent of staff surveyed reported that they had experienced a life-threatening situation as a result of patient aggression and almost half of the participants (47 per cent) indicated that they did not feel safe from patient aggression whilst at work (Fry, et al., 2002, p. 115-116).

Carr, et al. (2008) reported on a multi-centre study which was conducted in eleven mental health inpatient units, including psychiatric admissions units as well as high dependency units, across three health services (Hunter, Illawarra, and South Western Sydney) in NSW. The study offers a range of data concerning patient aggression as well as other adverse incidents including absconding behaviour but does not make comment on the numbers of nurses assaulted during the study period.

Carr, et al. (2008) used a number of data collection methods in their study including: a patient daily log (PDL) (Carr, et al. 2008) in which individual patient events (for example: contacts with staff and visitors and incidents of aggression) were reported by

the nurses responsible for the patient (aggressive incidents were rated as *reportable*, involving physical contact or definite intention to inflict physical hard, or *less serious*); a standardised Aggressive Incident Form which included the Overt Aggression Scale (Yudofsky, Silver, Jackson, Endicott & Williams, 1986); a ward event log (WEL) (Carr, et al. 2008) which included more general information related to the unit (for example: information about patient transfers, the number of incident forms completed). A Shift Climate Ratings Scale (SCR) (Carr, et al. 2008), on which levels of tension and patient acuity were recorded, was embedded in the WEL (Carr, et al., 2008, p. 269).

The findings from the above study are revealing. Twenty-three per cent of the total number of admission (n=3242) were associated with high levels of acuity (i.e. either 'life threatening', 'emergency' or 'urgent' … whilst demands upon staff were described as consistently "… 'moderate' to 'high' (Carr, et al., 2008, p. 270) and bed occupancy rates were recorded, on average, at 88.4 per cent (Carr, et al., 2008, p. 275). Incidents of aggression (calculated on the basis of incidents per month per occupied bed) were described by the authors as equating to an incident rate of one every 7.1 days for all of the inpatient units studied. By comparison the incident rate for high dependency units was one every 1.8 days "… clearly fostering the expectation among staff of an ongoing aggressive workplace" (Carr et al., p. 278).

Carr, et al. (2008, p. 280) concluded with an interpretation of the data which:

> show an acute inpatient mental health system operating under considerable strain … [being] taxed by moderate to high levels of patient aggression, not just serious incidents but the more common and constantly wearing instances of threatening behaviour, loud or demanding conduct and low-grade hostility, all of which adds to the picture of a system struggling to manage its patients safely and effectively.

4.2 Trends in violent crime statistics, including assaults, in Australian society

Given the dearth of information on trends of aggression in Australian mental health settings it may be useful to explore broader community trends given the assumption that there may be a relationship between the occurrence of aggression in the two contexts.

According to Bricknell, (2008, p. 2) homicides in the Australian community reached a peak of around 2 per 100,000 of population in the 1970s and 1980s with a subsequent decline during the 1990s up until the year 2006. According to Morrall (2006) Australian rates for murder (based upon per 100,000 of population) are low and are comparable to other countries in the European Economic Union, and New Zealand. In respect of assaults the (Australian) National Committee on Violence (1990, p. 23) reported that occurrence of serious assault[14], lesser assault, sexual assault, and robbery trebled in each of the Australian States in the decade after 1978. In similar vein to Whittington (1994), however, the National Committee on Violence, 1990, p. 23) issued the following cautionary note about the reporting of assaults:

> Whilst the committee is convinced that increases in reported rates of non-fatal assault do in fact reflect a real and substantial increase in violence, the magnitude of this increase is by no means certain. It seems quite likely that in addition to an actual increase in serious assault, these statistics reflect a number of other factors, including changing social attitudes as to what is acceptable social behaviour, an increase in the inclination of victims to report an assault, a broadening of the definition by police of what constitutes "serious" assault, and more rigorous record keeping by Australian police authorities.

Research by Cuthbert, Lovejoy and Fulde (1991) may shed some light on the phenomenon of underreporting of serious assault. The researchers surveyed victims of violence who presented to the accident and emergency department of Sydney's St Vincent's Hospital between December 1988 and June 1989 and found that the majority of victims (57 per cent) did not intend to report their assault to police.

More recent statistics on violent crime from the Australian Institute of Criminology (2008) revealed that the recorded rate of assault (i.e. those assaults reported to police) has continued to rise over the past decade. Indeed the rate of all assaults rose by 47 per cent in the years 1995-2006 with assaults committed by people in the 0-14 years age

[14] Serious assault is defined as the unlawful and intentional infliction of bodily injury, including offences such as grievous bodily harm, malicious wounding, assault occasioning actual bodily harm and aggravated assault

group increasing by 37 per cent and assaults committed by people in the fifteen years and over age group increasing by 27 per cent. Further, most of the increase was due to the reporting of aggravated assault[15] (Bricknell, 2008, p. 3). However, according to Bricknell (2008, p. 3) these statistics should be interpreted with caution because of variations in the rate of reporting (only about one third of assaults are reported to police) and relatively low rates of reporting of violence in corresponding victimisation surveys.

5. ESTIMATING THE FINANCIAL COST OF WORKPLACE VIOLENCE

There is evidence that occupational violence results in a substantial number of work hours lost and a subsequent financial burden upon employers and tax-payers (McKinnon & Cross, 2008; McPhaul & Lipscombe, 2004). Developing accurate estimates of the cost of workplace violence has, however, proven to be an elusive goal (Carmel & Hunter, 1992; Lanza & Milner, 1989; McKinnon & Cross, 2008; Ventura-Madangeng & Wilson, 2009) not least because of a lack of research in this substantive area (McGovern, Kockevar, Lohman, Zauidman, Gerberich, Nyman & Findorff-Dennis, 2002).

The National Audit Office (2003, p. 3) concluded that the accurate estimation of productive hours lost due to workplace violence internationally has been thwarted by "... too many uncertainties and factors to consider, such as being able to identify the reasons for staff absences" (recorded on incident reporting forms). In addition, published estimates of financial cost vary considerably depending upon calculation factors (McKinnon & Cross, 2008; Nurse Policy Branch, Victorian Government Department of Human Services, 2005). For example McGovern, et al. (2002) estimated the annual expense of workplace violence in the US state of Minnesota for the period 1994-1996 at 5.9 billion dollars (US) based upon a total of 344 reported non-fatal assaults. However although McGovern, et al. (2002) accounted for cost factors such as medical expenses,

[15] According to the Australian Bureau of Statistics (1997) aggravated assault is a form of serious assault involving any of the following aggravating circumstances: causing serious bodily injury; carried out in company; carried out using a weapon; carried out with the intent of preventing apprehension or committing a felony; or committed with the intent to recklessly endanger life or cause injury.

lost wages, legal fees, insurance, administrative expenses, lost fringe benefits and household production costs, other costs associated with unreported violence were not considered. Moreover the researchers accounted only for cases where there was physical violence and cases of other forms of violence such as bullying and sexual harassment were not considered (Nurse Policy Branch, Victorian Government Department of Human Services, 2005).

The European Commission (1999) have added to the debate concerning factors to be included in the calculation of the cost of workplace violence by arguing that the financial cost of stress should also be considered. Using data from European and US sources The European Commission (1999) estimated that the total cost of workplace stress for the European Union was 20 billion Euros with the corresponding cost to the US being estimated at around $35.4 (US). The proportion of the cost of stress attributable to workplace violence remains unclear, however, and few researchers have attempted to include the cost of stress in their estimates (di Martino, 2003).

Only one study could be found which estimated the dollar cost of violence to a national health care sector. The National Audit Office (2003) estimated that the total cost of workplace violence to the British National Health Service Trusts at around 69 million pounds annually. However the National audit Office (2003, p. 19) also indicated that the estimated cost does not account for the:

> additional cost of temporary staff; fees for legal action; counselling if required; and the costs of training for replacement staff should the member of staff leave the profession; or the human costs of physical and/or psychological pain; increased stress levels, loss of experienced staff and loss of confidence.

With respect to the Australian context one estimate by the Queensland Government (2002) put the national cost of workplace violence at between six and thirteen billion dollars annually, and this broad estimate included all forms of violence. However the Nurse Policy Branch, Victorian Government Department of Human Services (2005) have commented that "... there appears to be a dearth of studies that have estimated the economic cost of occupational violence in the Australian health care sector".

6. NURSES' ATTITUDES TO PATIENT VIOLENCE

There have been few studies conducted into the attitudes of mental health nurses to assaults by patients. Poster and Ryan (1989; 1994) and Poster (1996) have conducted most of the studies and their instrument, The Staff Attitudes Toward Physical Assaults by Patients Questionnaire (Attitudes Questionnaire) (Poster & Ryan, 1989) has been used subsequently, in modified form, by Baxter, et al. (1992) and, in unmodified form, by Bilgin and Buzlu (2006). The Attitudes Questionnaire is a 31-item instrument with questions relating to the issue of patient aggression in the areas of: patient responsibility; staff competence and performance; safety concerns; and prospects of support from colleagues.

Poster and Ryan (1989) conducted a study at a Los Angeles (US) psychiatric hospital where they surveyed 258 nurses and obtained 184 completed questionnaires (response rate of 71 per cent). Analysis of the participant's responses showed that 85 per cent of participants agreed with the statement: *the patients admitted to* [the unit] *where they work are likely to exhibit assaultive behaviour toward staff* whilst 75 per cent agreed with the statement: *staff members working with the mentally ill can expect to be assaulted at some stage during their careers*. Significantly 55 per cent disagreed with the statement: *the* (treatment setting) *does not admit patients whom it is not equipped or staffed to treat safely* whilst 49 per cent of participants disagreed with the statement: the *staffing pattern and physical environment of this unit are adequate to prevent assaults*. Whilst 84 per cent of participants said that they would expect to receive support from their nursing team colleagues in the event that they were assaulted by a patient, only 57 per cent said that they would expect to receive support from nursing management (Poster & Ryan, 1989, p. 319). In addition to the above Poster and Ryan (1989, p. 321) noted that although 93 per cent of participants disagreed with the statement: *Nurses who are assaulted and have only minor injuries should not report the assault* it was common practice for nurses not to report assaults.

Subsequent studies by Baxter, et al. (1992), Poster and Ryan (1994), Poster (1996) and Bilgin and Buzlu (2006) produced findings which were quite similar to the original Poster and Ryan (1989) study and so will not be reported here. It is clear, however, that study participants tended to have a fatalistic expectation that they would be assaulted in

their workplace and given the low expectation of support from nursing administration in the event that nurses experience assault the relationship between nurses and hospital administration staff was under some strain.

6.1 Nurses' attitudes towards assaulted colleagues

There is a small amount of somewhat dated research on the attitudes of nurses towards assaulted colleagues by Lanza (1984a; 1984b; 1985; 1987) and Lanza and Carifio (1990; 1991).

Lanza (1985) conducted a study at Veteran's Hospital in Bedford (US) employing six male and 93 female nursing staff who were asked to respond to vignettes in which staff assault scenarios were portrayed. Although 71 per cent of the participants said that they expected the 'victims' to suffer " ... fairly severe to very severe emotional reaction to the assault" (Lanza, 1985, p. 9), approximately 45 per cent expected that the victim would not receive any support from hospital administration or co-workers. Additionally 37 per cent of subjects had a moderate to high degree of belief that it is unprofessional for nurses as assault victims to express their feelings (Lanza, 1985, p. 10). Subsequent research by Lanza (1987) in the same context as above has indicated that nurse victims of mild assault were more likely to receive blame than nurse victims of severe assault. Further, female victims were more likely to receive blame than male victims and male nurses tended to place blame upon the victim more than female nurses (Lanza, 1987, p. 269).

Research by Shaver (1970) indicated that people may engage in the act of blaming others in order to promote their own self esteem, whilst Janoff-Bulman and Wortman (1977, p. 360) showed that self-blame by severe accident victims may actually assist victims in coping psychologically with their injuries. It is important to say, however, that whilst self-blame may have adaptive qualities in some circumstances, Vidal and Petrak (2007) found that self-blame was associated with shame and negative self-image by women who had suffered sexual assault.

7. CONCLUSION

This chapter outlined the available evidence indicating that patient aggression is a serious problem in mental health settings. Whilst it is fairly clear that the rate of assaults in inpatient mental health facilities increased some time during the 1980s, it is unclear whether this upward trend is continuing. To summarise some of the epidemiological data it appears that there is a core of approximately ten per cent of psychiatric inpatients who account for the majority of assaults upon others, including staff, and that the true extent of assaults upon staff is obscured by underreporting. Further, whilst it appears that the majority of assaults are minor in nature, the frequency of assaults points to evidence of work environments under significant strain where the therapeutic management of patients with a mental illness may be compromised. Finally, if it is possible to generalize from the studies on nurses' beliefs and attitudes about work safety, it appears that nursing staff live with the view that violence in their workplace is inevitable.

CHAPTER THREE

METHOD OF ENQUIRY

1. INTRODUCTION

In this study the researcher sought to explore the ways in which mental health nurses employed in a large regional health service in New South Wales, Australia, responded to the experience of being assaulted by their patients. Data were analysed using descriptive statistics and the grounded theory method devised by Glaser and Strauss (1967) and further developed by Glaser (1978; 1992; 1995). This necessitates a discussion of the rationale for using mixed methods of enquiry as well as grounded theory. Descriptions of grounded theory method, its philosophical basis, and its emergence along with other qualitative research methods will follow a discussion of the emergence of grounded theory as a method situated in the constructivist paradigm and firmly underpinned by perspectives drawn from symbolic interactionism. Further discussion will follow concerning the current debates and controversies which apply in respect of grounded theory research and a justification for the choice of the method developed by Glaser (1978; 1992; 1995) in preference to the method developed by Strauss (1987) and Strauss and Corbin (1990; 1998) for the conduct of this study. The chapter will end with a discussion about strategies for ensuring that the findings are credible, plausible and trustworthy (Glaser & Strauss, 1967, p. 223) and an appraisal of the strengths and limitations of the grounded theory method.

2. RATIONALE FOR USING MIXED METHODS OF ENQUIRY IN THIS STUDY

As mentioned in Chapter One of this thesis it was planned that assaulted nurses recruited into Phase Two of the study would initially be interviewed using three instruments: the demographic data form (see Appendix A); the Assault Response Questionnaire (Ryan & Poster, 1989) (see Appendix B); and the Perceived Stress Scale (Cohen, et al., 1983) (see Appendix C). The related data analysis would thus necessitate the use of statistical methods. The researcher then planned to conduct two subsequent semi-structured interviews with participants at three months and six months post-assault

with a view to recording the interviews, transcribing them into text form and then analysing them according to a grounded theory method.

According to Polit and Beck (2006) the judicious 'mixing' of qualitative and quantitative methods has the potential to enrich the data set as complementary data are generated. Moreover Polit and Beck (2006, p. 245) argued that the quantitative data generated during mixed method studies have the potential to enhance the validity of the study as well as generate new hypotheses that may be tested qualitatively. There are many researchers who have successfully employed mixed methods in their studies (for example: Andrew & Halcomb, 2006; Hayhow & Stuart, 2006) however it should be acknowledged that some researchers regard quantitative and qualitative research methods to be philosophically incompatible (Giddings & Grant, 2007) or have the opinion that quantitative data have the potential to diminish the capacity of qualitative data to represent the 'voice' of the participants (Tuckwell, 2001). It should be noted, however, that the use of quantitative data is compatible with grounded theory method. According to Glaser and Strauss (1967) and Strauss and Corbin (1990) almost any source which informs the researcher about the phenomenon being studied can be treated in the same way as interview data.

3. RATIONALE FOR USING GROUNDED THEORY METHOD IN THE PRESENT STUDY

Preliminary readings by the researcher revealed that there have been several detailed empirical studies conducted regarding the responses of nurses to the experience of patient-initiated assault (Caldwell, 1992; Conn & Lion, 1983; Lanza, 1983; 1984a; 1985; Nolan, et al., 1999; Ryan & Poster, 1989; Whittington & Wykes, 1992; Wykes & Whittington, 1991) with all studies employing mainly questionnaires and statistical analysis of the relevant data. Otherwise there has been a dearth of studies in this field using qualitative methodology, with the exception of the phenomenological studies conducted by Cutcliffe (1999), Duxbury (1999) and the grounded theory study by Collins (1996). Whilst all of the studies mentioned above examined, to varying degrees, the distress experienced by nurses in the post-assault period, none has been able to provide detailed insight into the personal process of recovery that nurses must negotiate in order to return to the workplace. Additionally there has been little detailed analysis of

the assaulted nurses' interactions with their patients and work colleagues, during the process of their recovery.

Essentially the choice of method was determined initially by the particular research questions devised for the present study. The questions: What is the process of response of mental health nurses who have experienced assaults by their patients?; and What is the effect of recent (patient initiated) assault upon the ability of the mental health nurse to engage therapeutically with his/her patients?; suggest the use of grounded theory method because the researcher sought to understand not only processes within the research setting but also the meaning of these processes within a social milieu.

Furthermore it was determined that grounded theory method would provide the flexibility required given that the researcher planned to use multiple methods, including structured questionnaires, during the initial interviews with assaulted nurses in order to establish baseline data regarding the participants' responses to assault. It was also planned to employ non-participant observation prior to other data collection which was consistent with grounded theory approach and appropriate to the study setting.

Finally the aim of the study was to develop a substantive theory about the relevant phenomena and not to test existing hypotheses or theories. This aim will be supported by observations of mental health nurses in inpatient settings, empirical data, and interviews conducted with nurses who have been assaulted by their patients.

4. RESEARCH METHODS USED TO STUDY SOCIAL PHENOMENA[16]

The history of social research is also a history of perspectives on the nature of reality based upon the different world views or paradigms of the researchers. According to Norton (1999) like-minded researchers can be grouped loosely into "colleges" of research communities based upon a commonality of paradigms, whilst Blaikie (1993) asserted that the worldviews of researchers may be examined according to basic

[16] The term 'phenomena' can be interpreted in the context of research methodology. In qualitative research the researcher is interested in human experiences and relationships as they occur in naturalistic settings. This varies from the more positivist view of 'phenomena' as variables which exhibit different values, examples of which are age, height or levels of education.

concepts such as ontology[17] and epistemology[18]. With this information in mind it is useful to trace the evolution of the qualitative research methods, and grounded theory in particular, against the backdrop of the prevailing naturalist tradition.

Naturalism is based upon the belief that both natural and social research may be conducted according to the same principles and methods and that there is a social reality that exists independently of the researcher. According to Blaikie (1993, p. 13) this position is well summarised by Karl Popper who declared:

> I do not intend to assert that there are no differences whatever between the methods of the theoretical [social] sciences of nature and of society; such differences clearly exist, even between the various natural sciences themselves, as well as between the various social sciences … But I agree with Comte and Mill –and many others … that the methods in the two fields are fundamentally the same (Popper, 1961, p. 130).

These basic tenets of naturalism are also the central claims of 'positivism' which, according to Miller (1999, p. 2) was a term first coined by the French philosopher August Comte (1798-1857). Positivist ontology proposes that social reality, like physics, is driven by laws and principles that are generalisable and that positivist epistemology privileges the researcher to test hypotheses in the search for the discoverable 'truth' (Norton, 1999, p.33). Quantitative research is based upon such principles and is, thus, concerned with the measurement and analysis of causal relationships between variables in the context of a research design which attempts to minimise the effect of the presence of researcher upon research outcomes by asserting controls in the research process.

4.1 The emergence of qualitative research methods

There are many different approaches to qualitative research, however Denzin and Lincoln (2005, p. 3) offered the observation that qualitative research "… involves an

[17] Defined by Blaikie (1993, p.6) as the claims or assumptions made by researchers about the nature of social reality, its components and how these components interact.

[18] Defined by Blaikie (1993, p. 6-7) as the ways in which it is possible to gain knowledge about 'reality': "An epistemology is a theory of knowledge; it presents a view and justification for what can be regarded as knowledge- what can be known, and what criteria such knowledge must satisfy to be called knowledge rather than beliefs."

interpretive, naturalistic approach to the world" and, in particular, that the researcher attempts to make sense of social phenomena in terms of the meanings that people ascribe to them. Moreover Denzin and Lincoln (2005, p. 14-20) have traced the evolution of qualitative research in the North American context through what are referred to as eight moments of epistemological theorising. These moments include:

The traditional period (1900- World War II) in which the positivist epistemological paradigm of enquiry influenced the study of the "other" by the researcher who remained aloof from their subjects. Studies typically involved the researcher venturing into foreign lands to record an alien culture; *The modernist* or *golden age* (post-World War II to 1970s) which was characterised by a post-positivist, epistemological approach in which researchers sought to formalise and codify various qualitative research methods which had their genesis in previous decades. This era saw the development of the constructivist paradigm where the researcher is seen as inseparable from social reality as, indeed, the researcher is acknowledged to contribute to that social reality. Interpretive theories gained prominence at this time when, for example, Blumer (1969) attempted to formalise the methods of symbolic interactionism. In addition, other interpretivist methods such as ethnomethodology, phenomenology, critical theory and feminism began to emerge. It was at this time that the grounded theory research method (Glaser & Strauss, 1967) had its beginnings; *The blurred genre stage* (1970-1986) in which the boundaries between social sciences and humanities had become blurred as new methods of analysis (including semiotics and hermeneutics) were adopted as well as new approaches to research (such as poststructuralism and deconstructionism); *The crisis of representation* (1986-1990) moment now emerged where there was an erosion of the classical forms of anthropology along with an emphasis on the need to consider more reflexive research procedures and there was a re-emergence of issues such as reliability, validity and generalisability and whether qualitative research can ever truly represent the lived experience of others; The *postmodern period of experimental ethnographic writing* (1990-1995) saw the development of more activist-oriented research with the search for the grand narrative replaced by more small-scale theories; *The period of postexperimental enquiry* (1995-2000) and *The methodologically contested present* (2000-2004) and the future (2005-) have seen the development of

fictional ethnographies, ethnographic poetry and multimedia texts against a background of confrontation associated with the evidence-based scientific movement.

4.2 Symbolic interactionism as a basis for grounded theory

According to Schwandt (1994) symbolic interactionism is a branch of interpretivism and there are several approaches that have developed including the Blumer-Mead model developed out of the Chicago School and alternative models developed by Kuhn (the Iowa model) and Denzin. Other perspectives are attributed to Goffman and Garfinkel (Osborne, 1994). Blumer (1969) acknowledged the early work of George Mead as a foundationalist for symbolic interactionism and is credited with the important task of translating Mead's work into both a social theory and a research method.

The influences which shaped symbolic interactionism include a diverse group from the Scottish moralists, to Charles Darwin and the 19th century German idealists (Benzies & Allen, 2001). The moralists provided concepts such as 'I' and 'me' as bases for the symbolic interactionist notions that both 'mind' and 'self' were socially determined whilst from the idealists was drawn the notion that people construct their world based upon their perceptions of that world. Other influences included the philosopher William James and, in particular, the early twentieth century pragmatists (Lewis, 1976) who held the view that the meaning of objects "… resides in the behaviour directed toward them and not in the objects themselves" (Benzies & Allen, 2001, p. 542).

Blumer (1969, p. 2) stated that symbolic interactionism rests upon three premises:

> (1)… that human beings act toward things on the basis of the meanings that the things have for them. Such things include everything that the human being may note in his world- physical objects, such as trees or chairs; other human beings, such as a mother or a store clerk; categories of human beings, such as friends or enemies; institutions, as a school or government; guiding ideals such as individual independence or honesty; activities of others, such as their commands or requests; and such situations as an individual encounters in his daily life. … (2) that the meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows; … and (3) that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he (sic) encounters.

Thus the symbolic interactionism of Blumer involves discovering how meaning has been socially constructed but there is also a recognition that meaning is often taken for granted or regarded as some neutral link amongst the various factors which comprise human behaviour (Blumer, 1969). In this way the assumptions of symbolic interactionism challenge the positivist tradition with the latter's emphasis on the analysis of a broad range of factors to explain human behaviour. Indeed, Blumer (1969, p. 3) asserted that " … to bypass the meaning of behaviour in favour of factors alleged to produce the behaviour is seen as grievous neglect of the role of meaning in the formulation of behaviour."

The place of the researcher, according to Blumer (1969, p. 47), should be to engage with the natural world in the conduct of her/his studies. It is in this natural world where the researcher should construct research questions and then collect data via observation of human beings interacting with one another. Symbolic interactionists are, in this way, similar to phenomenologists in their interests in the participant's lived experience and in their efforts to understand a situation from the participant's point of view (Charmaz, 1990; Jeon, 2004). Blumer (1969) further articulated the research processes undertaken by symbolic interactionists as depending not only upon the derivation of research questions and the gathering of research data in the real world of the participants but also upon the researcher's ability to form concepts based upon the analysis of the shared experiences of participants and to group these concepts into broader categories.

5. GROUNDED THEORY

5.1 Overview of the method

Grounded theory was first developed by Barney Glaser and Anselm Strauss (1967) and further developed by Glaser (1978; 1992; 1995), Strauss (1987) and Strauss and Corbin (1990; 1998). Consistent with symbolic interactionism, the grounded theory method places great importance on developing knowledge of the social world from the perspective of the lived experience of the 'actors' involved and there is a basic assumption that social groups "… share a specific social psychological problem that is not necessarily articulated" (Hutchinson, 1993, p. 185).

The process of grounded theory begins at the point where the researcher poses a general research question (rather than devising the tightly conceived hypotheses of positivist research) and proceeds to the subsequent collection of data. The researcher then engages in a process of conceptualisation of the data and the subsequent generation of a set of categories, or codes, with increasing degrees of abstraction. In this way data analysis becomes a process of inductive as well as deductive analysis (McCann & Clark, 2003). Data analysis may cease as the categories become saturated (i.e. no new categories are generated but, rather, there is repeated evidence for existing codes) (Charmaz, 1990, p. 1163).

Unlike other research methods, where data collection and analysis occurs in stages, grounded theory method requires the use of the constant comparative method where data collection and analysis take place simultaneously (Charmaz, 1990). This process facilitates the emergence of theoretical categories and subsequent processes of questioning and memo-writing are employed in order to analyse the key relationships between these categories. According to Green (1998) data collection and analysis become a cyclical process whereby the researcher interrogates the data in order to develop categories based upon the properties and dimensions of that data and then subsequent sampling decisions are made according to the principles of theoretical sampling. As a consequence the researcher constructs theory that is at once grounded in the data and relevant to the social environment in which the research occurred.

5.2 Types of theory produced by grounded theory research

Essentially two types of *theory*[19] can be developed using the grounded theory method: substantive and formal. Both are considered to be mid-range theories (Hutchinson, 1993). Blaikie (2000) offered a general description of mid-range theories as lying between empirical generalisations and grand theories. Blaikie (2000, p. 144) further

[19] Glaser and Strauss (1967, p. 3) state that the purpose of theory is to: "(1) enable the prediction and explanation of behaviour; (2) be useful to the advance of disciplinary knowledge; (3) be useful in practical situations where prediction and explanation might give guidance to the practitioner; (4) provide a perspective on behaviour; & (5) to guide and provide a style for further research about particular areas of behaviour."

explained that substantive theories are generated from studies of particular, circumscribed, and empirical areas of enquiry (such as chronic illness, dying patients, or family care-giving) whilst formal theories are concerned with a more conceptual level of enquiry (such as status passage, social control, stigma or illness) and are derived from studying phenomena under a variety of conditions. Substantive theories are, thus, more focused but may be the basis for the development of formal theories.

5.3 Further explanation of concepts related to grounded theory

According to Annells (1997), techniques fundamental to the formulation of grounded theory include: theoretical sampling, coding, constant comparative analysis, theoretical sensitivity, memo writing, identification of core category(s) and the ideal of theoretical saturation.

5.3.1 Theoretical sampling

Sampling theoretically is an evolutionary process which occurs as the data are collected. There are two main aspects which relate to the way in which people are selected to be participants in a grounded theory study and also to the type of data which might be elicited (during interviews, for example). Ultimately, however, theoretical sampling is a process reliant upon concepts which emerge from the data and also upon the emerging theory (Strauss & Corbin, 1998, p. 202).

Polit and Beck (2006, p. 246) observed that qualitative studies tend to use small, non-random samples and depend upon the good will of volunteers and the ensuing snowballing effect, as information about the research project spreads within a research context, so that a sample of participants may be obtained. Whilst grounded theory researchers certainly make use of the above strategies the practice of theoretical sampling, aligned with the goal of saturation of codes, becomes a chief consideration in the selection of participants (Hutchinson, 1993). To explain this process, Morse (1991) contended that a specific form of non-random sampling called purposeful sampling is used, initially, as participants are chosen according to their potential to articulate a broad general knowledge of the phenomenon under study. This process is then superseded by theoretic sampling which Glaser and Strauss (1967, p. 45) defined as a "… process of

data collection for generating theory whereby the analyst jointly collects, codes, and analyses his (sic) data and decides what data to collect next and where to find them."

At this point it is important to acknowledge that there is a debate about whether the researcher should aim for a wide and diverse sample of participants or a narrower and more homogenous sample. These positions are summarised by Hutchinson (1993, p. 203) who stated that diversity "… ensures extensive data that cover the wide ranges of behaviour in varied situations" and Cutcliffe (2000, p. 1478) who suggested that a focused sample is more consistent with the production of substantive theory which is, by definition, local and situated.

In this study the sample of participants was selected to reflect the narrow focus imposed by the research question(s) and the imperative of producing a substantive theory applicable to inpatient mental health nurses employed in a particular regional mental health service. The reasons for this choice also related to funding and time limitations associated with a research higher degree project. However, as Jeon (2004, p. 252) has asserted, the adequacy of theory depends not only upon the amount of data but also the quality of the data as well as the data analysis.

Interviews during this study were initially shaped by the researcher's previous nursing experience as well as the research questions but evolved as theoretical sensitivity was developed during the course of enquiry. In this way theoretical sampling became a process that took place when the researcher identified some emerging categories and included sampling via the interview process to enable the subsequent development of these categories. Decisions were made accordingly which affected interview questions, in particular the interview questions used in follow-up interviews.

5.3.2 Coding procedures and the constant comparative method

Kendall (1999, p. 746) explained that "… both Glaser (1978, 1992) and Strauss and Corbin (1990; 1998) described coding as an essential aspect of transforming raw data into theoretical constructions of social processes. According to Glaser and Strauss (1967, p. 105) the process of data analysis commences by coding each incident in the data set into as many categories of analysis as possible.

Glaser (1978, p. 56) distinguished between two types of coding procedures including *substantive coding* and *theoretical coding*. Substantive coding encompasses two coding procedures including open coding and selective coding. In open (or initial) coding the data is initially fractured or *run open* into as many categories as possible. Subsequent analysis is raised to a more conceptual level as the researcher begins to compare the data by asking the questions: "What is the data a study of? What category does this data indicate? What is actually happening in the data?" (Glaser, 1978, p. 57). As the core category begins to emerge (or core categories as it is possible that there is more than one for any given study) subsequent coding is delimited to only those categories which relate to the core category. This process then feeds back into the process of theoretical sampling as data are sought that inform the core category (Glaser, 1978, p. 61).

Meticulous coding practices contribute to the rigour of the grounded theory research. Indeed Charmaz (2000, p. 515) described the process of *line-by-line coding* as part of a disciplined approach designed to assist the researcher to become immersed in the data. Hutchinson (1993) and Charmaz (2000) described the process of line-by-line coding and the use of *in vivo* codes (which are labels for phenomena derived directly from the language of the research participants) as a way of overcoming bias in the interpretation of data.

Theoretical coding is a process which occurs in parallel with substantive coding and assists in the process of weaving the data back together again. In this study the coding families proposed by Glaser (1978, p. 73-82) were used as practical guides to assist the examination of the relationship between codes, the emergence of selective codes and the development of theoretical sensitivity.

5.3.3 Theoretical sensitivity

Glaser and Strauss (1967, p. 46) maintained that the researcher must develop *theoretical sensitivity* "… so that he (sic) can conceptualize (sic) and formulate theory as it emerges from the data." An important aspect of this sensitivity is the researcher's ability to have insights about the research context. In the present study the question of theoretical sensitivity was approached via a preliminary review of the literature prior to data collection, the author's previous professional experience as a mental health nurse

employed in a variety of contexts and as a nurse who has, on a small number of occasions, been assaulted by patients. In addition the researcher has engaged in many conversations with other nurses, from various disciplines, who have been assaulted. Theoretical sensitivity has also developed via the experience of completing a research project, during the years 1994-1997, into phenomena associated with the assaulted nurse in which the researcher interviewed recently assaulted mental health nurses (Harmon, 1997). Another source of evolving theoretical sensitivity has been the researcher's experience as a registered nurse employed in the settings described in this thesis.

There is a potential disadvantage to the development of this 'sensitivity', however, in that the researcher may develop certain biases due to preconceived notions or 'pet theories' about the data. Glaser and Strauss (1967) and Glaser (1978) warn that there is a consequent potential for theory to be developed that bears little relation to the data.

5.3.4 Complementary data analysis procedures: Memoing and sorting

Glaser and Strauss (1967, p. 108) recommended the writing of memos amongst field notes as a tactic to facilitate the "… immediate illustration for an idea" in terms of its properties and categories and described the process of writing memos as a crucial component of data analysis as inseparable from the cyclical processes of theoretical sampling and coding.

Problems can arise for the researcher in the open coding process as many phenomena are labelled giving rise to an equally large number of codes. Under the circumstances it is possible for an incident to be coded for more than one category and for a certain amount of confusion to arise due to the complexity of the data. Further, the researcher may be tempted to 'force' the coding process and create an analysis that is incomplete and so memoing can serve the purpose of ensuring rigour in the research process. According to Glaser (1978, p. 87) memoing also serves the twin purposes of slowing down the pace of analysis, thus mitigating against the adoption of premature conclusions, as well as providing an excellent source of directions for theoretical sampling.

Complementing the memoing process is the process of theoretical sorting where the researcher constantly compares ideas with ideas thus leading to "densification" of the emerging theory (Glaser, 1978).

5.3.5 The emergent core category and the basic social process.

As the process of developing substantive and theoretical codes develops, a core category emerges which forms the basis for the grounded theory. Glaser (1978) outlined a number of criteria for the core category including (Glaser's italics):

> 1. It must be central: that is related to as many other categories and their properties as possible … and … it accounts for a large proportion of the variation in a pattern of behaviour.
>
> 2. It must *reoccur frequently* in the data. By its frequent reoccurrence it comes to be seen as a stable pattern and becomes more and more related to other variables ….
>
> 3. By being related to many other categories and reoccurring frequently, it takes more *time to saturate* the core category than any other categories (Glaser, 1978, p. 95).

Glaser (1978, p. 96) maintained that the core category can be a process but it can also be an activity, a state, multidimensional or an implication. According to Fagerhaugh (1986, p. 135) a specific type of core category is the *basic social process* which accounts for process over time and is characterised by descriptors which refer to change such as "becoming", "limiting", or "routining". Moreover Glaser, (1978, p. 96) stipulated that the identification of such phases must also be accompanied by the conditions and resulting actions that precipitate change from one phase to another.

5.4 Literature as a source of data

There is a debate surrounding the use of literature in grounded theory research. Essentially this debate stems from the notion that the researcher should refrain from conducting a review of the literature prior to data collection and analysis to ensure that the emergent theory is grounded in the particular research data rather than being influenced by other sources (Charmaz, 1990). In response to this interpretation Blumer (cited in Charmaz, 1990. p. 1163) referred to Glaser and Strauss's grounded theory method as espousing pure induction and imposing a *tabula rasa* view of enquiry whilst

Hammersley (1992) was also critical of the practice of not reviewing the relevant literature prior to data collection as he believed that there was a consequent potential to overlook previous theories relevant to the study area. Hutchinson (1993) suggested that a review of the literature is necessary in order to identify gaps in the current knowledge and, as a starting point, as part of the process of deciding upon the research method appropriate to enquiring about a particular problem. Moreover Cutcliffe (2000) argued that a preliminary review of the literature has the potential to provide a conceptual clarity to the initial research questions and is also vital to the development of theoretical sensitivity.

Despite the above criticisms it is unlikely that either Glaser or Strauss fostered the notion that the researcher should approach the substantive area of research in ignorance. There is an assumption by these authors that researchers would be experts in their field and there is an acknowledgement that initial reading is necessary in order for researchers to develop a partial framework of concepts (Glaser & Strauss, 1967). Indeed a preliminary reading of the literature is not inconsistent with any of the major interpretations of grounded theory method. According to Cutcliffe (2000, p. 1481) the real issue is when a *secondary,* and more substantial, review of the literature should occur. Hutchinson (1993) and Strauss and Corbin (1990; 1998) argued that this secondary review should occur during the final stages of data analysis and the development of theory however Glaser (1978; 1992) argued that this secondary body of knowledge should only be accessed after the theory has emerged from the data.

5.5 *Glaserian* and *Straussian* versions of grounded theory method

Subsequent to the grounded theory method initially described by Glaser and Strauss (1967), Glaser (1978; 1992) articulated a method which was largely consistent with the original version. In contrast, however, Strauss and Corbin produced *Basics of qualitative research* (1990) and a subsequent second edition (1998) in which new procedures were introduced with the aim of making the process of data analysis more accessible for novice researchers.

On the surface the two versions of grounded theory method are quite similar: both methods are concerned with discovering a theory which is grounded in a set of data

derived from participant's stories and both employ, for example, coding procedures in association with the constant comparative method. The controversy lies, as explained in the Glaser publication: *Emergence vs forcing: Basics of grounded theory* (1992), in the degree to which the new procedures introduced by Strauss and Corbin are faithful to the ideal of allowing the theory to emerge from the data.

The divergence between Glaser and Strauss can probably be explained by the authors' different academic backgrounds[20]. Boychuk Duschler and Morgan (2004, p. 606) opined that the different epistemological emphases of the two men led Glaser to become concerned with tying the emerging theory tightly to the data whilst Strauss and Corbin stressed the "… interplay between researcher and the data" as central to the provision of "… standardization (sic) and rigour to the process" (Strauss & Corbin, 1998 in Boychuk Duschler & Morgan 2004, p. 606). Indeed these emphases play out in the way that the authors have approached the use of advanced coding techniques employed after the initial open coding common to both methods.

Essentially the method described by Glaser (1978) recommended the use of two coding stages: substantive coding, including open coding, and theoretical coding supplemented by memoing, a procedure crucial to the emergence of theory, and the employment, at the researcher's discretion, of the eighteen coding families. The method described by Strauss and Corbin, however, involves the addition of axial coding, an intermediary coding process, defined by Strauss and Corbin as "… a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories" (Strauss & Corbin, 1990, p. 96). This is done by using a coding paradigm involving conditions, context, action/interactional strategies, and consequences. This paradigm model is an organising scheme that connects subcategories of data to a central idea, or phenomenon, to help the researcher think systematically about the data and pose questions about how categories of data relate to each other. Moreover as Kendall (1999,

[20] According to Bryant and Charmaz (2007, p. 32-33) Glaser had a strong background in quantitative research whilst Strauss's background was aligned with "Chicago School and symbolic interactionist colleagues".

p. 745) observed Strauss and Corbin (1990) claimed that the use of axial coding and the paradigm model allow for a more complete conceptualisation of the data

In response to the controversy Denzin (1988) supported Strauss and Corbin's approach as a means to bringing clarity and rigour to the data analysis process. However a consensus appears to have been developed amongst other commentators that Strauss and Corbin's approach has the potential to be prescriptive and procedure-focused thus preventing researchers from developing the creatively required for the discovery of theory (Glaser, 1992; Kools, McCarthy, Durham & Robrecht, 1996; Melia, 1996; Robrecht, 1995). Further, Glaser (1992), proposed that the Stauss and Corbin version of data analysis is verification because the researcher is constantly verifying the fit between categories whilst, in Glaser's (1992) view, verification is possible only after the theory has emerged and been developed.

Other critics of the method espoused by Strauss and Corbin claim that the jargon that they have introduced (for example: *flip-flop*; *waving the red flag*; *dimensionalizing* (sic); and *axial coding*) may actually "befuddle" the researcher rather than providing clarity for novices (Boychuk Duchsher & Morgan, 2004, p. 608).

5.6 Circumstances leading to the use of the *Glaserian* approach in this study

In acknowledgement of Denzin's (1988) opinion that Strauss and Corbin's approach had the potential to bring greater clarity and rigour to the data analysis process as well as Strauss and Corbin's own claims about the use of axial coding and the related paradigm model the researcher initially chose to adopt the Strauss and Corbin (1990; 1998) version of grounded theory method. The researcher had the impression that this method would be superior to the approach recommended by Glaser partly because Strauss and Corbin (1990; 1998) appeared to present a more thorough explanation of grounded theory method and partly because, in an evolutionary sense, theirs' was a later version which continued to develop after Glaser had ceased the development of his method.

The initial data analysis for this study featured attempts to use axial coding and the associated paradigm model developed by Strauss and Corbin (1990; 1998). However, similar to the experience of Kendall (1999), the researcher found the practice of using

axial coding to be a distraction which took focus away from the data and the research questions. The researcher also began to *force* the data in a vain attempt to make it fit into categories and this impasse was discussed with the researcher's supervisors at the time. A decision was subsequently taken to employ the method developed by Glaser (1978; 1992) and this change in direction, although producing a hiatus in data collection and analysis, proved fruitful in terms of facilitating the research process and ensuring that the subsequent data analysis was a more faithful representation of the participants' stories.

5.7 Ensuring rigour in grounded theory research

Generally speaking the quality of any research depends upon the ability of the researcher to engage in methodological thoroughness and incisive analysis. Glaser and Strauss (1967, p. 223) maintained that qualitative research is sometimes labelled unsystematic, sloppy or unsophisticated and proposed that grounded theory should be judged according to its "credibility, plausibility, and trustworthiness". Indeed the discussion of grounded theory method thus far in this chapter explains techniques designed to accommodate for the methodical analysis of data as well as the accuracy and fit of the generated theory. In support of this Charmaz (1990, p. 1163) made the point that grounded theory specifies the analytical guidelines necessary to reliably allow for the emergence of theory that is a faithful representation of the data.

Based upon Beck's (1993) schema for ensuring credibility, auditability and fittingness, Chiovotti and Piran (2003, p. 430-433) suggested eight methods for ensuring rigour in grounded theory research:

> (1) let the participants guide the inquiry process; (2) check the theoretical construction generated against participants' meanings of the phenomenon; (3) use participants' actual words in the theory; (4) articulate the researcher's personal views and insights about the phenomenon explored; (6) specify how and why participants in the study were selected; (7) delineate the scope of the research; and (8) describe how the literature relates to each category which emerged in the theory.

The procedures used in the collection and analysis of data as well as the generation of theory will be described in the following chapter. In addition the researcher will also

provide the necessary audit trail to enable the reader to make judgements about the conduct of the study against Chiovotti and Piran's (2003) criteria.

5.8 Methodological limitations to grounded theory

Criticisms of grounded theory method are generally made on the basis of: imprecise explication of grounded theory terms and procedures; the potential for researcher bias; intrinsic positivistic assumptions; and, as a consequence of the above, the extent to which the voice of the 'other' may be articulated.

Firstly there are claims that grounded theory terminology and analytical procedures are sometimes poorly developed (Charmaz, 1990; Kools, McCarthy, Durham & Robrecht, 1996). According to Charmaz (1990, p. 1164) operational terms such as theory, category and saturation have been poorly explicated in the versions of grounded theory develop by Glaser and Strauss (1967) and Glaser (1978). As a consequence it is possible that grounded theories may be written which lack proper development. Moreover Hall and Callery (2001, p. 260) opined that, whilst there is a basic assumption that the natural world is the subject of study for grounded theorists, it is the researcher who makes decisions about when and where to conduct observations and what particular things should be observed and subsequently entered into field notes. It is also the researcher who decides upon the types of interview questions to be asked as well as which answers should be elaborated upon and clarified in the process of analysis. Charmaz (2000 p. 521) observed that operational activities such as creating codes and categories as the researcher defines themes within the data have the capacity to separate "… the experience from the experiencing subject, the meaning from the story" thus having the potential to reduce understanding of the participant's experience and curtail representation of both the social world and subjective experience".

In addition to the above Charmaz (1990, p. 1164) expressed concerns that the passivity of the researcher, in classical grounded theory method, in association with the emergence of theory from the collected data "… comes close to positing an external reality". Authors have subsequently questioned whether grounded theory method is phenomenological or whether it is positivistic (Annells, 1996; Annells, 1997; Charmaz,

1990) giving rise to further questions about representation and legitimation (Annells, 1997).

6. CONCLUSION

This chapter has provided an outline of the emergence of grounded theory in its historical context and, in particular, the importance of symbolic interactionism as providing the epistemological underpinnings for the method. In addition to describing the various procedures employed in the grounded theory method there was also an attempt to highlight some of the debates in grounded theory research brought about by different interpretations of the method as well as some of the limitations of the method. The next chapter will be concerned with the actual implementation of the study including the mechanics of gaining access to study settings and participants as well as the processes relevant to data collection and management.

CHAPTER FOUR

METHOD OF ENQUIRY: PROCEDURES

1. INTRODUCTION

The following chapter describes the study settings and the processes for recruitment of participants and data collection. Ethical issues relevant to the study will also be discussed along with procedures for the protection of participants.

This study was conducted in two phases, including a non-participant observation phase (Phase One) and an interview phase (Phase Two), across multiple settings within the adult psychiatric inpatient units of a large regional health service. The initial method for the recruitment of participants was purposeful sampling which was superseded, in the case of Phase Two of the study, by theoretic sampling, as data collection progressed (Glaser & Strauss, 1967, p. 45; Glaser, 1978, p. 36). The resultant data were then analysed in accordance with the grounded theory method described by Glaser and Strauss (1967) and Glaser (1978) with the relevant literature becoming an additional source of data after the theory had emerged from the study data (Glaser, 1978; 1992).

2. THE STUDY SETTINGS

The present study was conducted in the adult psychiatric inpatient settings of a regional health service located within the state of New South Wales (NSW), Australia. The region was described by the Acute Services Project Team (2003, p. 19) as a "… mixed industrial, rural, and urban area comprising eleven local government areas … and covering 31,000 square kilometers."

At the time of the study described in this thesis the adult inpatient mental health facilities for the regional health service were dispersed over three campuses. What follows is a brief description of the campuses and their respective units which will be labelled Campus A, Campus B and Campus C.

Campus A: was a stand-alone 82-bed purpose-built psychiatric hospital which had, for the most part, been built and commissioned during the 1980s including Units A1, A2, A3 and A4. The facility also contained Unit A5 which had been built during the

nineteenth century and refurbished during the 1980s as well as a psychiatric emergency centre (PEC).

Unit A1 was a Psychiatric Intensive Care Unit (PICU) which comprised eight beds. The unit was small, consisting of a central nurses' station surrounded by an enclosed courtyard, offices, lounge and dining and patient sitting area which were, in turn, flanked by patients' bedrooms. A seclusion room[21] was located in proximity to the nurses' station and the kitchen/pantry. The unit was isolated from other areas of the facility by an eight meter corridor which acted as a security 'airlock'.

Unit A1 was designed to accommodate involuntary patients[22] with acute psychosis and/ or depression and/or significant life crisis whose behaviour was assessed as sufficiently disorganised and/or violent towards others and/or of significant risk to self to occasion management in a secure environment. The unit was, as a consequence, locked at all times to prevent patients leaving. At the time of the study the unit serviced the needs of the regional health service described above as well as adjacent health regions as required. Unit A1 was staffed by registered nurses[23] (RNs) of whom there were three on morning shifts[24], three on afternoon shifts[25] and two on night shifts[26]. The nursing unit

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[21] The term 'seclusion room' refers to a single locked unfurnished room where the patient can be monitored by nurses and from which they cannot voluntarily leave. Seclusion is used primarily for the temporary incarceration of patients deemed to be unmanageable because, for example, of violent behaviour towards self or others (Meehan, Bergen & Fjoeldsoe, 2004; Salais & Fenton, 2000). There are strict rules governing the use of seclusion rooms in the State of NSW and periods of seclusion must be sanctioned by orders from a medical officer and the patient must be constantly observed by nursing staff. The use of seclusion must also be a last resort when other, less restrictive, methods to control behaviour have failed (NSW Parliament, 2007).

[22] These are patients who have been compulsorily incarcerated in a mental health unit under the provisions of the NSW *Mental Health Act 1990* (NSW Parliament, 1990) (since replaced by the NSW *Mental Health Act 2007* [NSW Parliament, 2007]).

[23] The term Registered Nurse was defined by the NSW *Nurses and Midwives Act 1991* (NSW Parliament, 1991) and included nursing staff educated to appropriate standards and with a defined scope of practice.

[24] Morning shifts span from 0700 hours until 1530 hours unless otherwise stated.

[25] Afternoon shifts span from 1430 hours until 2300 hours unless otherwise stated.

manager (NUM) generally worked as part of the morning shift staff numbers (i.e. three). There were no dedicated medical or allied health members attached to this unit as these personnel were provided by other units as required.

Unit A2 was an acute admission facility with accommodation for twenty patients. It was an unlocked unit[27] designed for the treatment of both voluntary[28] and involuntary patients. At the time of this study the unit served a defined geographical locality within the area health service. Its design included a nurses' station, dining and lounge area adjacent to a large courtyard which was flanked by patients' bedrooms.

Unit A2 was staffed on week-days by three RNs and an enrolled nurse[29] (EN) on morning shifts, three RNs and an EN on evening shifts and two RNs on night shifts. The NUM generally worked a Monday-to Friday day shift[30] that overlapped with the morning and evening shifts. On weekends the morning and afternoon shifts comprised three RNs on each shift. Medical staff appointments consisted of a visiting medical officer (VMO) supported by six others of varying seniority. There were also allied health staff[31] appointments.

Unit A3 was similar to Unit A2, in terms of the type of patient population served, design and staffing, but served a different geographical location of the area health service during the period of time that the study was conducted.

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[26] Night shifts span from 2300 hours until 0700 hours unless otherwise stated.

[27] Whilst units A2, A3 and A4 were *unlocked* the main access door to the hospital remained locked at all times. Voluntary patients from *unlocked* units were generally able to leave at any time but those (involuntary) patients deemed to be a danger to themselves or others were denied egress from the hospital complex by nursing staff and also (if the need arose) by security staff.

[28] As defined by the NSW *Mental Health Act 1990* (NSW Parliament, 1990).

[29] The term Enrolled Nurse was defined by the NSW *Nurses and Midwives Act 1991* (NSW Parliament, 1991) and included nursing staff educated to appropriate standards and with a defined scope of practice which was more limited than that of registered nurses.

[30] Generally from 0830 hours until 1700 hours but this could vary according to circumstances.

[31] Allied health staff consisted of psychologist, social worker and occupational therapist positions.

Unit A4 was an acute admission facility with accommodation for 18 people. It was an unlocked facility for the treatment of voluntary and involuntary patients who had a primary mental illness diagnosis with an associated co-morbidity in respect of alcohol and/or other drugs. The physical design of unit A4 was similar to that of units A2 and A3 but its staffing included three RNs on a morning shift, three RNs on an evening shift and two RNs on the night shift as well as a NUM rostered on a day shift on a Monday-to-Friday basis. No EN was employed in this unit. Medical staff appointments consisted of a visiting medical officer (VMO) supported by four others of varying seniority. There were also allied health staff appointments.

Unlike units A1-4, Unit A5 was a built in a previous era but had been significantly refurbished during the 1980s. The unit provided accommodation for eighteen mainly voluntary patients, all of whom were people with a history of psychiatric diagnosis and a current diagnosis which included dementia or the early onset of dementia. The unit consisted of two large day-rooms and a courtyard separated from a central nurses' station. The sleeping accommodation was varied with one single-bedded room, a four bed and a six bed room, as well as a larger dormitory-style area. The unit was staffed by two RNs and one EN on morning, afternoon and night shifts with the support from a 'primary nurse' who worked the same day shift hours as the NUM on a Monday-to-Friday basis. The unit was staffed by a consultant psychiatrist supported by two other medical officers. There were also allied health staff appointments.

The PEC unit facilitated patient admissions to the hospital and was staffed by one RN per morning, afternoon and night shifts as well as one RN rostered to an overlapping shift[32] between the morning and afternoon shift.

The hospital was also staffed by one nurse manager (grade two) per morning, afternoon and night shift who supervised the day-to-day nursing activities for the hospital. Other nurse managers were also employed (for example: nurse manager grade three) who worked day shifts but had relatively little contact with patients.

[32] Generally working from 1330 hours until 2200 hours but this could vary with circumstances.

Campus B: Consisted of a single 24-bed acute admission unit, B1, located within a general hospital. This unit had been constructed and commissioned during the mid-1990s and provided accommodation for eighteen, mostly voluntary, patients in an 'open area' (i.e. not locked unless for security purposes during the night) and for six involuntary patients in an 'observation area' (which was locked to prevent patients from leaving). The open area comprised a number of single bedrooms each with en suite bathrooms, a number of twin bedded rooms, a TV lounge and games room, a group/activities room, a dining room, offices, interview rooms, a clinic room and a courtyard. A nurses' station separated the open area from the observation area with access to the observation area being facilitated by small corridors either side of the nurses' station. One of these corridors contained a small clinic facility whilst the other corridor provided access to a seclusion room. The patient accommodation in the observation area included six single bedrooms, each with an ensuite bathroom, and a combined living and dining room. In one corner of the observation area was a small courtyard which had a bricked wall separating it from the grounds of the general hospital.

Unit B1 was mostly staffed by RNs of whom there were four on morning shifts, four on afternoon shifts and three on night shifts. Several ENs were also employed with one EN being rostered to each shift. The NUM generally worked a day shift from Monday to Friday in addition to a nurse manager (grade three) who was also rostered to Monday to Friday day shifts. Medical staff appointments consisted of a clinical director, two staff specialists as well as two more junior medical officers. There were also allied health staff appointments.

Campus C: was a large stand alone psychiatric hospital built mainly in the early part of the twentieth century which, through deinstitutionalisation, had now diminished to 130 beds spread across a number of widely disbursed wards and cottages. The main purpose of this hospital was to provide assessment and psychiatric rehabilitation services to

(mostly voluntary and some continued treatment[33]) clients of the local area health service as well as providing medium-secure beds as part of a broader forensic mental health service. The hospital consisted of four units, referred to here as units C1, C2, C3 and C4 which had all originally been built in the decades prior to World War II. The hospital also contained Unit C5 which had been built during the early 1990s. All units had a kitchen and dining facilities as well as individual bedrooms for clients.

Unit C1 was an assessment facility designed for twelve patients. Despite its small patient numbers C1 was quite large being built around two courtyards. As well as ample office spaces the unit also had a seclusion room. During the time of the study the unit was kept locked. Staffing for unit C1 consisted of three nurses on morning shift three nurses on afternoon shift and two nurses on night shift. In addition there was also a NUM who was rostered on a day shift on a Monday-to-Friday basis as well as one part-time allied health staff. The unit was staffed mostly with RNs but there were also several ENs who were generally rostered one per shift. Medical staff consisted of one clinical director plus two junior medical officers whose services were shared with other units in the service.

Unit C2 was a rehabilitation facility designed for fourteen patients. The unit had two courtyards, which could also be used as 'segregation' areas for patients, as well as a seclusion room. During the time of the study the unit was not locked. Staffing of C2 consisted of three nurses on a morning shift, three nurses on afternoon shift and two nurses on night shift. In addition there was also a NUM who was rostered on a day shift on a Monday-to-Friday basis. The nursing staff consisted mostly of RNs but there were also ENs who tended to be rostered one per shift. Medical staff consisted of three medical officers plus one visiting psychiatrist whose services were shared with other parts of the service.

Unit C3 comprised a collection of nine stand-alone cottages which housed 47 patients. There were no seclusion rooms within the cottages and nor were these houses locked

[33] These are patients who have been compulsorily incarcerated for up to six months in a mental health unit under the provisions of the NSW *Mental Health Act 1990* (NSW Parliament, 1990). NB: There was also a provision for review and extension of this order under the Act.

except during the night, for security purposes, by the residents. This network of facilities included two distinct areas known as group one and group two. Group one cottages were staffed by three nurses on a morning shift, three nurses on an evening shift with no nurses being rostered on the night shift. In addition there was also a NUM who was rostered on a day shift on a Monday-to-Friday basis. Group two staffing consisted of three nurses on ten hour day shifts[34], one nurse on an evening shift[35], one staff member designated as Team Leader, nine allied health staff, and one member of nursing staff designated as a bed manager. The nursing staff consisted mostly of RNs but there were also ENs who tended to be rostered one per shift per group. Medical staff consisted of three medical officers plus one visiting psychiatrist who were shared with other parts of the service. A small number of allied health staff members were, similarly, shared with the rest of the hospital.

Unit C4 was a 27-bed unit for older persons with a history of psychiatric diagnosis and a current diagnosis which included dementia. The unit was divided into two main areas: one for mobile residents and one for non-ambulatory patients. Unit C4 was locked to prevent patients from leaving. It was build around a large courtyard and had a seclusion room. Staffing consisted of six nurses on a morning shift, three nurses on an evening shift and two nurses on shifts which spanned between morning and evening shifts. There were also three nurses on night shift as well as a NUM who was rostered on a day shift. The unit was staffed mostly by RNs but there were also five ENs as well as one student nurse who had completed two years of tertiary education (who was employed as an assistant in nursing). Medical staff appointments included a clinical director and one other geriatrician as well as one other junior medical officer. Allied health staff consisted of one staff employed on a part time basis.

Unit C5 was a medium-secure forensic unit with 30 beds built during the early 1990s. For security reasons the layout of the unit will not be described. This unit provided accommodation for men, most of whom were acutely mentally ill, who required a medium-secure environment because they were: corrective services prisoners who

[34] Generally working from 0630 hours to 1800 hours not including (unpaid) meal breaks.

[35] Generally working from 1330 hours until 2200 hours but this could vary with circumstances.

suffered a mental illness[36]; persons found not guilty of an offence due to mental illness[37]; and involuntary patients from other mental health units in the service whose behaviour was deemed to be extremely violent. The unit had ten nurses on a morning shift, ten nurses on an evening shift and three nurses on night duty as well as one NUM who was rostered on a day shift from Monday to Friday. All nursing staff positions were filled by RNs apart from two EN positions. Medical staff appointments included a clinical director and two other VMOs who were psychiatrists. There were also seven allied health staff positions and as well as security staff.

The hospital was also staffed by one nurse manager (grade two) per morning, afternoon and night shift who supervised the day-to-day nursing activities for the hospital. A nurse manager grade three was also employed who worked day shifts but had relatively little contact with patients.

3. GAINING ENTRY AND RECRUITING STUDY PARTICIPANTS

3.1 Ethics committee approval

The present study was designed in consultation with the thesis supervisor, Professor Michael Hazelton, and the relevant ethics approval documentation was presented to the University of Newcastle Ethics Committee as well as the relevant Area Health Ethics Committee during June 2002. Phase One of the study, observation of nurses interacting with patients in inpatient units, subsequently commenced in December 2002 whilst Phase Two of the study, interviews with recently assaulted nurses, commenced during July of 2003.

3.2 Conduct of the non-participant observation phase

The main objective of Phase One of the study was to observe mental health nurses in their normal working environment in order to provide contextual information about: the

[36] These patients were categorised as 'forensic patients' in accordance with the NSW *Mental Health Act* (NSW Parliament, 1990).

[37] These patients were categorised as 'forensic patients' in accordance with the NSW *Mental Health Act* (NSW Parliament, 1990).

physical work environment; the unit milieu; working relationships between peers; relationships between nurses and patients; and the manner in which nurses engaged or did not engage with patients. It was anticipated that the data obtained during Phase One of the study would facilitate the development of theoretical sensitivity (Glaser, 1978) which would enhance data analysis during Phase Two of the study.

3.2.1 Sampling strategy for Phase One observations

The researcher employed purposeful sampling to limit the number of sites for Phase One observations to three settings: unit A1 (being the PICU) the 24-bed unit B1 (being a psychiatric admissions unit) and the forensic unit C5. The choice of these sites was based upon information from the literature which indicated that patient violence was more likely to occur in acute care units (Barlow, et al., 2000; Owen, et al., 1998a; Fottrell, 1980) as well as units where patients were frequently placed in seclusion (Owen et al., 1998a). In addition Ng, et al. (2001) and Owen at al. (1998b) indicated that a high level of bed occupancy was also associated with increased levels of violence.

Anecdotal information from staff employed in the study settings indicated that the psychiatric admissions units and the forensic unit, and particularly units A1 and C5, were sites where there was a high bed occupancy rate as well as a high incidence of patient aggression and the use of seclusion rooms. This was supported in an early draft of the report prepared by the Acute Services Project Team (2003, p, 22) which confirmed that the units selected had high occupancy rates averaging over 90% for the period prior to and during the study.

3.2.2 Timing of data collection for Phase One observations

The timing of the observations was based upon: information from staff in the units who advised that interactions between staff and patients increased at the changeover of the day shifts; findings by Barlow, et al. (2000) and Grassi, et al. (2001) who respectively reported that a greater number of violent incidents occurred on day shifts; and findings by Manfredini, et al. (2001) who reported that there was a peak in the occurrence of aggressive incidents, perpetrated by patients, in early afternoon. Observations were, thus, timed as below.

During Phase one the researcher observed interactions between patients and nurses for a total of 14 hours in each of three sites as follows:

> Unit A1: 16th December 2002 (0700- 1500 hours); 18th December (1200- 1400 hours); 22nd December (0700- 0900 hours); and 23rd December (1430- 1630 hours).
>
> Unit B1: 28th January 2003 (0700- 1500 hours); 11th February (1200- 1400 hours); February 17th (0700- 0900 hours); and February 18th (1430- 1630 hours).
>
> Unit C5: 27th February 2003 (0700-1500 hours); 3rd March (1200- 1400 hours); 4th March (0700- 0900 hours) and 6th March (1430-1630 hours).

After initial consent was given for the researcher to attend the selected units for observation a schedule for attendance was agreed upon between the researcher and the relevant NUM. The researcher agreed to occupy locations within the units that would not interfere with the normal day-to-day functioning of the unit and to complete data collection in a discreet fashion. Members of the nursing staff were asked for permission for the researcher to attend the unit on each occasion that observations occurred and other members of staff were kept informed of the researcher's presence. The researcher agreed to have little personal contact with patients so as not to interfere with the day-to-day running of the unit.

3.2.3 Gaining access to the study environment and participants during Phase One of the study

Prior to the commencement of Phase One of the study the researcher contacted the relevant area health service managers and nurse managers by phone and subsequently informed them about the ethics committee approvals. These personnel were provided with copies of the ethics application so that they might become familiar with the aims and scope of the study and permission was sought for commencement of observation on each of the units (A1; B1 and C5). Permission was subsequently given and the researcher then contacted the NUMs of units and commenced negotiations in regard to Phase One activities. The researcher provided brief information sessions (of about fifteen minutes duration) to staff at the conclusion of normally scheduled staff meetings at each of the units A1, B1 and C5 about one week prior the planned commencement of Phase One data collection. Staff were informed firstly about the aims and scope of the

study but also about issues such as: rights of staff in respect of having access to information about the research project; providing consent for data collection; anonymity in any thesis or report based on the study; the provision for unreserved withdrawal of data upon the request of the participant; and the rights of patients to be informed about the project, alerted when the researcher was observing interactions between them and staff members, and to remain anonymous in any thesis or report based on the study. Sample information sheets and consent forms were given to each of the NUMs and these were stored in the unit communications books for the staff members to read.

3.2.4 Providing information for Phase One participants and other ethical considerations

All nurses and allied health staff who participated in the observational phase of this study were given an information sheet (Appendix D) which explained: what the study was about; the rights of staff not to participate and the right of staff to withdraw data which they had provided at any time; the researcher's legal responsibilities (such as the necessity for the researcher to report any observed unethical behaviour, such as staff harming a patient, to the relevant authorities); study procedures including the storage of data; the potential that all data collected might appear in the final thesis; and the intention of the researcher to ensure that participants would not be identified in any subsequent written presentation of the data. Participants were also reassured that: a decision not to participate or to withdraw from this study would not affect their relationship status as an employee of the Hunter Area Health Service or their relationship with any personnel or services provided by the University of Newcastle; and that none of the data obtained would be available to employers or anyone else except the researchers and the participant other than in accordance with requirements of the law.

Participating staff signed a consent form which gave permission for the researcher to collect data (Appendix E). In addition, an advertisement was posted in prominent places around the unit informing patients and visitors of the researcher's presence and purpose (Appendix F). The rights of patients and visitors to not participate in the study were also explained. In all instances of information forms and advertisements it was made clear that the main focus of the researcher's attention was the behaviour of nursing staff and

that participation in the observations was voluntary. People who did not wish to be involved were asked to notify the researcher who would either: 1. ensure that observation data for that person was not included in the analysis of the data; or 2. cease the observation.

The identity and contact details of the researcher and chief investigator were included on all information forms and advertisements. Moreover patients and visitors were informed that observations would be conducted in public areas only (and not in private bedrooms or bathrooms).

During Phase One data collection the activities of the unit population were sampled every half hour when the researcher wrote field notes and employed sociograms to describe or depict nurse activity and the movements of medical staff, allied health staff and patients within the given environment (for an example of a sociogram see Appendix G). Additionally, any other events such as significant events that occurred, (for example an assault upon staff) became the subject of field note entries (examples of field notes are provided in the next chapter of this thesis, Chapter Five, which details data analysis and findings relevant to this study).

3.2.5 Profile of the study participants- Phase One of the study

In the 42 hours during which observations were conducted a total of 34 unit nursing staff were observed as well as an estimated 70 patients and 23 medical and allied health staff (including occupational therapists, social workers, court liaison staff as well as numerous hospital assistants and hospital visitors. Of the nurses observed 32 were RNs whilst two were ENs. No attempt was made to survey the staff for characteristics such as age or nursing experience since this would have unduly interrupted the unit but it was observed that the nurses were generally experienced RNs and within the 35-to-50 years-of-age demographic. All of the people asked to participate in the study did so without objection and no-one asked to withdraw data related to the observation of their behaviour either at the time of observation or afterwards.

3.3. Gaining access to the study environment and participants during Phase Two of the study

During Phase Two of the study recently assaulted nurses were initially interviewed (interview one) within three weeks of experiencing an assault by a patient using three questionnaires. Subsequent interviews (interviews two and three) were conducted at three months and six months post-assault, using open-ended questions, in order to establish: the severity and length of the nurses' responses following their assault; the strategies used by the nurse to overcome the effects of their assault; and the nature of social interactions with colleagues and patients that either helped or hindered them in overcoming any difficulties encountered.

Prior to the commencement of Phase Two of the study the relevant NUMs of all units at Campus A; Campus B and Campus C were contacted by phone and reminded about the relevant study procedures. The NUMs subsequently gave permission for the study to proceed in their units having discussed the appropriateness of this venture with their staff in the first instance.

Participants were recruited on the basis of their response to an advertisement (see Appendix H) which was initially placed in prominent places in all inpatient units of the regional health service. The researcher also conducted brief information sessions in all of the units across Campuses A, B and C in order to address any concerns that staff may have concerning the procedures and ethics of the study and also to raise awareness of the research project amongst the staff.

Every nurse who responded to the advertisements was accepted into the study regardless of the severity of their assault on the basis that she/he: i.) had experienced an assault by a patient (under the definition of assault[38] used for the purposes of this study) in the

[38] For the purposes of this study patient assaults is defined as: i. any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (for example: where the nurse is verbally threatened) OR ii. any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (for example: where the nurse is spat upon).

three weeks prior to contacting the researcher and ii.) was prepared to complete the relevant questionnaires and subsequent interviews as well as give written consent for these procedures.

3.3.1 Sampling strategy for Phase Two of the study

The initial method for the Phase Two recruitment of participants was purposeful sampling which was superseded by theoretic sampling as data collection progressed (Glaser, 1978, p. 36; Glaser & Strauss, 1967, p. 45). The researcher came to concentrate recruitment efforts in the acute admissions units as it became clear that these were the places where assaults upon staff were more likely to occur. Recruitment proceeded as below until data saturation was reached.

3.3.2 Period of data collection: Phase Two of the study

Sixteen recently assaulted nurses volunteered to be interviewed during Phase Two of the study. The first round of interviews was conducted between 25th June 2003 with participant 001 (Bruce[39]) and 14th March 2004 with participant 016 (Bill). In keeping with the developed protocol all nurses were interviewed within three weeks of their initial assault. Each of the participants provided a full set of responses to the interview one data forms: the demographic data form; the Assault Response Questionnaire (ARQ) (Ryan & Poster, 1989); and the Perceived Stress Scale (Stress Scale) (Cohen, et al. 1983).

The round of second interviews with the sixteen participants occurred between 15th September 2003 and 7th June 2004. The study protocol required that participants be interviewed within three months of the assault which brought them to this research project and this was done, allowing for several days either side of the due date except in the case of: participant 011 (Adam) who was interviewed 13 days later than scheduled owing to leave commitments; participant 014 (Joseph) who was interviewed 17 days later than scheduled owing to work and leave commitments; and participant 016 (Bill) who was interviewed 14 days later than scheduled due to leave commitments.

[39] All 'names' of participants provided in this thesis are pseudonyms.

The round of third interviews was conducted between 9th December 2003 and 15th August 2004 with each of the sixteen original participants providing data. In this case the study protocol required that participants be interviewed within six months of the assault which brought them to this research project and this was done, allowing for several days either side of the due date except in the case of: participant 004 (John) who was interviewed 14 days late because of leave commitments; participant 009 (Lexie) who was interviewed 13 days late because of leave and work commitments; participant 013 (Angus) who was interviewed 16 days later than expected due to work and leave commitments; and participant 015 (Joseph) who was interviewed six weeks later than scheduled due to extended leave commitments.

3.3.3 Providing information for Phase Two participants and related ethical considerations

3.3.3.1 Conducting interviews with Phase Two participants: Interview one

Each of the sixteen nurses recruited into Phase Two of the study participated in interview one. Prior to this interview the researcher discussed, and presented the nurses with, an information sheet (Appendix I) which explained: what the study was about; the rights of staff not to participate and the right of staff to withdraw data which they had provided at any time; the researcher's legal responsibilities (such as the necessity for the researcher to report any observed unethical behaviour, such as staff harming a patient, to the relevant authorities); study procedures including the storage of data; the potential that all data collected might appear in the final thesis; and the intention of the researcher to ensure that participants would not be identified in any subsequent written presentation of the data. As with the observation phase of this study participants were also reassured that: a decision not to participate or to withdraw from this study would not affect their relationship status as an employee of the area health service or their relationship with any personnel or services provided by the University of Newcastle; and that none of the data obtained would be available to employers or anyone else except the researchers and the participant other than in accordance with requirements of the law.

Subsequent procedures included the signing of a consent form (Appendix J); the establishment of a pseudonym to protect the participant's anonymity; and a series of three questionnaires. As previously mentioned the questionnaires included: a demographic data form which facilitated reporting of details such as the participant's age, sex, employment details, nursing experience, qualifications, history of being assaulted by patients, details about the recent assault which motivated them to provide information for this study and the level of threat that they had experienced during the assault (from nil to severe); the ARQ which facilitated reporting on their responses to the experience of being assaulted by a patient including emotional responses (such as sadness, depression, anger and anxiety), biophysiological responses (such as changed sleep patterns, changes in appetite, and body tension), cognitive responses (such as doubting self worth and disbelief that the assault had occurred), and social responses (such as changes in relationships with others and fear of the assaultive patient); and the completion of the Stress Scale (Cohen, et al., 1983) was used to estimate the presence of other background stressors which the nurse was experiencing due to difficulties at home and at work prior to her/his assault (see Appendices A, B and C).

This initial interview varied in duration according to the participant from 15 minutes to 45 minutes. It was expected that the information collected during this interview would provide base line data against which future responses could be compared.

The researcher prepared for a number of foreseeable risks in respect of interviewing potentially vulnerable people. Firstly there was a foreseeable risk that participants would experience significant distress[40] whilst providing data for this research project. The interview method (including data collection using the ARQ) was designed to allow participants to recount their experiences in their own time in a supportive environment.

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[40] The interpretation of "significant distress" was in the hands of the researcher who is an experienced mental health nurse. The researcher has also had experience interviewing recently assaulted nurses in a previous study (Harmon, 1997). Signs of significant distress were deemed to include a) the participant(s) displaying strong emotion, during the data collection process, which could not be easily or successfully resolved; b) non-completion of the data collection session with the participant(s) not displaying emotion but refusing to communicate the reasons for termination; or c) an expression by participant(s) that the data collection session was onerous and that they wouldn't want to continue with the procedure.

All nurses were informed about their health service policies[41] regarding support and counselling following an assault.

In the event that a participant should experience distress that was not easily resolved the researcher would (according to the relevant protocol established in consultation with the thesis supervisor, Professor Michael Hazelton, and the relevant ethics committees): i.) ask the participant to clarify his/her position; ii.) offer support to the participant; iii.) refer the participant, as appropriate, both to the service manager at the facility at which they were employed (as per service policy) as well as to the Employee Assistance Program (EAP).

The validity of employing the ARQ and the Stress Scale in the current research contexts

The researcher had used the ARQ and the Stress Scale in a previous study (Harmon, 1997). At the time of conducting this previous study the researcher had been concerned that these tools, being originally developed in the United States, would not have face validity in Australian settings (Elliott, 2003). Consequently the researcher employed fifteen psychiatric nurse experts to review and report their findings on the suitability and adaptability of these questionnaires in the study contexts. The panel of nurse experts consisted of nurse academics, nursing administrators, nurse educators and senior psychiatric nurses with a minimum of ten years of experience in their field. Advice from this panel indicated that no changes needed to be made to Ryan and Poster's (1989) modified ARQ in order for it to be used in an Australian service setting. Similarly, the panel of fifteen nurse experts did not foresee any difficulty in using the Stress Scale (Cohen, et al, 1983) in the Australian context (Harmon, 1997, p. 55).

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[41] The main NSW Health Department policies which relate to the support of assaulted staff are contained within the documents: *Zero tolerance response to violence in the NSW health workforce* (Employee Relations Branch, NSW Department of Health, 2005a); *Effective incident response: A framework for prevention and management in the health workforce* (Employee Relations Branch, NSW Department of Health, 2005b)]; and the related policy *Employee Assistance Programs: NSW Health Policy and Best Practice* (Employee Relations Branch, NSW Department of Health, 2005c).

Data on the reliability of the ARQ and the Stress Scale

The ARQ was originally developed by Lanza (1983) and subsequently modified by Ryan and Poster (1989) who described their (modified) ARQ as "... a 61-item self-report symptom inventory that measures responses in four categories: social, emotional, cognitive, and biophysiological" (Ryan & Poster, 1989, p. 326). Responses were rated on a five point scale (from one to five with five representing a severe response). Space was left in each category for staff to list additional responses. According to Ryan and Poster (1989, p. 326) the split half reliabilities (r) of each of the four scales of their modified ARQ were: r = 0.93 for the emotional scale; r = 0.87 for the biophysiological scale; r = 0.95 for the social scale; and r = 0.86 for the cognitive scale.

According to Cohen, et al. (1983) the Stress Scale was designed to measure the degree to which situations in one's life are appraised as stressful. The Stress Scale is a fourteen item questionnaire in which respondents may reply to questions on a five point scale (from nought to four with nought signifying 'Never' and four signifying 'Very Often'). According to Ryan and Poster (1989, p. 326) reliability of this tool was reported at 0.85 for both test-retest and coefficient alpha and it has concurrent, predictive and content validity.

3.3.3.2 Conducting interviews with Phase Two participants: Interview two

All nurses who were participants in the first interview continued to be participants during subsequent interviews. The second interview with recently assaulted nurses lasted from 20 minutes to 90 minutes, depending largely upon the acuity of the distress reported by individual participants. The median interview time was 40 minutes. In accordance with study procedures the participants were contacted prior to their second interview which was scheduled at three months post-assault. The nurses were particularly accommodating in respect of making time for the researcher and generally provided candid and detailed accounts of their experiences in coping with the effects of their assault.

The basic procedure for all second interviews was to: i.) remind the participant of the pseudonym that they had chosen in interview one; ii.) review consent and cover sheet procedures (established during interview one); iii.) review questionnaire data from

interview one and ask the participant to verify that the data were accurate; iv.) invite the participant to review a 'formulation' written by the researcher (encompassing the main elements of the questionnaire data and any other pertinent information which the researcher had noted during the first interview) (for an example of a formulation prepared prior to a second interview see Appendix K), and verify that the interpretation of events was reasonable; v.) proceed with the second interview, which was audio-taped, and conclude with appropriate thanks and a reminder regarding the due date for the third and final interview as well as the undertaking that the researcher would make a transcript of interview two available to the participant prior to the final interview.

The basic schedule for the second interview included questions such as:

- Tell me about what it is like to work on your unit
- Tell me about how you have been coping following your assault (and possibly)
    - *How have you responded emotionally following the assault?*
    - *How have you responded physically following the assault?*
    - *How have you responded cognitively following the assault?*
    - *How has the assault affected the way in which you nurse?*
- Have you experienced any difficulties in the way in which you relate to patients since the assault (short-term/ long-term)?
- What strategies have you adopted to help you cope with the effects of the assault generally/whilst you are at work?
- What measures have been put in place by your employer to support you following the assault? Could this situation be improved?
    - What other consequences should have resulted from your assault (legal, reconciliation?) (and if appropriate)
        - *What other supports from family and friends do you have?*

3.3.3.3 Conducting interviews with Phase Two participants: Interview three

Each participant was contacted at least one week prior to the third interview and provided with a transcript of their second interview. The duration of the subsequent interviews ranged from 20 minutes to 70 minutes with the median time being 45 minutes.

The basic procedure for all third interviews was to: i.) verify that the transcript was a fair and accurate account of the participant's second (all agreed); ii.) remind the participant of the pseudonym that they had chosen in interview one; iii.) review consent and cover sheet procedures (established during interview one); iv.) review a 'formulation' of their interviews thus far (for an example of a formulation prepared prior to the third interview see Appendix L), written by the researcher, encompassing the main elements of the previous interviews; v.) proceed with the third interview which was audio-taped; and vi.) conclude with appropriate thanks and the undertaking that the researcher would make a transcript of interview three available to participants in a timely fashion.

The basic schedule for the third interview included questions such as:

- What is your history of being assaulted by patients?
- What is your work history and for how long have you worked in acute psychiatry?
- Have you been assaulted since the assault recorded for this research
- In hindsight, what was the most difficult moment for you after the initial assault?
- Have you experienced any difficulties due to your initial assault since our last interview? Tell me about how you have been coping with these difficulties.
- What strategies have you adopted to help you cope with these effects of the assault generally/whilst you are at work?)
- What improvements have been put in pace to improve safety for nurses with respect to patient assaults?

- How equipped do you think you are with respect to handling assaultive patients in the future?
- Do you feel that you have been adequately supported (by colleagues, local unit management and area nursing administration) following your assault?
- Do you find that you have become more involved in safety issues with respect to patient aggression since your assault?
- Have there been any positive outcomes? What have you learned from this experience?

3.4 Journals, field notes and memos

Primarily the data records for phases one and two this study took the form of field notes and interview transcripts. Each data collection occasion was marked by events which assisted the researcher to understand the phenomena (for an example of an event which was recorded as a part of the field notes for Phase One of this study see Appendix M). Various journals were kept in which the researcher summarised events either: in the form of 'formulations' (as in the examples above); or in the form of memos which were primarily a record of the researcher's comments on the data and ideas about how they might be conceptualised. The journal writing thus gave rise to 'memoing' in which the researcher questioned the data in order, ultimately, to understand the phenomena central to the development of a grounded theory.

3.5 Protecting the confidentiality of participants

Every effort was made in order to safeguard the identity of participants. The name of each participant was known only to the researcher and the principal investigator. In all field notes and transcripts of audio-taped interviews pseudonyms were used in place of participant's names. Individual participants have not been identified in any report or publication based on the data.

Upon completion of the data collection and analysis phases of the study the researcher negotiated with each participating area health service campus to report the findings and share information with participants and other interested parties. In addition the

researcher has delivered academic papers at the annual conference of the local regional branch of the Australian College of Mental Health Nurses (ACMHN) as well as at an international conference conducted by the national ACMHN organisation (as well as at other professional conferences).

During the course of the study, and afterwards, all data pertaining to the study, including field notes, code breaking keys, questionnaires, interview tapes and transcripts have been stored in a locked filing cabinet in a secure office designated for this purpose at the School of Nursing & Midwifery, University of Newcastle. In transcribing the interview tapes all identifying information was either be removed or disguised to protect the identity of participants. After data was verified with participants, the audio-tapes were destroyed. Following the completion of the study, all remaining data (including written forms, transcripts and computer disks) have been stored in a locked filing cabinet within an office designated for this purpose at the School of Nursing & Midwifery for a period of seven years before they are destroyed. The Project Supervisor and Student Researcher are responsible for these processes.

4. CONCLUSION

This chapter has outlined details of the study setting, the participants, and the processes used to gain entry to study contexts and recruit participants. Other more technical aspects of data collection, such as sampling methods, were described as well as procedures used in the conduct of the observation and interview phases of the study. Moreover ethical considerations were also discussed in relation to participant care, confidentiality and processes for the recording and storage of data. The following chapter will provide a detailed account of the processes of data analysis relevant to the study as well as the major findings, including the emergence of a basic social process (BSP) (Glaser, 1978).

CHAPTER FIVE

DATA ANALYSIS AND FINDINGS

1. INTRODUCTION

This chapter provides a description of the processes used to manage the data generated in the study and also discusses the approaches used to analyse the data. As the study was conducted in two phases the discussion that follows will address the procedures relevant to Phase One and Phase Two respectively.

2. PHASE ONE

The main objective of Phase One of the study was to gather data which would provide contextual information about the study environment including: the social milieu; the general behaviour of the patients; and the behaviours of nurses as they attempted to provide care for patients. In particular, the researcher was interested in how the nurses responded collectively when there were incidents of abuse, threats of violence and violence by patients.

During Phase One the researcher observed interactions between patients and nurses for a total of fourteen hours in each of the three acute inpatient sites as per the time line set out in Chapter Four (see page 58).

2.1 Management of the data:

Phase One of the research project involved the researcher as a non-participant observer. Data took the form of field notes, sociograms (which were pictorial representations of staff social interactions and activities), memos and journal entries. Examples of field notes with journal entries are provided below.

16th December 2002- 0715 hrs: Phase One field notes, Unit A-1, p. 2:

> Staff (nurses) involved in: brief conversations with patients; paperwork (incident forms from the previous shift); reading files and discussion of case histories. Some discussion

re discrepancy re drug orders from pharmacy (wrong dose ordered). Discussion re discharge of patient.

Note: Answering telephones; making notes; filing notes; finding notes for doctors; ordering drugs and equipment etc. occupy enormous amounts of staff time. I estimate that this is at least 50% of what mental health nurses did in this setting. This may become a category when coding. It may be useful to more properly estimate this as percentage of staff time. There are different levels of activity here: planned (routine) activity and unplanned activity that is responsive to changed circumstances in a dynamic work environment.

16th December 2002- 0900 hrs: Phase One field notes, Unit A-1, p. 3:

Patient (#3) sings "Gummy bears" song.

Patient (#3) dialogue to staff: "Ya fucken' cunt … ya break the fucken' CTO … and ya end up here ya cunts".

Nursing staff (#1) asks patient (#3): "What's wrong?" "What can we do to help? Tries to calm patient #3. It has taken nursing staff (#1) some time to respond to patient #3's monologues. Remainder of staff engrossed in paperwork and answering telephone calls.

Note: Nonsense/ disorganised behaviours and dialogue appear to be a large part of the chaotic background noise. Nurses are generally in tune with changes in the constant background noises/chaos and try to respond accordingly. Otherwise a considerable amount of background noise is apparently ignored.

28th January 2003- 0900 hrs: Phase One field notes, Unit B-1, p. 4:

Situation in the obs. becomes very tense: patient (#1) becomes disturbed and his behaviour is threatening and he escalates quickly before he hits the nurses' station glass and a nearby pillar and shouts "Fuck". Nursing staff (#2) who had momentarily left the obs. area returns to investigate and is threatened by patient #1: "Come back here or I'll nail ya, you useless prick" (Pt #1). When the nurse opens the connecting door and

commences negotiations the situation quickly escalates and patient (#1) hits nursing staff (#2) on the nose with a closed fist.

Note: This appears to be the constant risk encountered in situations where there are volatile patients present: the potential for violence. Even though serious physical violence may occur rarely it is still a possibility and the extent to which that possibility plays on the mind of nurses needs to be explored.

Need also to explore the extent to which responding to crises is a preoccupation for staff: i.e. to what extent are staff devoted to efforts to keep order and prevent chaos? (not just incidents of frank violence but also periods of verbal abuse, disorganised behaviours and dialogue, and incidents involving non-compliant behaviours [for example: refusal to take medications]). Need also to explore the effects of constantly/ regularly abrasive patients on staff.

2.2 Coding processes used to analyse data

In keeping with the method outlined in Chapter Three of this thesis analysis of the data was undertaken in parallel with the data collection. Open coding was conducted in accordance with the processes outlined by Glaser and Strauss (1967) and Glaser (1978).

2.2.1 Open Coding

The data were coded as per the following examples.

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1. 16th December 2002- 0715 hrs; Phase One field notes, Unit A-1, p. 2:

Everyday caring: nurses engaging patients.

Housekeeping tasks: organising patients' affairs; completing paper work; facilitating handover; ordering medications; and prevention of error.

Staff (nurses) involved in: brief conversations with patients regarding matters of hygiene and cleanliness of sleeping quarters [**organising patients' affairs**]; [**nurses engaging patients**]; paperwork (incident forms from the previous shift) [**completing paper work**]; reading files and general discussion of patients' progress [**facilitating**

handover]. Some discussion re discrepancy re drug orders from pharmacy (wrong dose ordered) [**ordering medications**] and subsequent phone calls [**prevention of error**. Discussion about paperwork relevant to a patient's discharge from the unit [**completing paper work**].

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2. 16th December 2002- 0900 hrs: Phase One field notes, Unit A-1, p. 3:

Abuse towards nurses

Everyday caring- nursing actions to sooth patients

Patient (#3) dialogue to staff: "Ya fucken' cunt … ya break the fucken' CTO … and ya end up here ya cunts". [**Abuse towards nurses**]. Nursing staff (#1) asks patient (#3): what's wrong?; what can be done to help you?; tries to calm patient #3 [**Nursing actions to sooth patients**].

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3. 28th January 2003- 0900 hrs: Phase One field notes, Unit B-1, p. 4:

Undirected aggression

Verbal threats directed towards nurses;

Everyday caring- nursing actions to sooth patients;

Physical violence directed towards nurses.

Situation in the obs. becomes very tense: patient (#1) becomes disturbed and his behaviour is threatening and he escalates quickly before he hits the nurses station glass and a nearby pillar and shouts "Fuck" [**Undirected aggression**]. Nursing staff (#2) who had momentarily left the obs. area returned to investigate and is threatened by patient #1: "Come back here or I'll nail ya, you useless prick" (#Pt. 1) [**Verbal threats directed towards nurses**]. When the nurse opens the connecting door and commences negotiations [**Nursing actions to sooth patients**] the situation quickly escalates and patient (#1) hits nursing staff (#2) on the nose with a closed fist [**Physical violence directed towards nurses**].

Following the methods described by Glaser and Strauss (1968) and Glaser (1978), data were contemporaneously examined and compared with previous and concurrent data. The various codes were subsequently entered on an *Excel* spreadsheet which facilitated the process of constant comparison and enabled the researcher to make decisions about the emergence of more abstract theoretical (level two) codes (see Appendix N for an example of how associated codes were tabled for the Phase One data).

Following the above process a total of 55 initial codes were generated. Codes were subsequently changed, discarded or integrated as the process of constant comparison proceeded giving rise to the emergence of 41 level one (substantive) categories. This process gave rise to the emergence of four subsequent second level (theoretical) categories which delimited the levels of process exhibited in nurse-patient relationships.

2.2.2 Identifying the core category

A core category was identified during this phase of the study. The core category met the requirements described by Glaser (1978, p. 95-96) in that it related closely to the other categories, occurred frequently in the data, took more time to *saturate* than the other categories, and accounted for much of the variation in properties contained within the other categories.

The core category to emerge from the data for this phase of the study was *responding to others in an ad hoc manner* which was an overarching category which emerged in association with the four second level categories which described nursing behaviours: *defusing crises*; *housekeeping*; *everyday caring*; and *therapeutic nursing*. The context for these behaviours was the nurses' chaotic work environment.

2.2.3 The emerging theoretical codes

Defusing crises: This category was found to have clearly identified properties related to soothing or limit-setting activities for irritable patients who found the slightest discomfort or frustration intolerable (exemplified by the level one codes categories: *nursing actions to appease patients*; *nurses sorting situations before they escalate*; *verbal de-escalation*; *crisis management*; and *safety measures to secure the unit*).

‘Crises’ were sometimes generated from anxiety over simple unmet needs which quickly escalated, particularly where there was a perception that nurses did not care and/or where the patient was demanding attention. An example is provided below.

27th February 2003- 0940 hrs: Unit C-4. (Phase One field notes, Unit C-4, p. 13):

> “I want my 9:30s” (cigarettes) … (nurses have been busy and it is only just 9:30. Patient (#1) suddenly escalates to a roar) … “I want my fucken’ *9:30s* now!”

More commonly *defusing crises* involved dealing with patients who were vexed by more pressing problems, either real or imagined:

18th February 2003- 1230 hrs: Unit B-1. (Phase One field notes, Unit B-1 p. 12).

> Patient demands immediate contact with her daughter whom, she has decided, may be sexually assaulted at any moment (the patient is female, agitated and appears to be ‘hearing voices’). The nursing staff promised to do what they could and tried to engage her. Suddenly she exclaimed: “When I get out of here I’m going to get fucken’ mad if anything has happened to my kids! I’m gunna hold you cunts responsible!” (Makes towards staff aggressively but then stops and sobs- she is inconsolable).

Occasionally there were threats of violence and even violent acts:

23rd December 2002- 1600 hrs: (Phase One field notes, Unit A-1, p. 7).

> [Terry is psychotic, irritable, and angry at the world.] Terry’ - hits the windows on the nurses’ station repeatedly; pushes other patients; abuses nurses- on-and-off for (reported by staff as) 4 hours in close cycles of escalation: “I’m gunna smash your face in … If I meet you on the outside I’m gunna kill you and your trash family”. The staff members at one point lock themselves in their nurses’ station for a time before venturing out to

placate this patient. After a while 'Terry' 'tag teams' with a female patient" … who takes on the mantle of 'abuser'.

Housekeeping: The nurse-initiated behaviours referred to here and which delimit this category include activities concerned with the level one categories:

1. *Organising patients' affairs* as exemplified by the initial codes: *organising patient's laundry*; *tidying up after patients have left the unit*; *reminding patients to do things*; *ordering cigarettes*; *ordering food.*

2. *Organising the unit* as exemplified by the initial codes: *facilitating handover (for next shift)*; *nurses ordering/writing memos for the next shift*; *note taking and filing*; *answering the telephone*; *nurses running errands*); and

3. *Assisting other health professionals* exemplified by the initial codes: *locating medical staff*; *locating diagnostic equipment, completing paper work.*

Everyday caring: Involved soothing activities and acts of kindness exemplified by the level one categories: *nursing actions to sooth patients*; *nurses engaging patients; caring for patient's physical needs; running errands for patients*; *helping patients to manage money and belongings; providing orientation for patients.*

Therapeutic nursing: was delimited by situations where there was a genuine attempt to engage the patient; assess their current mental status; apply planned nursing interventions; &/or share relevant information with other nurses (exemplified by the level one categories: *nursing staff actions to counsel patients, gathering intelligence/ assessment; talk of ethical concerns*; *positive nursing philosophy*; *nurses planning patient care*).

2.2.4 Memoing and the Phase One data

According to Glaser (1978, p. 83) "Memos are the theorizing (sic) write-up of ideas about codes and their relationships as they strike the analyst while coding." The researcher's thinking about the Phase One data was also facilitated by the questions:

"What is the data a study of? What category does this data indicate? What is actually happening in the data?" (Glaser, 1978, p. 57).

What follows is a memo which facilitated the researcher's thinking about the data and subsequent identification of a core category:

> Nurses spent their shifts dealing with significant challenges to their ability to provide a safe environment for their patients and meet institutional requirements including local hospital procedures (such as completing patients' progress notes) and legal requirements (such as complying with occupational health and safety standards). There was considerable disorder on the units created by: physical factors (noise within the unit; architectural and other constraints to efficiency); housekeeping problems (who will update the patients' notes? who will work the overtime shift? etc.) and exacerbated mainly by needy patients (especially those who are demanding, non-compliant, abusive and/or aggressive and violent). It is hypothesised that chaos is the main problem that must be dealt with and this drives a need to maintain order - a state in which staff are required to direct a considerable amount of their time and effort towards *defusing crises* and *housekeeping* to the point where processes more readily associated with nursing, such as *everyday caring* and *therapeutic nursing*, are overshadowed[42]. The main problem that nurses have is therefore hypothesised as *chaotic work environment*.
>
> The main thing that strikes me about the data, however, is that nurses were constantly 'responding to others'- i.e. they were rarely involved in planning nursing activities but, in the main, were either carrying out (or not carrying out) the wishes of patients; responding to crises involving their patients; or they were carrying out the wishes of management or doctors. The effect of demands and directives from others combined with the requirement to endure constant chaos was that nurses were distracted from spending any length of time with patients unless a particular crisis was extended. Even the management strategies for patients in crisis (for example: giving medications) were often prescribed by others. Nursing interventions were largely ad-hoc but tempered by the nurses' experience in handling numerous similar previous instances. The proposition that nurses are mainly engaged in therapeutic nursing is not supported by the data since

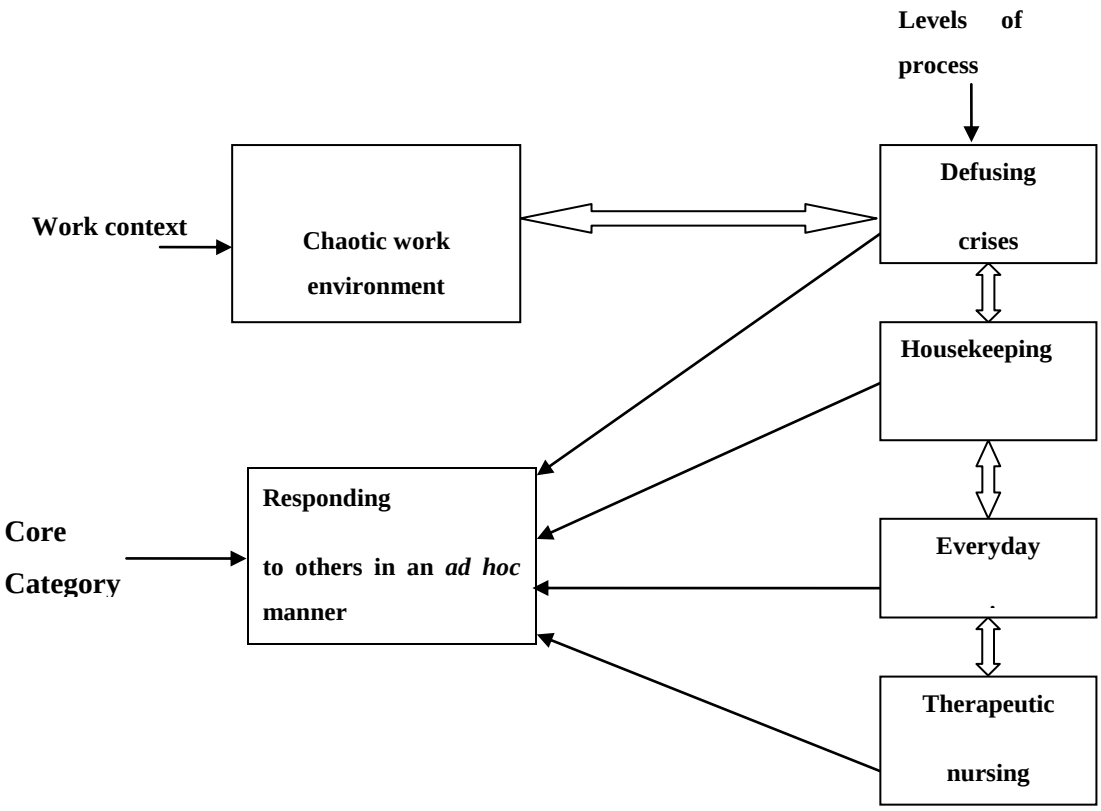
[42] NB: The processes: defusing crises and housekeeping do not exclude either of the processes: therapeutic nursing or everyday caring. Indeed the four levels of process may occur together.

nurses rarely sought out/had opportunities to assess patients for psychic distress and nor did they regularly discuss/plan intervention strategies other than those 'prescribed'.

2.2.5 Diagramming and the Phase One data

What comes out of the data is that nurses observed in this study were reactive rather than proactive to situations as they occurred in their working environment. A representation of the core category *responding to others in an ad hoc manner* in relation to: their chaotic work environment; and levels of nursing process: defusing crises; housekeeping; everyday caring; and therapeutic nursing; is depicted in Figure 1.

Figure: 1: Depiction of nursing levels of process in relation to the Phase One core category: *Responding to others in an ad hoc manner.*



3. PHASE TWO

The objective of Phase Two of the study was to gather information from participants that would facilitate the development of a grounded theory concerning the process of response of mental health nurses to the experience of assaults by patients.

3.1 Management of the data

Data from the first interview included: completed questionnaires; formulations for each interview; and journal entries and memos. These quantitative data were collated on an *Excel* spreadsheet prior to being summarised in the form of tables and graphs.

Data from the subsequent interviews (two and three) took the form of interview transcripts, journal entries, formulations for each interview, and memos. In accordance with the methods described by Glaser and Strauss (1968) and Glaser (1978), data were continuously examined and compared. In the process of initial coding a total of 286 codes were generated

The various codes were subsequently entered on an *Excel* Spreadsheet which further facilitated the process of constant comparison and enabled the researcher to make decisions about the emergence of selective (level one) categories and the more abstract theoretical (level two) categories (see Appendix O and Appendix P for examples of how associated codes were tabled for the Phase Two data).

3.2 Literature as a source of data

In keeping with the conventional grounded theory practice the review of the literature for this study was delayed until the theory had emerged from the study data (Glaser, 1978; 1992). The researcher acknowledges, however, that a considerable amount of prior reading had occurred during the completion of a previous study (Harmon, 1997) and for the ethics approval stage and other preliminary activities pertinent to the present study. In keeping with the approach taken by Sheldon (1998) the literature was used to test and validate the categories which had emerged from the study. Further discussion about the relevant literature and its relationship to the specific findings from this study will be discussed in the following Chapter Six.

3.3 Phase Two, interview one data

3.3.1 Personal characteristics of Phase Two participants

Of the sixteen nurses who volunteered to be participants in Phase Two of the study, eleven were men and five were women. All participants persevered with the study during the three interviews which occurred up to approximately six months after their assault. Participants reported their ages as follows: two reported that they were between 26 and 30 years of age (12.5 per cent of the total); two reported that they were between 36 and 40 years of age (12.5 per cent); five reported that they were between 41 and 45 years of age (32.25 per cent); two reported that they were between 46 and 50 years of age (12.5 per cent); four reported that they were between 51 and 55 years of age (25 per cent); and one reported being between 56 and 60 years of age (6.25 per cent). Details of the age distribution of the participants can be seen in Table 1 and tables summarising the nursing experience of participants can be found in Tables 2 and 3. Two of the

participants were ENs and the remainder were RNs. A summary of the educational qualifications of the participants can be seen in Table 4.

Table 1: Age distribution of Phase Two participants in years (n=16)

Respondents Age in years	Numbers of participants	Percentage of total number of participants
26-30	2	12.5
31-35	0	0
36-40	2	12.5
41-45	5	31.25
46-50	2	12.5
51-55	4	25
56-60	1	6.25

Table 2: Total years of nursing experience of Phase Two participants (n=16)

Categories in years	Number of participants	Percentage of total number of participants
0-5	2	12.5
6-10	2	12.5
11-15	4	25
16-20	2	12.5
21-25	0	0
Over 25	6	37.5

Table 3: Total years of mental health nursing experience of Phase Two participants (n=16)

Categories in years	Number of participants	Percentage of total number of participants
0-5	6	37.5
6-10	3	18.75
11-15	1	6.25
16-20	2	12.5
21-25	0	0
Over 25	4	25

Table 4: Summary of educational qualifications attained by Phase Two participants (n=16)

Highest educational qualification	Number of participants	Percentage of total number of participants
Single nursing certificate	3	18.75
Multiple nursing certificates	3	18.75
Diploma	1	6.25
Bachelors Degree	8	50
Masters Degree	1	6.25
Other	Nil	0

Participants reported being previously assaulted by patients as follows: one participant reported no previous assaults; one reported experiencing between one and three previous assaults; one reported experiencing between ten and fourteen previous assaults; three participants reported experiencing between fifteen and nineteen previous assaults; one of the participants reported experiencing between 20 and 24 previous assaults; and

nine participants reported that they had been assaulted on more than 50 occasions. Those participants who reported few previous assaults were the least experienced nurses whilst the participants who reported being assaulted on 50 or more occasions were the most experienced nurses. A summary of the number of assaults experienced by the participants can be found in Table 5.

Table 5: Number of previous patient assaults experienced by Phase Two participants (n=16)

Number of previous assaults	Number of participants	Percentage of total number of participants
None	1	6.25
1-3	1	6.25
4-9	0	0
10-14	1	6.25
15-19	3	18.75
20-24	1	6.25
Over 50	9	56.25

3.3.2 Details of assaults suffered by Phase Two participants

Each of the assaults involved a single assailant. Nine of the assailants were male and seven were female. The most common form of assault reported for this study was a single punch (reported by seven participants) although three participants reported that they had been slapped, three reported that they had been verbally threatened, and three said that they had been attacked with a weapon (in one case a nurse was attacked by a patient who was trying to capture him using a sheet; in another case a patient threw an ashtray at the nurse; and in another case a patient lunged at the nurse with a knife). In all cases there was significant abuse aimed at the nurse. A summary of the types of assaults experienced by the participants can be found in Table 6.

Patient assaults where multiple means of attack were used occurred on five occasions. In one instance a patient threatened that she "would get" the nurse if he continued to set limits upon her behaviour. Constant threats were followed by a malicious accusation of sexual assault against the nurse which, despite clear evidence from witnesses (during a subsequent police investigation) that no wrong had been committed, caused significant psychological trauma for the nurse. On two occasions nurses had been punched and slapped by their assailants. On another occasion the nurse was pushed before the assailant threw an ashtray at his head and there was another occasion where the patient had assaulted the nurse with a knife before pushing the nurse and attempting to punch him.

Injuries reported by participants included one nurse who suffered a broken thumb (this participant reported experiencing a moderate level of threat) whilst another experienced a broken tooth (this participant reported experiencing a mild level of threat) but the remainder of the nurses suffered no serious physical injury apart from bruising or lacerations. Four of the nurses reported experiencing significant psychological trauma as a result of their assault. The overall level of threat perceived by participants during their assaults was reported as severe by five participants, moderate by six participants, mild by four participants and negligible by one participant. A summary of the types of injuries experienced by the participants can be found in Table 7 whilst level of threat is summarised in Table 8.

Table 6: Type of assault experienced by Phase Two participants (n=16)

	Number of participants[43]	Percentage of total number of participants
Accusation	1	6.25
Punch	7	43.75
Push	3	12.5
Slap	3	18.75
Spat on	1	6.25
Threat	3	18.75
Weapon	3	18.75
Multiple	5	31.25

Table 7: Type of injury experienced by Phase Two participants (n=16)

	Number of participants	Percentage of total number of participants
Bruise	5	31.25
Fracture	2	12.5
Laceration	3	18.75
Psychological	4	25
Multiple	3	18.75
Nil apparent	5	31.25

[43] NB: Some participants experienced more than one type of assault. Krystal (participant 003), for example, was punched by her assailant before being slapped.

Table 8: Level of threat perceived by Phase Two participants during their assault (n=16)

	Number of participants	Percentage of total number of participants
Severe	5	31.25
Moderate	6	37.5
Mild	4	25
Nil	1	6.25

As a result of the assaults described above five of the participants took time off work One nurse took one hour off to attend an accident and emergency centre for first aid prior to going home at the end of his shift. This nurse attended work the next day. One other participant completed his shift despite having sustained a broken thumb in his assault. This nurse attended his general practitioner's surgery the next day and, upon discovering that his thumb was broken, took five days off work. Another nurse did not take time off immediately after her assault but required six days off work following a further incident where a patient assaulted another staff member. She reported that her assault had led to her losing confidence in her ability to deal with the chaos of her working environment and she subsequently asked to be moved to another unit for a period of four weeks. Two other nurses required 2 days and one day off work, respectively, following the assaults that they experienced. Thirteen of the participants reported their assault to hospital management via the incident management system and three did not.

3.3.3 Details of the initial responses to assault reported by Phase Two participants at the first interview

Initial responses to the experience of being assaulted by a patient, as recorded on the ARQ (Ryan & Poster, 1989), ranged from one nurse (June) who had reported just one 'slight' response (anger) to another nurse (Robert) who had reported three 'severe' responses, five at a 'fairly intense level', nine at a 'moderate' level and ten at a 'slight' level. As a general statement, however, responses tended to be reported mostly at

'slight' and 'moderate' levels with nine participants recording at least one response in the 'fairly intense' or 'severe' categories. Responses typically included feelings of anger, anxiety, and disbelief that the assault had occurred, in association with either body tension or an increased awareness in the body area assaulted. A summary of the post-assault responses reported by participants can be found in Table 9. A more complete summary of the ARQ results can be found in Table 10 (see Appendix Q).

3.3.4 Level of background life stressors reported by participants on the Stress Scale

Each of the sixteen participants provided responses for all of the items of the Stress Scale (Cohen, et al., 1983). The Stress Scale scores were generally low with a mean score of 16.75. The standard deviation was 6.8 and the range of scores was from four to 27.

It is unlikely that there was a statistically significant association between responses to assault reported on the ARQ (Ryan & Poster, 1989) and participant's scores on the Stress Scale (Cohen, et al., 1983). Moreover the small number of Phase Two participants would have insufficient power to determine such an association.

3.4 Phase Two, interview two data

Each of the participants completed a second interview during Phase Two of the study. Post assault responses reported for this stage of the study were understood by all participants to be responses which had persisted past the initial interview. The duration of the interviews was between twenty minutes and 90 minutes with a typical interview time being between 40 and 45 minutes. Audio-taped interview data were transcribed prior to the commencement of coding procedures. To enhance the researcher's understanding of the data, and facilitate the process of making constant comparisons, the researcher repeatedly listened to the interviews and re-read transcripts prior to developing individual formulations (for each interview) and recording codes on an *Excel* spreadsheet.

Table 9: Responses to assault reported on the ARQ by Phase Two participants during their first interview (n=16)

Participant details		Responses by intensity					Reported Assault
ID	Name	*None	Slight	Moderate	Fairly Intense	Severe	Yes/No
001	Bruce	50	5	1	1	-	Yes
002	Nigel	54	1	2	-	-	No
003	Krystal	43	3	9	1	1	Yes
004	John	25	13	11	6	2	Yes
005	George	28	12	13	4	-	Yes
006	Bobby	52	5	-	-	-	No
007	Peter	43	9	4	1	-	Yes
008	Anne	27	22	8	-	-	Yes
009	Lexie	42	6	9	-	-	Yes
010	June	56	1	-	-	-	Yes
011	Adam	29	13	11	3	1	No
012	Robert	30	10	9	5	3	Yes
013	Angus	40	8	6	3	-	Yes
014	Louise	43	6	8	-	-	Yes
015	Joseph	50	4	1	2	-	Yes
016	Bill	49	8	-	-		Yes

*Means that the participant chose to not record a response for the particular questionnaire item.

3.4.1 The emerging data

The most prominent piece of data to emerge from the second interviews was that all of the participants reported that they had recovered from the major effects of their assaults. The participants spoke about their responses to being assaulted in past tense and all reported feeling confident that, despite some 'residual feelings' in some cases, they were substantially recovered. Bruce (001 interview 2, p.4), reported that "… I would say probably a couple of weeks, 2 or 3 weeks to actually wind down from that event", whilst Lexie (009 interview 2, p. 6) reported that "… I think after 3 weeks I was back to the normal me". Similarly Robert (012 interview 2, p. 8) said that:

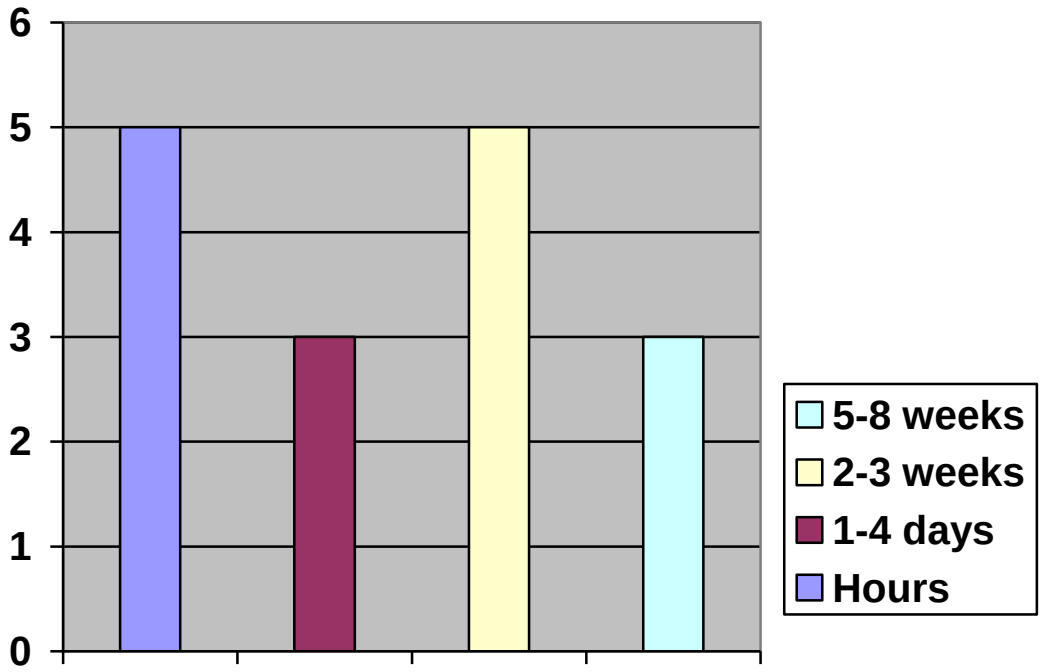
> … I think that [his emotional responses] pretty much … dissipated … soon after, within 24 hours and that … I was probably a bit anxious and that … after all that had happened.

Of the sixteen participants five reported being over the effects of their assault in a few hours, three reported being over the effects of their assault within a few days, five reported being over the effects of their assault within 2-3 weeks and three reported being over the effects of their assault within 5-8 weeks. A graph representing the recovery time reported by participants can be found in Figure 2.

3.4.2 The emerging selective categories

Analysis of the transcribed data from the Phase Two second interviews facilitated the emergence of several selective categories. The selective category *assault reminders* was found to have clearly identified properties related to factors which reminded the participant of her/his assault and may cause post-assault responses to remain pertinent for the participant. Codes which delimited the properties of *assault reminders* included *fear of the assaultive patient, wariness, assault-related dreams, intrusive thoughts,* and *physical reminders*.

Figure 2: Reported period of time taken to recover from assault at interview two: Phase Two participants (n=16)



Participants reported an ongoing *fear of the assaultive patient* as well as an emotional response whenever they came into contact with them. Bobby (006 interview 2, p. 7) said: "I definitely have my heart in my throat whenever (the patient who assaulted him) is around" whilst Adam (011 interview 2, p. 5) reported: "… there is always that recurring fear, y'know, when I'm walking around the place, if we should pass in the corridor".

Indeed participants reported a generalised concern directed towards all patients as a result of their assault which was coded as *wariness* (in-vivo code). Bruce (001, interview 2, p. 5) said: "… there's now a bit of wariness there ... (post-assault) assessing situations quickly each time to see if I'm comfortable". George (005 interview 2, p. 16) revealed: "I feel now … that I treat everyone the same, like they're all that potential for … very high risk" whilst Bobby (006 interview 2, p. 11) said: "… every time now (when he is in an environment where he is the sole nurse) ... I have a quick look across my shoulder".

The selective category *passive coping strategies* was found to have clearly identified properties related to the codes *passive personal emotions strategies* and *passive patient management strategies*.

The initial codes relevant to *passive personal emotions strategies* were: *shutting down, not thinking about the assault, minimising the importance of the assault* and *behaving as though the assault had not happened*. Krystal (003 interview 2, p. 3) reported that she "… just shut down thinking about the assault and I got on with things- my life and my job." Similarly George *(*005 interview 2, p. 5) reported that he "… didn't do anything much at all" but "just wanted to forget about it". The relevant initial *passive patient management strategies* codes were: *keeping a distance from patients, not engaging with patients* and *not disclosing personal information.* Bruce (001, interview 2, p.11) reported that:

> I would be a bit more conscious of the physical distance between myself and the patients ... (and on occasions) ... I have simply stepped back ... (to show the patient how to stand at a distance) whereas, in the past, I may have allowed him to get a lot closer.

George (005, interview 2, page 16- 17) said that he tended to get more involved in ward activities which involved the least patient contact "... getting everyone ready for discharge, making beds, I've distanced myself away from it all." Robert (012, interview 2. p. 15) added "I won't even tell them (patients) where I live now ... whether I'm married (if they ask about the absence of a ring) I'll just make an excuse".

The selective category *assault response mediators* had clearly delineated properties related to relationships which were either helpful or unhelpful to the process of recovery and included the initial codes *peer support;* and *lack of support from nursing administrators*[44]. A factor which improved the situation for participants was *peer support.* Krystal (003, interview 2, p. 3) reported that she was buoyed when "... a

[44] The term 'nursing administrator' refers to nurse manager personnel who were working outside the participant's unit (or ward) environment. An example would be the nurse manager grade three staff who have responsibilities in managing multiple units within the hospital.

few people got around me ... those involved to debrief if only for 5 or 10 minutes" whilst Adam (011, interview 2, p. 7) spoke about the value of "... people encouraging me to ventilate which allowed me to cope with things at the time". Whilst support from peers was valued, however, there was an overall perception that a *lack of support from nursing administrators* (not including the participant's peer group) made responses worse. John (004, interview 2, p. 7), for example, reported that his line manager had ignored him after his assault which made him feel "unsupported" declaring "... that's one of my major gripes [regarding my assault] ... I don't feel supported here by administration" whilst George (005, interview 2, p. 20) reported his continued frustration that "... it seems to me that (nursing administration) should have had someone approach me or say, you know, do you want to talk about this ... but it didn't happen". Louise (014, interview 2, p. 15) described the lack of support that she received as "stressful". Indeed nine of the participants reported either dissatisfaction with the level of support received from administrators or that they had received no contact at all.

Not all participants were dissatisfied with the level of support that they received from administrators. For example, Robert (012, interview 2, page 20) reported a high level of satisfaction with the support that he received from all staff. In addition he reported that administrators had spoken to him often and had urged him to seek counselling to help him to deal with the emotional effects of his assault. Indeed the four participants who took time off following their assault reported some level of contact with administrators.

The selective category *futility* had clearly delineated properties related to the participant's overall sense of post-assault despair which emerged from perceptions that:

1. they worked in an environment in which there was a *constant threat of violence* with an *inevitability of assaults* against nurses. (Joseph (015, interview 2, p. 5) said, in respect of the large number of assaults against nurses in his unit "… this is just sort of a small incident but, y'know … that's just an indication of the fact that it's par for the course and you just have to get used to it."

2. (despite support from colleagues in their unit) their (workplace) *safety concerns* (are routinely) *ignored or minimised by administrators.* Angus (013 interview 2, p. 13)

reported that: "management] don't show sensitivity … I think they show a lack of awareness of what actually goes on here." Whilst Louise (014 interview 2, p. 15) said:

> … (assaults by patients upon nurses) are happening on this ward … not only on this ward, other places but despite what we have said we weren't supported in any way by the management … by senior management. … It's very frustrating.

Other aspects of *futility* included perceptions that patients were under-medicated and that some patients with strong criminal tendencies had managed to manipulate the system so that they would be incarcerated under the mental health act rather than in prison. Another source of futility was the belief that violence was inevitable and that nurses had little prospect of seeking legal redress from the patient. Most importantly was a belief that some patients, who were perceived as being highly dangerous, were not properly allocated to a secure unit. Angus (013 interview 2, p. 5) said:

> If someone is really dangerous they should go to a secure unit, don't come here [to a psychiatric admission unit] first, you've got a patient transferred in because they've ripped some place apart … they shouldn't come here.

Similarly Lexie (009 interview 2, p. 14) said:

> (my assailant was a) forensic patient … actually there was a constant underlying threat. Usually you have difficult patients and you don't have that ongoing fear and there was with this particular individual … and he was inadequately medicated. Even though this person is well known he was under-medicated. There is a long history with this particular person … and there has never been a charge laid … there are difficulties laying charges (against patients in mental health facilities).

3.4.3 Memoing, the Phase Two interview two data, and the emergence of the theoretical category: churning anxiety

What follows is a memo which facilitated the researcher's thinking about the data to emerge from the Phase Two interview data:

> The most prominent and lasting post-assault responses reported by the participants were emotional in nature and these persisted between hours and weeks after the assault depending upon the individual.

What strikes me about the data is that, whilst all of the participants reported that they were over the effects of their assault, a number of participants appeared to have responses which were ongoing and this will need to be explored during interview three. Five participants: Bruce (001), George (005), Lexie (009, Robert (012) and Louise (014) reported a continuation of overt symptoms. Bruce reported (001, interview 2, p. 12) "… down the track have my responses lost any intensity? … nope, its still pretty much the same." The same participant also reported 001, interview 2, p. 17):

> On the outside … my outlook can be quite calm … [but] internally I can be churning [with anxiety] at times. I feel that there's a more stressful element underlying my feelings … and because of that I am so much more conscious of my vulnerability since that incident.

George (005, interview 2, p. 9) reported:

> There's been that constant barrage of not only physical assaults but also verbal … which, y'know you get used to …but [his assault] was pretty much it. I haven't had any serious incidences like it since but … this one certainly weighs heavily on my mind still.

Similarly Robert (012, interview 2, p. 7) reported recently experiencing "flashbacks … little intrusive thoughts … and assault-related dreams" in addition to feeling "… moderately angry" (3 months after the event).

The following interim hypotheses were developed from the data which emerged following (Phase Two) interview two:

> Interim hypothesis #1: The participants developed a range of emotional responses following their assault. The intensity of these responses was affected by *assault response mediators*, in particular the participant's subsequent support from their peers and the degree to which they perceived that they were ignored by nursing administration staff outside their peer group.

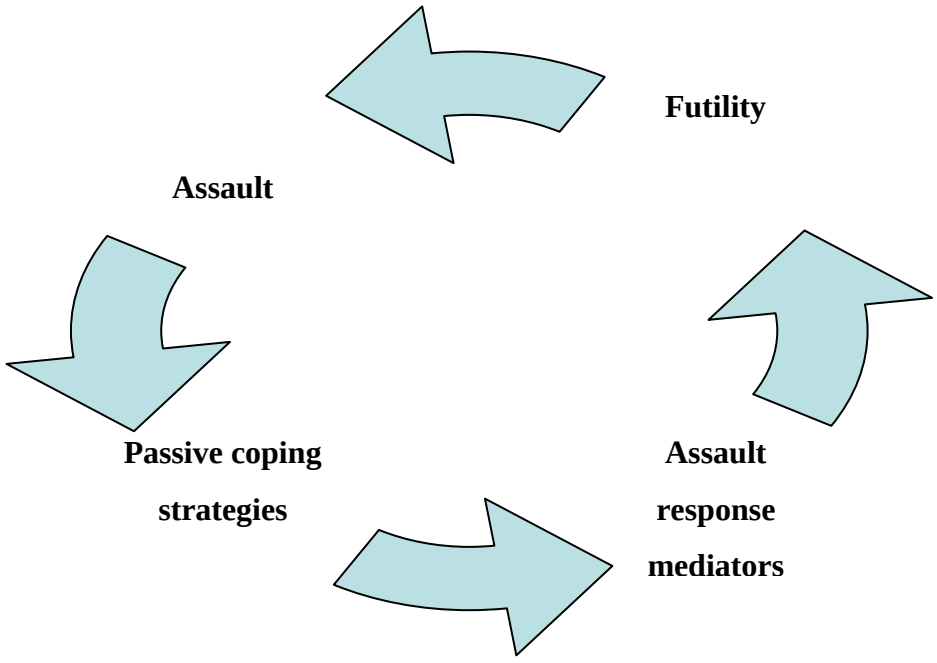
> Interim hypothesis #2: Subsequent to their assault the participants engaged principally in *passive coping strategies* such as trying to ignore the event and minimising the effects of their assault. However whilst some participants were only mildly affected by their assault (with responses lasting from a few hours to a few days) others were affected more severely and remained distressed for a period of several weeks to several months.

Interim hypothesis #3: The participants who were unable to recover quickly from their assault (i.e. those with responses lasting more than a few days) were affected by a state of continued distress labelled *churning anxiety* (theoretical category) which featured: *assault reminders* (related to exposure to assault-related persons, places and events, re-experiencing the assault via intrusive thoughts; or dreams); the use of *passive coping strategies*; the presence of *assault response mediators*; and an increased sense of workplace *futility.*

3.4.4 Diagramming and the Phase Two interview two data

The experiencing of *assault reminders, passive coping strategies, assault response mediators,* and *futility* appears to have a cyclical pattern which the researcher has labelled *churning anxiety* (in-vivo code). This phase of coping is depicted in Figure 3.

Figure 3: Depiction of *churning anxiety phase* of recovery: Phase Two participants.



3.5 Phase Two, interview three data

Each of the sixteen participants completed the third and final interview for Phase Two of the study. The duration of the interviews was between 20 minutes and 70 minutes and

a typical interview time was between 40 and 45 minutes. As with the previous interviews, all were audio-taped and transcribed prior to analysis. To aid in the process of analysis the researcher repeatedly listened to the interviews and developed individual formulations for each participant prior to transcribing all emerging codes onto an Excel spreadsheet.

3.5.1 The emerging data

Data from the third interview confirmed the intensity and duration of the post-assault responses however four of the participants reported that they had taken longer to recover from the major effects of their assault than they had previously reported. Bruce (001), George (005), Lexie (009) and Robert (012) all reported taking a longer period of time to recover than was reported during interview two. The differences between recovery time estimates between interviews two and three for these participants are listed in Table 11 and depicted in Figure 4.

Table 11: Comparison of reported time taken to recover from the major effects of assault at interview two and interview three by four participants: Phase Two of the study.

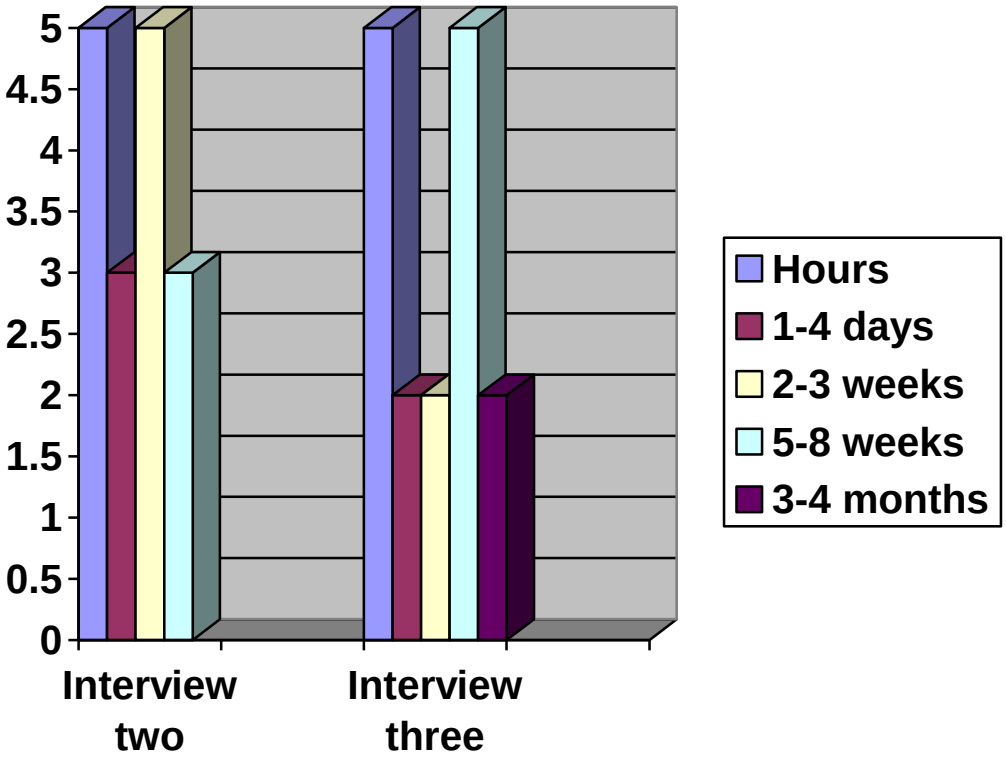
	Interview 2	Interview 3
Bruce	2-3 weeks	3-4 months
George	2-3 weeks	3-4 months
Lexie	2-3 weeks	7 weeks
Robert	24 hours	2 months

All participants reported that they were over the main effects of their assault at six months post-assault and none of them reported experiencing major ongoing problems. Bruce (001, interview 3, p. 9) said that [he was] "… reasonably confident that [the major effects of the assault are] settled, its gone now … each episode [in which there is

a potential for assault] … now is dealt with as it is … without drawing up past feelings." George (005, interview 3, p. 8) reported:

> … I've pretty much forgotten about it … I haven't forgotten about it altogether … its still pretty clear in my mind what happened that day … but to me I feel like I'm over it.

Figure 4: Comparison of period of time reported for recovery from major effects of assault at interview two and interview three: Phase Two of the study (n=16)



Eight of the participants reported being the victims of minor physical assaults since interview two: Bobby reported experiencing (minor) physical assaults by patients at a rate of once per fortnight with verbal threats against him occurring daily whilst Robert (012, interview 3, p. 3-4) reported experiencing verbal threats "… once per day" since the time of his assault and that he'd been injured in subsequent "… restraints and things like that … [because of people] being physically aggressive towards me or other people." Seven participants reported that experiencing or witnessing subsequent assaults had caused an exacerbation of the symptoms experienced as a result of the assault which

brought them to this study. Lexie (009, interview 3, p. 2) reported witnessing one patient assault, soon after the assault which brought her to this study, which caused her to experience a loss of confidence in her nursing abilities and caused her to temporarily leave the unit in which she was working.

During the process of analysing the data three selective categories emerged as the data were constantly compared: *active coping strategies*; *residual vulnerability*; and *ongoing futility*.

3.5.2 The emerging selective categories

The selective category: *active coping strategies* was found to have clearly identified properties related to *patient management strategies* and *managing safety concerns* and included the codes *closer assessment of patients*, *being more assertive with patients; participating in work safety programs*, and *considering a new job*.

Participants reported being more active in the way that they managed patients in their care. Bruce (001, interview 3, p. 10) reported being more physical with patients, at one time pushing a patient away and then putting his hands up as a barrier. Similarly George (005, interview 3, p. 4) reported

> (now) I'm not gunna back down and let them (patients) do what they want. (I'm) … very assertive now … not to the point of being physically assertive but, basically voice: (to patients) "Yes you will do this, this is what you've got to do now, that sort of thing."

Robert (012, interview 3, p. 10) reported being more involved in reading patients' notes so that he could identify possible assailants

> I'm actually finding myself more now talking to patients … trying to learn as much (about them) as I can … cause the more I know about them the more I know how they're feeling … and this and that … and here we have say five allocated patients (per staff) … it's not uncommon for me to go through the whole 20 … just for my own piece of mind.

Participants reported becoming more active in the way that they dealt with safety issues in the aftermath of their assault. Krystal (003, interview 3, p. 8) reported attending meetings with the hospital occupational health and safety committee where she was able

to identify problematic structural and procedural matters which, she says, adversely influenced the outcome of her assault. Similarly Adam (011, interview 3, p. 11) reported

> I've been more pro-active about … attending (Occupational Health and Safety) meetings and what have you where those issues (similar to the circumstances of his assault) have been on the agenda. Whereas, in the past, I wouldn't have gone out of the way to attend meetings about aggression on the ward.

Robert (012, interview 3, p. 14) reported that he had become the occupational health and safety representative for his unit and had subsequently initiated the unit garden being stripped and searched for possible weapons which had been previously concealed by patients:

> … we're replanting the garden … we found, when we were digging up the garden, beer bottles, syringes, drugs, weapons all hidden in the foliage … there was an arsenal out there … knives and everything.

Indeed safety issues appeared to be a major issue in the decision by five participants to consider changing jobs. Bruce (001, interview 3, p. 3) reported on his resignation and subsequent choice of employment (in an acute care mental health unit) "I'm now working (in a unit) where the whole setup … just seems a lot more secure". Similarly John (004, interview 3, p. 6) reported that, in his new job, "I've got support behind me and its really nice to work in this sort of environment where you're not out there (with the patients) by yourself". At the time that the third interviews were conducted four participants had left their job and one participant was currently making enquiries. In addition three other participants had expressed a desire to change their current work circumstances.

A second selective code *residual vulnerability* refers to a fear held by the participants that they could return to their emotional state immediately post-assault with the occurrence of a subsequent incident. All of the participants who had reported the persistence of initial responses to their assault for a week or more reported experiencing *residual vulnerability,* at 6 months post-assault. George (005, interview 3, p. 7) reported

> ... this afternoon something might happen and it will take me all back again … so that's always in the back of my mind something could happen and it would be just like it was before.

For one of the participants there was *residual vulnerability* which related to assaults which pre-dated the assault which brought them to this study. Anne (008, interview 3, p. 3) reported that: " … you think that you have dealt with [your responses to the assault] … but when I get assaulted [again]… I have a flashback."

Ongoing futility is a selective code which refers to the same types and sources of futility reported at three months post-assault. Participants continued to report despair associated with the *constant threat of violence* and the *inevitability of assaults* as well as perceptions that patients were either under-medicated or inappropriately placed in the mental health service (i.e. that certain patients should be placed in a secure unit). Importantly the perception that *concerns* (about workplace safety are routinely) *ignored or minimised by administrators* continued to be a category as was the perception that the participant was *not valued by administration staff*. Louise (014, interview 3, p. 9) reported

> I think working in mental health is a hard enough job without having to worry about being stabbed in the back … and undermined and devalued by your management people … I think that is terrible.

3.5.3. Memoing, the Phase Two interview three data, and the emergence of the theoretical category: reintegration

What follows is a memo which facilitated the researcher's thinking about the data which emerged from the Phase Two interview three data:

> The interviews at six months revealed a more active and participatory coping style by the participants who had reported taking a week or longer to overcome the initial effects of their assault. This activity also gives the impression that the participants have substantially overcome the effects of their assault which brought them to this study. It is striking, however, that at least half of the participants had experienced either (minor) physical assaults and/or regular abuse and it is difficult to speculate what role these other events really had upon their trajectory of recovery.

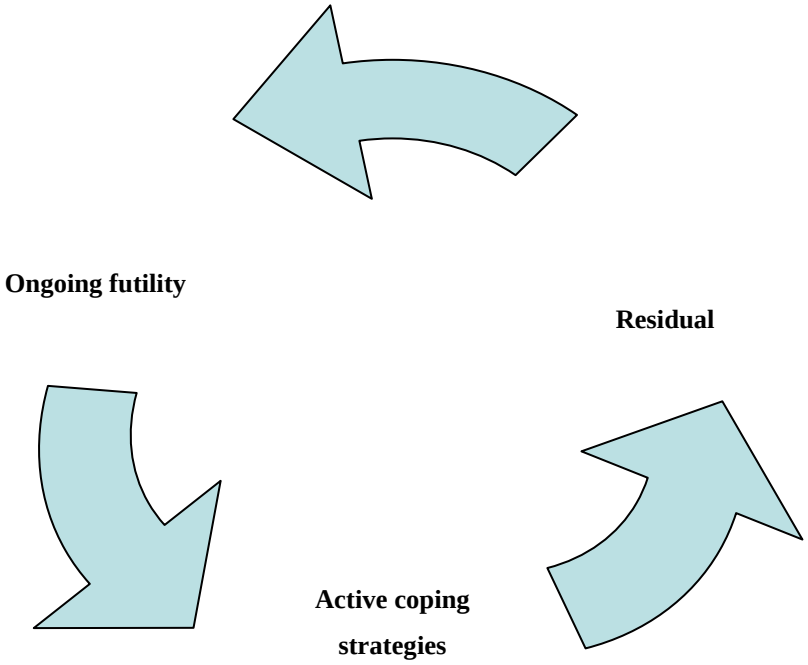
The following interim hypotheses were developed from the data which emerged following (Phase Two) interview three:

> Interim hypothesis #4: The assaulted nurse who develops churning anxiety has a (further) recovery marked by *residual vulnerability* and *ongoing futility* but develops *active coping strategies* including *closer assessment of patients, participating in work safety programs* and *contemplating changing employment.* The occurrence of *active coping strategies, residual vulnerability* and *ongoing futility* appears to have a cyclical pattern which the researcher has labelled *reintegration*.
>
> Interim hypothesis #5: There appear to have been two distinct phases of recovery for the participants who were more severely affected by their assault: *churning anxiety* and *reintegration.*

3.5.4 Diagramming and the Phase Two interview three data

The *reintegration* stage of recovery appears to have a cyclical pattern which is depicted in Figure 5.

Figure 5: Depiction of *reintegration phase* of recovery: Phase Two participants.



3.6 Regarding the level of support offered to participants by nursing administrators

It is clear from the data that the experience of assault has brought varying levels of distress to the participants of this study. However, as was discussed earlier in this chapter, although the participants were generally satisfied with the level of emotional support offered by colleagues within their particular unit environment they were not always satisfied with the level of support received from nursing administrators. It is important to note that just five of the participants (i.e. Bruce, Krystal, Lexie, Adam and Robert) reported that they received an adequate level of support from nursing administrators. Generally, however, this support was short-term, being limited to the hours or the day immediately after their assault. Only two participants (Lexie and Robert) reported that they had received ongoing support from their nursing administrators (at the third interview, conducted approximately six months after their assault). Five other participants reported minimal or no contact with nursing administrators but that this was not distressing to them whilst the remaining six participants reported that they received little or no contact and/or support from administrators and that this was distressing to them and, indeed, exacerbated their distress. Four of the participants, generally those who reported the most distress and took time off after their assault, reported that they had been advised by a nursing administrator to attend further counselling with the Employee Assistance Program (EAP) to assist them with their post-assault distress. None of the other participants reported that they had been informed about the possibility that they might seek further counselling.

3.7 Identifying the core category or process

As with Phase One of the study, a main problem was identified but, instead of a core category *per se*, a basic social process (BSP) emerged from the data. The basic social process met the requirements of a core category as described by Glaser (1978, p. 95-96) in that it related closely to the other categories, occurred frequently in the data, took more time to *saturate* than the other categories, and accounted for much of the variation in properties contained within the other categories. According to Glaser (1978, p. 96) BSPs are core categories but not all core categories are BSPs. The main difference is

that BSPs are ‘processural’ in that they have two or more clear emergent stages which reveal a process with discernable breaking points.

The main problem that nurses had to contend with in the study settings was *overcoming futility focused about the assault*. The core process or basic social process (BSP) (Glaser, 1978, p. 94) to emerge from the data for this phase of the study was *moving from passive to active coping strategies* (which facilitated a recovery that was satisfactory to the participants).

3.8 Diagramming and the Phase Two data

What comes out of the Phase Two interview data is that eleven participants who experienced significant distress following their assault experienced two distinct phases of recovery which the researcher has labelled *churning anxiety* and *reintegration.* A representation of the central problem (*overcoming futility focused about the assault*) and the basic social process (*moving from passive to active coping strategies*) is depicted in Figure 6.

4. CONCLUSION

This chapter has provided a detailed account of the processes of data management as well as data analysis relevant to the two phases of the present study. Following analysis of the Phase One data the researcher has provided details of a theory which revealed the behaviour of mental health nurses in the study contexts. The core category *responding to others in an ad hoc manner* emerged from the data and describes the basis for nursing behaviour conducted in the context of a chaotic work environment in which there was little planned nursing activity and, rather, nurses responded to crises as they occurred. Analysis of the Phase Two data revealed the theory of the nurse participant *moving from passive to active coping strategies* in the context of the experience of assault by one of their patients. The following chapter will provide a detailed account of the published literature in relation to the categories which emerged from the data during the two phases of the present study accompanied by an examination of the extent to which the major findings of the study are supported by findings from previous research.

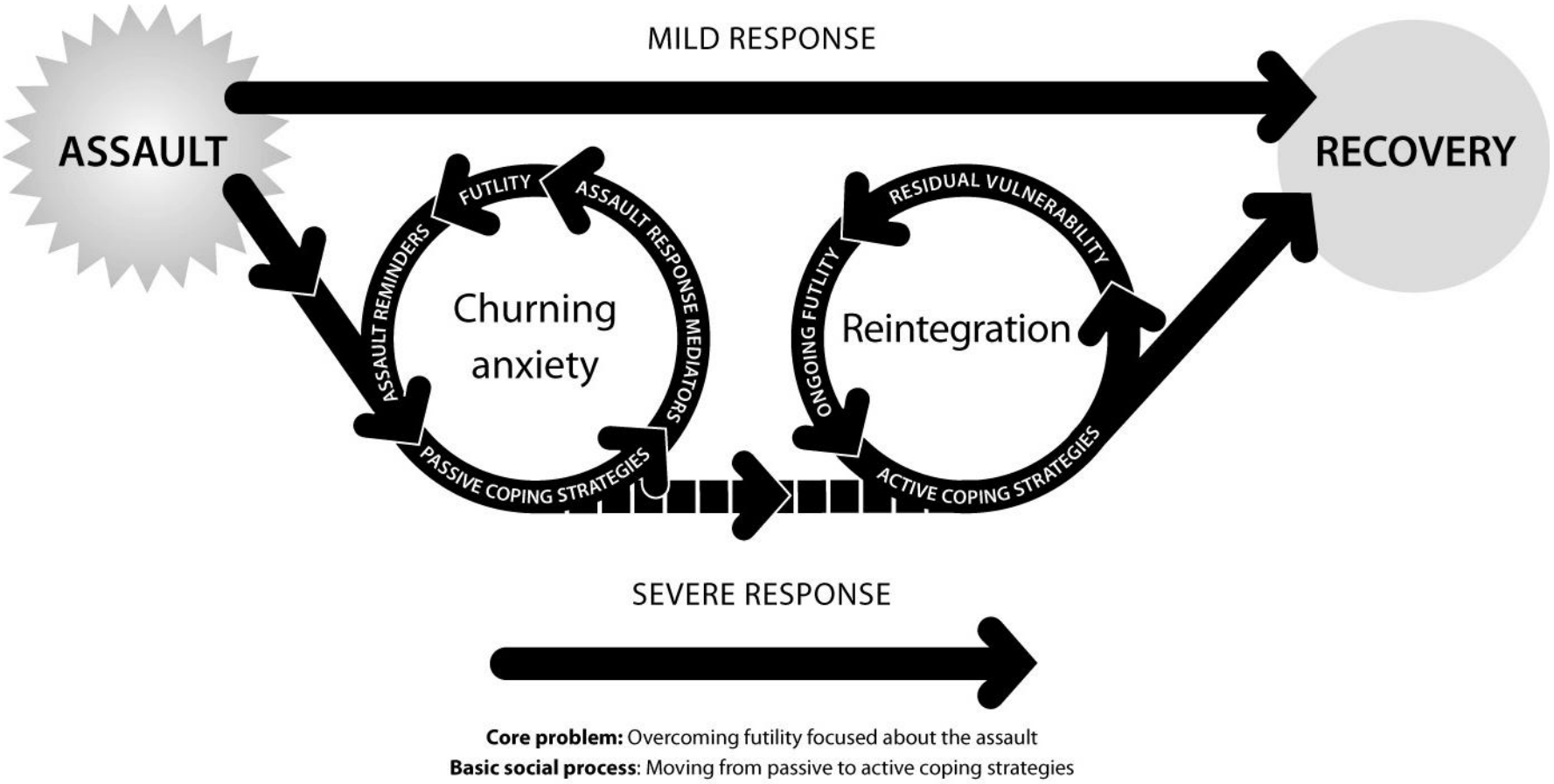


Figure 6: Depiction of the recovery trajectory for Phase Two participants as they moved from passive to active coping strategies.

CHAPTER SIX

DISCUSSION OF FINDINGS

1. INTRODUCTION

The aim of this chapter is to provide a discussion of the findings from the present study, particularly in relation to the existing body of literature. This is in accordance with grounded theory method where the existing body of literature plays a role not only in the development of theory (Glaser & Strauss, 1967; Glaser 1978; 1992) but also in the process of ensuring rigour (Chiovitti & Piran, 2003).

The chapter commences with a discussion of the findings from Phase One of the study in which nurses were observed interacting with patients in three acute inpatient mental health units. A discussion of the findings from Phase Two of the study will then examine the main categories to emerge from the several interviews which were conducted over a six month period with each of the sixteen mental health nurse participants who had been recently assaulted by a patient. Consideration then moves to the implications of the study findings for the professional lives of the participants who responded to their assault by progressing through the churning anxiety and reintegration phases of recovery. Here our interest will be on how such a process of recovery might impact upon the participants' ability to engage therapeutically with patients in view of some of the passive as well as active coping strategies reported. There will also be a discussion of the implications for teamwork at the level of the unit in which the participants worked and also in respect of the participants' relationships with nursing administrators given that the behaviour of these latter staff appeared to be an important mediator of post-assault responses. The researcher will then examine possible remedies which may assist mental health nurses to recover from the effects of patient assault with appropriate reference to the NSW government policies which relate to the support of assaulted staff.

2. DISCUSSION OF PHASE ONE FINDINGS:

2.1 Introduction

An analysis of the Phase One data from the present study indicated that the main problem for the nurses observed was dealing with a chaotic work environment whilst the set of activities which dominated nursing actions was described by the core category *responding to others in an ad hoc manner*. The main sub-categories to emerge during this phase related to nursing activities which were ranked in a hierarchy from defusing crises, housekeeping, everyday nursing care, and therapeutic nursing with defusing crises being the most frequent activity and therapeutic nursing being the least common activity that occupied nurses' working time during the periods of observation. The following discussion examines, firstly, findings from related studies into the behaviour of mental health nurses in acute mental health units that are consistent with findings from the present study. Secondly the author will explore factors which influence the nurses' behaviour in responding to the needs of others rather than taking a more proactive role in engaging therapeutically with their patients including: the stressful nature of the nurses working environment; the limitations imposed upon the nurses by their perceived professional status within the multidisciplinary team; and *institutionalism*.

2.2 An exploration of mental health nurses' work environment and their lack of engagement with their patients

The most striking feature of the findings from Phase One of this study was that the nurses observed were engaged in various activities in order to manage the chaos rather than seeking engagement with their patients and the subsequent provision of therapeutic interventions. Indeed an analysis of the nurses' activities showed that they were more inclined towards [45]housekeeping duties than they were towards providing [46]therapeutic

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[45] *Housekeeping* was characterised by two main types of the activities- organising patients' affairs (including: organising laundry; tidying up; reminding patients to do things; ordering cigarettes; ordering food when new patients came to the unit) and organising the unit (including attending handover; ordering/writing memos for the next shift; note taking; and filing).

[46] *Therapeutic nursing* included counselling patients and planning patient care in association with them.

nursing which appears to mitigate against the main purpose of the mental health unit as a place for people to recover from mental illness with the support of caring and involved staff.

Mental health nurses have historically laid claim to the therapeutic relationship as an essential part of their practice (Barker, 1990; Peplau, 1952). Research over several decades supports the notion that mental health nurses see therapeutic engagement and the subsequent provision of therapeutic interventions as a mainstay of their professional activity (Barker, Jackson, & Stephenson, 1999; Chiovitti, 2006; Cleary, Walter & Hunt, 2005; Fourie, McDonald, Connor & Bartlett, 2005; Mackay, Paterson & Cassells, 2005; Towell, 1975). Moreover there is ample evidence that the clients of mental health inpatient units want nurses to engage with them (Breeze & Repper, 1998; Gerolamo, 2004; Hansson, Bjorkman & Berglund, 1993; Middelboe, Schjodt, Byrsting, & Gjerris, 2001; Rydon, 2005; Summers & Happell, 2003) and provide support.

Contrary to expectations, and congruent with findings from the present study, researchers have consistently found that mental health nurses tend to spend less time engaging with patients or initiating therapeutic endeavours than they do in tasks which require superficial engagement or no engagement at all (O'Brien & Cole, 2003; Whittington & McLaughlan, 2000). Martin (1992, p. 35), who conducted an audit in a British hospital, found that patients in acute psychiatric inpatient units spent between six and twelve percent of their time interacting with nursing staff. In a study of nurses in a British acute admission environment Gijbels (1995, p. 462) noted that nurses were often distracted from achieving therapeutic goals with their patients commenting that:

> Administrative duties, responding to senior management, and servicing other disciplines took priority over therapeutic activities. The clinical grade influenced the amount of time a nurse spent on administration which resulted in the office becoming the focal point for a variety of interactions.

Higgins, Hurst and Wistow (1999) conducted a multi-site study in eleven acute mental health inpatient units in the UK. In addition to collecting a wealth of statistical data about the hospitals, the researchers conducted interviews and distributed questionnaires

to both nursing staff and patients concerning ward routines and practices. The average bed occupancy rates for nine of the sites were over 85 percent with between 25-33 percent of these beds being occupied by patients who had been admitted on an emergency basis. Many of the patients had been admitted with alcohol and other drug problems in addition to mental illness. Reasons for the high proportion of emergency admissions amongst ward populations were reported by Higgins et al. (1999, p. 54) as lack of suitable accommodation, increased psychiatric morbidity in cities, insufficient bed management, and inadequate community support staff and arrangements to ensure the continuity of care as patients moved between community and hospital contexts. The nurses also reported that it was difficult for them to maintain a safe and therapeutic milieu because of the type of patients admitted to their units and the series of crises that frequently ensued leading Higgins et al. (1999, p. 54-56 to conclude:

> Too much staff activity focused on events associated with crises of a minority of severely ill patients with enduring mental health problems such as schizophrenia. Consequently nurses' scope to implement co-ordinated, planned programmes of care was significantly limited … As a result the time available for nurse-patient contact was restricted.

It is perhaps not surprising that patients in the above study reported that they had minimal time with staff (reported as four percent of the total time that the patients spent in the unit) and that a large proportion of their time (28 percent) was spent doing nothing of therapeutic value or watching television (Higgins, et al., 1999, p. 59). Similarly, researchers Whittington and McLaughlin (2000, p. 264), who conducted an observational study in a British acute psychiatric unit, found that nurses spent an average of 6.75 percent of their time in *potentially* psychotherapeutic one-to-one interaction with their patients whilst much of their time (33 percent) was spent away from patients; talking and reporting to other staff or engaged in office administration.

Studies conducted in Australian contexts largely echo the British findings. In their study conducted in Australian in-patient mental health units Hodges, Sandford and Elzinga (1986, p. 6) found that patients received little attention from their nurses once they had been in their unit more than ten days. In another Australian study, Horsefall and Cleary

(2000) found that mental health nurses displayed a lack of supportive interventions and devoted relatively little time to negotiating nursing care with their patients.

Cleary (2004) also described a psychiatric acute care unit in which nurses were prevented from fulfilling their expectations for their practice by excessive and unpredictable environmental demands. Cleary (2004) had conducted a five-month observational study in a 22-bed psychiatric admission unit in New South Wales, Australia, in which nurses variously described their working day as "meeting unrelenting demands", being "squeezed like a sponge", and "pulled in different directions" (Cleary, 2004 p. 55). Cleary (2004, p. 56) included one nurse's description of the working day as follows:

> In the day time … the phone never stops ringing because there's so many things that you have to do as a registered nurse that may be non-nursing duties but we still do anyway … Things come up unexpectedly … and often the workload is too much ...

In discussing her findings Cleary (2004, p. 57) described how the nurses had an obligation to respond and negotiate with a variety of people, including members of the multidisciplinary team as well as patients, which she labelled *multiple subordination,* a term which certainly echoes the core category from the present study: *responding to others in an ad hoc manner*.

2.3 Stress experienced by mental health nurses working in acute inpatient settings

There is ample evidence that nurses employed in acute mental health inpatient units are busy and work in stressful environments (Taylor & Barling, 2004). The causes of workload strain may be summarised as: increased patient acuity; extensive deinstitutionalisation; high patient turnover (Higgins, et al., 1999); high levels of bed occupancy, the risk of patient violence and the perception by nurses that they work within units with insufficient staffing and difficult patient mixes (Gentle, 1996; Gourney, 1994); and insufficient follow-up resulting in a revolving door approach to psychiatric care (Carr, et al, 2008; Higgins, et al., 1999). Additional sources of stress emanate from insufficient health care budgets as well as spending cutbacks and restructuring (Cleary, et al., 2005; Hummelvoll & Severinsson, 2001) whilst other

researchers have found that the intense process of interacting with people with a mental illness can be innately stressful (Collins & Long, 2003; Jenkins & Elliott, 2004; Melchior, Philipsen, Abu-Saad, Halfens, van de Berg, & Gassman, 1996; Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne, & Reno, 1999; Thomas, Hagerott, Hilliard, Kelly, Leichman, Osborne & Thurston, 1999).

Cleary, et al. (2005) asserted that, in the Australian context, there has been a gradual decrease in the number of available acute care beds resulting in patients entering care facilities at a later stage of their illness with a consequent increase in their level of disturbance. Indeed Rey, Walter and Giuffrida (2004) surveyed psychiatrists working in the public hospital sector who reported the perception that they were serving an increasingly disturbed and demanding clientele. There is also a perception by mental health professionals that the clientele are not only more disturbed but also more violent and there is much literature to support the association between psychotic disturbance and violence (Angermeyer, 2000; Chou, et al, 2002; Grassi, et al, 2001; Mullen 1997; Paterson, Claughan & McComish, 2004) although this link is not universally acknowledged (Pilgrim & Rogers, 2003).

Surprisingly there have been a small number of studies which specifically examine the degree of work stress experienced by mental health nurses in acute inpatient settings. In a study of mental health nurses working in community centres (community psychiatric nurses or CPNs) and inpatient mental health units (ward-based psychiatric nurses or WBPNs) Fagin, Brown, Bartlett, Leary and Carson (1995) interviewed 323 WBPNs from seven psychiatric hospitals across the UK using a number of instruments to measure occupational stress including: the CPN stress questionnaire (revised) (Fagin, et al., 1995); the General health questionnaire (GHQ-28) (Goldberg & Williams, 1988, cited in Fagin, et al., 1995); the Maslach Burnout Inventory (Maslach & Jackson, 1986, cited in Fagin, et al., 1995); the Rosenberg Self-Attitude Questionnaire (Rosenberg, 1965, cited in Fagin, et al., 1995); the Minnesota Job Satisfaction Scale (Koelbel, Fuller & Misener, 1992, cited in Fagin, et al, 1995); and the Coping Skills Questionnaire (Cooper, Sloan & Williams, 1988, cited in Fagin, et al. 1995). According to Fagin, et al. (1995, p. 352) the results for the WBPNs revealed high levels of emotional burnout combined with average-to-high levels of depersonalisation, high levels of detached

interaction with patients and low levels of perceived occupational accomplishment. Individual coping was enhanced by peer support and taking sick days and, significantly, nineteen percent of participants felt that their line manager was unsupportive (Fagin, et al. 1995, p. 354-355).

In a more recent study of the views of mental health nurses concerning the standard of nursing care in a Sydney psychiatric inpatient setting, Cleary, et al. (2005, p. 76) found that:

> One third of the respondents were dissatisfied with the continuity and consistency of nursing work, nursing status within the multidisciplinary team, nurse patient ratios and patient continuity of care. Further, over half the respondents were dissatisfied with the number of permanent mental health staff belonging to their unit and one third of respondents considered the system of nursing care in their setting to be fairly or very difficult.

2.4 The status of mental health nurses within the multidisciplinary team

The category *responding to others in an ad hoc manner*, and the similar category from the Cleary (2004) study *multiple subordination* suggest that not only are nurses distracted from engaging with their patients but that they are also directed, intentionally or otherwise, to do so.

Nurses have historically held a low status within psychiatric hospitals in comparison with other health professionals. Scull (1993) described how members of the medical profession gained control of asylums when these institutions were introduced to Britain during the latter part of the eighteenth century sometimes via their ownership of some of these establishments, but more typically as appointed medical superintendents. According to Scull, McKenzie & Herney (1996) this control was secured following the creation of county asylums in line with the statutory requirements in the British *Lunatics Act* of 1845. Meanwhile a second tier of employee, the attendant (ancestor to the modern day mental health nurse) had been introduced at the start of the asylum era primarily to attend to chores related to the care of patients. According to Haw (1990) the role of attendant was subservient to the medical superintendent and *rule books* governing the behaviour of attendants stressed the requirement for *iron rod discipline*

and the obedience of attendants to the medical superintendent. Brimblecombe (2005) opined that it was the physicians, both in Britain and the US, who lobbied for the introduction of specific education courses for attendants however the attendant of the early twentieth century was no less bound in a power relationship with the medical profession which required them to "… carry out the orders of the physician" (Medico-Psychological Association, 1909, cited in Brimblecombe, 2005, p. 346-347).

The relationship between members of the medical profession and attendants/mental health nurses changed during the 1950s with: the advent of antipsychotic medications; the introduction of psychological interventions such as the therapeutic community; the evolution of less custodial systems of care; the eventual move towards devolvement of the large institutions; and the subsequent development of community care for people with a mental illness. Significantly, mental health nurses had their professional status increased with the implementation of initiatives such as those suggested by the (UK) *Clarke Report* (1968) which recommended that nurses be accepted as participating members of the multidisciplinary team (cited in Brimblecombe, 2005, p. 348). Nonetheless psychiatrists retained a significant amount of power and influence at the clinical level since they remained the primary decision-maker in respect of the admission or discharge of patents under the mental health act, and were the prescribing agents responsible for medications as well as forms of somatic treatments such as electroconvulsive therapy. In respect of nursing's involvement at the clinical level Barker (1990, 343) opined that "psychiatric nursing has continued to stand in the ideological shadow of psychiatric medicine, functioning mainly as a medical support system."

Despite the more recent development of roles for mental health nurses as therapists, independent practitioners, health facility administrators and academics and not withstanding the development of some nurse-led initiatives in inpatient care (Norton, Jones, Quarles & Danielle, 1999) nursing in acute inpatient care has remained stagnant. In reference to these environments Bowers (2005, p. 232), citing various authors, has lamented:

> inpatient units have been left to drift with little research, little investment of clinical expertise, discussion and development, and no statement of their positive purpose and benefit … [with] … high levels of chaos and untherapeutic care.

Other researchers have conducted studies with the purpose of examining the relationship between medical staff and other members of the multidisciplinary team (MDT) in acute care mental health settings. Gijbels (1995) conducted a qualitative study on the perceptions of nurses and other MDT members on their roles and functions in British acute inpatient psychiatric unit. Gijbels (1995, p. 463) commented that nurses often felt demeaned when other members of the MDT called upon them to deal with disruptive patients describing their primary function on acute care units as dealing with the "everyday muck". Indeed Gijbels (1995) proposed the power of the medical profession and a lack of assertiveness on behalf of nurses as reasons for nurses continuing their subordinate roles. Barker and Walker (2000) interviewed 26 nurses in their study on the perceptions of nurses of the care and treatment delivered by a MDT in acute care mental health facilities in the UK. The authors concluded that the MDT was largely a medical-nursing activity with the authority of medicine over other members of the team most evident during admission activities. This dominance led to tension within the team when nurses felt that their advice concerning the suitability of certain patients for admission and, indeed, their in-depth knowledge of patients was being ignored. Significantly, Barker and Walker (2000, p. 544) commented that patients had only limited involvement in decisions about their plan for nursing care indicating that they remain on the bottom of the power hierarchy in the ward settings studied. Similar findings were reported in Australian studies by Hazelton (1999) and Cleary (2003). One of the nurses in the Cleary (2003, p. 217) study summed her experience of participating in a MDT as follows:

> I thought it was fantastic, that's great, it really does work as a multidisciplinary team, but then if a crisis or disagreement occurs … we fall back into … there's a doctor and they're here, and we're the nurse and we're here, and never the twain shall meet.

2.5 Mental health nurses and institutionalism

As described above there are a number of factors relating to the nature of nurses' work (busy, chaotic, stressful, lack of autonomy, multiple subordination) and the

characteristics of patients of mental health units (high levels of acuity, sometimes homeless, many use substances, may be violent) which are pertinent in explaining why nurses are often unable to engage therapeutically and, rather, conduct their business on the basis of defusing crises or dealing with housekeeping duties. Another perspective on what is going on here can be drawn from those who argue that institutions such as mental health facilities are self-serving to the point where the provision of human services becomes a lower priority compared with the goal of ensuring the smooth and efficient running of the organisation.

In *Asylums*, a series of essays based upon the author's observations of a large US psychiatric institution in the 1950s, Goffman (1961, p. 184) described *total institutions* as places where:

> … the inmate lives all aspects of his life on the premises in the close company of others who are similarly cut off from the wider world. These institutions tend to contain two broad and quite differently situated categories of participants, staff and inmates.

Goffman (1961, p. 137) further described how patients became (institutionalised) inmates in the large US psychiatric institutions of his day via a process in which he/she was stripped of familiar objects and defences and was subject to constant surveillance, coercion, a restriction of free movement, and the authority of others. Further, the person became increasingly dependent upon the institution as his/her concept of self was eroded as traditional sources of support were removed. This process was overseen and, indeed, facilitated by staff, the most powerful of whom were doctors (frequently the administrators of the institutions), and Goffman (1961) devoted one of the four essays which comprise *Asylums* to the relationship between the process of hospitalisation and the dominance of the *medical model*.

In similar vein to Goffman other theorists have posited that, despite good intentions, the nature of power structures within mental health institutions may make the provision of patient-centred activities problematic. Etzioni (1975, cited in Porter, 1993), for example, categorised organisations according to the type of power that they employ. Etzioni (1975, cited in Porter, 1993) identified three types of institutional power, coercive, remunerative or normative (persuasive), with one type of power being dominant. Mental

health facilities may thus be categorised as using coercive power not least because of the power of staff to invoke the Mental Health Act which, in turn, alienates those who are coerced making the application of therapeutic interventions (normative power) problematic.

More contemporary views on the nature of institutionalism may be found in the works of authors such as Hazelton (1999) who conducted a discourse analysis on the basis of interviews conducted with staff of a psychiatric institution in Tasmania, Australia. Using ideas based on Foucault's (cited in Burchell, Gordon & Miller, 1991) essay on *Governmentality* as a framework, Hazelton (1999, p. 227) argued that new emerging technologies, such as high dependency units, alongside old technologies, such as security fences, have become the responses to perceptions of the dangerousness of patients and represent a rationale for the continuation of a tradition of coercive practices. Further, Hazelton (1999) described how the bureaucratised responses to the problems of safety and risk were leading to a new form of institutionalism in acute mental health care. In support of Hazelton (1999), Fourie, et al. (2005, p. 136), in their observational study in New Zealand inpatient acute care facility, noted that the twin themes of safety and risk management had increasingly become fundamental to nursing practice in inpatient care at the expense of other more therapeutic aims.

In light of Goffman's work, Quirk, Lelliott and Seale (2006, p. 2107), who conducted an observational study in three UK mental health acute care units, claimed that the *total institution* of the 1950s has been replaced by more *permeable* modern mental health units which feature: a comparatively shorter length of stay for patients; greater access to visitors and other members of the public (including sellers of illicit drugs); and the extension of the nurses' responsibilities beyond the ward (for example to liaise with community mental health teams). Whilst the authors acknowledged that these features of the more contemporary institutions may moderate the effects of institutionalisation they also contended that the cumulative effects of heavily scheduled activities (for activities ranging from medication rounds to occupational therapy sessions), an unstimulating environment, the restriction of liberty (even for voluntary patients since many mental health units in the UK were locked [Ashmore, 2008] or had staff who *guarded* entry points), and the segregation of patients into situations of forced intimacy,

were certainly features which resonated with the concept of the *total institution*. Further, the authors contended that the practice of community care had extended the surveillance of mental health consumers into their own homes.

2.6 Phase One findings: Conclusion

The literature provides conformation for the Phase One findings from this study: particularly in relation to mental health nurses devoting a relatively small amount of their time to therapeutic engagement with their patients and their preoccupation with ensuring the smooth operation of their unit by attending to housekeeping duties and diminishing the amount of chaos in the unit. However given that nurses are unable, for a variety of reasons, to fulfil the requirements of engagement and the chaotic and stressful nature of their workplace it would appear that acute mental health units are toxic places for nursing staff not least because they are unable to fulfil their mission as carers but also because they are subject to unrelenting demands and safety risks. As a consequence mental health nurses are limited in their capacity to determine how they will conduct their practice to the extent that their professional status may be diminished.

3. DISCUSSION OF PHASE TWO FINDINGS

3.1 Introduction

Analysis of the Phase Two data from this study revealed that seven of the sixteen participants reported that they were only mildly inconvenienced by their assault by a patient with responses to assault lasting from a few hours to a few days However nine others reported that they had responded more severely with initial responses before passing through stages described in this thesis as *churning anxiety*, followed by *reintegration* during their recovery trajectory. The period of recovery for this latter group of participants was from several weeks to several months.

Categories associated with the overarching category *churning anxiety* (from interviews three months post-assault) included:

A**ssault reminders-** including the codes fear of the assaultive patient, wariness, assault-related dreams, intrusive thoughts, and physical reminders of the assault;

Passive coping strategies- including the sub-categories passive management strategies for personal emotions (for example: shutting down, not thinking about the assault, minimising the importance of the assault, and behaving as though the assault had never happened); and passive patient management strategies (for example: keeping a distance from patients, not engaging with patients, and not disclosing personal information); and

Assault response mediators- including the codes peer support and (presence or) lack of support from hospital administrators; and

Futility- including perceptions that there is a constant threat of violence on the mental health unit that there is an inevitability of assaults on the unit as well perceptions that safety concerns are ignored or minimised by administrators.

An important finding was that whilst all of the participants claimed to be over the effects of their assault at three months post-assault, it was later discovered (at interviews six months post-assault) that four participants had underestimated the duration of their responses with two of the participants reporting strong responses, consistent with the *churning anxiety* category, up to four months post-assault.

Categories associated with overarching category reintegration (from interviews six months post-assault) were:

Active coping strategies- which included the sub-categories assertive patient management strategies (including the codes closer assessment of patients and being more assertive with patients) and assertively managing safety concerns (including the codes participating in work safety programs and considering a new job);

Residual vulnerability- concern that a further assault would swing the participant back into a traumatised state; and

Ongoing futility- including codes related to perceptions about the ongoing constant threat of violence and inevitability of assaults on the unit as well as beliefs that workplace safety is (routinely) ignored or minimised by nursing administrators and that the participant was not valued by nursing administrators.

Owing to the design of the study it is not possible to establish exactly when individual participants passed from one stage of recovery to the next but the data indicates that

those who experienced *churning anxiety* had done so shortly (in most cases within one week) after their assault whilst those who experienced *reintegration* had done so by four months post-assault. The strength of the psychological responses experienced post-assault by these nurses was significant, as was the length of time taken to resolve the initial sense of trauma, especially given that none of the nurses suffered any lasting physical injury.

The following discussion will examine the findings from the literature relevant to the responses of the victims of assault. Particular attention will be given to the research literature including detailed descriptions of the seminal papers which have examined the responses of health care workers to assaults by patients. Whilst the author acknowledges that it is unlikely that any of the participants developed posttraumatic stress disorder (PTSD) as a result of their assault reported in this study it is, nonetheless, recognised that PTSD is the lens through which most of the data in modern victimisation studies are interpreted. Consequently there will be a summary of the development of some of the key concepts within the PTSD paradigm before aspects of the cognitive model of PTSD developed by Ehlers and Clark (2000), with reference to the Phase Two findings, are examined in more detail. It is proposed that the Ehlers and Clark (2000) cognitive model is useful in interpreting some of the responses of the participants in this study particularly in respect of: the suppression of thoughts related to their assault; the presence of intrusive thoughts and other re-experiencing phenomena; and the development of negative appraisals of self as well as aspects of the work environment.

3.2 The effects of patient-initiated assaults upon nurses

A number of researchers have studied the effects of patient assaults upon nursing staff with the seminal studies being conducted during the 1980s and 1990s. A consistent finding from these studies is that some nurse participants experienced severe psychological responses because of their assault despite suffering only minor physical injuries. Further, some of the participants suffered long-term psychological effects up to one year after they had been assaulted. The theoretical perspectives on victimisation adopted in these studies include crisis theory and posttraumatic stress disorder (PTSD). The following discussion examines the literature which investigates, in order, the short-

term responses of nurse-victims of patient assault, then the longer-term responses, to allow comparisons with findings from this study.

3.2.1 Some limitations regarding studies on the responses of nurses to patient assault

As mentioned in the preliminary literature review for this study (Chapter Two. p. 11) the reader should exercise some caution when reviewing the literature relevant to patient assaults upon health care staff not least because operational terms, such as aggression and violence, are defined differently by the various researchers. Additionally there is a lack of standardisation in respect of the description of the responses of victims to assault. Needham, at al. (2005, p. 288) provided an example of this phenomenon by observing that words such as guilt, self-blame and shame, although they have semantic proximity, are often used by different researchers to describe the same type of response to assault. Further, most of the studies reviewed for this chapter are retrospective, sometimes involving interviews with nurses up to a year or more following their assault, thus limiting accuracy in describing not only the responses of nurses victims to the experience of assault but also the timing of those responses. It is also clear that, whilst some aspects of nurses' responses to the experience of assault have been well researched (psychological responses for example), there are gaps in the research literature regarding the breadth and implications of the effects of patient assaults upon nurses. In support of this statement Lanza, et al. (2006, p. 79) opined that:

> few researchers have attempted to clarify and document the professional, social, and emotional impact of violence exposure on the individual victims themselves.

3.3 The short-term effects of patient assault upon staff working in mental health units

There are four seminal papers which provide a detailed discussion of the short-term effects of patient assaults upon mental health nurses. Lanza (1983) discussed short-term responses of nurses to patient assaults, with 'short-term' being defined as a one-week period after the assault. Ryan and Poster (1989) also discussed short-term responses

however, in keeping with the tenets of crisis theory[47], 'short term' was defined as a six week period post assault. Wykes and Whittington (1991) reported on coping strategies used by nurses to alleviate the 'strain' that they experienced because of their assault but also defined 'short-term' as a six week period post-assault. In contrast to the previous studies, which primarily used a combination of quantitative and qualitative methods, Collins (1996) conducted a study of nurse responses to the experience of patient assault using a grounded theory method. Coping strategies and factors which influenced the ability of mental health nurses to cope after their assault were principal areas examined in this study.

The reader should note that Lanza (1983), Ryan and Poster (1989) and Collins (1996) also reported on the longer-term responses of nurses after their assault by a patient and the relevant data will be explored in a subsequent section of this chapter. What follows will be a discussion of the four seminal studies on the short-term responses of nurses to the experience of patient assault accompanied by a discussion of relevant findings in relation to this study with the author drawing upon several additional sources of literature in order to explore the relevant phenomena in more detail.

In her retrospective study of assaulted nurses at a large veterans' hospital in Bedford Massachusetts (US) Lanza (1983) recruited forty nurses (seventeen RNs and 23 Nursing Assistants) from the 67 nursing staff from both psychiatric and medical wards who reported injury due to patient assault for the period August 1979 to August 1980. In completing a self-administered questionnaire participants reported assault-related injuries ranging from lacerations and bruising to bone fractures and injuries causing loss of consciousness with eight (or approximately 21per cent) of the victims reporting that they had received a "… life endangering injury" (Lanza, 1983, p. 45).

Participants were asked to provide demographic data about themselves and the patient who assaulted them as well as information about their short term responses (those which lasted no more than one week) and long term responses (those which lasted from one week to one year) according to a questionnaire which listed emotional, cognitive, social

[47] According to Caplan (1964) the period of 'crisis' tends to be time-limited and normally resolves from four-to-six weeks following the precipitating event.

and biophysiological categories of response. The nurses were asked to rate the intensity of a particular response on a five-point scale ranging from "no response" to "severe intensity" in addition to answering a number of "open ended" questions (Lanza, 1983, p. 45).

The participants most frequently reported minimal reactions to their assault with 20 participants (50 per cent) indicating no response. Emotional, social and biophysiological reactions were acknowledged by twelve of the victims with no one response being consistently reported by all participants. According to Lanza (1983, p. 46) short-term responses reported by some of the participants included anger, anxiety, helplessness, irritability, feelings of resignation, sadness, depression, shock, apathy, disbelief, self-blame, dependency, fear of returning to the scene of the assault, fear of other patients, feeling sorry for the patient who committed the assault, and feelings that the participant should have done something to prevent the assault. Significantly Lanza (1983, p. 46) noted that some nurses who recorded no reactions also communicated that "… if they allowed themselves to experience feelings about the likelihood of assault, they would not be able to function", whilst others stated that they had "… no right to react since being assaulted was part of the job". Lanza (1983, p. 47) speculated that some nurses may be suppressing their feelings in respect of their experience of assault by a patient or, alternatively, that their lack of response might be due to nurses being sensitised to working in a dangerous environment where violence against staff was both expected and accepted. It should be acknowledged, however, that the study was retrospective and so it may be that the participants' minimisation of the significance of the assault may simply be due to recall bias.

Ryan and Poster (1989) conducted a prospective study to determine the short-term and long-term responses of psychiatric nurses to physical assaults by patients. This research was conducted at a 160-bed 'neuropsychiatric' hospital in Los Angeles (US). According to Ryan and Poster (1989, p 325) assault criteria included a focus on situations where:

> ... (a) the patient physically contacts a nursing staff member with an intent to harm, or (b) The patient physically contacts a nursing staff member while opposing the intervention of a staff member (i.e. during a restraint procedure). Staff response criteria ... (were also used whereby) ... (a) The nursing staff member is injured and feels

threatened or does not feel threatened, or (b) The nursing staff member is not injured and feels threatened.

During the study 64 of the nursing staff employed at the hospital were identified through the use of incident reports as having been recently assaulted (within the past week), 61 of whom agreed to participate in the research. These nurses were subsequently asked to complete three questionnaires: The Assault Response Questionnaire (ARQ), a modification of that used by Lanza (1983); The Perceived Stress Scale (Stress Scale) (Cohen, et al., 1983); and The Attitudes Questionnaire (Poster & Ryan, 1989) and were interviewed to ascertain their attitudes to physical assaults by patients, their reactions to assaults and the burden of stressors, apart from that which they had experienced as a result of their assault, which they were currently experiencing. Following the initial interview, the nurses were asked to complete questionnaires weekly for six weeks, then at six months and one year post-assault.

As with the Lanza (1983) ARQ, responses to the Ryan and Poster (1989) ARQ were recorded on a five-point scale from none to severe. Four scales were incorporated in the ARQ allowing responses to be recorded in emotional, biophysiological, cognitive and social categories. Of the 61 staff who took part in the study, 41 met what Ryan and Poster (1989, p. 327) referred to as responder criteria (that is individuals who reported one severe response, two fairly intense responses, or three moderate responses in any of the four categories at any given period of time) one week after their assault. Despite a steady decline in the number of responders for the first five weeks of data collection, there was a slight rise after six weeks when eighteen per cent of the sample of participants continued to meet responder criteria. Whilst 21 per cent of the sample of participants met responder criteria at six months, sixteen per cent met responder criteria twelve months after their assault.

The most common responses recorded at one week post-assault were reported in the emotional and biophysiological categories. Anger was the most often reported emotional response whilst anxiety was the next most common response. The most common biophysiological response was increased body awareness in the area assaulted. According to Ryan and Poster (1989, p. 328) the majority of participants had resolved their “crisis” within six weeks of their assault despite experiencing a number of short-

term reactions. A major finding was that some participants continued to experience moderate to severe responses up to six weeks post-assault (and beyond) in the absence of any serious and lasting physical injury.

In their study of the short-term responses of psychiatric staff to the experience of assault by a patient Wykes and Whittington (1991, p. 39) recruited 24 consecutive victims of assault by a patient (23 nurses and one doctor), from a British psychiatric hospital, who had been involved in violent incidents, defined as "... one in which an aggressive physical contact had taken place between a patient and member of staff." Participants were asked to participate in three interviews: the first was conducted within three days of their assault; the second was conducted from seven-to-ten days post-assault; and the third was conducted 21 days post-assault. At the first of the interviews participants were asked to complete two measures of 'strain' in order to measure their psychological reactions to assault including: The Speilberger State Anxiety Questionnaire (Speilberger, Gorsuch & Lushene 1970, cited in Wykes and Whittington, 1991); and the Maudsley Strain Questionnaire (Whittington & Wykes 1989, cited in Wykes & Whittington, 1991). Individual coping was also measured during the first interview during which a series of open-ended questions was used in order to invite participants to discuss cognitive and behavioural coping strategies that they had purposely employed to minimise the effects of their assault. Additionally two scheduled 'probes' were conducted (at the second and third interviews) in order to investigate two main types of coping strategy: 'denial' of the assault (deliberately not thinking about the assault); and re-experiencing the assault (deliberately talking about the assault or thinking about it). All participants complied with the interview schedule and Wykes and Whittington (1991, p. 41) described the severity of physical damage to the majority of participants as involving "… no detectable injury …" although some of the participants reported experiencing bruising and swelling. None of the participants required treatment in a Casualty Unit (i.e. Emergency Department) and none took time off after their assault.

Regarding the psychological consequences of assault Wykes and Whittington (1991, p. 41) revealed that many staff reported experiencing high levels of strain with a range of individual differences in symptoms. Fatigue, need for alcohol or tobacco, need to smoke, headaches, need for food, muscle tenseness, ruminations, intrusive thoughts,

irritability, anxiety with people and 'anxiety in location' (i.e. the vicinity where the assault had occurred) were the most commonly described symptoms of strain. Although most subjects reported a decrease in symptoms over the time of the study, six reported an increase in symptoms.

According to Wykes and Whittington (1991, p. 42) the coping strategies identified by participants at the first interview included: talking about the incident; thinking about the incident; wanting/taking time away from the job; avoiding thinking about the incident; just getting on with the job; planning for next time; filling in an incident form; and planning to leave the job. During the three interviews (including the two 'probes'): fifteen participants reported deliberately avoiding consideration of their assault (eleven at the first interview, eleven at the second interview, and seven at the third interview); and twelve people reported deliberately re-thinking their assault (twelve at the first interview, four at the second interview and five at the third interview) (Wykes & Whittington, 1991, p. 43).

In discussing their findings Wykes and Whittington (1991) observed, firstly, that most of the staff had used palliative strategies (such as 'denial') to alleviate their emotional state rather than using problem-solving in order to more actively cope with the 'stressor'. Secondly, the researchers observed an association between higher levels of strain (psychological responses) and a higher number of coping strategies used by participants post-assault. Thirdly the researchers recalled the work of Genest, Bowen, Dudley and Keegan (1990, p. 3), who observed that higher levels of avoidant and escape behaviour were associated with higher current anxiety than more active coping strategies (such as 'facing up' to the particular situation) and hypothesised that the tendency of participants to work as normal after their assault may be due to the presence of psychological defences such as 'denial'.

In her qualitative study Collins (1996) recruited 30 psychiatric nurses who had previously been assaulted by a patient from four US mid-western states. Collins (1996) was able to describe the nurses' responses to the experience of patient assault and also to develop a theory regarding their progress towards recovery. Essentially, Collins (1996) recruited most of the nurses (25) via advertisements in a nursing newsletter which had distribution over the mid-western states whilst two other nurses were

recruited having heard of the study from others and three nurses joined the participant group via their association with a panel of experts which appears to have been an advisory group for the study. Collins (1996) did not specifically report on the time between the assaults upon individual participants and interviews undertaken for the purposes of her research. There is, however, an instance where Collins (1996, p. 57) reported the experiences of a participant who stated that she had been assaulted seventeen years prior to her interview. Similarly the researcher did not report on the injuries sustained by participants in any systematic way. However Collins (1996, p. 47-49) did report that:

> The more serious injuries included head and face injuries, abdominal injuries, and those perpetrated by patients' (sic) throwing large objects such as heavy pieces of furniture …. Two nurses had been knocked unconscious and one more than once.

Using the grounded theory method described by Chenitz and Swanson (1986), Collins (1996) was able to describe a four stage process which led to a resolution of the participants' reactions to their assaults (although not all participants were able to achieve a satisfactory resolution). The stages of response were described by Collins (1996, p. 47-53) as: 1. *feeling frozen,* which contained the sub-categories: *shock/disbelief*; *anger/fear*; and *physical/emotional violation* (longer-lasting physical and emotional responses which continually brought the assault experience back into the consciousness of the victim)*;* and the subsequent categories (labelled as phases of recovery); 2. *sliding into a funk* which was characterised by immediate physical and/or emotional withdrawal from the assaultive experience accompanied by the nurse victims doubting their competence (feeling shame due to an inability to control the situation because the nurse felt that he/she had done something to provoke the assault) and efforts by victims, with the assistance of their peers, to buffer themselves from psychic pain (for example work colleagues assisted assaulted nurses to confine themselves to housekeeping tasks, such as filing or answering 'phones, which enabled them to minimise patient contact); 3. *minimizing* (sic) the effects and circumstances of the assault by a) making comparisons with less fortunate others, b) focusing on attributes that make one appear advantaged, c) creating hypothetical worse worlds, d) construing benefit from the experience, e) creating standards of normalcy, f) depersonalising (the

attack was not directed towards me personally), and g) repressing (where the victim of assault pushes the incident to the back of their mind); and 4. *getting on*, a longer-term stage of recovery[48], the elements of which were reported as *redefining the self*, *defining a new world order*, *personal and professional support* and *organizational and administrative roles and responsibilities*. This category will be discussed in relation to longer-term response to assault later in this chapter.

What follows is a discussion of the findings from the present study, regarding the short-term reactions of participants to the experience of assault by a patient, in relation to the findings from the four seminal studies cited above as well as others as cited below.

3.3.1 Discussion of categories related to short-term responses to assault from the present study in relation to findings from other studies

There is certainly resonance in the four seminal studies as discussed above, as well as others, with the *churning anxiety* category from the present study, and the related sub-categories *assault reminders*, *passive coping strategies; assault response mediators*, and *futility*.

3.3.1.1 Assault reminders

The *assault reminders category* was associated with the related codes: fear of the assaultive patient; wariness; assault-related dreams; intrusive thoughts; and physical reminders of the assault. Similar phenomena were described by Lanza (1983) as fear of the assaultive patient and fear of returning to the scene of the assault, by Ryan and Poster (1989) as ongoing emotions such as assault-related fear, anger and anxiety, by Wykes and Whittington (1991) as ruminations, intrusive thoughts, and 'anxiety in location' and by Collins (1995) as elements of the category *feeling frozen* (physical and emotional violation). Ongoing fear related to the workplace and/or the violent patient is frequently reported by researchers into the effects of assaultive behaviour upon health care staff (Atawneh, Zahid, Sahlawi, Shahid & Al-Farrah, 2003; Conn & Lion, 1983;

[48] Collins (1996) does not define the time period for 'short-term' and 'longer-term' responses however this is not surprising given that interviews were sometimes conducted many years after participants had been assaulted.

Croker & Cummings, 1995; Lanza, et al. 2006). Re-experiencing phenomena, including assault-related dreams (nightmares), intrusive thoughts, and 'flashbacks' are also reported by researchers including studies into nurse' responses to 'verbal aggression' (Flannery, Hanson & Penk, 1995; Walsh & Clarke, 2003), and the responses of nurses to physical aggression (Bonner & McLaughlan, 2007; Caldwell, 1992; Conn and Lion, 1983; Flannery, et al. 1995; Wykes & Whittington, 1998). Much of the discussion about re-experiencing is usually in the context of a broader discussion of PTSD theory, which will be discussed in more detail later in this chapter (p. 128).

3.3.1.2 Passive coping strategies

The short-term responses of participants in the present study also featured the category *passive coping strategies* with related sub-subcategories including: *passive personal emotions strategies* including the codes *shutting down*, *not thinking about the assault*, *minimising the importance of the assault and behaving as though the assault had never happened*; and *passive patient management strategies* with related codes including *keeping a distance from patients, not engaging with patients* and *not disclosing personal information*).

Phenomena associated with the subcategory *passive personal emotional strategies.*

These phenomena are reported widely in the literature on assaults on individuals usually under the general heading of *thought suppression*, for example: in a study of assaults upon psychiatrists (Madden, Lion & Penna; 1976); in a meta analysis on the effects of violence upon individuals (Weaver & Klum, 1995); and in a study of distress following armed robbery (Harrison & Kinner, 1998). There is also reference to associated phenomena in the seminal literature on assaults upon nurses reported as suppression[49]

[49] According to Coleman, (2006) suppression is "… deliberate banishing from consciousness of selected thoughts, feelings, wishes, or memories, as in thought stopping". In this way, individuals control impulses consciously as opposed to unconsciously.

(Lanza, 1983), denial[50] (Wykes & Whittington, 1991), or repression[51] (Collins, 1996). It is clear, however, that all three sources are referring to patterns of thinking consistent with the definition of *suppression* provided by Coleman (2006) since each of the researchers appears to refer to a deliberate, that is conscious, process of banishing thoughts and feelings. In her discussion of participants "repressing" unwanted thoughts associated with the trauma of patient assault Collins (1996, p. 53), for example, sites one participant's response as follows:

> Had I been more experienced, I could have read the cues better and seen it [the attack] coming. I just pushed the incident to the back of my mind. I didn't realize (sic) how much the incident has affected my practice.

The link between traumatisation and thought suppression

The phenomenon of people avoiding thoughts, either consciously or unconsciously, of traumatic events is generally related to the fear and anxiety which is generated by the traumatic event(s) (Harrison & Kinner, 1998) and the occurrence of intrusive thoughts (Dyregrov, Krystoffeson & Muller, 1991, cited in Harrison & Kinner, 1998). One of the more extreme unconscious processes which might occur as a result of traumatic events is dissociation[52] which is discussed in the more general literature on the effects of assaults (for example, the after effects of traumatic such as the experience of violence in

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[50] NB: According to (Coleman, 2006) denial is an unconscious "… psychological defence mechanism in which a person is unable to consciously acknowledge thoughts, feelings, desires, or aspects of reality that would be painful or unacceptable". However Wykes and Whittington (1991, p.40) define "denial" as "refusing to consider the event" which implies a conscious rather than an unconscious process.

[51] According to Coleman (2006) repression is a defence mechanism whereby unacceptable thoughts, feelings, or wishes are banished from consciousness. Unlike denial, however, which involves the inability to deal consciously with "aspects of reality" (such as a diagnosis of cancer) repression involves instincts whose demands are unacceptable (so the person may acknowledge their diagnosis of cancer but the feelings associated with it may be prevented from entering into the conscious thought.

[52] Coleman (2006) defines dissociation as a partial or total disconnection between memories of the past, awareness of identity and of immediate sensations, and control of bodily movements, often resulting from traumatic experiences, intolerable problems, or disturbed relationships.

young children [Jonker & Hamlin, 2003] and the experience young adults injured by community violence [Jaycox, Marshall & Orlando, 2003]).

Much of the research done on understanding thought suppression has been done in the context of understanding PTSD. As Koss, Bailey, Yuan, Herrera and Lichter (2003, p. 130) have observed, PTSD has become the predominant paradigm for the study of victimisation generally whilst Hourani, Yuan and Bray (2003, p. 736) state that PTSD is the most frequently studied psychological effect of trauma exposure. According to Ehlers and Clark (2000, p. 323):

> (PTSD) is a common reaction to traumatic events such as assault, disaster or severe accidents. The symptoms include repeated and unwanted reexperiencing (sic) of the event, hyperarousal (sic), emotional numbing and avoidance of stimuli (including thoughts) which could serve as reminders for the event. Many people experience at least some of these symptoms in the immediate aftermath of the traumatic event.

Hourani et al. (2003, p. 736) stated that the estimated lifetime prevalence of PTSD is from one per cent to twelve per cent (a figure which they describe as relatively low) whilst the American Psychiatric Association (2000) stated that lifetime prevalence is eight percent of the adult population in the United States. The diagnostic criteria from the most recent Diagnostic and Statistical Manual for PTSD (American Psychiatric Association, 2000) (See Appendix R) includes diagnostic 'criterion A' which states that to have a diagnosis of PTSD the person must have been exposed to a traumatic event in which both the following are present:

> 1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and
>
> 2. the person's response involved intense fear, helplessness, or horror.
>
> (American Psychiatric Association, 2000).

Whilst it is not being suggested that participants in the present study should have a diagnosis[53] of PTSD, not least because it is doubtful that they would meet criterion 'A', the theory(s) underpinning PTSD should be examined in relation to the participants' responses in order to achieve some understanding of their distress and the possible origins of that distress. What follows is a brief description of the major theories which account for PTSD followed by a more detailed description of the cognitive model proposed by Ehlers and Clark (2000).

Ray (2008) described how PTSD first developed as a diagnosis following the influential work of Horowitz (1976) and the subsequent publishing of the third edition of the Diagnostic and Statistical Manual (DSM III) (American Psychiatric Association, 1980). The development of PTSD as a diagnosis has been further traced by Brewin and Holmes (2003) from early theories including:

- the *stress response theory* (Horowitz, 1976; 1984) in which the post-trauma individual is distressed as they try to match their current thoughts and memories of the traumatic event with ways of thinking established before the traumatic event. A further problem arises for the individual as their psychological defence mechanisms (principally denial, repression and suppression) are activated to enable the individual to avoid memories of their trauma whilst intrusive memories of the event continue to cause further distress and anxiety for them;

- the *theory of shattered assumptions* (Janoff-Bulman, 1992) in which the person's assumptions about the world (for example "the world is benevolent; the world is meaningful; the self is worthy; other people are well disposed towards me" [Brewin and Holmes, 2003, p. 347]) may be subject to quite radical change after a traumatic event to accommodate new ways of thinking (or schema) about the world;

- *conditioning theory* (Keane, Zimering & Caddell [1989, cited in Brewin & Holmes, 2003]) which proposes that fears associated with the traumatic event condition the individual to experience ongoing fear whenever memories of the event come to mind.

[53] Although the author is not qualified to provide a medical diagnosis for the participants of this study and, indeed, that is not the purpose of this research, it is acknowledged some of the participants may have been diagnosed with a psychiatric disorder as a result of their assault by a patient.

Under usual circumstances these fears would be extinguished, over time, if the individual remained able to think about and work through what had happened to them and the associated anxiety. However the individual's avoidance of the conditioned stimuli prevent a re-exposure to memories of the event (at least those that are under the control of the victim) thus leading to the maintenance of PTSD;

- *information processing theories* (for example Foa, Steketee & Rothbaum, 1989) in which it is proposed that traumatic events may be represented in the memory in a way that does not allow the brain to adequately process the event thus leading to pathology.

- More recent developments in theories about the development of PTSD, as described by Brewin and Holmes (2003), include *emotional processing theory* (Foa & Rothbaum, 1998 [In Brewin & Holmes, 2003]) in which it is proposed that individuals with strong and rigid pre-trauma views concerning personal competency and the world as a safe place will be more vulnerable to PTSD;

- *dual representation theory* (for example van der Hart & Horst, 1989 [In Brewin & Holmes, 2003] proposed that there are (at least) two memory systems with trauma memories being better represented in one system than the other, leading to the maintenance of PTSD symptoms. In their seminal paper Brewin, Dalgleish and Joseph (1996) proposed that the two memory systems include verbally accessible memory (VAM) which contains autobiographical memories which are characterised by a personal context including the individual's experiences in past, present and future, and situationally (sic) accessible memory (SAM) which contains information about sights, sounds, smells, emotions and bodily responses to stimuli that were too briefly experienced to be recorded in the VAM system (and thus are not autobiographical. That is: they are not accurately situated in the past, present or future). According to proponents of this theory VAM memories associated with the traumatic event are suppressed by the traumatised individual in order to prevent activation of fear and anxiety associated with the event. However SAM memories may be triggered by stimuli associated with the traumatic event and these may present themselves in the form of intrusive thoughts about the event or re-experiencing phenomena as though the traumatic event were occurring in the present. This theory may explain why people who develop PTSD display apparently poor autobiographical memories of the traumatic event and yet have very vivid memories of selected experiences within that traumatic event with strong emotional valence (Bonner & McLaughlin, 2007).

The cognitive model of PTSD proposed by Ehlers and Clark (2000) is eclectic and draws heavily upon the ideas developed by the authors mentioned above. Ehlers and Clark (2000) observed that individuals with PTSD present an interesting puzzle because their anxiety is not caused by the anticipation of an event which is impending (as is usually the case with anxiety disorders) but by memories of an event that has already happened. Thus the individual with PTSD experiences symptoms of ongoing anxiety because he/she processes the traumatic event and/or its sequelae in a way which produces a sense of "serious current threat" (Ehlers & Clark, 2000, p. 320).

According to Ehlers and Clark (2000) the individual with persistent PTSD is unable to perceive their trauma as a time-limited event and they have persistent negative appraisals of the world around them (including overgeneralisations such as, for example, a belief that "the world is a dangerous place"), as well as a distorted appraisal of general personal abilities (for example: "I am inadequate and unable to achieve my goals in life") and personal attributes related to the trauma (such as "I attract disaster" or "bad things always happen to me") (Ehlers & Clark (2000, p. 321). Symptoms such as intrusive thoughts and flashbacks may further fuel personal beliefs that the person is losing control of his/her mind or that these symptoms represent a permanent change in the person's ability to deal with the world leading to the development of unwanted emotions leading to (further) anxiety and depressed mood. Negative self appraisal and alterations in mood may also lead to withdrawal from social supports which can potentially be exacerbated by awkwardness on the part of relatives and friends (who may not know how to respond to the affected individual's post-trauma distress) and the subsequent withdrawal of support by significant others. A further cascade of consequences may apply to the person's life including a worsening in mental and physical health as well as a deterioration in occupational abilities which, in turn, strengthen the victim's negative self-appraisal as well as negative appraisals about the 'world' (Ehlers & Clark 2000, p. 322-323).

In accordance with earlier theorists Ehlers and Clark (2000) elaborated upon some of the memory phenomena associated with PTSD. These include:

- poor autobiographical memories of the traumatic event;

- limited ability to intentionally recall aspects of the traumatic experience with memories usually being fragmented and poorly organised;

- re-experiencing of events consists mainly of sensory impressions, usually visual, which are experienced in the present time;

- the emotions associated with the traumatic event are usually re-experienced even when it is clear that the individual's initial impressions of the incident have, in the light of forensic evidence, proved to be incorrect;

- individuals may experience strong affects associated with the traumatic event even in the absence of a recall of the event;

- individuals may re-experience the traumatic event triggered by stimuli which were only temporally associated with the event (for example smells, patterns of light, a certain tone of voice similar to that which occurred at the time of the traumatic event may be triggers).

(Ehlers & Clark, 2000, p. 324-325)

The reasons for the above memory phenomena are, according to Ehlers and Clark (2000), due to:

- poor elaboration and incorporation into autobiographical memory (similar to VAM phenomena which apply to traumatic events theorised by Brewin, Dalgleish and Joseph [1996]);

- strong conditioning in respect of the traumatic event as described by the conditioning theory first described by Keane, Zimering and Caddell (1989, cited in Brewin & Holmes, 2003);

- strong perceptual priming for stimuli that are temporally associated with the traumatic event (similar to the SAM phenomena described by Brewin, Dalgliesh & Joseph [1996]);

- the relationship between the nature of the trauma memory and trauma appraisals. Here Ehlers and Clark (2000, 327) theorised that individuals recall the traumatic event in a biased way that reinforces their negative appraisals (an example is given of a woman whose negative post-trauma appraisal was that her

> accident showed that no-one cared for her, selectively recalled some unfriendly actions by nurses but did not recall those people who had tried to help her). Concurrent inability to remember details of the traumatic event (particularly autobiographical details) may lead to the selective appraisal that there is something wrong with the victim.

Ehlers and Clark (2000) further theorised that, as memories of the event continue to cause problems for the individual, a number of strategies are employed in order to diminish anxiety. These strategies are meaningfully linked with the individual's appraisals of the trauma and/or its sequelae and their general beliefs about how best to deal with the trauma however they often serve to maintain post trauma responses (Ehlers & Clark, 2000, p. 327) and include *thought suppression*, *safety behaviours* and *trying not to think about the event* and *avoiding reminders of the assault*.

According to Ehlers and Clark (2000) one maladaptive strategy designed to diminish distress is *thought suppression*. Research by Wegner (1989, cited in Wenzlaff & Wegner, 2000) has shown that attempts by individuals to push thoughts out of their mind only serve to increase the frequency of these thoughts. Similarly it is hypothesised that *safety behaviours*, such as being vigilant, may be reasonable responses to the occurrence of a traumatic event but may serve principally to increase thoughts of the event or cause a lack of attention to other behaviours which may increase the likelihood of further trauma (such as the motorist who exercises extreme caution after a motor vehicle accident [Ehlers & Clark, 2000, p. 328]). In addition *not thinking about the assault* and avoiding reminders of the assault may maintain post trauma responses by preventing the individual from processing the event and, in particular, may further impair the degree to which autobiographical memories of the traumatic event are formed.

Phenomena associated with the sub-subcategory *passive patient management strategies.*

These phenomena are mentioned only briefly in the seminal literature and elsewhere. Although the participants in the studies by Lanza (1983), Ryan and Poster (1989) and Wykes and Whitington (1991) were described, to various degrees, as distressed, afraid of the assaultive patient, cognitively impaired and avoidant, little mention is made of

their inclination or ability to engage with patients. It is true, however, that each of these authors implied that assaulted nurses would face difficulties in returning to work, sometimes having to provide nursing care for their assailant. In addition Wykes and Whittington (1991, p. 45) commented directly about the decreased problem-solving capacity of their participants which may limit their capacity to find creative ways of coping with the perceived threat presented by their assailant. Collins (1996, 49), on the other hand, described phenomena associated with the category from her study *sliding into a funk* in which nurses reported being avoidant with comments such as "… I spent a lot of time in the nurses' station afterward (i.e. post-assault) trying to avoid the patient" and:

> I didn't think that my level of care was affected [by her experience]. It wasn't until I was working in a different setting that I realized (sic) I had been avoiding working with paranoid schizophrenics because of my earlier experience.

Amongst the broader literature which discusses the implications of patient assault upon nurses there is, occasionally, explicit comment about the difficulties that nurses have experienced engaging with patients post-assault because they are being avoidant (for example Levin, Hewitt & Misner, 1998). However much of the discussion on changes in the nurses-patient relationship relates to decreased quality of care because of post-assault cognitive impairment for nurse-victims (for example Arnetz & Arnetz, 2001; Deans, 2004a) or is related to the amount of sick leave that nurses take because of assaults (for example: Findorff-Dennis, et al., 1998; Rix, 1987).

Although there is only moderate concurrence between the findings of the present study and the research findings in the literature the writer contends that it makes sense that nurses would respond to the experience of patient assault by avoiding their patients and that this is an under-reported phenomenon. The reasons for this statement are, firstly, that avoidance is one of the common strategies used by the victims of trauma according to Ehlers and Clark (2000, p. 327) and, secondly, as Lanza et al. (2006, p. 79) contended, this area of nurses' behaviour has not been adequately researched.

3.3.1.3 Assault response mediators

Codes associated with the category *assault response mediators* include the *presence or absence of support from colleagues* and *presence or absence of support from nursing administrators.* Neither Lanza (1983) nor Ryan and Poster (1989) mentioned these phenomena but they were briefly characterised by Wykes and Whittington (1991) as *talking to others*, described as a coping strategy which was subsumed under the general coping strategy (deliberately) *re-experiencing the assault*. Social support was mentioned as an important factor in the recovery of nurses in the Collins (1996) study and appears to play a role during the nurses' recovery: firstly in the *minimizing* phase, in which colleagues assisted the assaulted nurses in the process of *buffering* after the assault (Collins, 1996, p. 50) by keeping the assaulted nurse away from direct patient care duties; and then during the later (long term phase) *getting on* phase sub-category *personal and professional support* (which will be further described in the discussion on the long-term effects of assault).

Discussion of the relationship between appropriate support from professional peers and management/ administrative staff and the diminishment of anxiety in victims of occupational violence appears in the literature on: patient assaults upon nurses in health care settings (Hislop & Melby, 2003; Leather, Lawrence, Beale, Cox & Dickinson, 1998); violence against caregivers in nursing homes (Gates, et al., 1999); violent incidents against child-protection social workers (Littlechild, 2005); 'nasty teasing' at worksites (Hogh, Henricksson & Burr, 2005); serious untoward incidents in inpatient psychiatric units (Bowers, Simpson, Eyres, Nijman, Hall, Grange & Phillips, 2006); and patient aggression towards social workers in mental health services (Spencer & Munch, 2003). According to Lazarus and Folkman (1984) the ability of people to access and use social support is a key factor in alleviating stress. Further, the primacy of social support as a mitigating factor against the severity of post trauma responses is emphasised in an account of the psychological effects of intimate partner violence by Coker, Smith, Thomson, McKeown, Bethea and Davis (2002) as well as in a meta analysis by Brewin and Holmes (2003) which found that social support was the strongest factor which mitigated against the occurrence of PTSD.

3.3.1.4 Futility

Codes associated with the category *futility* include perceptions by participants that: i) there is a *constant threat of violence* on the mental health unit and that there is an *inevitablility of assaults*; and ii) *safety concerns are (routinely) ignored or minimised by administrators*. These codes have some resonance in the literature on the effects of assaults upon individuals. Such perceptions are also consistent with the negative cognitive appraisals of the 'world' that the individual may develop post-assault. According to Ehlers and Clark (2000) this type of maladaptive strategy, aimed at minimising distress after a traumatic incident, may actually contribute to avoidance strategies.

The phenomenon of victims reporting an increased expectation of violence after an incident of assault are also reported in the general literature on violence against individuals such as in: accounts of workplace victimisation (Kaukainen, Salmivalli, Bjorkqvist, Osterman, Lahtinen, Kostamo & Lagerspetz, 2001); customer aggression against service employees (Grandy, Dickter & Sin, 2004) and reports of generalised fear following physical and sexual abuse in young women (Csoboth, Birkas & Purebl, 2005). In respect of violence against health care staff Walsh and Clarke (2003) conducted a study of 126 employees of a UK national health care service community trust who had reported an incident of aggression during the three-month period of their study. The researchers hypothesised, on the basis of their findings, that many of their participants had developed generalised feelings of distrust towards others and had come to view 'the world' as a more dangerous place (Walsh & Clarke, 2003, p. 178).

Accounts of nurses having an altered expectation of violence after patient assault are present in the seminal literature on violence against nurses. Lanza (1983, p. 46) makes specific reference to nursing staff having a heightened expectation of violence post-assault. There is little mention of assaulted nurses having an increased expectation of assault in the papers by Ryan and Poster (1989) or Wykes and Whittington (1991). Ryan and Poster (1989, p. 330) did report that over half of their participants had an "expectation of assault" after their encounter with an assaultive patient, however there was no measure of the extent of this belief taken before their assault.

Collins (1996) mentioned the phenomenon of fears about assault being generalised from the assaultive patient to other patients when discussing the *minimising* subcategory *repressing.* Collins (1996, p. 53) provided the example of a participant who reported becoming "paranoid" (and was subsequently subject to psychiatric assessment) as she became increasingly fearful of patients after she had been a victim of patient assault.

Further accounts of nurses having an increased expectation of violence after patient aggression are present in the broader literature on violence against nurses. In their study of violence in hospital accident and emergency (A&E) units Hislop and Melby (2003) conducted a phenomenological study with 26 nurses from an A&E department in Northern Ireland who had experienced patient aggression (which was loosely defined "… as any form of behaviour directed toward the goal of harming or injuring another who is motivated to avoid such treatment" [Baron, 1977, cited in Hislop & Melby, 2003]). Whilst most participants reported feelings of frustration, anger and fear in their response to the experience of violence many also reported generalising their expectations of violence and abuse to include all of the people in the A&E department waiting room. As one participant of the Hislop and Melby, 2003, p. 8) study reported:

> The waiting room turns against you and I feel so embarrassed when people shout at me in front of the waiting room who act as an audience. It just wrecks my spirit.

Other participants in the Hislop and Melby (2003) study also generalised fear to include the 'type' of patient who had assaulted him/her reporting:

> It's the stranger, the person you don't know, the one with alcohol on board-they're the ones to watch and be afraid of. You just don't know how they are going to behave because they can just turn around and let loose on you.
>
> (Hislop & Melby, 2003, p. 10).

It is not surprising that the experience of patient assault and the subsequent generalisation of fear has consequences for both victim and employer. As Atawneh, et al. (2003, p. 103) observed the victim's fear and perceived vulnerability may lead to victims taking sick leave, cause poor staff morale and result in higher rates of staff turnover.

No reference could be found in the literature to the short-term effects of assault on individuals relating to the code *safety concerns are (routinely) ignored or minimised by administrators.* There is, however, material relating to this phenomenon in the literature on the long-term effects of assault. As a consequence this category will be explored later in this chapter as it also appears as a sub-category in the long-term effects category *ongoing futility*.

3.4 The long-term effects of patient assault upon staff working in mental health units

Four seminal papers were identified which provided detailed discussion on the long-term effects of patient assaults upon mental health nurses. One of the earliest attempts to document the effects of patient violence upon the staff employed in health care settings was completed by Conn and Lion (1983). These researchers conducted a study at a large (800 bed) US general hospital, which also contained 54-bed psychiatric unit, between July 1979 and December 1980. Conn and Lion (1983) recruited participants for their study having first identified them on incident forms which were completed by staff post-assault. A total of 61 incidents were selected for investigation by the researchers (on the basis that there had been a physical injury to staff) with the injuries sustained ranging from minor cuts and bruises to an incident where a staff member's teeth were broken. Twenty five of these assaults had occurred in the psychiatric unit whilst the remainder had occurred elsewhere in the hospital. It is not clear, however, how many staff had been assaulted and nor do the researchers mention the specific occupation of victims. The responses of victims are reported as insomnia, eating disturbances, anxiety, exaggerated startle response, depression and flashbacks (re-experiencing phenomena). Conn and Lion (1983, p.65) commented:

> Following the assault victims typically suffered from the psychological sequelae that have come to be regarded as the posttraumatic stress disorder including insomnia, eating disturbances, anxiety, an exaggerated startle response, depression, trouble concentrating and "flashbacks" in which the attack would be vividly relived. Staff members who had been attacked often developed fear of working with unpredictable or dangerous patients, particularly a hesitancy to confront them or set limits. One staff member reported that

> after she was assaulted, feelings of helplessness and vulnerability when she was at work persisted for months.

In her retrospective study Lanza (1983, p. 46), who defined "long-term" responses as those which persisted past one week, found that the long-term emotional responses of participants included fear of the patient who committed the assault, anger, anxiety, and feeling sorry for the person who committed the assault. Long-term biophysiological responses included body tension and soreness. In addition, and perhaps most importantly, some participants continued to report reactions to their assault at six months and one year after the event despite having avoided major physical injury. This may not be surprising, however, given that some participants reported that their life had been threatened during their assault. Having established that her participants had the potential to be diagnosed with PTSD, however, Lanza (1983, p. 46) rather ambiguously refers to their short-term and long-term, responses to assault as exemplars of "posttraumatic stress".

Ryan and Poster (1989), in their longitudinal study, also reported that some of their participants continued to experience distress into the longer-term. Using the 'responder' criteria[54] as a marker for distress Ryan and Poster (1983, p. 327) found that 67 per cent of participants met responder criteria at one week (that is 41 out of the 61 participants) post-assault whilst eighteen per cent (that is eleven out of the 61 participants) continued to be responders at six weeks post-assault. At six months post-assault there were eleven (or eighteen per cent) out of the 51 participants who remained in the study who continued to meet responder criteria for distress. Significantly three participants who were not responders at six weeks post assault met responder criteria at six months post assault. At one year post assault there were ten out of the 44 remaining participants who met responder criteria. As with the inventory of responders at six months there were participants (four at one year post assault) who had not previously met responder criteria (Ryan & Poster, 1989, p. 327). The most frequently reported long-term responses were anger, anxiety, fear of the patient who committed the assault, feeling sorry for the

[54] 'Responders were individuals who reported one severe response, two fairly intense responses or three moderate responses in any of the four categories of the ARQ at any time.

patient who committed the assault, body tension and soreness (Ryan & Poster, 1989, p. 325).

As with Conn and Lion (1983) and Lanza (1983), Ryan and Poster (1989, p. 328) drew a comparison between the long-term reactions experienced by nurses in their 'responder' sample and symptoms of PTSD with the statement:

> The assaulted staff members in the current sample who remained responders after week 6 or those who became responders at 6 months or 1 year may be experiencing chronic or delayed Posttraumatic Stress Disorder (PTSD) … as a consequence of the assault experience.

In respect of Collins' (1996, p. 55-57) retrospective study the phase *getting on*, and the related sub-categories *redefining the self, defining a new world order, personal and professional support and organizational and administrative roles and responsibilities*, may reasonably be interpreted as longer-term responses of participants to the experience of patient assault(s) principally because it represents the final stage of post-assault resolution and is a phase which requires a level of reflective thinking and the re-organisation of the participant's life which is incompatible with an individual whose experience of assault is new and distressing.

According to Collins (1996) the sub-category *redefining self* marked a period of adjustment in the participant's life post-assault where participants had reached some decisions regarding their resolve to feel less vulnerable to future assaults by a patient. Some participants had enrolled in self defence courses whilst others had come to a resolution, based on their age, that they would no longer be able to defend themselves as well as they had done in the past. Participants also reported that they had become increasingly wary, of potentially unsafe situations involving potentially aggressive patients in the workplace, as well as increasingly safety-conscious (Collins, 1996, p. 54). The subcategory *new world order* refers principally to nurses redefining aspects of their professional world. For several nurses in the study by Collins (1996, p. 55) this meant changing work circumstances so that they could work under safer conditions within the same hospital (four participants) or resigning and seeking employment in other hospitals considered to be safer (three participants). Participants in the study by Collins (1996) also reported their experiences in respect of seeking *personal and professional support,*

which are concepts that were dealt with in relation to *assault response mediators* in the present study (and principally involve participants' perceptions of the degree of support provided by family and friends as well as workplace peers and administrative staff). Collins reported that participants in her study also commented upon *organizational* (sic) *and administrative roles and responsibilities* which included further sub-categories:

- *organizational* (sic) *administrative responses* which referred to a range of institutional responses to workplace practices and procedures in respect of the potential for patient violence such as reporting procedures, the training of staff in the management of patient aggression as well as the adequacy and confidentiality of counselling services via Employee Assistance Programs [EAP][55]); and

- *organizational and administrative responsibilities* in which participants described their perceptions of their inability, in some areas, to administer medications to patients involuntarily[56] whilst other participants made comments about the possibilities of being assaulted by a patient with the human immunodeficiency virus (HIV).

3.4.1 Regarding participants who misjudged being 'over' the effects of their assault

It is noteworthy that all of the participants in the present study reported that they were "over" the effects of their assault, at the interview conducted approximately three months after they had been assaulted by a patient, but subsequently four participants reported that they had actually continued to be significantly affected by their assault for a longer period (up to four months post-assault for two of the participants) at the final

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[55] In some of the hospitals from which Collins (1996) recruited participants there was a perception of decreased provision of EAP services or inadequate provision of service by poorly trained counsellors who did not respect the need for confidentiality.

[56] NB: Some of the US states in which Collins (1996) recruited participants allow treating psychiatrists to prescribe medication that can be administered, usually by nurses, against the patient's wishes. However other states, from which participants were also recruited, allow the administration of medications only after the patient has been violent. Under the *NSW Mental Health Act* (NSW Department of Health, 1990; 2007) patients who have been involuntarily admitted to a declared mental health facility may be given medication against their will.

interview scheduled at six months post-assault (that is: they reported experiences consistent with the category *churning anxiety*). Similar findings were reported in the longitudinal study of the effects of patient assault upon mental health nursing staff by Ryan and Poster (1989, p. 327), who found that several participants became responders at six months as well as one year post assault who had not previously met responder criteria. This phenomenon is also consistent with the maladaptive coping strategies: *thought suppression*; and *trying not to think about the assault* (Collins, 1996; Lanza, 1983; Wykes & Whittington, 1991).

The question of whether the participants in studies of patient assaults on nurses, including the present study, were actually responding to the assault reported for the study cannot be easily addressed. It is possible, for instance, that they were simply re-traumatised by their 'current' assault. This author has no definitive response to this sort of question except to make reference to a retrospective study by Croker and Cummings (1995) who reported on the experience of 35 non-psychiatric nurses to the experience of assault. Despite the fact that Croker and Cummings used Lanza's (1988) revised ARQ, the authors did not detail individual nurses' responses to items on the scale, preferring to comment on the relationship between the intensity of responses and the number of previous assaults experienced by the subjects. A major finding of the Croker and Cummings (1995, p. 85) study was that:

> The number of previous assaults correlated significantly with emotional reaction, biophysiological reaction, and social reaction. As nurses experienced more assaults, their emotional, biophysiological, and social reactions intensified.

Moreover some of the studies on the responses of health care staff to the experience of patient assault reported on PTSD symptoms (for example Caldwell, 1992; Lanza, 1983; Wykes & Whittington, 1998) or post-trauma symptoms (for example Ryan & Poster, 1989) whether the participants had received or were even eligible for this diagnosis[57]. This apparent preoccupation with PTSD may be a reflection of the dominance of PTSD paradigm as mentioned earlier in this thesis (see Koss, et al. 2003, p. 130). This

[57] NB: It is unlikely, for example, that any of the Ryan and Poster (1989) study participants met the criteria for PTSD because they did not meet criteria 'A' (American Psychiatric Association, 1987).

dominance may also be problematic since it appears to this author that the diagnosis of PTSD is almost required in order to give legitimacy to the victim's distress. A further problem with PTSD studies is that they are, principally, studies of what happens when the victim of (for example) assault becomes distressed to the point of developing pathology. There is not, however, a great deal of literature in which the author(s) posit theories or develop models relevant to the individual who recovers from their distressed state, post assault, but does not have a diagnosis of PTSD (the grounded theory developed by Collins (1996) is an exception). Nor are there theories or models relevant to the individual who develops an alternative diagnosis to PTSD such as major depression (Koss, et al., 2000).

3.4.2 Discussion of categories related to long-term responses to assault from the present study in relation to findings from other studies

There is resonance in the four seminal studies as discussed above, as well as others, with the *reintegration* category from the present study, and the related sub-categories *active coping strategies*, *residual vulnerability; and ongoing futility*.

3.4.3 The reintegration phase

During the present study the stage which appears to indicate a sense of renewal in the participants as they recovered from their assault has been labelled *reintegration*. Categories associated with the overarching category *reintegration* include *active coping strategies, residual vulnerability* and *ongoing futility*. The findings from the present study are similar to those reported in the literature by Collins (1996, p 55), who characterised participants at a similar phase from her study as "… arising out of immobilization (sic) and seizing one's own agency".

3.4.3.1 Active coping strategies

For participants, engaging in *active coping strategies* marked a departure from the passive strategies which were a feature of the *churning* phase of recovery. These involved: *active patient management strategies* (for example: *closer assessment of patients and being more assertive with patients*); and *actively managing safety concerns* (for example: participating in work safety programs and considering a new job). Similar

findings have been reported in studies of the long-term effects of assault, although in some aspects the findings of the present study are unique.

The participants in the present study reported that they became more active in the way that they dealt with patients as they recovered from the effects of their assault and this activity contrasted with the passivity of the earlier churning anxiety phase. Closer assessment of patients, particularly in respect of potential for violence, is rarely mentioned in the seminal literature but is alluded to by Lanza (1983, p. 46) when she described the behaviour of her participants as extra-cautious, as they shared "… intuitive feelings" with other nurses about which patients might be assaultive. Similarly, adopting more assertive strategies when dealing with patients (one participant [George, interview 3, p. 4)] from this study, for example, reported that he had started telling patients what they had to do "… Yes, you will do this … this is what you've got to do") was a phenomenon which was not reported elsewhere in the literature. There are, however, other examples in the relevant literature of staff becoming more active as they recovered from the effects of their assault as described below.

Other responses relevant to participants in this study, such as actively managing safety concerns (including participating in work safety programs and considering a new job), were more widely reported in the related literature. Heightened safety concerns were reported by participants in the studies conducted by Lanza (1983, p. 46) and Collins (1996, p. 54) with Collins noting that some of the participants in her study had undergone self-defence (martial arts) training so that they might feel less vulnerable to attack by a patient in the future. Safety behaviours, as mentioned previously, are also described in the literature on maladaptive behaviours which individuals can exhibit in a post-traumatic state and these behaviours may be exhibited, according to Ehlers and Clark (2000, p. 328), specifically to prevent or minimise anticipated further catastrophes.

Other authors have reported on participants who sought to change their working circumstances or find a new job after they had been assaulted in their workplace. Collins (1996, p. 55) reported that seven of the participants in her study chose to change their work environment (two participants simply changed shifts but continued to work on the unit in which their assault had occurred, two changed areas of practice within the same

facility, whilst three participants sought employment in a hospital which was felt to be safer). Similar findings are reported by Arnetz, et al. (1998) in their literature review and by Findorff-Dennis, et al. (1999) in their study of the responses of participants from a number of employment settings (including health care, law enforcement and education) to workplace violence. These findings are consistent with the *reintegration* phase from the study described in this thesis.

3.4.3.2 Residual vulnerability

Residual vulnerability refers to a fear held by participants in this study that they could return to the emotional state which distressed them immediately post-assault with the occurrence of another assault. Lanza (1983, p. 46) reported that the participants in her study felt a lasting sense of vulnerability that was magnified if they also had ongoing physical injuries as a result of their assault. Collins (1996) also reported that her participants had a sense of vulnerability which was an underlying factor that gave rise to their need to *redefine self* (a part of which was becoming proficient in self-defence) and *create a new world order* (where the person re-evaluates aspects of their professional 'world'). Otherwise there was little mention of participants developing a residual vulnerability in the literature however the author contends that it is reasonable to assume that people who have been assaulted would tend to be wary of others in the aftermath of their assault.

3.4.3.3 Ongoing futility

Ongoing futility related to the perception of the participants in this study that they worked in an environment where there was a constant threat of violence and an inevitability of assaults as well as concerns by participants that workplace safety was ignored or minimised by nursing administrators. Phenomena relating to the perceived inevitability of assaults were discussed (as short-term responses to assault) in the relevant section of this thesis (see pp. 136-37).

The perceptions that workplace safety is ignored or minimised by administrative staff and that the participant was not valued by administrative staff have resonance in the literature on the long-term effects of assaults upon staff in health care facilities. Conn and Lion (1983, p. 66), for example, reported that participants in their study were

concerned that hospital 'administrators' had ignored safety issues such as perceived understaffing, poor physical design of the wards, and the admission of numbers of patients known to be previously assaultive despite the opinion of staff who felt that they could not deal with these patients safely. Participants in this study also reported the perception that their professional abilities had been questioned by administrative staff who felt that the assaulted staff member was to blame for the assault (even in the cases of unprovoked assaults).

Collins (1996, p. 57-58) also explored the actions of administrative staff towards assaulted psychiatric nurses, in the sub-category *organisational and administrative responses* (which relates to the over-arching category *getting on*), stating that assaulted victims sometimes reported frustration either because they perceived that hospital administrators had minimised the importance their assault (usually when the participants had experienced no physical injury or only minor physical injuries), or when there was a perception by participants that administrators were compromising staff safety by blocking opportunities for training in the minimisation of aggression.

3.5 Conclusion regarding Phase Two findings

The literature substantially supports the Phase Two findings from the present study, particularly in relation to the change from passive to active coping strategies as participants recovered from their experience of patient assault. Moreover there is good support for the theory that recovery is 'processural' with distinct recovery phases. Whilst it is unlikely that any of the participants involved in the present study would have been diagnosed with a mental disorder during the study period, PTSD theory provides possible explanations for some of the reported maladaptive responses. Thought suppression and re-experiencing (intrusive thoughts) phenomena as well as changes in the victim's appraisal of the surrounding environment may be aproached from this perspective.

4 PROFESSIONAL IMPLICATIONS OF PATIENT ASSAULT

According to the findings from the present study one of the most important implications of the development of post-assault churning anxiety is the potential for diminished engagement with patients. As discussed previously in this chapter the relevant literature

has revealed that this phenomenon may find expression in a number of ways other than overt non-engagement such as victims becoming diverted to types of work (including administrative tasks such as answering the telephone or filing documents) which demand less patient contact (Collins, 1996) or increased absenteeism (Gerberich, Church, McGovern, Hansen, Nachreiner, Geisner, Ryan, Mongin & Watt, 2004; Rix, 1987; Rugulies, et al., 2007). What ever the expression, it is clear that a good number of mental health nurse victims of patient assault are not engaging with their patients, generally held to be a mainstay of their professional activities, and this has clear implications for patients, especially where the nurse-victim is employed as a primary nurse. Moreover there are implications for teamwork amongst the nursing unit staff where one of their number is compromised in her/his capacity to provide safe and competent care for patients and, most importantly, accurately assess and intervene with distressed patients, particularly those whose behaviour indicates an escalation towards (further) aggression or self-harm.

Several authors have explored the professional implications related to the phenomenon of patient assaults upon nurses (such as Bowie, 1996; Deans 2004a; Deans, 2004b; Farrell, 1997). Deans (2004a), for example, explored the question of the professional competency of assaulted nurses in the post-assault period. Using a phenomenological approach, Deans (2004a) studied the post-assault responses of a convenience sample of 55 nurses, from the state of Victoria (Australia), who had reported experiencing patient aggression. Deans (2004a, p. 34) found that assaulted nurses had to negotiate a stage where they experienced an initial shock immediately after their assault followed by a period where they experienced some confusion about their professional roles and their ability to function as a registered nurse. Deans (2004a) also found that reporting behaviour in the post-assault period was largely affected by the participant's need to be perceived as a competent person by peers and administrative staff.

There are also potential challenges to the therapeutic alliance between patients and participants in the present study who progressed from passive to active coping strategies post assault. The assertive patient management strategies reported (for example: by Bruce [participant 001] who reported pushing patients away or using his hands as a barrier between himself and patients whose behaviour he deemed to be inappropriate;

and George (participant 006) who assertively adopted the strategy of telling patients what they should be doing rather than listening to them [see Chapter Five p. 98]) are strategies which do not align with the conciliatory responses (such as the use of verbal de-escalation techniques) recommended by the evidence-based literature relevant to the minimising aggression in the workplace (Cowin, Davies, Estall, Berlin, Fitzgerald & Hoot, 2003; Irwin, 2006; Stubbs & Dickens, 2008) or, indeed, by the participants' employer (Employee Relations Branch, NSW Department of Health, 2005a). The evidence is that such strategies may be regarded as inflammatory and have the potential to lead to an escalation towards violence (Davis, 1991; Grenyer, Barlow & Ilkiw-Lavalle, 2000).

Further, the safety-conscious behaviours reported by participants, for example by Robert (participant 012) (see Chapter Five, p. 99), and the residual *wariness* reported, for example by George (participant 005) and Anne (participant 008) (see Chapter Five, p. 99), indicated that these participants were understandably preoccupied with their own safety possibly to the detriment of initiating and/or promoting a therapeutic relationship with their patients. Ultimately this focus upon unit safety led to five participants from the present study actively seeking a change in employment with four participants having changed employment by the completion of the Phase Two interviews (six months after the participant's assault). In keeping with the findings of Collins (1996), Arnetz, et al. (1998) and Findorff-Dennis, et al. (1999) it is clear that significant distress following patient assault may have implications for the retention of staff.

The findings of this study also indicated that there were changes in the working relationships between participants and their nursing colleagues in the post-assault period. Whilst there appeared to be an accommodation in the relationship between participants who had been recently assaulted and their supportive mental health unit colleagues, the relationship between participants and nursing administration staff may be compromised by the participants' perceptions that administrative personnel were unsupportive. The findings from seminal studies by Conn and Lion (1983) and Collins (1996) provide a degree of confirmation that this perception has the potential to undermine teamwork between unit staff and their managers. At best some of the administrative staff referred to by participants in the present study appeared to have

taken an inconsistent approach towards ensuring that participants were not unduly distressed following their assault and also in advising participants of their right to access further counselling or at least take time off duty to recover.

Whittington and Wykes (1992), in their UK study involving 23 nurses and one doctor recruited from a large London mental health facility, found that, although social support was a moderating factor (or 'buffer') in the degree of distress (strain) suffered by nurses-victims of assault, most of the participants reported that they received only "informal" support from their colleagues with only "some" reporting that they received counselling from their "managers". Moreover, Whittington and Wykes (1992, p. 485) noted that, as with the present study, the support received was typically within the first 24 hours after the assault had occurred even though some participants reported that their distress lasted well after the assault had occurred (up to two and a half weeks in the study by Whittington & Wykes, 1992). The problem of senior nursing staff reacting insensitively towards assaulted staff was also identified by Deans (2004a) who reported on the apparent perception by senior nursing staff that victims of assault should simply be able to cope with their assault. Deans (2004a, p. 34) also reported on the stories of participants who said that their main interaction with senior staff in the aftermath of their assault by a patient had been the advice that dealing with the effects of aggression was akin to "… getting back on your horse after you have fallen off, or getting into the car to drive when you have had an accident".

5. DIMINISHING THE DISTRESS EXPERIENCED BY VICTIMS OF ASSAULT

5.1 The role of *actual* and *perceived* support for victims of assault

There is good evidence from the research literature that social support has a buffering effect[58] upon the emotional distress experienced by victims of violence (Kanaisky & Norris, 1992; Rosenthal & Wilson, 2008). Whilst Kanaisky and Norris (1992, p. 213)

[58] According to Kanaisky and Norris (1992, p, 211-212) buffering is term which is used to describe how social support operates to promote or protect a sense of personal well-being.

proposed that there were many facets to social support which contribute to a person's perception about the quality of the support received, Rosenthal and Wilson (2008, p. 696) proposed that both social support and a sense of personal control were protective factors in the event of assault.

In their seminal research paper, based upon the work of Janoff-Bulman and Frieze (1983) and Janoff-Bulman (1985), Kanaisky and Norris (1992) described the types of support received by people who had been victimised as a result of crime. The study was conducted in the state of Kentucky (US) and the researchers surveyed 12,226 people via telephone in order to establish: cohorts of people who had been victimised in the past six months either by violence (175 participants) or property crime (328 participants); and a cohort of non-victims, or *controls* (310 participants). All participants were interviewed on three occasions (referred to as 'waves' by the researchers) over a one-year period. Response rates were relatively high over the three interviews ranging between 85 per cent for wave 2 violent crime victims to 76 percent for wave 3 violent crime victims (Kanaisky & Norris, 1992, p. 219). In particular the researchers were interested in the buffering potential of three types of support: tangible support (such as money, transportation or shelter); informational support (such as advice on the form of guidance that might assist victims to deal with their distress); and esteem support (aimed primarily at blocking the lowering of self esteem that victims often experience in the post-assault period). The researchers were also interested in the role of support which was *perceived* by participants (meaning the belief that support would be provided if needed) as opposed to the type of support which was actually *received* by participants (meaning the actual assistance received) (Kanaisky & Norris, 1992, p.234- 235). Numerous instruments were used in order to measure levels of distress experienced by victims including: the Brief Symptom Inventory (Derogatis & Spencer, 1982, cited in Kanaisky & Norris, 1992); the Interpersonal Support Evaluation List (Cohen & Hoberman, 1983, cited in Kanaisky & Norris, 1992); and the Inventory of Socially Supportive Behaviours (Barrera, Sandler & Ramsay, 1981, cited in Kanaisky & Norris, 1992).

Kanaisky and Norris (1992) established, first of all, that the victims of violent crime had experienced significant amounts of distress on all measures of psychological states. In

respect of the efficacy of different types of support in buffering distress Kanaisky and Norris (1992, p. 230-231) concluded that, although received emotional, informational and tangible support protected victims of violence from high levels of fear, the level of *perceived* support (emotional and informational) was most indicative as a buffer against distress. Indeed the increased perception of support promoted well-being regardless of crime state and also protected victims of violent crimes from experiencing excessive fear of crime generally. However, whilst perceived support was most influential in assisting victims, Kanaisky and Norris (1992, p. 231) concluded that:

> In general these findings conform to our broad view prediction that, because crime impacts many facets of well-being, a variety of social support types may be of value.

5.2 Work-related benefits to providing support for nurse victims of assault

The need for nurse managers to provide recognition and support for assaulted nurses has been highlighted in the literature (Day, 2005; Deans 2004b; Farrell, 2001). Apart from the obvious humanitarian benefits of providing support (*perceived* and *received*) for the nurse victims of patient assault there also appear to be benefits in respect of increased perceived competency of assaulted staff and improved workplace morale. Deans (2004b), in his study in which he surveyed a random sample of 380 nurses in the state of Victoria (Australia), compared two groups to which nurse participants were allocated according to their reported high or low level of occupational violence. The nurses were surveyed for levels of perceived professional competence using an (unnamed) instrument to measure: experienced occupational violence; organisational support; and perceptions of professional competence. Data analysis (t-test) revealed that the group which reported experiencing high levels of occupational violence demonstrated a significantly lower perceived competence compared to the group which reported experiencing low levels of occupational violence ($p<0.002$). Further regression analysis revealed that, amongst the group with participants who reported experiencing relatively high levels of occupational violence, there was a significant relationship between perceived higher levels of organisational support and higher levels of perceived professional competence. Conversely perceived low levels of organisational support was

associated with significantly lower levels of perceived professional competence ($p<0.001$) (Deans, 2004b, p. 17).

Whether increased perceived levels of professional competence, as reported in the study by Deans (2004a), actually lead to measurable improvements in professional standards for nurses is debatable, however what is indicated by the study is that organisational support appears to be an important moderator of professional confidence and, as a consequence, morale.

5.3 Policy directions in respect of violent incidents in NSW health facilities

Given the apparent inconsistency of administrative staff in offering post-assault support to participants in the present study (and as reported elsewhere) it is useful to examine the policy directives issued by the NSW Department of Health in relation to post-incident support for assaulted staff.

The main NSW Health Department policies which relate to the support of assaulted staff are contained within documents which relate to: general policy regarding assaults in public hospitals (*Zero tolerance response to violence in the NSW health workforce* [Employee Relations Branch, NSW Department of Health, 2005a]); policy specific to post-incident procedures following an incidence of workplace violence (*Effective incident response: A framework for prevention and management in the health workforce* [Employee Relations Branch, NSW Department of Health, 2005b]; and the policy related to the appropriate use of employee assistance programs (*Employee Assistance Programs: NSW Health Policy and Best Practice*, Employee Relations Branch, NSW Department of Health, 2005c]). All of these policies are designed to reflect the regulations of the NSW *Occupational Health and Safety Act* (NSW Parliament, 2000), namely: the duties relating to health, safety and welfare at work detailed in division one (in particular the provisions describing the duties of employers); and the related duties of division three (in particular the provisions relevant to aid for injured workers). These

regulations are made specific to issues concerned with workplace violence in the document *Violence in the workplace* (WorkCover NSW, 2002)[59].

Employee Relations Branch, NSW Department of Health (2005a, p. 36) are quite clear in their general directives to administrative staff in their document *Zero Tolerance to Violence in the NSW Health Workplace* to ensure support actions for staff in the post-assault period should, in addition to incident reporting, investigation and the subsequent implementation of risk management strategies, include the:

> provision of prompt support services including comfort and support, response to physical and personal needs [which includes the option of time out from duties]; provision of ongoing support and future follow-up as necessary; … and … the provision of outreach/follow-up for staff with specific needs.

Similarly the document *Violence in the workplace* (WorkCover NSW, 2002, p. 19) provides the general directives to employers in respect of workplace violence to:

> provide debriefing to workers; allow workers to recover (this may range from a few hours off work to much longer periods; … offer professional counselling; acknowledge incident and take steps to prevent a repeat occurrence …

The content of these policies are similar to those developed elsewhere in Australia (see, for example, Nurse Policy Branch, Victorian Government Department of Human Services [2005]) and in the UK (Noak, Wright, Sayer, Parr, Gray, Southern & Gournay (2002). Indeed the concept of *zero tolerance* appears to be an imported entity having had its origins in law enforcement services in the United States before being incorporated into health policy by UK National Health Service (Middleby-Clements & Grenyer, 2007).

[59] It should be noted that there is other related legislation such as the *Crimes Act 1900* (NSW Parliament, Act 40 of 1900) and the *Public Sector Employment and Management Act 2002* (NSW Parliament, 2002).

5.4 Some observations about the levels of support offered to patients and distressed nurses in acute mental health settings

It would appear that some nursing administrators experienced difficulty recognising the distress of the participants of the present study in the post assault period and consequently did not meet the requirements of departmental policy by offering support to the satisfaction of the participants. However it may be that this lack of recognition is influenced, at least in some cases, by the assaulted nurses' minimisation and/or suppression of the psychological impacts due to their assault. A large part of the problem of lack of recognition of participants' distress, however, was that, in most cases, administrative staff either did not appear to enquire about the participant's level of distress or only enquired about their distress during the 24 hours following the assault (at least this was the perception reported by the participants).

We might also wonder about the influence of the history of mental health nurses receiving or not receiving support from nursing administration staff within the study context upon subsequent levels of *perceived* support discerned by the participants of the present study. Indeed the phenomenon of nurses (and others) vicariously experiencing distress due to the assault of another person was explored by Hockley (2003). Although this is speculation, and there is no specific evidence amongst the data of the present study in relation to the expectation of support based upon historical precedent there are indications that levels of *perceived support* by participants may be influenced by the previous adverse experiences of colleagues.

One issue which should be mentioned at this stage is the similarity between the phenomenon of mentally ill patients not being engaged, in a therapeutic sense, by nurses in acute mental health inpatient settings (a finding from Phase One of this study) and, indeed, the phenomenon of the assaulted participants in this study who, similarly, reported that they were not sufficiently engaged by administrative staff. The findings of this study do not provide specific reasons for these phenomena or about the relationship between them if any exists. However questions must arise about whether there is a process of enculturation which has led to this apparent lack of caring as an orientating behaviour and the subsequent implications of this lack of caring.

As an extension to the questions posed above the researcher has noted that there appears to be an association between various aspects of the milieu of the acute inpatient units which were phenomena of interest in this study as well as in other studies. The apparently related phenomena are: relatively high levels of violence within the units; low levels of engagement of patients by staff; staff burnout; and subsequent levels of decreased engagement with patients by staff (referred to by Fagin, et al. [1995 p. 352] as "detached interaction"). Intuitively authors such as Arnetz and Arnetz (2001, p. 418) have proposed that the lack of time that nurses spend caring for patients has led to a situation where violence has become "… the mode of communication between patient and caregiver when normal communication is lacking:" This latter quote may serve to illustrate how the key phenomena listed above contribute to a degeneration of working conditions for nurses and, almost as a corollary, diminished living conditions for patients.

5.5 Educating stakeholders about the need for victim support following patient assaults

One venue for the dissemination of information on the potential effects of patient violence upon nursing staff is the ubiquitous aggression management program[60]. These programs have proliferated in Australia and abroad since the mid-1990s and into the current decade. However Farrell and Cubit (2005, p. 47), in their audit of management of 28 aggression programs in eight countries including Australia, Canada, Ireland, Japan, New Zealand, Switzerland, the UK, and the USA, reported that the duration and content of these programs varied widely with content typically including: causes of aggression, interpersonal skills to facilitate effective communications in order to prevent or minimise aggression, physical techniques in managing aggression (which presumably means the use of body posture and physical movement to prevent injury during assault) and the use of physical restraint techniques; risk assessment and legal issues. In the

[60] Actually there are many variants of this program including the Prevention and Management of Violence and Aggression (PMVA) programs which exist in the health service in which the present study was conducted.

discussion of their findings Farrell and Cubit (2005, p. 51) (citing Gates, et al. [1999] and Hoel, Sparks & Cooper, [2000]) stated:

> Most programs appear not to address the psychological and organizational (sic) effects associated with aggression. This is surprising since the literature suggests that the effects of aggression are wide and varied, including increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, worker's compensation, reduced job satisfaction together with recruitment and retention issues.

5.6 Providing support via peer support groups and clinical supervision

There is a history of employers and private counsellors providing some level of support for staff after they have experienced a traumatic event such as interpersonal violence (for example: Asaro, 2001; Dawson, Johnson, Kehiayan & Nyanko, 1988; Keim, 1999; Lee & Rosenthal, 1983; Sales, Baum & Shore, 1984). This tradition was initially influenced by the notion of critical incident stress debriefing (CISD)[61] (Antai-Otong, 2001; Paterson, Leadbetter & Bowie, 1999) however this practice was discontinued in NSW Health facilities due to controversies about whether the process of CISD may effectively 'pathologise' normal responses to the experience of traumatic such as denial and forgetting (Antai-Otong, 2001) and doubts as to the effectiveness of CISD in reducing distress and longer-term psychological sequelae (Adler, Litz, Castro, Suvak, Thomas, Burrell, McGurk, Wright & Bliese, 2008; Deahl, Gilhman, Thomas, Searle & Srinivasan, 1994; Matthews, 1998). This tradition of employers providing a type of first-line counselling of potentially traumatised staff was superseded by the practice of referral to EAP programs which are currently available to all employees of the NSW Department of Health in the event they are, for example, assaulted by a patient. Whilst the author concedes that there is a lack of evidence to support the continuation of CISD practices as a preventive measure for the development of post-trauma responses in recently assaulted nurses it may be contended that the withdrawal of this type of support

[61] According to Antai-Otong (2001, 129) CISD is a form of early intervention, conducted as soon as is practical after the person has experienced a traumatic event, which allows staff to "… recognize understand, resolve, and normalize (sic) their reactions."

for assaulted nurses has led to a cessation of pastoral care and, in some cases, a basis for the perception that hospital administrators are uncaring.

Another strategy to ensure the provision of support for recently assaulted staff following the experience of patient violence has been the support group. The efficacy of support groups has been explored sporadically over the past twenty years (Engel & Marsh, 1986; Fagan-Pryor, Femea, P. & Haber, 1994; Flannery, Fulton, Tausch & DeLoffi, 1991; Flannery, Hanson, Penk, Goldfinger, Pastva, & Navon, 1998; Lanza, Demaio & Benedict, 2005). Engel and Marsh (1986, p. 162) reported on the impediments to recruiting assaulted staff to such programs which included the propensity of assaulted health professionals to deny or downplay the extent of their post-assault distress and perceptions by the assaulted health professional that: work-related violence is just part of the job; they do not have rights in the workplace; reporting and acknowledging victim status may diminish their sense of control in the workplace; workplace assault by a patient may cause her/his competency as a health professional to be questioned; admitting to a victim status may lead to a perception by others that they lack professional competence; and disapproval from peers. The most recent addition to these programs has been the support group model instigated by Lanza et. al. (2005) which contained a curriculum including: introductory material and sharing of assault experiences; information on victim responses from past studies and the current group members; analysis of the assault experience for the group members; exploring participants' relationships with patients in the post assault period; exploring participants' relationships with co-workers in the post assault period; exploring participants' relationships with significant family members in the post assault period; the role and significance of blame placement post-assault; role conflicts experienced by participants in the post-assault period; interventions to relieve distress reported by participants; strategies aimed at enhancing coping strategies for participants; and developing personal plans for further personal development of participants.

Despite the existence of these programs there is a dearth of hard evidence which indicates that they have provided assaulted staff with any relief from their symptoms of distress. Indeed most of the reported evidence in these studies has been anecdotal. For example Lanza et. al. (2005, p. 658) reported, in respect of the participants in their

study, "… that they felt 'better' and that it was good to have a place to go to where they didn't feel 'different'".

The strategy for supporting staff and improving outcomes for consumers in mental health settings which has most currency at the moment is clinical supervision. According to Rice, Cullen, McKenna, Kelly, Keeney & Richey (2007, p. 517) clinical supervision is both "… a framework and a process whereby a clinical practitioner (supervisee) has the opportunity to meet regularly with an experienced colleague (supervisor) and discuss issues of relevance to their practice." Moreover Hawkins and Shohet (1989) suggested that a purpose of clinical supervision was to engage and empower the supervisee whilst Inskip and Proctor (1993, cited in Howard, 2008) defined three broad functions of clinical supervision as: "formative", which refers to the supervisee's learning and development during supervision sessions; "normative", which refers to the supervisee's capacity to reflect upon ethical and professional considerations; and "restorative", which refers to the capacity for clinical supervision to provide support for the supervisee in respect of the emotional effects of work. Storey and Minto (2000) emphasised that the focus of this endeavour should not be upon the monitoring or surveillance of healthcare staff: a practice which is echoed in the litany of poor supervisory outcomes outlined by Grant and Townend (2007) in their study of mental health nurse managers whose clinical supervision was provided by their workplace managers. Moreover Butterworth (2001, in Rice at al., 2007, p. 517) commented that patients were amongst the main beneficiaries of clinical supervision because the main aim of the supervisory process was to "… support and develop the professionals offering care to them."

There are several models for clinical supervision and, as Rizzo (2003, p. 136) has observed, "… clinical supervision can mean different things to various organizations (sic) and the people they employ." Accordingly Cleary and Freeman (2005, p. 490-491) explored various formats of clinical supervision including: one-on-one sessions with a supervisor from the same professional background; one-on-one peer supervision; networking supervision; open and closed group supervision. Edwards, Cooper, Burnard, Hannigan, Adams, Fothergill and Coyle (2005, p. 409-410), in their study which employed a sample of community mental health nurses in Wales (UK), explored factors

which influence the quality of clinical supervision including: length of sessions, with supervision quality being optimal during sessions which lasted more than one hour; frequency of supervision, with supervision quality being optimal during sessions which were organised on at least a monthly basis; choice of supervisor, with supervision quality being optimal during sessions in which the supervisor was chosen by the supervisee; and location of supervision sessions, with supervision quality being optimal for sessions which were held away from the workplace.

A variety of studies appear to indicate that clinical supervision can result in improved outcomes for mental health consumers due to: specific improvements in the nurse-patient the therapeutic relationship (Storey & Minto, 2000); generally improved nursing standards (Edwards, et al., 2005); as well as educational benefits for nurses and subsequent symptom reduction for patients (Bradshaw, Butterworth & Mairs (2007). Investigations into the association between stress levels experienced by nurses and the introduction of clinical supervision have, historically, been inconclusive (Sloan & Watson, 2001). In their study, in which 21 Swedish district nurses were recruited, Palsson, Hallberg, Norberg, and Bjorvell (1996) found no change to the nurses' levels of burnout following the introduction of clinical supervision whilst other studies appear to show an association between the practice of clinical supervision and reductions in work-related stress reported by nurses (for example: Butterworth, Jeacock, Clements, Carson & White, 1997).

Despite the instances of research mentioned above the relationship between clinical supervision and the work-related stress experienced by nurses has not often been explored by researchers. Further, it would appear that the 'measurement' of *work-related stress* is difficult because of the many factors which contribute to this phenomenon. These complexities have been exposed to some extent by studies conducted by Berg and Hallberg (1999) and Teasdale, Brocklehurst and Thom (2001). In their one-year study of 22 general psychiatric ward nursing staff Berg and Hallberg (1999) adopted a pre- and post-test design to measure facets of nurse behaviour, including creativity, work-related strain and satisfaction with the type of nursing care that they had delivered to patients during a period in which clinical supervision and a program of individualised patient care were introduced. The study appeared to show that

the introduction of clinical supervision was related to a greater sense of teamwork (referred to as coherence by Berg and Hallberg [1999]) amongst the nursing staff which appeared to have a buffering effect upon the work-related strain experienced by these individuals. However overall levels of workplace stress, measured by a Work-Related Strain Inventory (Revicki, May & Whitley, 1991, In Berg & Hallberg, 1999) were not changed significantly by the intervention.

In a study by Teasdale, et al. (2001) an opportunity sample of 211 qualified nurses were recruited from national health service trusts in one region in England, with comparisons being made between two groups of nurses: one receiving supervision and the other group consisting of nurses not receiving clinical supervision. Both qualitative and quantitative data were collected in this study and, in particular, three main instruments were used: a critical incident questionnaire (which asked about a recent incident discussed either in clinical supervision or in the context of an informal support group); the Maslach Burnout Inventory (Maslach & Jackson, 1981, cited in Teasdale, et al., 2001); and the Nursing in Context Questionnaire (NICQ) (Brocklehurst, 1999, cited in Teasdale, et al., 2001). No difference in levels of burnout was found between the two groups of nurses however closer inspection of the data (Teasdale, et al., 2001, p.223) revealed that receiving clinical supervision:

> … may be associated with higher levels of perceived support. Particularly for hospital-based nurses of lower grades and receiving supervision from line managers. Whilst the evidence from these associations must remain tentative in view of the limited validation of the new NICQ, further independent data … lend support to these results.

6. CONCLUSION

It is clear that the experience of assault is unpleasant for victims, with implications for not only their emotional well-being but also their ability to perform their jobs. Participants reported distancing themselves from patients after their assault which is consistent with the avoidant phenomena often associated with the reactions of victims after a traumatic event. In particular, participants also reported phenomena associated with the suppression of thoughts and feelings related to their assault which was a part of

a suite of passive reactions to their experience. Further, participants developed the perception that they were not supported by nursing administrative staff.

Some general observations can be made about the participants' responses to assault and the environment in which they work. Firstly, the findings from Phase One of this study described a milieu where nurses were responsive to the needs of others but did not engage pro-actively in problem-solving and therapeutically engaging with their patients. Further, the nurses were significantly engaged in activities aimed at facilitating the smooth running of the institution in which they worked. Nurses working in this sort of milieu may be retarded in their efforts to actively problem-solve and 'work through' their own personal emotional turmoil, post-assault, because of their passivity. Secondly, nursing staff in management positions may have been, or were at least perceived to be, unaware of the responses of the nurse victims of assault which caused a reported exacerbation of the nurses' responses post-assault. Given the reported perceptions of participants in the present study and elsewhere, it would appear that nursing administration staff members have much to do in order to address this problem.

There are directions, provided by the current policy and by the literature, about remedies for nurses who are assaulted in their workplace. There are policy directions about the provision of education and support for mental health nurses either in general forums (such as management of aggression programs) and in the event that they require post-assault counselling. The literature also provides clear indications about the need for improved workplace culture that is both supportive and *perceived* to be supportive by all staff members and the important buffering effect that this can have for people who have been assaulted. However there are some difficulties to overcome in respect of the assaulted nurse who is experiencing distress. This study and others have explored the propensity of assaulted staff to suppress and minimise the extent of their distress and this can make it difficult to identify those nurses most in need of support and services. Moreover the benefit of offering support groups or clinical supervision, or a combination of the two, to assaulted nurses remains unclear.

In the next chapter the author will summarise findings from the present study prior to discussing the limitations of the study. A discussion concerning the significance of the

study findings will precede suggestions for nursing practice and recommendations for future research.

CHAPTER SEVEN

FINAL DISCUSSION AND CONCLUSION

1. INTRODUCTION

The main aim of this chapter is to draw conclusions relevant to the findings from this study. The chapter begins with a summary of the major findings followed by a discussion of the limitations of the study which have the potential to modify the extent to which the findings might be considered a valid reflection of the study contexts and the experiences of participants. The significance of the study is then considered relative to current knowledge about the responses of mental health nurses who have been assaulted by their patients and in terms of the theory of personal trauma and PTSD. Suggestions for practice are then discussed followed by recommendations for future research. The chapter ends with some concluding comments.

2. A SUMMARY OF FINDINGS

The study was conducted in the inpatient units of a regional mental health facility in NSW Australia. Data from Phase One of the study revealed a workplace milieu in which the inpatient mental health nurses struggled with the twin imperatives to keep order in a chaotic work environment and to constantly respond to the needs of others in an ad hoc manner. It was hypothesised that the preoccupation of the nurses with these imperatives restricted their capacity to engage therapeutically in planned activities with patients thus limiting the ability of the nurses to fulfil their professional role. This hypothesis was found to have strong support in the related literature.

Five of the inpatient mental health nurses who became participants during Phase Two this study reported only mild discomfort, with responses to their assault lasting several hours after they had been assaulted by a patient, whilst two participants reported mild responses which lasted for up to four days. In contrast nine participants reported strong reactions to their experience of assault and commenced a process of recovery, lasting from several weeks to months, marked by two distinct phases which were labelled *churning anxiety* and *reintegration*.

Features of the churning anxiety phase were: assault reminders including ongoing distress related to fear of the assaultive patient and intrusive thoughts about the assault; passive coping behaviours, including passive management strategies for personal emotions (such as minimising the importance of the assault or not thinking about it) and passive patient management strategies (such as keeping a distance from patients or not engaging with them). Participants who reported the perception that they had received 'adequate' support from colleagues during the post-assault period said that this experience helped to alleviate their distress whilst those who reported the perception that colleagues were not supportive, especially nursing administrators, reported an exacerbation of their distress. In addition the churning anxiety phase appeared to be marked by a sense of futility related to the participants' continued expectation of being assaulted as well as the perception that nursing administrative staff had not acknowledged their distress. It was hypothesised that PTSD theory is a useful vehicle for analysing behaviours reported by participants such as the minimisation and suppression of psychological reactions. An example of the suppression of post-assault responses in the present study can be seen in the four participants who reported that they were 'over' the effects of their assault at interview two before realising that they had underestimated the duration of their reactions to their assault by several weeks at interview three. It was also hypothesised that participants may have experienced temporary cognitive impairment after their assault to the extent that they were unable to effectively problem-solve and were thus compromised in their capacity to find more effective ways to respond to their personal distress.

The reintegration phase marked a departure from the passive coping strategies which were a feature of the earlier phase of recovery. Participants in this phase of recovery reported adopting active strategies in the management of their professional lives including active patient management strategies (such as being more assertive with their patients) and actively managing safety concerns (such as participating in work safety programs and considering a new, and safer, job). Participants also reported a residual vulnerability, particularly in relation to the presence of aggressive patients, and an ongoing sense of futility related to their concerns about administrative staff with participants reporting perceptions that workplace safety was being ignored by the latter.

Ultimately the researcher set out to answer the questions: *What is the process of response of mental health nurses who have experienced assaults by their patients?*; and *What is the effect of recent (patient initiated) assault upon the ability of the mental health nurse to engage therapeutically with his/her patients?* Findings from this study provide a contribution to the understanding of the process of response of mental health nurses via the theory of assaulted nurses moving from passive to active coping strategies and the emergence of churning anxiety and reintegration phases of recovery. It also emerged that, in the process of moving through these stages of recovery, assaulted mental health nurses employ coping strategies which diminish their capacity to engage therapeutically with their patients.

3. LIMITATIONS OF THE STUDY

There are several factors which must be considered as limitations of the present study and, by extension, caveats to the acceptance of the findings as credible, plausible and trustworthy (Glaser & Strauss, 1967, p. 223). Firstly there are a set of factors which relate to the inexperience of the researcher as well as factors which are potentially inherent in the grounded theory method which must be considered. It is true, for example, that the author has limited experience in conducting research using grounded theory methodology. All efforts were made to ensure methodological thoroughness, however, and the researcher had access to more experienced researchers as supervisors. Moreover all aspects of the project were not only subject to the scrutiny of supervisors but also by delegates at various local and international conferences, and the feedback from these sources was taken into account as the project progressed towards completion.

It should also be acknowledged that the researcher chose the study contexts: where to conduct Phase One observations; and where to recruit participants for Phase Two (interview phase of the study); and that these decisions may have been made in a biased way (Hall & Callery, 2001). Moreover as Charmaz (1990) and Canales and Bowers (2001) observed, the researcher may also have introduced bias based upon the types of interview questions employed as well as the way in which codes and categories were attributed to the study data. As has already been acknowledged the researcher is an experienced mental health nurse who has worked as a registered nurse within the study contexts and so forms of bias may have been introduced due to a lack of objectivity and

an over familiarity with the study context. As a counter to this possibility of bias, however, it should be noted that the researcher attempted to foresee sources of bias before the beginning of the study. Processes within the data analysis process, including journal writing, memoing and discussions with the study supervisor, also helped in the minimisation of researcher bias. Moreover participants were provided with summaries of the researcher's impressions of the data as well as transcripts of their own data during the subsequent stages of the (Phase Two) interview process and asked for their opinions on the accuracy of this information and, indeed, upon the way that the researcher interpreted their responses to their experience of assault by a patient. The findings from this study were also compared with the findings from previous studies during the review of the literature into the responses of mental health nurses to the experience of patient assault with the result that there was a considerable amount of congruence.

Further challenges to the acceptance of the study findings may arise from the limited scope of the study. The study was conducted in a small part of a mental health service, within a much larger area health service in NSW, Australia, with a small group of participants and so caution must be exercised regarding the transferability and applicability of the findings (Denzin & Lincoln, 2005). However, whilst the researcher was limited in the capacity to employ theoretical sampling (due mainly to the small number of participants who volunteered to participate in Phase Two of the study), the sample size was largely determined on the basis of data saturation, which contributed significantly to the eventual generation of a theory which is grounded in the data (Jeon, 2004).

Another aspect related to the limited scope of the study concerns the limited time frame over which Phase Two data was collected and the apparent linearity of responses suggested by the study findings. Whilst it appears that symptoms of distress associated with churning anxiety were followed by the renewal of the reintegration phase, on a trajectory of recovery, it may be the case that participants moved on to another phase of recovery or, indeed, reverted to the churning phase beyond the timeframe of this study (i.e. beyond the six months in which interviews were conducted).

Other limitations related to the scope of the study are associated with the small and homogeneous pool of study participants, particularly in respect of Phase Two. Whilst a

sample of recently assaulted nurses who worked on the mental health inpatient units was recruited it is true that subsequent data also implicated work colleagues (who may or may not have been perceived by participants as supportive) and nursing administrators (who were generally perceived by participants as unsupportive). Since the concept of collegial support appeared to be an important determinant of recovery by recently assaulted nurses, the inclusion of these significant others from the work environment as participants in this study may have provided a useful source of alternative data.

Another potential limitation of the present study also relates to the Phase Two study participants, many of whom described a past major episode in which they were assaulted by a patient. It should be noted that all but one of the participants reported that they had fully recovered from previous assaults and none had reported experiencing a recent serious assault. It is true, however, that Anne (participant 008) reported that:

> [C:.. . Just to paraphrase .. you're saying … that, clearly you're responding to this assault
>
> A: Yeah
>
> C: But you think this has awakened feelings from past incidents as well?]
>
> A: I think (the experience of this assault) also brings back those memories of previous times. I think when the things like the fear of, fear of other patients and things …I think that's just a general anxiety about …being assaulted in general because of, because you know its not just this one person, it has happened before.

Whilst the researcher is confident that the study participants were genuine in saying that the post-assault responses reported for the purposes of this study were associated with their recent assault it cannot be discounted that they were re-experiencing responses to a previous assault(s) but lacked awareness of this re-experiencing. Further, whilst the researcher found no evidence that the participants were experiencing PTSD during the time of the present study, the possibility that they had previously experienced PTSD, or at the very least significant trauma, cannot be discounted.

An additional limitation relates specifically to the finding that participants who reported symptoms consistent with ongoing futility during the reintegration phase of recovery. As

identified in the previous chapter (see page 153) it is difficult to discern how much of the reported futility was actually due to the participants' experience of assault and what components of ongoing futility might have been associated with the experience of other nurses who have been assaulted or, alternatively, prior levels of workplace fatigue or 'burnout'.

4. SIGNIFICANCE OF THE FINDINGS

The findings from the present study confirm much of what is already known about how the activities of acute inpatient mental health nurses are shaped by their workplace milieu and how mental health nurses respond to the experience of assault. The major contributions of the present study lie in the emergence of a theory about the stages of recovery from assault and the related implications for the assaulted nurse's capacity to engage effectively in patient care.

In respect of the post-assault responses of mental health nurses, other researchers (Collins, 1996; Lanza, 1983; Ryan & Poster, 1989) reported post-assault responses by participants, similar to the responses categorised in the churning phase of recovery in the present study, which were consistent with symptoms associated with PTSD including: suppression of thoughts related to the traumatic event; and re-experiencing of that event. According to the literature these symptoms may also occur in conjunction with a degree of cognitive impairment and, in particular, diminished problem-solving abilities (Lanza, 1983; Ryan & Poster, 1989; Wykes & Whitington, 1991). Whilst other studies reported symptoms consistent with cognitive reappraisal (e.g. Collins, 1996) the findings from the present study indicated that cognitive reappraisal was particularly consistent with the reintegration phase of recovery (exemplified by decisions to actively manage patient behaviours and actively manage the perceived dangers in the work environment by acting on perceived safety concerns and considering a change in employment).

A common factor in much of the literature on human responses to traumatic events reviewed in this thesis is that it is pathology-focused and concerned with describing aspects of psychological distress and, in many cases, ongoing dysfunction. In much of this body of literature signs of recovery tend to be couched in terms of lack of

pathology. The present study, because of the prospective approach to data collection, implicates the change in responses from the *churning phase* to the *reintegration phase* as an indicator of recovery. The researcher should pause, at this point, to acknowledge the fact that Collins (1996) described the categories: *redefining self* and *new world order* -which marked a period of adjustment in the participant's life post-assault where they were able to resolve to feel less vulnerable to future assaults by a patient. However the retrospectivity of the Collins (1996) study imposed limitations on that researcher's capacity to delineate these phases within the chronological period of recovery and also discuss whether the phenomena associated with these categories overlapped with other events.

It can be argued that the findings of the present study are an authentic reflection of the responses of assaulted nurses. Moreover it may be possible to firstly develop tools which may be used to identify the development of the symptoms of initial distress marked by churning anxiety and, further, identify signs of recovery associated with the reintegration phase. In addition it is probable that remedies might be made available to victims of patient assault consistent with their phase of recovery. These remedies may also present benefits in terms of improved teamwork and morale within mental health units as well as the retention of staff employed in these units. Ultimately, improved outcomes for assaulted mental health nurses may have benefits for the nurse patient relationship and, as a consequence, consumers of mental health inpatient services.

5. HOW COULD THINGS BE DIFFERENT? SUGGESTIONS FOR PRACTICE

The workplace milieu and professional difficulties experienced by the study participants who experienced *churning anxiety* and *reintegration* following their assault by a patient might be summarised as: variable degrees of insight into their own distress following their assault; varying degrees of support from colleagues, particularly nursing administration staff; and the potential for diminished professional confidence and competence during the period in which they recovered from the effects of their assault. Solutions to these problems might include:

- better preparation of mental health staff in respect of the potential effects of patient assaults (including information on strategies for the recognition of post-assault distress in colleagues and the subsequent potential for professional disengagement by victims of assault);

- specific training for nursing administration staff regarding the importance of their role in the recovery of assaulted staff and also the requirement for them to engage in: pastoral care in enquiring on a more regular basis about the welfare of assaulted nurses; and the initial counselling of assaulted nurses followed by subsequent referral to more specialised support services such as EAP;

- the appointment of specific occupational health staff who might assist in the ongoing monitoring and support of assaulted nursing staff;

- the creation of support groups for assaulted nurses; and

- the option of clinical supervision for all assaulted nurses who experience distress.

5.1 Recommendations about the education of inpatient mental health nurses regarding the potential effects of patient assaults

Farrell and Cubit (2005) made a strong argument for the inclusion of information about the psychological and other costs of aggression during the course of management of aggression programs. The researcher would also argue that there is a great need to ensure the additional inclusion of information such as: what (potentially) assaulted nurses should be able to expect from their employer including support and counselling; the availability of further support and counselling via EAP; and the occupational health and safety provisions which relate to assaulted nurses being able to take time off work after they have experienced workplace violence (as per the recommendations made by WorkCover NSW [2002, p. 19]).

The provision of support by nursing administration staff is, of course, another of the WorkCover NSW (2002) recommendations. However the findings from the present study indicate that there needs to be a provision of specific education for nursing administration staff about: i). the need for improved pastoral care and enquiry about the health and levels of distress experienced by assaulted staff in the period after they have

been assaulted by a patient which should extend to a number a occasions beyond the 24 hours after the incident; and ii). recognition of staff distress (which might include more overt symptoms of distress or less obvious symptoms including disengagement from patients and the taking of periods of sick leave) and the expectation that a number of assaulted staff may attempt to suppress the psychological effects of assault and thus not identify that they are experiencing difficulties. The delivery of this sort of education might be difficult because administrative staff lead busy professional lives and several staff may temporarily occupy the role of administrator as part of a relief roster. A solution to this problem might be providing education opportunistically at meetings, by using an online learning platform, or a combination of learning situations. The role of nursing administrator in identifying and managing responsibilities *vis-à-vis* assaulted nurses might also be supported by occupational health and safety staff who are employed by the particular area health service.

An initial solution to the problem of staff distress and the associated perceived lack of support from nursing administrators might be the preparation of administrative staff as first-line counsellors of assaulted staff en-route to referral to EAP counsellors. The researcher has some reservations about the efficacy of this strategy, however, firstly because the prevailing workplace culture may well determine that nurses are reticent to share information with their managers and secondly because of the historical reticence of mental health nurses (including nursing administrative staff) to provide counselling. This reticence may be linked, as mentioned earlier, to a general reticence of mental health nurses to engage therapeutically. There is, of course, a more disturbing reason why mental health nurses, in administrative positions or otherwise, are not comfortable providing counselling for others. As Stickley (2002) found (modern) nurse training (sic) does not equip mental health nurses to engage in counselling. It may therefore be argued that the preparation and training of nursing administration staff in dealing with staff experiencing the distress of patient assault may need to include educational material related to appropriate counselling methods complimented by a change management process in order to address the problems of a milieu where nursing administration staff are not perceived as helpful and engagement and counselling are not perceived as a part of the roles of mental health nurses.

5.2 Recommendations about the provision of support groups and clinical supervision for assaulted mental health nurses

Firstly there is a dearth of hard evidence to indicate that peer support groups have provided assaulted staff with any relief from their symptoms of distress. As previously reported in Chapter Six (p. 156) most of the evidence in support of the efficacy of peers support groups appears to be anecdotal. Whilst the notion of the support group makes good sense intuitively it would seem prudent to wait until there is better evidence in respect of program efficacy until adoption recommendations are made.

It is tempting to suggest clinical supervision as a key to the resolution of problems faced by assaulted nurses. However the evidence for clinical supervision providing a forum for the reduction of work-related stress remains limited. Further, as White and Roche (2006) have opined, the mental health nursing workforce has yet to embrace clinical supervision in any systematic way in Australia and this view is supported by Grant and Townend (2007) in respect of the situation in the UK. There are several reasons for this under-adoption of clinical supervision including: the casualisation of the mental health nursing workforce (White & Roche, 2006); the uncertainties of rotating rosters and clinical demands (Cleary & Freeman, 2005); and a tardiness in the training and availability of suitable clinical supervisors (Edwards, et al., 2005).

In order to explore nurses' beliefs related to clinical supervision Cleary and Freeman (2005) conducted an ethnographic study employing a phase in which metropolitan acute-care inpatient mental health nurses from Australia were observed in their workplace settings, ten of whom were interviewed about their views on clinical supervision in a later phase of the study. According to Cleary and Freeman (2005, 498-499) participants reported a strong commitment to reflective practice however many believed that they did not require clinical supervision as they already had existing formal and informal support strategies that were more "naturalistic and easily accessible". Notwithstanding the lack of efficacy associated with clinical supervision, however, there appear to be some distinct benefits of clinical supervision in terms of the type of support *received* by nurses and, most importantly (given the findings of Kanaisky and Norris, 1992), there may be a benefit for recently assaulted nurses for whom increased levels of *perceived* support may be protective. The challenge for mental

health nursing and health administrators is to make clinical supervision an attractive option for mental health nurses and this may, once again, involve a change to the nursing culture within acute mental health settings.

6. RECOMMENDATIONS FOR FURTHER RESEARCH

This study was conducted on a small scale within one section of a large health service. Clearly the extent to which the study findings may be generalised is dependent upon validation studies. A factor which might be considered in future validation studies might include the extent to which 'current' responses of participants to the experience of assault are affected by previous experiences of assault. Moreover data might be elicited from a wider range of sources other than the assaulted mental health nurse to include work colleagues and nursing administration personnel. This broadening of the range of participants might provide information on the gap, if it exists, between perceived and actual support received by victims in the post-assault period.

As previously suggested in this chapter future studies might also consider the longer-term responses of assaulted nurses (up to one year) and the linearity of the trajectory of recovery from the distress marked by churning anxiety and reintegration. Whilst it is reasonable to hypothesise that a future assault might cause an exacerbation of distress responses it may also be the case that assaulted nurses might spontaneously revert to the churning phase, at some later point in their recovery, as a part of the recovery process not foreseen by the present study.

An important role of future research, assuming that churning and reintegration phases of recovery can be validated, might be the development of self-report instruments which have the potential to facilitate the identification of personal distress for recently assaulted nurses. Findings from the present study and others indicate that assaulted mental health nurses may minimise or suppress the extent of their distress to the point where they may effectively sabotage attempts to help them. A self-reporting tool which assists the assaulted mental health nurse to identify symptoms associated with churning anxiety may have the effect of motivating the nurse to seek help in either in the form of initial counselling by a line manager or through the EAP process.

A qualitative analysis which aims to elicit the views of nurses on what they consider would enhance the *perception* of support in the event that they were assaulted might also be a valuable avenue for future research. The literature reviewed in this thesis shows that a heightened sense of perceived support might lessen the extent of futility and distress experienced by assaulted nurses, both in the churning and reintegration phases of recovery, as well as acting as a buffer against perceptions by the assaulted nurses in respect of reduced professional competence.

A vitally important topic for future research might include the types of medium-to-long-term support that might be appropriate for the assaulted nurse who has entered the reintegration phase of recovery. Whilst the use of options such as support groups and clinical supervision for assaulted nurses appears to make sense intuitively there is, as was indicated in Chapter Six, a dearth of hard evidence for the effectiveness of either. Further research into the effectiveness of such support strategies might also consider the role, if any, of changes to the level of perceived support experienced by assaulted nurses and buffering effects which might accrue in respect of levels of personal distress reported by recently assaulted nurses as well as perceived professional competence.

Perhaps the most significant question to arise from this research relates to the toxic effects that workplace violence may create within mental health inpatient units where there appears to be a culture which alienates both staff and mental health consumers. Research into, broadly, the creation of a workplace culture which values both staff and consumers may have the benefits of providing buffering for both distressed staff and the distressed clientele that it purports to serve.

7. CONCLUDING COMMENTS

This study has provided significant information in respect of the initial research questions which related to the process of response of mental health nurses to assaults by patients as well as the effect of a recent (patient-initiated) assault upon the ability of the mental health nurse to engage therapeutically with their patients. The grounded theory method chosen for the purpose of this study has proven to be useful in the elucidation of the recovery trajectory of assaulted nurses and it would appear that nurses who experience difficulties in their journey towards recovery may experience severe

limitations in their capacity to work effectively as mental health nurses due to their compromised capacity for engagement. Whilst the major findings of this study relate to the description of the churning and reintegration phases of recovery many questions are then raised regarding the most effective options for resolving staff distress. What remains clear, however, is that these questions require resolution so that the milieu of mental health inpatient units may be improved for all of its inhabitants.

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Appendix A: Demographic data form

Office use only

DEMOGRAPHIC DATA FORM

Instruction: ***Please answer these questions or circle the appropriate response category.***

A. Personal Details:

1. Sex: a. Male b. female	**2. Age:** a. 20-25 f. 46-50 b. 26-30 g. 51-55 c. 31-35 h. over 56 years. d. 36-40 e. 41-45

B. Employment Details:

1. Position: a. Enrolled Nurse b. Registered Nurse c. Clinical Nurse Specialist d. Nursing Unit Manager e. Assistant Director of Nursing f. Other _____	**2. Nursing Experience** (in years): a. 0-5 b. 6-10 c. 11-15 d. 16-20 e. 21-25 f. Over 25 years.
3. Number of years of Mental Health Nursing experience: a. 0-5 b. 6-10 c. 11-15 d. 16-20 e. 21-25 f. Over 25 years	

Office use only

Instruction: ***Please answer these questions or circle the appropriate response category.***

C. Educational Background:

Your qualifications include:

	Year(s) Obtained
a. Single Nursing Certificate	_____
b. Multiple Nursing Certificates	_____
c. Diploma	_____
d. Bachelors Degree	_____
e. Masters Degree	_____

f. Other (please state) _____

_____

D. Number of previous assaults by patients:

a. none	b. 1 - 3	c. 4 – 9
d. 10 – 14	e. 15-19	f. 20-24
g. 25-29	h. 30-34	i. 35-39
j. 40-44	k. 45-49	l. over 50

Office use only

Directions: Please answer these questions or circle the appropriate response category.

E. Details of the Assault:

1. Date of the assault: _____

2. Nature of the assault:

* I was:	a. punched	b. slapped	c. pushed	d. kicked
	e. head butted	f. attacked with a weapon		
	g. other _____			
* Injury sustained:	a. nil apparent	b. bruising	c. laceration(s)	
	d. strain	e. sprain	f. broken bone(s)	
	g. psychological trauma			
	h. Other_____			
* Location of injury:	a. head	b. neck	c. shoulder(s)	
	d. arm(s)	e. hand(s)	f. upper torso	
	g. lower torso	h. leg(s)	i. feet	
* My assailant was:	a. male	b. female		

3. Level of threat experienced during the assault:

a. Severe b. Moderate c. Mild d. Nil

4. Did you report the assault? a. Yes b. No

5. Did you require time off work? a. Yes b. No

6. How much time off work did you require? _____

Are there any further details that you wish to add? _____

_____

Appendix B: Patient assault response questionnaire

Office use only

PATIENT ASSAULT RESPONSE QUESTIONNAIRE

Section A- <u>Emotional Responses</u>

Directions: Please circle the number under the heading that best indicates the degree to which you experienced each of these feelings **<u>within 3 weeks</u>** following the assault.

	None	Slight	Moderate	Fairly Intense	Severe
1. Sadness	1	2	3	4	5
2. Depression	1	2	3	4	5
3. Anger	1	2	3	4	5
4. Anxiety	1	2	3	4	5
5. "In a state of shock"	1	2	3	4	5
6. I feel I should have done something to prevent the assault	1	2	3	4	5
7. Guilt	1	2	3	4	5
8. Fear of being alone	1	2	3	4	5
9. Helplessness	1	2	3	4	5
10. Loss of control	1	2	3	4	5
11. Shame	1	2	3	4	5
12. Apathy	1	2	3	4	5
13. Feeling of heaviness	1	2	3	4	5
14. Increased irritability	1	2	3	4	5
15. Feeling of loss	1	2	3	4	5
16. Fear of returning to the scene of the assault	1	2	3	4	5
17. Feeling sorry for the patient who assaulted you	1	2	3	4	5
18. Withdrawal	1	2	3	4	5
19. Decreased ability to feel emotions of any type.	1	2	3	4	5

<u>Others (specify)</u> _____

Office use only

Section B- <u>Biophysiological Responses</u>

Directions: Please circle the number that best represents the degree to which you experienced each of these reactions **<u>within three weeks</u>** following the assault.

	None	Slight	Moderate	Fairly Intense	Severe
1. Easier to fall asleep	1	2	3	4	5
2. Difficulty falling asleep	1	2	3	4	5
3. Awakening at night	1	2	3	4	5
4. Loss of appetite	1	2	3	4	5
5. Increased appetite	1	2	3	4	5
6. Constipation	1	2	3	4	5
7. Diarrhoea	1	2	3	4	5
8. Rapid breathing	1	2	3	4	5
9. Body tension	1	2	3	4	5
10. Increased awareness in the body area assaulted	1	2	3	4	5
11. Headaches	1	2	3	4	5
12. Nausea	1	2	3	4	5
13. Dizziness	1	2	3	4	5
14. Crying spells	1	2	3	4	5
15. Assault-related dreams	1	2	3	4	5
16. Nightmares related to the assault	1	2	3	4	5
17. Hyperalertness/exaggerated startle response	1	2	3	4	5

<u>Others (specify)</u> _____

Office use only

Section C- <u>Cognitive Responses</u>

Directions: Please circle the number under the heading that best describes the degree to which you experienced each of these thoughts **<u>within three weeks</u>** following the assault.

	None	Slight	Moderate	Fairly Intense	Severe
1. Doubting self worth	1	2	3	4	5
2. Disbelief that the assault had occurred	1	2	3	4	5
3. Blaming yourself for the assault	1	2	3	4	5
4. Memory impairment	1	2	3	4	5
5. Difficulty concentrating	1	2	3	4	5
6. Recurrent and intrusive thoughts of the assault	1	2	3	4	5
7. Difficulty completing tasks	1	2	3	4	5
8. Sudden acting or feeling as if the assault were recurring	1	2	3	4	5

<u>Others (specify)</u> _____

_____

_____

_____

_____

Office use only

Section D- <u>Social Responses</u>

Directions: Please circle the number under the heading that best describes your behaviour for each item **<u>within three weeks</u>** following the assault.

	None	Slight	Moderate	Fairly Intense	Severe
1. Change in relationship with spouse/partner	1	2	3	4	5
2. Change in relationship with children/family	1	2	3	4	5
3. Change in relationship with friends outside of work	1	2	3	4	5
4. Change in relationships with co-workers	1	2	3	4	5
5. Difficulty returning to work	1	2	3	4	5
6. Not wanting to leave your home	1	2	3	4	5
7. Fear of patient who assaulted you	1	2	3	4	5
8. Fear of other patients	1	2	3	4	5
9. Fear of strangers	1	2	3	4	5
10. Fear of all other people	1	2	3	4	5
11. Increased dependency on others	1	2	3	4	5
12. Decreased interest in previously enjoyed activities	1	2	3	4	5
13. Avoidance of activities that arouse thoughts of the assault	1	2	3	4	5

Others (please specify) _____

_____

_____

The Patient Assault Response Questionnaire was developed by Ryan and Poster (1989).

Appendix C: Perceived stress scale

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Directions: *The questions in this scale ask you about your feelings and thoughts during the month prior to your assault. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.*

For each question circle the number which best applies:

		Never	**Almost Never**	**Some-times**	**Fairly Often**	**Very Often**
1	In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2	In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3	In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4	In the last month, how often have you dealt successfully with irritating life hassles?	0	1	2	3	4
5	In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?	0	1	2	3	4
6	In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
7	In the last month, how often have you felt that things were going your way?	0	1	2	3	4
8	In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4

9	In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
10	In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
11	In the last month, how often have you been angered because of things that happened that were outside of your control?	0	1	2	3	4
12	In the last month, how often have you found yourself thinking about things that you have to accomplish?	0	1	2	3	4
13	In the last month, how often have you been able to control the way you spend your time?	0	1	2	3	4
14	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

15. Of the events in your life that influenced your responses to the previous 14 questions, please estimate the extent to which they are work-related.

(i) none

(ii) 1 - 25%

(iii) 26 - 50%

(iv) 51 - 75%

(v) 76 - 100%

THANKYOU FOR YOUR PARTICIPATION IN THIS RESEARCH PROJECT.

The perceived stress scale was developed by Cohen, S., Kamarck, T. and Mermelstein, R. (1983).

Appendix D: Information sheet (Phase One)

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INFORMATION SHEET - Participant's Copy: Observation of nurses in a mental health unit (Phase One)

Dear Colleague,

My name is Charles Harmon and I am currently conducting a research project titled ***The process of response of mental health nurses to assaults by patients*** as part of my PhD studies with the School of Nursing and Midwifery at the University of Newcastle. The Project Supervisor is Professor Michael Hazelton who is a Professor of Mental Health Nursing. As the title suggests, the main purpose of this study is to determine patterns in the responses of nurses to assaults by patients but the researcher is also interested in the way that the experience of assault affects the capacity of nurses to engage with their patients. It is anticipated that the findings of the study will contribute to better defining the nature and extent of nurse reactions for employer and rehabilitation organisations as well as informing service provision, e.g. Post-assault counselling and follow-up services, for victims. This study has met with the approval of the Area Health and University Ethics Committees.

Mental health nurses who work in public-sector psychiatric in-patient units are invited to participate in this phase of the study in which the researcher wishes to observe nurses working in their normal environment. All participants are asked to sign the attached consent form prior to being observed. The purpose of this observation is to obtain information about:

i) The physical environment in which nurses work;

ii) The social milieu in which nurses work; &

iii) How nurses deal with difficult situations in which patients may become agitated, argumentative, demanding or aggressive.

The researcher proposes to observe nurses and also to take notes, draw diagrams that depict social interactions and prepare diagrams that depict the unit environment. Please note that participation in the above activities is voluntary and people who decline to participate in this phase of the study can do so without fear of any penalty. Prior to the commencement of each 'shift' when observation is planned, the nurses working the shift will be asked for their permission for observation to occur. Observation will not occur in the event that a nurse does not give her/his permission. Additionally, a sign will advise patients and visitors that research is being conducted.

All data that accrues from this research project may, potentially, be used in the final PhD thesis either in the form of general descriptions, direct quotations or summary tables of statistics. To ensure confidentiality, no names of staff-members, patients or patients' relatives will be recorded on any data sheets or in the final PhD thesis. Instead, all people will be referred to using pseudonyms. All data resulting from this phase of the study will be stored in a locked cabinet at the School of Nursing and Midwifery. Following data analysis all data will be stored securely at the University for a period of five years before they are destroyed. The thesis and any resulting publication will present grouped data only and will not identify individuals.

Participants may withdraw from the research project at any time without having to provide a reason and may ask to review or reclaim any data that they have provided. Further, a person's decision not to participate or to withdraw from this study will not affect their relationship status as an employee of the Hunter Area Health Service or their relationship with any personnel or services provided by the University of Newcastle. None of the data obtained will be available to employers or anyone else except the researchers and you other than in accordance with requirements of the law.

Participants who agree to participate in this phase of the study should be aware that during the periods of observation their actions and comments could be recorded in detail. Those intending to be involved in the study are advised that in the event that participants are observed engaging in behaviours that are unethical or potentially illegal (such as harming a patient), it may be necessary for the researcher to report such details to the appropriate authorities.

Yours sincerely,

(Charles Harmon, RN, BHS, MN) (Professor Michael Hazelton, RN, MA, PhD).

Appendix E: Consent form (Phase One)

School of Nursing and Midwifery

University of Newcastle

University Drive Callaghan 2308

Charles Harmon

Tele: (02) 49 2162324

Charles.Harmon@newcastle.edu.au

Professor Michael Hazelton

Tele: (02) 4921 6770

FAX: (02) 4921 7069

Michael.Hazelton@newcastle.edu.au

CONSENT FORM- Observation of nurses in a mental health unit (Phase One)

I agree to participate in the observation phase of the project The Responses of Mental Health Nurses to assaults by patients and I give my consent freely. I understand that the study will be carried out as described in the information statement a copy of which I have retained. I realise that whether or not I decide to participate my decision will not affect my status as an employee of Hunter Mental Health Services. I also realise that I can withdraw from the study at any time and do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signature _____ Date: _____

Appendix F: Advertisement (Phase One)

School of Nursing and Midwifery

University Drive Callaghan NSW 2308

Charles Harmon

Tele: (02) 4921 62324

Charles.Harmon@newcastle.edu.au

Professor Michael Hazelton

Tele: (02) 4921 6770

Michael.Hazelton@newcastle.edu.au

ADVERTISEMENT: ATTENTION ALL PATIENTS AND VISITORS

My name is Charles Harmon and I am a PhD student with the School of Nursing and Midwifery at the University of Newcastle. I am currently conducting a research project with Professor Michael Hazelton as the chief Investigator.

PLEASE BE AWARE THAT RESEARCH IS CURRENTLY BEING CONDUCTED AT THIS MENTAL HEALTH FACILITY IN WHICH NURSES WILL BE OBSERVED INTERACTING WITH PATIENTS.

The purpose of this observation is to obtain information about:

i) The physical environment in which nurses work;

ii) The social situation in which nurses work; &

iii) How nurses interact with their patients.

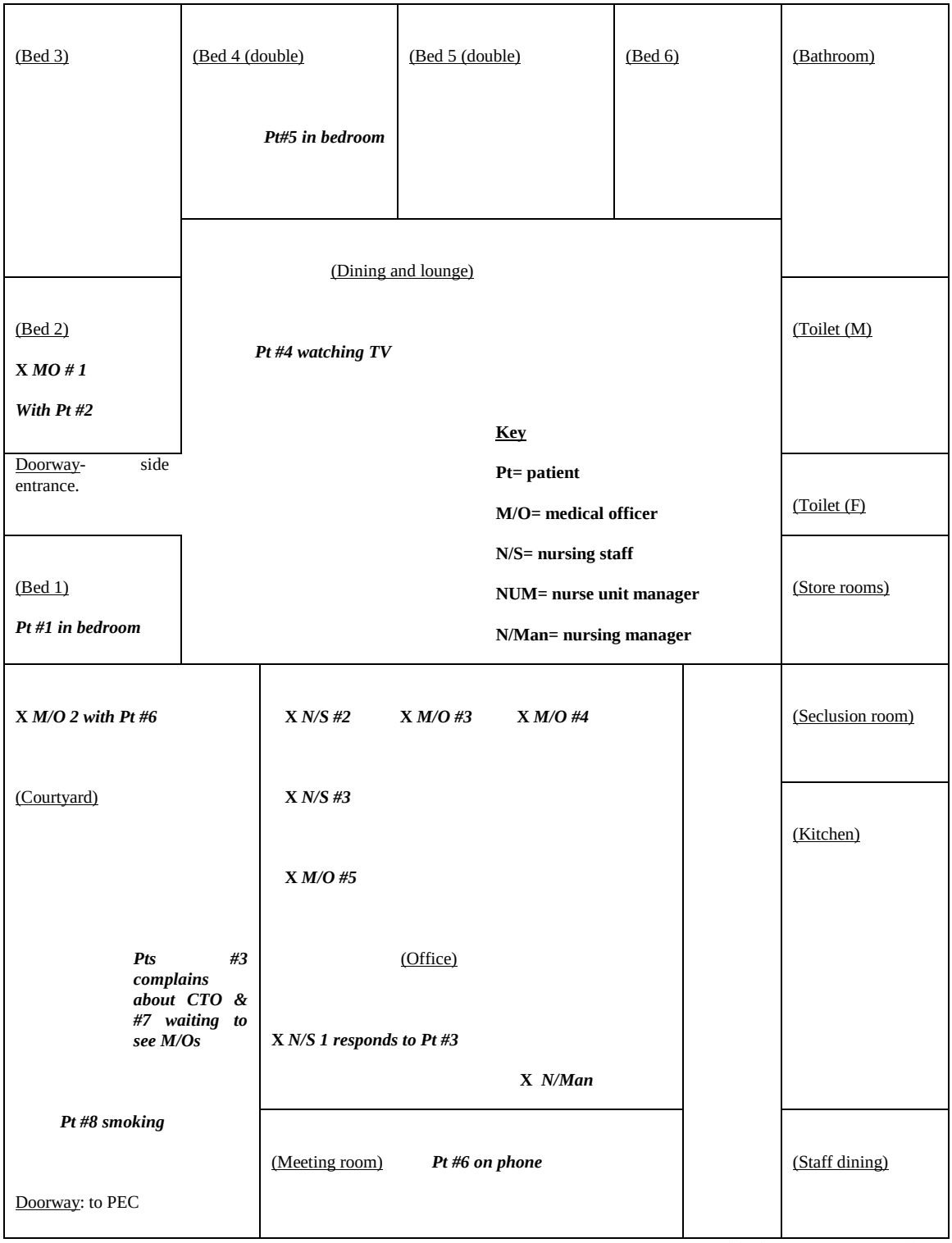
The observations will be conducted in public areas only and not in bedrooms and bathrooms.

Involvement in the observations is voluntary. Should you not wish to be involved please notify the researcher who will either ensure you are not included, or cease the observation.

ADDITIONAL INFORMATION*:* Any further questions may be directed to Charles Harmon or Professor Michael Hazelton.

Appendix G: Example of sociogram

EXAMPLE OF SOCIOGRAM DEPICTING ACTIVITY ON UNIT A1: MONDAY DECEMBER 16TH 2002- 0900 hours (Phase One)



Doorway- to 'airlock', store rooms, staff toilets & main entrance.

Appendix H: Advertisement (Phase Two)

School of Nursing & Midwifery

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Professor Michael Hazelton

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Michael.Hazelton@newcastle.edu.au

ADVERTISEMENT: DETAILS OF RESEARCH PROJECT

(Phase Two)

My name is Charles Harmon and I am a PhD student with the School of Nursing and Midwifery at the University of Newcastle. I am calling for recently *assaulted nurses to participate in stage #2 of my research project that examines the effects of patient assaults upon mental health nurses. It is anticipated that the findings of this study will contribute to better defining the nature and extent of nurse reactions to assaults with the aim of subsequently improving service provision for assaulted nurses, e.g. Post-assault interventions and follow-up services, for victims. In addition, this study aims to explore the capacity of recently assaulted mental health nurses to engage therapeutically with their patients. The project supervisor is Professor Michael Hazelton.

Study procedures-

Consenting nurses will be asked to participate in an initial interview within 21 days of their assault as well as two follow-up interviews at 3 months and 6 months following their assault. Recruiting of people into the study will occur between April 2003 and the end of December 2003. Please note that: i. nurses are asked to voluntarily participate in this project and are under no obligation to do so & ii. all information will be kept confidential and secure by the researcher.

***Definition of assault-**

For the purposes of this study patient assault is defined as:

i. any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (e.g. where the nurse is verbally threatened) OR

ii. any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (e.g. where the nurse is spat upon).

Additional information:

The full title of the project is "The responses of mental health nurses to assaults by patients". All participants will receive an information letter that will provide further details about this research project. Any further questions may be directed to Charles Harmon or Professor Michael Hazelton.

Appendix I: Information sheet: participant's copy (Phase Two)

School of Nursing and Midwifery

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Professor Michael Hazelton

Tele: (02) 4921 6770

Michael.Hazelton@newcastle.edu.au

INFORMATION SHEET- Participant's Copy- Initial interview

Dear Colleague,

My name is Charles Harmon and I am currently conducting a research project titled *The process of response of mental health nurses to assaults by patients* as part of my PhD studies with the School of Nursing and Midwifery at the University of Newcastle. The Project Supervisor is Professor Michael Hazelton who is a Professor of Mental Health Nursing. As the title suggests, the main purpose of this study is to determine patterns in the responses of nurses to assaults by patients but the researcher is also interested in the way that the experience of assault affects the capacity of nurses to engage with their patients. It is anticipated that the findings of this study will contribute to better defining the nature and extent of nurse reactions to assaults with the aim of subsequently improving service provision for assaulted nurses, e.g. Post-assault interventions and follow-up services for victims. This study has met with the approval of the Area Health and University Ethics Committees

Mental health nurses who have been assaulted by a patient in a psychiatric in-patient unit within twenty-one days prior to the current date are invited to participate in this study. For the purposes of this study patient assault is defined as i. any interaction between a nurse and a patient that results in a staff member feeling personally threatened and distressed (e.g. where the nurse is verbally threatened) OR ii. any interaction between a nurse and a patient where there is unwanted physical contact and the nurse sustains an injury (such as where the nurse is injured following a physical attack or during a restraint procedure) or where there is an exchange of body fluid (e.g. where the nurse is spat upon). All participants are asked to sign the attached consent form prior to providing information for the initial interview in which you are asked to complete three activities:

i) Providing information about yourself according to the questions asked on the *Demographic Data form*;

ii) Completing the *Patient Assault Questionnaire*; &

iii) Completing the *Perceived Stress Scale*.

These activities will be presented in the form of an interview that should take about 40 minutes to complete. More time is available to you if required. The interview will occur at a location that is convenient to you and ensures privacy. Interview rooms at either the University or at your place of work are suggested as possibilities.

It should be noted that you will be contacted in three month's time, and again in six month's time regarding your participation in subsequent interviews. These (two) later interviews will be, with your permission, audio-taped and will consist of questions about how you have coped following your assault. Participants should note that consent to provide information in the first interview in no way obligates them to participate in any other interview. During the subsequent interviews, you can expect to be asked questions such as:

"Tell me about how you have been coping following your assault."

"How has your assault affected the way in which you nurse" &

"**Have you experienced any difficulties in the way in which you relate to your patients since your assault"**

These subsequent interviews should take from 30 to 60 minutes to complete and will occur at a location that is convenient to you that ensures privacy. Interview rooms at either the University or at your place of work are suggested as possibilities. More time will be available to you if required. Please note that you can review, edit or ask the taping to cease at any time.

Participants are also advised against making incriminating disclosures (i.e. disclosing details about unethical or potentially illegal behaviour such as harming a patient) during the interviews and should note that, in the event that an incriminating disclosure is made, it may be necessary for the researcher to report such details to the appropriate authorities.

Participants may withdraw from the research project at any time without having to provide a reason and may ask to review or reclaim any data that they have provided. A person's decision not to participate or withdraw from this study will not affect their status as an employee of the Hunter Area Health Service or their relationship with any personnel or services provided by the University of Newcastle. None of the data obtained will be available to employers or anyone else except the researchers and you other than in accordance with requirements of the law.

All data that accrues from this research project may, potentially, be used in the final PhD thesis either in the form of general descriptions, direct quotations or summary tables of statistics. To ensure confidentiality your name will be substituted with a pseudonym on all data sheets and the cover sheet with your name on it will be removed and securely stored in a locked cabinet in a designated office at the School of Nursing and Midwifery. All other data will be stored separately, also in a locked cabinet at the School of Nursing and Midwifery. Following data analysis all cover sheets, demographic forms and questionnaires will be stored securely at the University for a period of five years before they are destroyed. The thesis and any resulting publication will present grouped data only and will not identify individuals.

Any Hunter Area Health staff member who becomes distressed during the interviews will be referred to their Service Manager, contactable through the Hospital "switch". If an independent counselling service is required, The Employee Assistance Program (EAP) will provide you with the names and telephone numbers of independent counsellors. EAP may be contacted by telephone on: (02) 49 212822.

yours sincerely,

(Charles Harmon, RN, BHS, MN) (Professor Michael Hazelton, RN, MA, PhD).

Please note: *The University requires that all participants are informed that if they have any complaint concerning the manner in which a research project is conducted it may be given to the researcher or the Project Supervisor, or, if an independent person is preferred, to the University's Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, 2308**,** (Tele: (02) 4921 6333). Area Health Employees may wish to direct concerns or complaints to Dr. Nicole Gerrand, Professional Officer, Hunter Area Research Ethics Committee, C/- Hunter Area Health Service, Locked Bag No. 1, New Lambton 2305, (Tele: (02) 4921 4950).*

Appendix J: Consent form (Phase Two)

School of Nursing and Midwifery

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Professor Michael Hazelton

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FAX: (02) 4921 7069

Michael.Hazelton@newcastle.edu.au

CONSENT FORM- Interviews with assaulted nurses (Phase Two)

I agree to participate in the project: The Responses of Mental Health Nurses to assaults by patients and I give my consent freely. I understand that the study will be carried out as described in the information statement a copy of which I have retained. I realise that whether or not I decide to participate my decision will not affect my status as an employee of Hunter Mental Health Services. I also realise that I can withdraw from the study at any time and do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signature _____ Date: _____

Appendix K: Example of a 'formulation' prepared prior to the second interview (Phase Two)

Interview with nurse 001 (Bruce) on Monday 15/9/03 1035- 1215 hours

Background (interview #1) Description: Nurse 001 (Bruce- a pseudonym) by a patient on 11/6/03 at around 2000 hours. The patient had been involved in a number of incidents over a period of time and had been incarcerated in the observation unit for 14 days. His behaviour was often threatening towards staff but Bruce had been able to manage him on previous occasions and he felt confident that he could manage the patient on this occasion. In his own words, Bruce had become 'a bit too confident' with the patient. The situation escalated rapidly with the patient throwing three punches: one flush onto the bridge of Bruce's nose- causing a cut and bruises after his glasses were pushed into his skin from the force of the blow. One other punch glanced off Bruce's right cheek and he was able to block a further blow to his chest. Bruce said that he just tried to get as close to the patient as possible in order to prevent the patient from " … getting a good swing at me". Assisting staff were initially prevented from entering the observation area because the patient and Bruce were blocking the door. They were, however, able to offer rapid and effective assistance and the patient was placed in seclusion.

The patient was a young male 19-20 years of age who was experiencing a psychotic episode. He had been, in Bruce's opinion, under-medicated receiving mostly Olanzapine. The patient had been angered by this medication regime angrily exclaiming that the medication was "fucking crap" and that he preferred injections (Midazolam). Nursing staff were reluctant to give injections to the patient as they were concerned that he might keep demanding more benzodiazepines. Staff were concerned, however, that the patient had been confined in unit where there was little stimulation and no-where to go to get away from the inhabitants. Bruce said that "… the environmental factors (i.e. confinement) may have contributed to the assault". Bruce was full of praise for his peers whom, he says, supported him admirably. Unfortunately, the security staff members were unable to attend the incident and it was "all over" by the time that they arrived on the scene.

After the incident, Bruce was given time to clean himself up and attend the accident and emergency unit of the hospital. Here he received first aid and attended a precautionary facial X-ray to rule out any break to the nose or eye sockets. Bruce took 1 hour off duty at the A & E before going home. Apart from the above his main reaction to the assault was anger- he said that he had a real struggle getting his anger in check so that he "… did not handle the patient roughly". He also said that he experienced anxiety when he saw patients "… winding up", i.e. escalating towards aggression. Bruce only required one hour off-duty. He attended a shift at the unit the day after his assault.

Appendix L: Example of a 'formulation' prepared prior to the third interview (Phase Two)

Interview with nurse 003 (Krystal) on 15/12/03: 1505-1545 hours.

Krystal was assaulted by a patient who was much larger that her and she experienced about 5 blows to the head a moderate level of threat. She became upset for a number of reasons due to: i. to the ferocity of the assault; ii. the poor process for readmission of the patient (the police brought the patient directly to the unit; iii. the poor procedure followed by staff –who watched the assault without offering adequate assistance and called a code 'red' instead of a code black.

Initial reactions included a wide range of responses including: Decreased ability to feel emotions of any type (severe); anger (fairly intense); anxiety, being in a state of shock, feeling like she should have done something to prevent the assault, heaviness, increased irritability, withdrawal, body tension, increased awareness in the body area assaulted, & recurrent intrusive thoughts of the assault (all at a moderate level); and sadness, loss of control, & headaches (at a slight level). Krystal also had tinitis. These responses were exacerbated by Krystal's belief that the nurse who called the code red might have been acting maliciously and her disbelief that staff had not supported her/ given her assistance to restrain the patient. She was also concerned that her reputation had been damaged because she was not called to part of the 'response team' in subsequent assaults. She was also fearful that she may be moved off her unit. 'Re-experiencing was mainly due to Krystal being upset that she was not assisted/supported by staff at the scene of her assault.

Post-assault, Krystal has had a lot to do. Principally she has organised debriefs concerning the poor procedure mentioned above. She has also organised mediation for herself and the nurse who ineptly called the 'code red'. She has only been able to do these things because she "emotionally shut down" for about 2 weeks after the assault- a protective state that she did not completely recover from for about 6 weeks but which enabled her to move toward a full recovery that she had pursued single-mindedly.

Problematically, Krystal was not able to debrief with her closest colleague because he was responding poorly himself. She also did not want to burden her children who are mental health nurses. She also works long hours which prevents her from finding outlets to discuss this matter.

Appendix M: Example of field notes from Phase One of the study

UNIT B1-OBSERVATION #1- TUESDAY JANUARY 28TH, WHOLE A-SHIFT. THIS SAMPLE OF FIELD NOTES FOR 0645-0900 HRS ONLY.

(Advertisements posted to walls in clear view of patients; identification worn.}

6 patients in observation area (obs. patients).

18 patients remainder of unit (unit patients).

At this time, there are five nurses on duty. One other nurse- a clinical co-ordinator will arrive at about 7:30 whilst a NUM will arrive at about this time. Two E shift nurses (com 12 MD) are also expected.

06 45 Commence shift @ 'handover'

Full house; patients knock on window of observation area trying to get the attention of the staff- mostly want cigarettes; one patient indicates that he wants to get access to his car.

Staff express concerns re being 1x staff member below acceptable numbers for the shift; - also the duress system is not working- and there appears to be no-one to service the computer; there is much talk in the observation area, all staff very worried re the above. (Staff on morning shift resolved- but afternoon shift staffing becomes an ongoing concern during the morning and obtaining staff becomes a time-consuming exercise).

Patient from the 'unit' seems rather desperate- wants assurances that she can get to Cessnock to get her methadone. Staff assure he that this will happen.

There have been a number of recent admissions- some suicidal others mentally disordered (mostly weekend additions to the numbers); some other patients appear to have been inappropriately admitted- should be involuntary as opposed to voluntary. This situation needs to be discussed with psychiatrist(s).

0730 Lights turned on in the observation area;

Patient returns to nurses station to remind staff of her methadone appointment- Staff reassure her once again- she looks desperate;

Clinical co-ordinator on duty- second handover occurs/ clinical review. She attempts to solve staffing problem- no luck thus far.

0750 Duress system back on line- problem is that the installer no longer owns the company- new owner still trying to figure out the system.

Patients arrive at observation area windows to make requests; mime requests as the sound-proofing is quite effective. No other way to communicate unless via staff stationed in the obs. area.

High demand for beds a problem for staff who feel that they are constantly 'juggling' admissions and discharges- sometimes discharging people who are sick and require assertive follow-up by the community team. Also a problem re getting transfers to <Campus A> who only seem to want patients on an 'exchange' basis, i.e. they want to exchange for one <Campus B> patient currently at <Unit A> who is now more settled.

Current problem with one <unit B1> male who has been aggressive; <Campus A> currently 2 over on bed numbers and will only accept this male patient on an 'exchange' basis.

0800 Staff working on patient discharges- mostly patients admitted on the (long) weekend who are now well enough to go home.

Dr#1 now on the unit; S/W#1 also on unit.

Problem- 1x afternoon shift nurse not available today; staff commence the process of acquiring extra staff.

Problems encountered with radio contact with security staff- staff can talk to security but security are not able (it seems) to talk back;

Problem due to long weekend- patients discharged prematurely on Friday (in view of some staff). It appears that some of the patients have history of aggression and other

signs of disturbed behaviour and tend to 'bounce back' – this scenario has caused concern for a number of the staff who feel that a responsible course of action has not been followed.

Patients in the obs. area keen to look at the security TV monitors perched high on the wall (near the obs. area glass but protected by a panel on the side of the monitor).

Staff sort through paperwork from the weekend, trying to sort out their tasks for the day.

(Researcher moves into obs. area-) Patients in the obs. area concerned that they are being observed by people in the nurses station–glass between nurses station and obs. unit seen as an "invasion of privacy".

0830 Drs#1 & #2 consult with Staff #5 & SW#1 re patients' progress.

(Researcher moves back into nurses station) New staff arrive at nurses station- Dr#3; Unit secretary; OT and RMO (Dr#4) as well as Dr#5 (who promptly interviews a patient).

Much activity in observation area; two patients appear to be disturbed at this time; one man (patient #1) shouts the word "Fuck" every 15 seconds or so. Man paces about the obs. area ignoring staff and seems to be very agitated. Staff try to engage the man; bring him cigarettes (cigarette rolling as therapeutic intervention). Man settles for the time being.

Patients from 'unit' try to negotiate with nurses for 'phone calls; extra cigarettes & other favours. Some very 'entitled' patients demand when a request would suffice (nurses are not ignoring or denying requests).

0900 Meeting of clinical staff in the conference room (adjacent to the nurses station)

Situation in the obs. area becomes very tense; patient #1 becomes disturbed, hits the nurses station glass and a nearby structural pillar and shouts "Fuck"; one staff member in the obs. area at the time remains at position near patient's dining table, another staff member who has momentarily left the obs. area returns to investigate and is threatened by the patient when he opens the connecting door and commences negotiations. The situation quickly escalates and patient #1 hits the nurse with a closed fist on the nose- the nurse quickly retreats behind the connecting door and the patient withdraws to the lounge chair at the far corner of the obs. area. The nurse was in the wrong place at the

wrong time –not much he could have done, however- by the time he (quickly) realised he was in danger and attempted to retreat it was too late.

The assault recorded above casts a shadow over the unit. Everyone is clearly upset.

NOTE: The atmosphere in the unit was electric. The researcher had the impression that something was going to occur. The noise in the unit increased as soon as the lights came on and the unit's occupants moved about at a frenzied rate. Much of the noise was the result of disturbed behaviour and one wonders about the relationship between this noise and the mental status of the occupants.

Two things stand out: 1. the nursing staff were principally engaged in house-keeping activities where they tended to the running of the unit rather than engagement with their patients. One wonders how much of their day actually involved engagement with individual patients and how much of their time is consumed by chores. 2. if it is the case that nurses are consumed by tasks which draw them away from direct contact with their patients –are they therefore more likely to be targets for abuse and even assault?

Appendix N: Examples of initial codes, selective codes and related theoretical codes with examples of occurrence in the data set: Phase One of the study

Codes which relate to nursing management of patients					
Unit	**Date**	**Page**	**Selective code**	**Theoretical code**	**Initial codes**
A-1	16/12	2	Nursing actions to appease patients	**Defusing crises**	
C-5	27/2	2	Nurses sorting situations before they escalate		
B-1	28/1	5	Verbal de-escalation of aggression		
B-1	18/2	12	Crisis management		
C-5	27/2	3	Safety measures to secure unit		
A-1	23/12	13	Seclusion of violent patient		
A-1	16/12	2	Organising patient's affairs	**Housekeeping**	Organising laundry; tidying up after patients have left the unit; reminding patients to do things; ordering cigarettes; ordering food; attending to meals.
B-1	28/1	2	Organising the unit		Facilitating handover; ordering/ writing memos for next shift; ordering medications; note-taking and filing; answering the telephone; running errands.
A-1	16/2	4	Assisting other health professionals		Locating medical staff; locating diagnostic equipment; completing paper work; prevention of error; gatekeeping; humour; *black* humour; staff soothing other staff.

C-5	27/2	2	Nursing actions to sooth patients	**Everyday caring**	
A-1	16/12	2	Nurses engaging patients		
C-5	27/2	5	Helping patients to manage money and belongings		
B-1	28/1	2	Providing orientation for patients		
C-5	27/2	2	Dispensing medications		
A-1	16/12	3	Physical treatments		
B-1	28/2	10	Nursing actions to counsel patients	**Therapeutic nursing**	
A-1	19/12	2	Gathering intelligence/assessment		
B-1	18/2	12	Talk of ethical concerns		
C-5	3/3	8	Positive nursing philosophy		
			Nurses planning patient care		
Other codes					
A-1	16/2	7	Inappropriate sexual overtures towards others	**Chaotic work environment**	
B-1	29/1	4	Abuse towards nurses		
C-5	27/2	9	Abuse towards other patients		
A-1	16/1	3	Undirected aggression		
C-5	3/3	10	Verbal threats directed towards nurses		
B-1	28/2	4	Physical violence directed towards nurses		
			Patient demands		
A-1	16/1	2	Patient disorganisation		Patient disorganised speech; Patient disorganised behaviour.
B-1	28/1	3	Confusion/ disorganised nurse behaviour		
A-1	16/1	5	Nurses show signs of increased stress		
			Increased tempo in the unit		
A-1	16/1	5	Increased noise in the unit		

B-1	28/1	3	Lack of privacy	**Architectural constraints**	
			Patient overcrowding		
			Overcrowding of staff office		
A-1	16/1	2	Patient requests	**Patient assertion**	
B-1	29/1	6	Patients soothing each other		
A-1	29/2	8	Refusal of medication		
			Manipulation of others		
			Patients complain of boredom		
C-5	27/2	4	Nurse stories about patient violence		

Appendix O: Examples of initial codes, selective codes and related theoretical codes with examples of occurrence in the data set: Phase Two, interview two of the study

ID	I/view	Page	Initial code	Selective code	Theoretical code
006	2	7	Fear of the assaultive patient	Assault reminders	**Churning anxiety**
012	2	2	Intrusive thoughts		
001	2	5	Wariness		
003	2	3	Shutting down	Passive personal emotions strategies (Passive coping strategies)	
005	2	5	Not thinking about the assault		
001	2	4	Minimising the importance of the assault		
001	2	11	Keeping a distance from patients	Passive patient management strategies (Passive coping strategies)	
005	2	16-17	Not engaging with patients		
012	2	15	Not disclosing personal information		
003	2	3	Peer support	Assault response mediators	
004	2	7	Lack of support from nursing administrators		
009	2	11	Support from family		
008	2	16	Constant threat of assaults	Futility	
015	2	5	Inevitability of assaults		
013	2	5	Safety concerns minimised by nursing administrators		

Appendix P: Examples of initial codes, selective codes and related theoretical codes with examples of occurrence in the data set: Phase Two, interview three of the study

ID	I/view	Page	Initial code	Selective code	Theoretical code
012	3	9	Close assessment of patients	Active patient management strategies (Active coping strategies)	**Reintegration**
005	3	4	Being more assertive with patients		
001	3	10	Pushing patients away		
012	3	10	Reading patients' notes more thoroughly	Managing safety concerns (Active coping strategies)	
011	3	11	Participating in work safety programs		
004	3	6	Considering a new job		
006	3	8	Re-encountering assaultive patient	Residual vulnerability	
005	3	7	Patient aggression reminders		
006	3	8	Constant threat of violence	Ongoing futility	
002	3	2	Inevitability of assaults		
014	3	9	Safety concerns minimised by nursing administrators		

APPENDIX Q: Table 10

Table 11: Summary of participants' responses to the assault response questionnaire (n=16)

Section A- <u>Emotional Responses</u>

	Slight	Moderate	Fairly Intense	Severe	TOTAL Responses
1. Sadness	7	1	0	0	**8**
2. Depression	2	2	0	0	**4**
3. Anger	6	2	5	1	**14**
4. Anxiety	5	8	3	0	**16**
5. "In a state of shock"	4	3	1	1	**9**
6. I feel I should have done something to prevent the assault	1	4	1	0	**6**
7. Guilt	2	2	2	1	**7**
8. Fear of being alone	0	0	0	1	**1**
9. Helplessness	3	2	0	1	**6**
10. Loss of control	4	3	1	0	**8**
11. Shame	3	1	2	0	**6**
12. Apathy	1	2	0	0	**3**
13. Feeling of heaviness	0	4	0	0	**4**
14. Increased irritability	2	4	1	0	**7**
15. Feeling of loss	3	1	0	0	**4**
16. Fear of returning to the scene of the assault	4	1	1	0	**6**
17. Feeling sorry for the patient who assaulted you	5	3	1	0	**9**
18. Withdrawal	3	1	0	0	**4**
19. Decreased ability to feel emotions of any type.	2	1	0	1	**4**
TOTAL RESPONSES	**57**	**45**	**18**	**6**	**126**

Section B- Biophysiological Responses

	Slight	Moderate	Fairly Intense	Severe	TOTAL Responses
1. Easier to fall asleep	0	0	0	0	**0**
2. Difficulty falling asleep	3	3	1	0	**7**
3. Awakening at night	1	2	1	0	**4**
4. Loss of appetite	1	0	0	0	**1**
5. Increased appetite	1	0	0	0	**1**
6. Constipation	0	0	0	0	**0**
7. Diarrhoea	0	0	0	0	**0**
8. Rapid breathing	4	2	0	0	**6**
9. Body tension	4	5	0	0	**9**
10. Increased awareness in the body area assaulted	2	4	2	0	**8**
11. Headaches	5	1	0	0	**6**
12. Nausea	0	0	0	0	**0**
13. Dizziness	1	0	0	0	**1**
14. Crying spells	1	0	0	0	**1**
15. Assault-related dreams	3	1	0	0	**4**
16. Nightmares related to the assault	1	0	0	0	**1**
17. Hyperalertness/exaggerated startle response	3	2	0	0	**5**
TOTAL RESPONSES	**30**	**20**	**4**	**0**	**54**

Section C- Cognitive Responses

	Slight	Moderate	Fairly Intense	Severe	TOTAL Responses
1. Doubting self worth	7	1	0	0	**8**
2. Disbelief that the assault had occurred	2	5	0	1	**8**
3. Blaming yourself for the assault	1	1	2	0	**4**
4. Memory impairment	2	0	0	0	**2**
5. Difficulty concentrating	3	1	0	0	**4**
6. Recurrent and intrusive thoughts of the assault	5	3	0	0	**8**
7. Difficulty completing tasks	1	1	0	0	**2**
8. Sudden acting or feeling as if the assault were recurring	0	0	0	0	**0**
TOTAL RESPONSES	**21**	**12**	**2**	**1**	**36**

Section D- Social Responses

	Slight	Moderate	Fairly Intense	Severe	TOTAL Responses
1. Change in relationship with spouse/partner	2	1	0	0	**3**
2. Change in relationship with children/family	1	1	0	0	**2**
3. Change in relationship with friends outside of work	0	1	0	0	**1**
4. Change in relationships with co-workers	3	2	0	0	**5**
5. Difficulty returning to work	2	2	0	0	**4**
6. Not wanting to leave your home	1	0	0	0	**1**
7. Fear of patient who assaulted you	2	3	2	0	**7**
8. Fear of other patients	4	2	0	0	**6**
9. Fear of strangers	2	1	0	0	**3**
10. Fear of all other people	0	0	0	0	**0**
11. Increased dependency on others	0	0	0	0	**0**
12. Decreased interest in previously enjoyed activities	0	1	0	0	**1**
13. Avoidance of activities that arouse thoughts of the assault	1	1	0	0	**2**
TOTAL RESPONSES	**18**	**15**	**2**	**0**	**35**

Total number of 'slight' responses= 126

Total number of 'moderate responses= 92

Total number of 'fairly intense responses= 26

Total number of 'severe' responses = 7

The Patient Assault Response Questionnaire was developed by Ryan and Poster (1989).

Appendix R: DIAGNOSTIC CRITERIA FOR Posttraumatic Stress Disorder (American Psychiatric Association, 2000. p. 467-468).

Diagnostic criteria for **309.81** Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

    1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

    2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

    1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

    2. recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

    3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

    4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

    5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

    1. efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. efforts to avoid activities, places, or people that arouse recollections of the trauma

3. inability to recall an important aspect of the trauma

4. markedly diminished interest or participation in significant activities

5. feeling of detachment or estrangement from others

6. restricted range of affect (e.g., unable to have loving feelings)

7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. difficulty falling or staying asleep

2. irritability or outbursts of anger

3. difficulty concentrating

4. hypervigilance

5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.